Discovery
Health Medical Scheme

INTEGRATED ANNUAL REPORT 2018

WE EXIST FOR OUR MEMBERS

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

This is how we define value.

Discovery Health Medical Scheme registration number 1125

Discovery
Health Medical Scheme

NAVIGATING OUR REPORT

THIS REPORT IS BEST VIEWED IN ADOBE ACROBAT FOR DESKTOP, MOBILE OR TABLET*.

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This is an interactive report. Navigation tools at the top right of each page and within the report are indicated below.

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

IN THIS REPORT

Our Integrated Report demonstrates, both in our aspirations and in our performance, the accountability of the Board of Trustees of Discovery Health Medical Scheme to our members and to the Scheme's other stakeholders.

This Report provides an overview of Discovery Health Medical Scheme (DHMS or the Scheme), 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. With increasing economic pressure on our members and above-inflation increases in healthcare costs, this Report sets out the Scheme's efforts to balance the needs and expectations of our stakeholders: achieving this balance underpins the Scheme's financial and operational sustainability. As the largest open medical scheme in South Africa, this in turn supports the overall capacity and viability of the private healthcare sector.

Board of Trustees responsibilities and approval

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

The Trustees are satisfied that this Report complies with the requirements of the Medical Schemes Act 131 of 1998, as amended, the Scheme Rules, International Financial Reporting Standards, and all additional financial reporting requirements of the Council for Medical Schemes.

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

Signed on behalf of the Trustees

Neil Morrison
Chairperson

J Human
Trustee

Dr Nozipho Sangweni
Principal Officer

01 ABOUT OUR REPORT

01

SCOPE AND BOUNDARY

This Report covers the benefit year from 1 January 2018 to 31 December 2018, also referred to as the 2018 financial year (the year). In addition, this Report touches on some events in early 2019 that occurred prior to the date of approval of this Report by the Trustees, and contains some forward-looking information.

This Report takes guidance from the King IV Report on Corporate Governance for South Africa 2016 (King IV). The Scheme uses the International Integrated Reporting Framework as the basis for preparing and improving its reporting, and applies it insofar as it is relevant and applicable to medical schemes in South Africa.

The Report discusses how we manage our relationships and our resources responsibly. The boundary of the report therefore includes our interactions with entities outside the organisation that underpin our ability to create value for our members and other stakeholders.

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

The terms 'the Scheme', 'DHMS', 'we' and 'our' refer to Discovery Health Medical Scheme. The terms 'Discovery Health' and '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 our members and ensure the sustainability of the Scheme over time, and that these matters are effectively managed. The Trustees review material matters formally on an annual basis.

The Trustees scan the broader 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 is also considered, both formal (stakeholder engagement activities) and informal (emails and calls to the Scheme). The Trustees ensure that the Scheme's strategic objectives are adapted, where appropriate, to ensure that all material matters are considered in implementing the Scheme's strategy.

COMBINED ASSURANCE

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

- **First line:** Scheme management provides the Trustees with assurance that risk management is integrated into the day-to-day running of the Scheme and that it is monitored on an ongoing basis.
- **Second line:** the outsourced Group Risk Management, Compliance, and Forensics functions assess the effectiveness of the Scheme's internal control and risk management processes.
- **Third line:** 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 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. Rotation of the designated partner forms part of the independence assessment. The Audit Committee is satisfied that the auditor is independent of the Scheme.

Details of fees paid to the external auditors for audit and non-audit services are included in the 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.

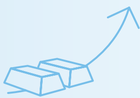
Who we are

Discovery Health Medical Scheme (the Scheme or DHMS) is a registered open medical scheme which any member of the public can join, subject to the Scheme Rules.

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, value-based healthcare that meets their needs now and sustainably into the future.

COVERING
2 819 139
BENEFICIARIES
at 31 December 2018

DHMS IS THE
LARGEST OPEN MEDICAL SCHEME
in South Africa



WITH AN OPEN MEDICAL SCHEME
MARKET SHARE OF
56.6%[1]

02 ABOUT DHMS

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

The Scheme outsources its administration and managed care functions through a formal contractual arrangement with Discovery Health (Pty) Ltd.

1 *Based on beneficiaries, according to the Council for Medical Schemes Quarterly Reports for the period ending 30 September 2018 (www.medicalschemes.com/Publications.aspx).*
2 *Medical Schemes Act 131 of 1998, as amended.*

02

WHY JOIN DHMS?

Quality of care is key to our membership proposition

One of the Scheme's key strategic priorities is to drive value-based healthcare. This delivery model places members at the centre of care and ensures that providers are reimbursed based on health outcomes, not inputs. This ensures that it is the health results that matter, not the volume of services delivered. This approach gives our members access to programmes and providers that are committed to continuous improvement in quality healthcare.

Through Discovery Health, the Scheme is deeply engaged in many quality of care initiatives and ongoing monitoring to ensure 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.

We make sure your investment in membership takes care of you

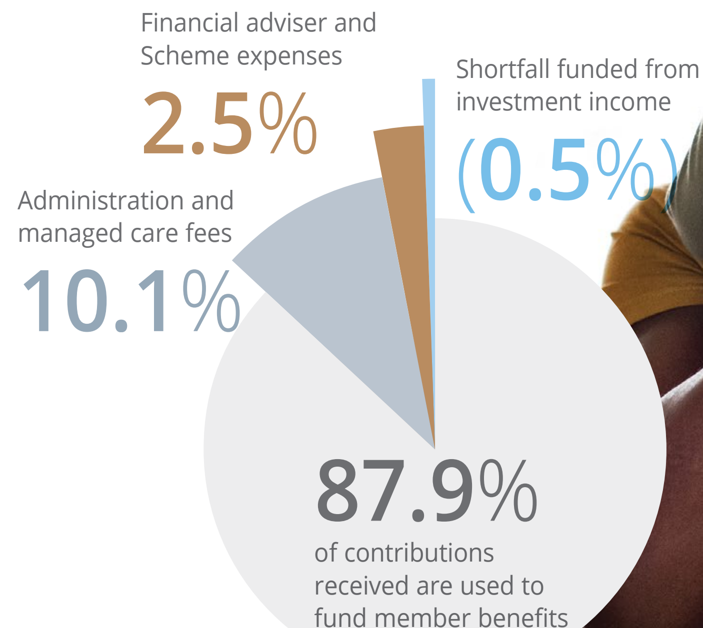
The Scheme's income is only derived from member contributions and investment returns. The Scheme pools all members' contributions to fund members' claims, and any surplus funds are transferred to Scheme reserves for the security and benefit of members.

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

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

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

2018 DHMS EXPENSE BREAKDOWN*



* As a percentage of contributions received.

02

Pricing is a function of balancing a number of factors while keeping contributions affordable... we strive to ensure a seamless integration of services, quality of care for members, and cost efficiency in the context of a fragmented healthcare system.

OUR OPERATING CONTEXT

The CMS was established through the Act to regulate registered medical schemes and to protect the interests of scheme members, among other objectives.

The registration of medical schemes is subject to compliance with the provisions of the Act and the promotion of public interest.

The CMS is responsible for ensuring that:

- Members of the boards of trustees and principal officers are fit and proper[1]
- Medical schemes are financially sound, with a sufficient number of members who contribute to the scheme
- Schemes do not unfairly discriminate against any person on arbitrary grounds

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

The CMS 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. All fees paid by medical schemes to financial advisers are prescribed by the Minister of Health.

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 while keeping contributions affordable. These factors include holding sufficient reserves to weather times of economic difficulty and unexpected claims, making provision for increased utilisation of healthcare services and escalation in the cost of treatment, optimising benefits, and ensuring equitable treatment of all scheme members.

Pricing is further negatively impacted by an incomplete regulatory framework. Medical schemes operate under principles of social solidarity: schemes must accept all members who wish to join; members are community risk rated so there is no differentiation of pricing based on, for example, the status of individuals' health; and members' funds are pooled to provide healthcare funding for members in an equitable manner. However, other key elements of a social solidarity framework such as mandatory membership and risk equalisation have not been implemented.

At the end of 2017 there were 80 medical schemes registered with the CMS, consisting of 21 open schemes and 59 restricted schemes, covering over 8 872 000 beneficiaries. These schemes paid out approximately R160.5 billion in total healthcare benefits[2] in 2017 (2016: R151.2 billion). The average age of scheme members in 2017 increased by 0.7 years to 33.2 from 32.5 in 2016, and the proportion of pensioners increased to 8.4% from 7.9%[3]. Aging scheme membership and stagnant membership growth, reflecting economic and demograpic trends, are factors that have been evident over a number of years, with negative implications for cross-subsidisation within scheme risk pools.

DHMS acknowledges the important part we play in South African society and our responsibility as a corporate citizen, given our significant share of the open schemes market of 56.6%[4]. Through our Administrator and Managed Care Provider, Discovery Health, and in partnering with healthcare providers, we strive to ensure a seamless integration of services, quality of care for members, and cost efficiency in the context of a fragmented healthcare system. Fragmentation of healthcare has a significant impact on member health outcomes as healthcare providers frequently operate in silos, and therefore experience barriers to health information, difficulty navigating the healthcare system and lack of care co-ordination for patients across disciplines and processes.

The Scheme works closely with regulatory authorities as necessary. Engagements in the past few years related to Prescribed Minimum Benefit (PMB) reforms by the CMS, proposed amendments to the Medical Schemes Act, developments around National Health Insurance (NHI) and the Competition Commission's Health Market Inquiry (HMI) into private healthcare in South Africa.

1 *The CMS undertakes its own process of vetting trustees and principal officers; this is in addition to the process undertaken by DHMS's Nomination Committee.*
2 *Total healthcare benefits paid refers to the sum of the benefits paid from both the risk pools of medical schemes and the savings accounts of members.*
3 *Source for industry information: CMS Annual Report 2017–2018 (www.medicalschemes.com/Publications.aspx), which does not include data for 2018.*
4 *Based on beneficiaries, according to the Council for Medical Schemes Quarterly Reports for the Period ending 30 September 2018 (www.medicalschemes.com/Publications.aspx).*

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

Our material matters are informed by our risks, opportunities and strategic objectives, and the key concerns of our members and other stakeholders. With careful management, our material matters present opportunities for the Scheme to create value for our members, differentiate our service offering, protect our leading market position and enhance our reputation – all of which contribute to the Scheme's long-term sustainability.

We exist for our members, which puts member health and wellness at the heart of what is most important for the Scheme. To ensure that we can continue to fund the healthcare needs of our members, Scheme sustainability and healthcare affordability must be maintained in a challenging economic climate, influenced by healthcare system reform and also a number of drivers of healthcare inflation, including demand and supply side factors, as well as elements of fraud, waste and abuse.

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

OUR MATERIAL MATTERS

Member health and wellness

- A fragmented healthcare system that results in variable quality of care and compromises the provision of patient-centric care.
- High levels of utilisation and increasing costs, together with South Africa's high burden of communicable and lifestyle diseases, and an ageing population.
- Promoting a patient-centred healthcare model and ensuring knowledgeable and empowered members.

Scheme sustainability and healthcare affordability in a challenging economic climate

- Slow economic growth and rising unemployment exacerbated by retrenchments by employer groups.
- Affordability constraints with limited resources that threaten medical scheme sustainability, potentially increasing the burden on the public healthcare system.

Healthcare system reform

- Incomplete implementation of social solidarity principles contributing to inflation and reducing access to healthcare.
- Relevance and equitability in a complex regulatory environment.

Ethical business and stakeholder engagement

- Heightening awareness and increasing environmental scanning with a focus on proactive and inclusive stakeholder engagement.
- Focusing on ethical leadership, fairness and social responsibility to the benefit of society.
- Mitigating the impact of any lack of governance and controls in the broader business and political environment.
- Misperceptions of the true nature and context of the Scheme by stakeholders, which may constrain the achievement of strategic objectives.

The Vested® outsourcing model

- Sustaining and optimising the model to ensure that best value is obtained from the Administrator and Managed Care Provider.
- Pursuing excellence, opportunities for positive industry disruption and innovation for the benefit of members.

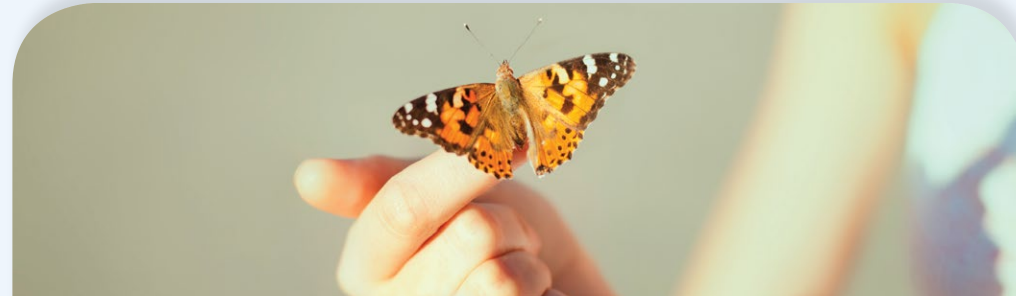
02

OUR BUSINESS MODEL

The Scheme exists for the benefit of our members.

Sustaining the Scheme's financial, operational and reputational wellbeing ensures our ability to continue funding quality healthcare for individual members, which requires equitable consideration of the interests of our whole membership base. As a funder that connects our members into the private healthcare value chain, the quality of our relationships with all our stakeholders is essential to how we create sustainable value for our members in line with our purpose, and to realising our vision of market leadership in a better healthcare system.

The business model diagram shown on these four pages depicts our material capital inputs (excluding manufactured and natural capital as they are not core to the nature of our business) and the value outcomes of our propositions to each of our key stakeholder groups, which in turn secure affordable access to the inputs to our business model.



CAPITAL **INPUTS**

The most relevant relationships and resources we need to create value through our business activities

FINANCIAL CAPITAL

- Member contributions of **R64.6 billion** (2017: R59.7 billion)
- Investment income of R1 465 million (2017: R1 433 million) generated from members' funds of **R17.6 billion** (2017: R16.7 billion)

SOCIAL AND RELATIONSHIP CAPITAL

- Maintaining our social licence to operate in the best interests of our members
- Retaining and attracting a demographically balanced membership base
- Maintaining collaborative partnerships with all of our stakeholders
- Balancing our oversight role and the constructive collaboration with our Vested outsource partner and other suppliers that defines how we operate
- Reputation as a stable and accessible medical scheme with integrity
- Reputation as a responsible and involved corporate citizen
- Supporting healthcare reform towards an effective and equitable healthcare system

HUMAN AND INTELLECTUAL CAPITAL

- Balanced, knowledgeable, independent Board of Trustees accountable for effective oversight and delivery against the Scheme's mandate
- Mature governance framework and structures
- Effective and efficient operating model with optimised outsourcing
- Management team with appropriate capability and capacity, enabled by a culture of continuous learning and improvement
- Values-based behaviour that conforms to the highest ethical standards

BUSINESS **ACTIVITIES**

Our service offering as a centre of medical scheme excellence

The Scheme's business is to enable funding for and access to quality, affordable healthcare for our members. The Scheme Office manages the Scheme's resources and connects and coordinates the stakeholder relationships that give effect to the operational life of the Scheme and the work outsourced to Discovery Health.

The Scheme Office provides best practice governance and thought leadership, with a specific focus on:

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

ACTIVITIES SUPPORTING EXCELLENCE

CONTINUOUS IMPROVEMENT AND LEARNING

SET STANDARDS FOR EXCELLENCE

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

EXECUTE FOR EXCELLENCE

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

MONITOR AND REPORT FOR EXCELLENCE

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

EVALUATE AND REFINE FOR EXCELLENCE

- Standards
- Execution requirements

VALUE OUTCOMES

Value created for our key stakeholders through our business activities

MEMBERS AND EMPLOYER GROUPS

The Scheme provides members and their families the ability to access healthcare at every stage of their lives. One of our key strategic priorities is to drive value-based healthcare, giving our members access to programmes and providers that are committed to continuous improvement in quality healthcare.

QUALITY OF CARE

- Better health outcomes achieved through a value-based approach to partnering with providers

SUSTAINABILITY

- Largest open medical scheme, with **2 819 139** beneficiaries and **56.6%** market share.
- Favourable demographics, with an average age of **34.6** and a pensioner ratio of **9.3%** (versus an average age and pensioner ratio of 35.3 and 10.8% across all other open medical schemes)[1].
- Financial strength, with **R17.6 billion** in member funds, **27.3%** solvency level, and an AAA credit rating highlighting the Scheme's ability to meet large, unexpected claim variations.

PLAN RANGE

- **23** plan options, providing members with sufficient choice to meet their medical and financial needs.

AFFORDABILITY

- Average contributions **16.5%** lower than the next eight largest open medical schemes.

VALUE OF BENEFITS[2]

On average, **R1 532** per beneficiary collected in risk contributions each month. Members receive substantial value in terms of their healthcare benefits, when they need to claim.

The largest hospital claim made would require 210 years of contributions by the member to cover that single claim.

- **R58.4 billion** paid in claims including, on average:
  - **R4 764** per beneficiary with a chronic condition (682 187 beneficiaries)
  - **R43 057** per admission (671 016 hospital admissions)
  - **R96 096** per beneficiary undergoing oncology treatment (36 783 beneficiaries).
- **16.3%** of beneficiaries claiming more than their contributions.

SERVICE

- Member perception score of **8.78** out of 10.
- Ask Afrika Orange Index winner of the medical aid category for the highest service score.

DIGITAL CAPABILITIES[3]

- The member app gives members easy access to all their health plan information, with the added value of providing seamless access to high quality medical information via Dr Connect. 367 430 members have downloaded the app, and there are 8 230 unique member logins to the app each month.
- HealthID, the only comprehensive payor electronic health record in South Africa, allows members to consent to the sharing of their health records with their doctors, improving quality of care and reducing the administration burden for doctors. 2 025 doctors regularly use HealthID in treating DHMS members, and 1.98 million members have given consent to their doctors to access their records on HealthID.

FINANCIAL ADVISERS

Financial advisers play a critical role in connecting the Scheme to existing and prospective members, and ensuring that their cover is best suited to their health and affordability needs. The Scheme reimburses them for their services according to legislated fees and provides ongoing training and support through Discovery Health.

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. The Scheme is a diverse workplace with a focus on transformation. Employees' satisfaction with the value proposition the Scheme offers as an employer is regularly assessed.

REGULATORY BODIES

Maintaining constructive relationships with industry 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 relevant authorities.

1 *Source: CMS Annual Report 2017–2018; values are for 2017.*
2 *Note: All figures for the period October 2017 to September 2018, with the exception of the number of DHMS members with a chronic condition and number of DHMS members undergoing oncology treatment, where the figures are as at September 2018.*
3 *For members of all schemes administered by Discovery Health.*

VALUE **OUTCOMES** *continued*

ADMINISTRATOR AND MANAGED CARE PROVIDER

The Vested model focuses on outcomes for the ultimate benefit of our members. Discovery Health is a global leader in healthcare administration and managed care, with a strong reputation for excellent service and innovation. This contractual relationship has allowed DHMS to become the largest open medical scheme in South Africa. Measured against our competitors:

- High efficiency resulted in 87.9% of contributions used for members' direct benefit (2017: 86.0%).
- DHMS gross administration expenditure is the sixth lowest out of 21 schemes in the open scheme market (2017: sixth lowest).
- **94.24%** of members did not change their plan in 2018 (2017: 93.86%), reflecting member satisfaction, stability in benefit design and appropriate pricing.

HEALTHCARE PROVIDERS AND FACILITIES

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

HEALTHCARE SYSTEM

We work with relevant stakeholders and advocate for greater effectiveness in the healthcare system and regulatory reform, including contributing towards health policy and legislation amendments proposed by the Department of Health and CMS, to drive positive change in the healthcare sector.

SOCIETY

Private healthcare financing inherently benefits society by ensuring that individuals have access to needed healthcare and by protecting individuals and organisations from adverse effects. The Scheme seeks to amplify these benefits by delivering an integrated value-driven healthcare system.

02

MITIGATING OUR RESIDUAL RISKS

The Scheme constantly scans the internal and external environment to assess risks and opportunities emanating from the triple context of economy, society and the environment, and in relation to the capitals that the Scheme uses and affects in conducting its business.

Risks are assessed according to the Scheme's Board-approved enterprise risk management framework as well as the risk appetite framework and statement, and rated according to impact and likelihood on a five-point scale of low to catastrophic. The assessment includes the organisation's dependence on resources and relationships represented by the various forms of capital. The assessment process not only identifies the risks which have the potential to negatively affect organisational objectives, but also the opportunities made available by the effective management of these risks.

Risk responses and mitigation plans are put into place and monitored by the Scheme Office, with regular reporting to the Risk Committee, which oversees Scheme risk management, to other Board Committees where relevant, and to the Board. High and medium-high residual risks and their mitigation strategies are described alongside. DHMS currently has no catastrophic risks.

AFFORDABILITY OF CONTRIBUTIONS AND MEDICAL INFLATION

The risk that contributions to the Scheme become unaffordable in the long term due to the impact of demand-side factors (such as age, gender, chronic status and anti-selective behaviour) and/or supply-side factors (such as technology and provider-driven increases in utilisation), as well as fraud, waste and abuse, which drive above-inflation increases to healthcare costs.

- Each year, the Trustees critically assess the benefit plans offered by the Scheme to ensure that the full spectrum of member needs are met, within the bounds of affordability and sustainability. The Trustees also satisfy themselves that value for money is obtained from Discovery Health, as well as from providers and suppliers.
- Risk management interventions are implemented by Discovery Health on behalf of DHMS. These include close management of hospital admissions, sophisticated fraud prevention and recovery services, clinical funding policy design and implementation, extending quality-based networks and implementing innovative value-based contracting and reimbursement mechanisms.
- Attracting and retaining members who enable effective cross-subsidisation, in keeping with the social solidarity principles according to which the Scheme operates is a priority.

COMPLIANCE

The risk of being assessed as not completely compliant with laws, regulations, rules and related self-regulated Scheme standards and codes of conduct, as well as the failure to uphold the Scheme's core values and codes. This may impact on the Scheme's ability to operate effectively and efficiently.

- Operating in a highly regulated environment requires extensive controls to ensure ongoing compliance with complex legislated obligations. DHMS has an acute focus on ensuring compliance in all areas and has implemented appropriate operational, oversight and assurance processes.

Mitigating our residual risks *continued*

INFORMATION AND CYBER

The risk of data leakage or loss, financial loss and business disruption, including the integrity and availability of information assets and personal information.

- DHMS zealously protects Scheme information, particularly the personal information of our members.
- Cyber and information risk is closely monitored by the IT Governance Forum, consisting of representatives from the Scheme Office and the Administrator, with regular reviews performed on controls and their effectiveness.

REGULATORY CHANGE AND CHALLENGES

The risk that changes in the regulatory environment may have an adverse impact on the operations, competitive advantage, strategy and sustainability of the Scheme. This includes the challenge of navigating a potentially contradictory or incomplete regulatory environment, with reforms currently underway potentially influencing changes to the structure and operating requirements of the medical schemes industry.

- Regular, detailed and proactive engagement with relevant regulators at all stages of the regulatory change process.

STAKEHOLDER MANAGEMENT

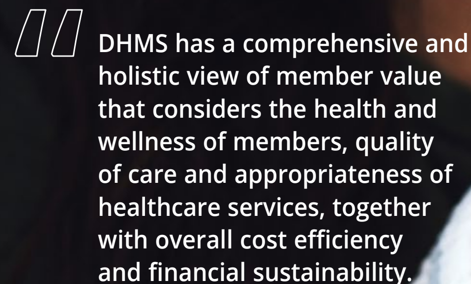
The risk of inadequate stakeholder engagement and management, resulting in harm to the Scheme's ability to perform optimally and its reputation in the eyes of members and other key stakeholders, which may impact on sustainability.

- Engaging proactively and frequently with all stakeholder groups to obtain increased understanding and alignment. Effective engagement is overseen by a dedicated Board Committee.
- The Trustees embrace the Treating Customers Fairly (TCF) principles and framework, and receive regular reports on the performance of Discovery Health on key TCF fairness indicators, as well as other engagements conducted.
- The Scheme conducts ongoing environmental scanning to identify possible risks related to our key stakeholders and develops or amends strategies to deal effectively with these.
- The Scheme proactively shares evidence-based information with stakeholders to educate them with regards to their healthcare needs, best means of access to healthcare, awareness of quality outcomes, regulatory changes, and the non-profit status of the Scheme.

02

OUR STRATEGIC THEMES

To ensure the long-term sustainability of the Scheme, it is essential that internal and external factors and material risks are constantly reviewed and considered.



While these considerations require that the Scheme's strategy evolves over time, its development is always guided by our purpose and vision. In this respect, DHMS formulates its strategy to be responsive to the operating environment and the needs of its members and other stakeholders.

DHMS has a comprehensive and holistic view of member value that considers the health and wellness of members, quality of care and appropriateness of healthcare services, together with overall cost efficiency and financial sustainability. The Scheme's overarching goal is to optimise member value.

The Scheme has only two sources of financial capital available to it: member contributions and returns on the investment of member funds. This limitation requires a careful balancing of the resources required to meet our objectives and meeting the long-term financial sustainability and solvency requirements of the CMS.

DHMS has a fiduciary obligation to maximise investment returns while having due regard for associated risks; thus, considering issues that can impact the longer-term sustainability of investment performance is important. In this regard, the Trustees have adopted a framework for responsible investment that includes both strategic and tactical elements and is cognisant of legislative requirements.

A formal strategy planning session is held annually, where the Trustees and Scheme Office closely review material matters and discuss the Scheme's overall long-term strategy and strategic objectives for the coming year. High-level objectives are broken down into work streams, with key performance indicators set to measure progress and assess outcomes. The work streams are not necessarily tied to a specific benefit year, and may be carried over several years depending on the complexity of the objectives.

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

The Scheme Office applies a performance management strategy that requires strategic, structural, values and cultural alignment for employees to attain their overall performance targets. Reward structures are designed to reward excellence in performance and foster an environment of continuous learning and development.

The strategic themes discussed in our 2017 Integrated Report have largely been retained and are forward looking to 2019, but their details have been amended in line with Scheme priorities and current environmental factors.

Our strategic themes respond to our material matters and in their execution mitigate our various risks.

02

PERFORMANCE

AGAINST OUR STRATEGIC THEMES IN 2018

SUPERIOR QUALITY OF CARE FOR MEMBERS

- Key longer-term strategies for DHMS are to
  - **Drive value-based healthcare** with initiatives introduced during 2018 including a value-based multiplier that gives contracted general practitioners the opportunity to earn an additional fee for achieving selected quality metrics in their practices.
  - **Develop new clinical governance programmes** incorporating peer review mechanisms and alternative reimbursement models, which included the Hip and Knee Arthroplasty Network implemented during 2018, and concluding the relevant engagements with SASOG[1] and GMG[2] for the obstetric governance project to be implemented in 2019.
  - **Expand disease management programmes** with the HIVCare programme and Designated Service Provider (DSP) network for lower-end benefit plans implemented during 2018.
- DHMS and Discovery Health continue to test and refine supply side re-engineering models through pilot projects in partnership with providers, designed to promote the provision of care by multi-disciplinary teams, with better coordination and outcomes-based reimbursement.

LOWEST HEALTHCARE COSTS

- For 2019, the average contribution of a Scheme member was 16.5% lower[3] (2018: 16.4% lower) than the next eight largest open schemes for comparable plan types.
- The Scheme monitors claims cost drivers, utilisation and clinical risks on an ongoing basis, and we leverage our scale and Discovery Health's analytics capability to identify risks early and respond quickly.
- In 2018, various risk mitigation strategies yielded positive results, including interventions directed at inefficient hospitals and health professionals, careful management of hospital admissions, fraud prevention and recoveries, and price negotiations with pharmaceutical and surgical device companies.

PERSONALISED, PREDICTIVE AND PREVENTATIVE APPROACH

- The Scheme ensures that our range of plans allow sufficient choice to our members, and we continue to optimise benefits and plan design.
- We offer extensive preventative and health screening benefits.
- Our members may elect to join Vitality[4], a world-leading science-based wellness programme. Ongoing monitoring of the impact of the various wellness activities and interventions are reported to the Clinical Governance and Non-healthcare Expenses Committees.

MEMBER-CENTRIC SERVICING

- Discovery Health's strong focus on service excellence and peace of mind for members is measured using metrics such as member perception, first call resolution and service levels. In 2018, the average member perception score was 8.78 out of 10 (2017: 8.81[5]).
- The member experience on the website, app and call centre was enhanced with various improvements made during the year.
- Discovery Health continues, on behalf of DHMS, to implement new digital and other technologies to enhance members' experience and engage them in their healthcare. Dr Connect was introduced in 2017 and uptake and platform activity has increased significantly.

  Dr Connect is:
  - An information platform for doctors and members, providing access to a database of 6.5 billion curated medical questions and allowing members to ask questions of a network of over 108 000 doctors internationally.
  - Available at no charge to our members through their smartphones and the website, and to doctors via HealthID.
  - Member and doctor engagement on the platform increased significantly during 2018, with 372 525 members registered by January 2019, asking an average of about 1 000 health questions and conducting an average of 300 virtual consultations monthly.

1 The South African Society of Obstetricians and Gynaecologists

2 The Gynaecology Management Group

3 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 dependant and one child dependant (i.e. a family of three). These average contributions are then weighted (for DHMS and the next eight largest open schemes) according to the distribution of members across DHMS plans. This ensures that plans with similar benefits are being compared on a like-for-like basis, thereby providing a reasonable estimate of the lower contribution that a typical member of DHMS pays relative to members of similar options in competitor schemes.

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

5 These results differ from those reported in the 2017 Integrated Report, due to a change in methodology. As services inevitably grow or change, we have to constantly ensure that each metric still measures the right outcome. Member perceptions are measured after a variety of interactions, for example joining the Scheme, claiming, or through a telephonic or written interaction with us. Prior to the change in methodology, the score included perception ratings for the billing function (which is more relevant to employer groups than individual members) and ratings of member lounge visits. Ratings for the latter service were generally very high, but the sample was not significant enough to have a weighting in such an important metric. These two scores have now been removed from the overall member perception calculation and the new methodology applied retrospectively to obtain the 2017 score.

The Scheme and Discovery Health constantly analyse the causes of changes in member perception in order to address member concerns and barriers.

02

Performance against our strategic themes in 2018 *continued*

EXCELLENT GOVERNANCE

- During 2018, the Scheme continued to embed King IV requirements into our governance structures and processes. We obtained an independent external assessment of our progress and will address identified gaps.
- To ensure a balance between Board independence and retention of institutional knowledge, the terms that Independent Board Committee members may serve has been set at three years with the possibility of subsequent re-appointment, limited to no more than two consecutive terms. This is consistent with the term that a Trustee may serve.
- An enterprise-wide ethics risk assessment, which will include all executives in the DHMS office and significant numbers of Discovery Health staff across all levels of management, was designed in 2018 for implementation in 2019.
- In 2018, Deloitte conducted an independent review of the Scheme's relational governance practices. The results of this review indicated that significant progress to ensure proper governance and governance structures has been made since 2013.

BEST PRACTICE OUTSOURCING AND A FOCUS ON INNOVATION

- The Scheme introduced Innovation and Relationship Management Committees to further optimise the working relationship with Discovery Health.
- The 2018 assessment of the value added by Discovery Health for the Scheme and its members showed that in 2017, for every R1.00 the Scheme spent on administration and managed care services, R2.02 of value was added by Discovery Health (2016: R2.00).

STAKEHOLDER ENGAGEMENT

- The Scheme engages with all our stakeholders on an ongoing basis.
- In 2018 the Medical Schemes Amendment Bill, the draft NHI Bill and the HMI's Provisional Report were published. The Scheme undertook extensive work to review and respond to these in a constructive manner towards overall healthcare system improvements.
- The Scheme continued to participate actively in the HMI process, and engaged regularly with the CMS.
- Stakeholder engagement work undertaken by Discovery Health on the Scheme's behalf, for example to negotiate alternative reimbursement arrangements for value-based care, continues to be overseen by the Scheme Office and relevant Board Committees.

FINANCIAL PERFORMANCE

- The Scheme aims to maintain solvency above 25% and achieved this throughout 2018, with a year end solvency of 27.3%.
- The Scheme delivered a negative net healthcare result (contribution income less claims and all other Scheme expenses) of R352 million for the year ended 31 December 2018 (2017: positive healthcare result of R968 million). The year-on-year reduction in the result was mainly attributable to the impact of the VAT increase, as well as to higher claims costs due to increased utilisation of in-hospital and out-of-hospital health services over the period. In the absence of the VAT increase, the Scheme would have had a break-even net healthcare result for 2018.
- The Scheme manages our diversified investment portfolio across a number of asset classes to optimise investment returns within our Board-approved risk appetite.
- The Scheme earned a gross investment return of 5.85% for 2018 (2017: 10.00%), outperforming its strategic benchmark.

02

HOW WE OPERATE

The Scheme Office as a centre of medical scheme excellence

The Scheme's operating model centres on delivering excellence in our core activities, which are primarily effective medical schemes governance and oversight.

The Scheme has defined an operating model, with the help of external experts, to ensure effectiveness and efficiency in fulfilling our purpose and realising our vision.

THE KEY COMPONENTS OF THE OPERATING MODEL ARE:

A delivery model that is closely aligned to the Scheme Office's role within the healthcare value chain, being that of a centre of excellence.

An organisational design that supports excellence in thought leadership, governance and oversight – as separate and distinct from administration and healthcare services – through exceptional people, for the ultimate benefit of the Scheme's members.

Efficient processes that are iterative, self-reinforcing and interdependent, underpinned by a culture of learning that acts as a catalyst for excellence in all areas of the business.

The sector leadership contemplated in our vision is served by not only satisfying the needs of our members and other stakeholders, but by exceeding them. To this extent, the Scheme endeavours to be first to market with effective value-based healthcare innovations, and to ensure services and products of a consistently high standard. This is achieved through the Vested outsourcing model (Vested model) with Discovery Health.

Delivering value through an integrated provider model

In accordance with the Act and the Scheme Rules, the Trustees appoint an accredited administrator and managed care provider to provide such services to the Scheme.

DHMS purchases these services from a single provider, Discovery Health, as the Trustees believe that an integrated model (as opposed to a fragmented model, where multiple service providers are utilised) delivers optimal efficiency and value to Scheme members. The Trustees believe that this gives us access, as an open scheme, to the best administrator in the sector.

Administration and managed care agreements specify defined and measured outcomes expected of Discovery Health. Performance management is effected through service level agreements (SLAs) that are strictly adhered to and reported on, and that set out the expected level of performance across a wide range of key operational measures. Discovery Health reports formally to the Scheme on contractually agreed key performance indicators on a monthly, quarterly and annual basis. In addition, any operational or strategic concerns are raised with the Scheme Office.

In 2018, Deloitte conducted an independent review of the Scheme's relational governance practices. This was an update from a review originally conducted in 2013.

The review assessed the relationship between DHMS and Discovery Health, and critically evaluated the nature of this relationship against local and international governance and legal best practice requirements and the ability to meet members' needs.

The results of this review indicated that significant progress to ensure proper governance and governance structures, when measured against King IV, commercial best practice and the Medical Schemes Act No. 131 of 1998, has been made since 2013. Improvements include increased Scheme Office governance capacity, with an operating model that allows DHMS to work more efficiently with Discovery Health; and substantial improvements in agreements and reporting frameworks which differentiate and draw clear lines of independence between the two organisations.

WHAT THIS MEANS FOR OUR MEMBERS

These detailed agreements are in place to ensure the best value is provided for Scheme members, with performance managed against SLAs.

Members are assured through independent assessments of our governance and outsourcing practices that DHMS is one of the best schemes in the industry.

An outcomes-driven approach to creating value

The working relationship between the Scheme and Discovery Health, governed by the Vested model, is operationalised by Innovation and Relationship Committees whose mandate is to monitor, review and improve the relationship and the innovation work that the model promotes.

The Vested model aligns the transactional and relational governance elements of this relationship with global best outsourcing practice.

A Vested outsourcing agreement is characterised by:

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

The integrated model described on the previous page, together with Vested, also encourages Discovery Health to invest in innovation and new technologies as there is an added certainty in terms of the commercial arrangements and scope of the agreement. This means that both organisations can take a long-term view to effecting positive changes to the healthcare system, and in turn providing outstanding value to our members.

The Vested principles strengthen the strategic alignment between organisations and encourage a value-driven relationship. In effect, Vested 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.

The Vested model recognises and embeds the Scheme's independence through robust governance arrangements, while allowing it to leverage Discovery Health's considerable knowledge, expertise, systems, innovation and value-added services in the best interests of the Scheme and our members.

WHAT THIS MEANS FOR OUR MEMBERS

The improved outcomes from the Vested model are seen in the following tangible results:

- An unmatched record of innovation.
- High levels of member satisfaction.
- Focused clinical risk management solutions resulting in significant claims cost reduction, enhancing the sustainability of the Scheme.
- Investment in market leading technology to enable efficiencies in healthcare delivery and member experience.
- Improved stakeholder relations.
- Improved outsourcing governance ensuring that the Scheme can measure and report on the performance of and value provided by the Administrator and Managed Care Provider.
- High assurance on risk management and controls.
- Continued excellent Scheme performance across all key metrics, including financial performance, forensics savings, membership growth and average age, ensuring sustainability.

Value for money provided by Discovery Health

The Trustees conduct a formal evaluation of the value for money provided by Discovery Health to the Scheme every year.

A pragmatic and replicable methodology for measuring the value added by Discovery Health has been applied since 2014, and the latest results were reported to the Trustees. The assessment takes account of value added from providing basic administration services, managing claims costs, making members healthier, attracting and retaining members, any additional services offered, and innovation.

The Scheme engaged Deloitte to review the reasonability of the data, revised methodology and results. Deloitte concluded that the methodology is appropriate, that the increase in value added from 2016 to 2017 is reasonable, and that they did not encounter any significant anomalies in the data and calculations reviewed.

2017:	2016:	2015:	2014:
R2.02[1]	**R2.00**	**R1.85**	**R1.73**

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 members receive more value than has been paid on their behalf. In other words, for every R1.00 spent by DHMS on administration and managed care fees in 2017, members of DHMS received R2.02 (2016: R2.00) in value from the activities of Discovery Health. This is equivalent to nominal added value of R6.24 billion in 2017 (2016: R5.56 billion).

WHAT THIS MEANS FOR OUR MEMBERS

Our members are better off when the Administrator and Managed Care Provider adds more value than the fees paid to it by the Scheme. The value for money that Discovery Health provides plays out in many ways for members, from access to highly effective managed care programmes, innovative provider networks, a wide range of benefit plans, and a significant difference in contribution costs: for 2019, members pay an average of 16.6%[2] less than they would at the next eight largest open schemes.

Nominal value added by Discovery Health was R6.24 billion in 2017.

1 *As the assessment uses industry information, results are only available for the preceding year.*
2 *To ascertain the contribution differential between DHMS and competitors, we calculate an average contribution within each plan category for a family unit comprising one principal member, one adult dependant and one child dependant (i.e. a family of three). These average contributions are then weighted (for DHMS and the next eight largest open schemes) according to the distribution of members across DHMS plans. This ensures that plans with similar benefits are being compared on a like-for-like basis, thereby providing a reasonable estimate of the lower contribution that a typical member of DHMS pays relative to members of similar options in competitor schemes*

Discovery Health's initiatives for the Scheme

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

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

Ongoing investments in digital innovation and a significant focus on improving value in healthcare through efficiency and quality care helps ensure better health outcomes, while maintaining extensive care, support and the latest medical technologies for where and when members need it most.

DHMS's full spectrum of plan options enables the Scheme to offer members excellent value for money, and the comprehensive and integrated wellness offering helps members to understand and improve their health. The downstream impact of these initiatives is manifested in lower costs for the Scheme and improved quality of care for members.

Discovery Health's business model: shared value health insurance

Discovery Health shares DHMS's vision to deliver an integrated value-driven healthcare system, which is centred on meeting the needs of Scheme members and delivering access to the best quality care at outstanding value. This vision is realised through a pioneering shared value healthcare model that incentivises people to be healthier, and actively manages healthcare claims costs, which generates increased growth and sustainability. It also incentivises healthcare professionals through value-based contracting with an emphasis on quality of care. Ultimately, share value healthcare leads to a healthier society.

Giving life to shared value

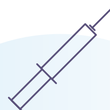
Discovery Health's approach to improving the healthcare system through shared value means making innovative initiatives available to stakeholders:

CO-ORDINATED DISEASE AND CARE MANAGEMENT

HOMECARE

Enables a quality out of hospital experience in the comfort of the member's home.

Read more



DIABETESCARE

Provides incentives and technology to ensure more effective treatment of members diagnosed with diabetes.

Read more

CADCARE

Reduces risk and cost for members in cardiac care.

Read more

KIDNEYCARE

Provides educational insights, analytical data and clinical direction to improve the quality of care and quality of life of our members.

Read more

ARTHROPLASTY NETWORK

Provides access to a network of high quality hip and knee joint surgery centres of excellence.

Read more

DIGITAL INITIATIVES

MEMBER APP

Gives members access to their health plan on the go.

Read more

DISCOVERY HEALTH ID

Reduce fragmentation of care through secure electronic health records.

Read more

DR CONNECT

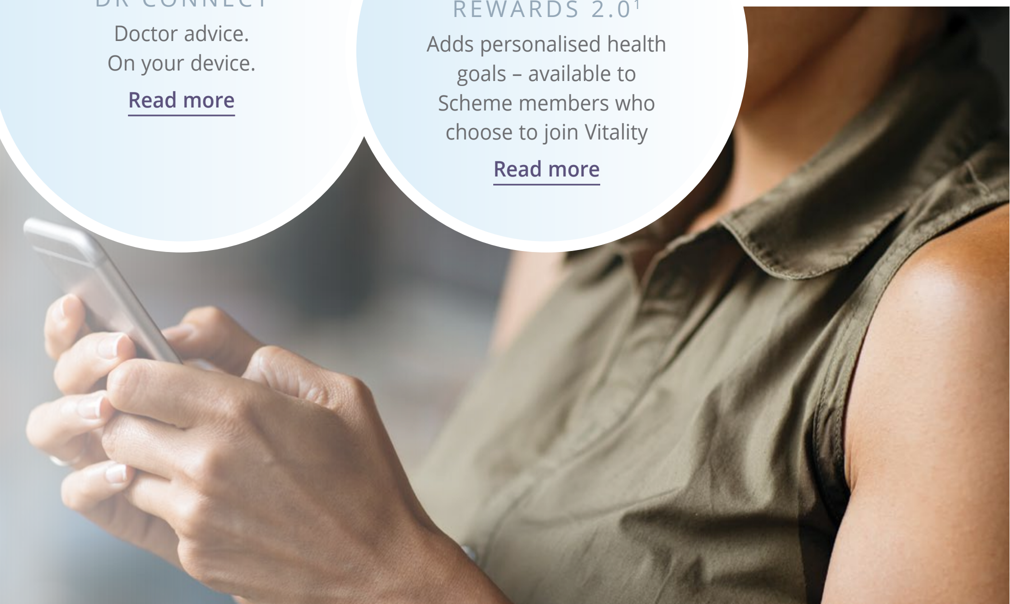
Doctor advice. On your device.

Read more

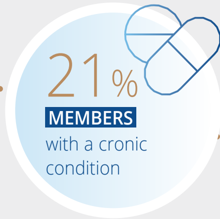
ACTIVE REWARDS 2.0[1]

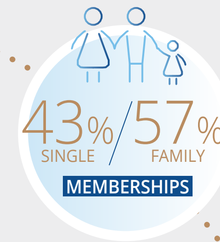
Adds personalised health goals – available to Scheme members who choose to join Vitality

Read more



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





New business

New membership activated every **22 seconds**

Discovery Baby is born every **6 minutes**

Benefit management

3 140 hospital admissions approved per day

1 990 chronic illness benefit applications received per day

69 200 HIV programme members

60 300 oncology programme members

Service and claims

34 400 calls received per day

R6.7 billion billed in contributions per month

271 000 claims received per day

R32.7 million paid in claims per hour

Wellness management

3.5 million lives covered

15 900 wellness screenings per month

32 390 Vitality checks per month

28 780 personal health reviews completed per month

Digital support

2.1 million website users

359 700 mobile users

28% of calls Interactive Voice Response assisted

4 550 monthly HealthID users

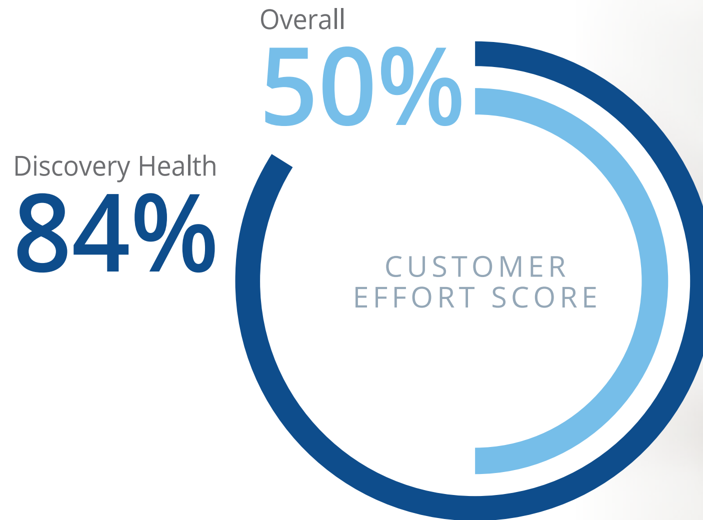
376 350 social media followers

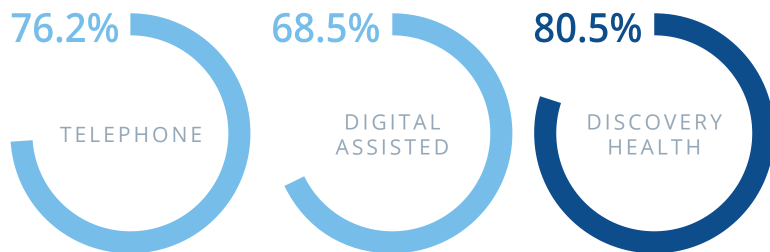
1 963 058 digital membership cards downloaded

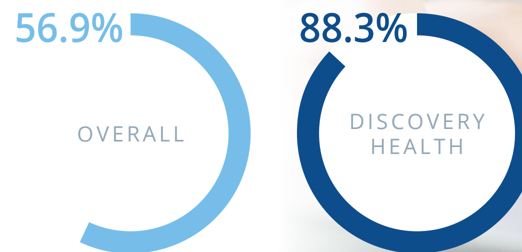
** For members of all schemes administered by Discovery Health. As at 31 December 2018, Discovery Health administered 3.48 million beneficiaries, including 2.8 million for DHMS.*

Maintaining world-class service levels

Discovery Health's service metrics exceed international best practice benchmarks[1].







1 As compared with benchmarks from the Dimension Data 2019 Global Customer Experience Benchmarking Report. The report was published on 15 January 2019 and makes use of data obtained globally in 2018.

03

CREATING STAKEHOLDER VALUE

OUR APPROACH

The Scheme exists for the benefit of all our members and this guides everything we do. We apply social solidarity principles in balancing the needs of individual members with the collective wellbeing of the Scheme.

As a non-profit medical scheme in South Africa, Discovery Health Medical Scheme (DHMS or the Scheme) operates according to social solidarity principles, whereby the Scheme pools member contributions and manages them to fund member healthcare equitably.

The Scheme's commitment to social responsibility, through our corporate citizenship framework, recognises that the support of all our stakeholders and the wellbeing of broader society are essential both to our licence to operate and our ability to achieve the Scheme's purpose and vision.

03

ETHICS, VALUES AND CULTURE

The Scheme operates according to the highest ethical standards. Policies set the standard of behaviour expected of its Board of Trustees (the Board or the Trustees) and employees, in areas such as compliance with the law, protection of personal information, human rights, employee rights and sound business practices.

The policies are available to all Trustees and employees, and are referenced in employment contracts. Regular assessments are conducted into the effectiveness of the Scheme's governing body, which extend to considering whether the Scheme's ethics are upheld and to identifying any areas of concern. Similar assessments of employees will be formalised in the near future.

An ethics review of the Scheme and of our Administrator and Managed Care Provider, Discovery Health, which will include all executives in the Scheme Office and significant numbers of Discovery Health staff across all levels of management, was designed in 2018 for implementation in 2019. Discovery Health, as our partner in implementation in a fully integrated outsourced model, is the most immediate organisation in the Scheme's supply chain and the Scheme considers it important to have independent assurance that ethical standards required by the Scheme are upheld.

During 2017, the Scheme's organisational culture was assessed by independent experts and the features of a desired culture of excellence were mapped out to support the Scheme's operating model. The Scheme's values were affirmed as the foundation of our culture. In 2018, the behaviours associated with our values were more clearly articulated to emphasise the importance of our relationships with all our stakeholders to the Scheme's effectiveness and sustainability.

Moral duties and ethical values

The Scheme's standards of behaviour are aligned with the outcome of an ethical culture contemplated in the King IV Report on Corporate Governance for South Africa 2016 (King IV) and the expectations of the Council for Medical Schemes (CMS), and are articulated in our governance framework:

MORAL DUTIES

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

ETHICAL VALUES FOR GOVERNANCE, MANAGEMENT AND OPERATIONS

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

OUR VALUES GUIDE OUR BEHAVIOURS AND INTERACTIONS:

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

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

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

TEAM WORK, SUPPORT AND CARE
We will support and care for ourselves and others. When working together, we will share the load and work interdependently.

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

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

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

03

TREATING CUSTOMERS FAIRLY

The Treating Customers Fairly (TCF) Framework is founded in sound business principles and good governance. The Scheme voluntarily embraces the TCF principles and recognises their relevance to the quality of service we provide to our members.

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

THE **DESIRED OUTCOMES OF TCF** ARE:

- Customers can be confident that they are dealing with organisations in which 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 and services are of an acceptable standard and perform as organisations have led customers to expect.
- Customers do not face unreasonable post-sale barriers imposed by organisations to change products, switch providers, submit a claim or make a complaint.

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

Sunday Times
TOPBRANDS

In 2018, DHMS was awarded two Sunday Times Top Brands awards: the top medical aid award and the grand prix business brand award. These awards affirm and recognise the relationship the Scheme has developed with its members.

03

SOCIAL RESPONSIBILITY

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

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

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

The Scheme considers all items in the framework to be important, but given the nature of the Scheme's business we prioritise those that are most material to realising the Scheme's purpose, vision and strategic objectives. We also believe that a strategic approach to responsible corporate citizenship is by necessity long-term, as it requires extensive stakeholder engagement and alignment of organisations and bodies with the intent of the Scheme, for example in working with our extended supply chain to assess and reduce environmental impact.

RESPONSIBLE CORPORATE CITIZENSHIP FRAMEWORK

Economy

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

Workplace

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

Natural environment

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

Social environment

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

Note: *areas specified in King IV are shown in italics.*

1 *Crane, Matten & Spence (2008); The Ethics Institute material from 2017.*

03

ENGAGING WITH OUR STAKEHOLDERS

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

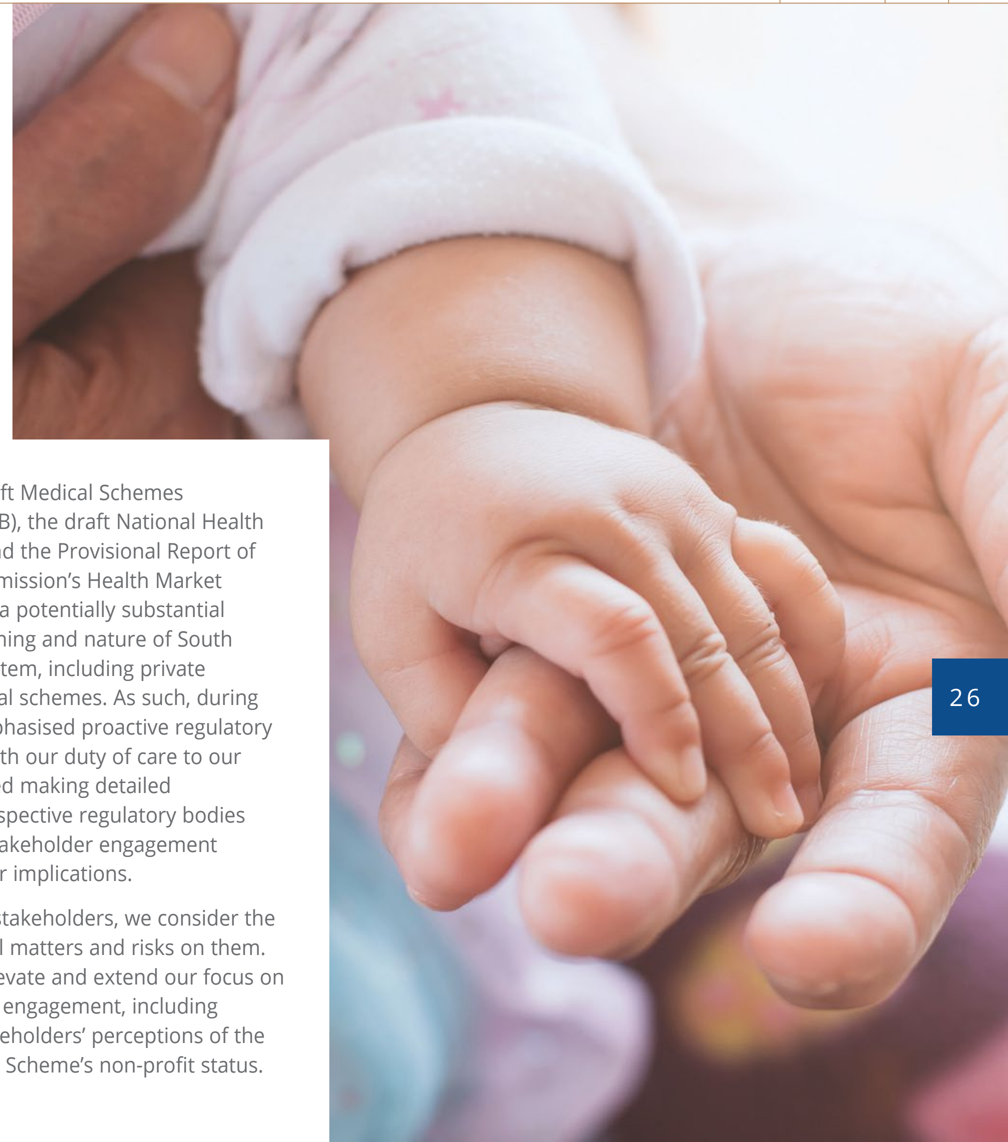
The Stakeholder Relations and Ethics Committee oversees all stakeholder engagement activities and reports to the Trustees on these matters. The Committee uses a defined framework and methodology, which entails identifying stakeholder groups and assessing their needs as well as the impact that the Scheme has on them. The Committee seeks to ensure that appropriate management and engagement plans are in place and monitors their effectiveness, with close attention given to the resolution of specific incidents and stakeholder concerns.

As the Scheme's Administrator and Managed Care Provider, Discovery Health conducts some of our stakeholder engagement work in accordance with the agreements between DHMS and Discovery Health. The Committee receives regular reports from Discovery Health on stakeholder engagement and perceptions, supplemented by presentations and discussions on significant matters of concern to the Scheme.

Some of Discovery Health's stakeholder engagement activities on behalf of the Scheme:

- Responding to member queries via call centres, through e-mail, the member app and website.
- Engaging with health professionals through multiple communication channels to communicate new initiatives.
- Providing training and support to financial advisers on the Scheme's products.
- Developing innovative healthcare provider networks to control costs for our members and the Scheme.

Discovery Health reports to the Scheme on all such interactions and, where necessary, items are escalated to the Scheme Office for its direct involvement.



The release of the draft Medical Schemes Amendment Bill (MSAB), the draft National Health Insurance (NHI) Bill and the Provisional Report of the Competition Commission's Health Market Inquiry (HMI) all have a potentially substantial impact on the functioning and nature of South Africa's healthcare system, including private healthcare and medical schemes. As such, during 2018 the Scheme emphasised proactive regulatory engagement in line with our duty of care to our members. This entailed making detailed submissions to the respective regulatory bodies and participating in stakeholder engagement forums regarding their implications.

In engaging with our stakeholders, we consider the impact of our material matters and risks on them. In 2019, we plan to elevate and extend our focus on proactive stakeholder engagement, including working to clarify stakeholders' perceptions of the Scheme, including the Scheme's non-profit status.

During 2018, the Scheme emphasised proactive regulatory engagement in line with our duty of care to our members.

OUR MEMBERS

We recognise that we exist for our members, who entrust us with their healthcare funding needs. The Scheme therefore aims to manage, as best it can, the long-term affordability of contributions so that 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.

One of the Scheme's key strategic priorities is to drive value-based healthcare, a delivery model which places members at the centre of care. In such a model providers are reimbursed based on health outcomes, not inputs. This ensures that it is the health results that matter, not the volume of services delivered. This gives our members access to programmes and providers that are committed to continuous improvement in quality healthcare and encourages healthcare providers to collaborate in providing holistic, high-quality patient care.

Through Discovery Health, the Scheme 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. This includes comprehensive information on the website, which also has a virtual agent (bot) capability that utilises artificial intelligence to respond to member questions. Members can also make contact through a call centre, on the website, via the member app, or by visiting one of five client service centres in South Africa. Members are also able to contact the Principal Officer directly if they need to.

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

Additional services provided by Discovery Health to all members include the "Ask a Doctor" function through the member app or the website, where they can search a growing library of over 6.5 billion doctor-created answers to common medical questions or get a personalised answer to a short question from a doctor.

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

OUR MEMBERS *continued*

MEASURING MEMBER SATISFACTION

The satisfaction of our members is fundamental to the Scheme. To this end, we track members' perceptions of the service they receive at multiple points and locations, including after-claims processes and the call centre. Follow-up surveys are also frequently conducted with members after they have interacted with us.

The Scheme maintained a high average member perception score in 2018:

8.78 out of 10

(2017: 8.81[1])

DHMS has many innovative programmes and initiatives to support members in their healthcare journey,

EMPLOYER GROUPS

Many employers offer their employees the opportunity to join a medical scheme as part of their employee benefit package.

Employers 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 – 72% of members belonging to an open medical scheme as part of an employer group belong to DHMS[2].

Providing employers of DHMS members with an integrated health and wellness solution

Discovery Health offers DHMS employers and their employee members a fully integrated corporate health and wellness solution. This includes onsite wellness days for Scheme members where a range of key health metrics are assessed, allowing wellness specialists to identify members at risk and to refer them to appropriate care where necessary. It further includes the provision of executive wellness screenings and onsite healthcare clinics where required by employers, and Discovery Healthy Company, a proactive, digitally enabled employee assistance programme.

In 2018, the following engagement activities were conducted:

- Corporate wellness days encouraged 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 national rollout to employer groups.

1 *These results differ from those reported in the 2017 Integrated Report due to a change in methodology. As services inevitably grow or change, we have to constantly ensure that each metric still measures the right outcome. Member perceptions are measured after a variety of interactions, for example joining the Scheme, claiming, or through a telephonic or written interaction with us. Prior to the change in methodology, the score included perception ratings for the billing function (which is more relevant to employer groups than individual members) and ratings of member lounge visits. Ratings for the latter service were generally very high, but the sample was not significant enough to have a weighting in such an important metric. These two scores have now been removed from the overall member perception calculation and the new methodology applied retrospectively to obtain the 2017 score.*
The Scheme and Discovery Health constantly analyses the causes of changes in member perception in order to address member concerns and barriers.

2 *Based on 2016 Global Credit Ratings reports for the seven largest open medical schemes that subscribe.*

HEALTHCARE PROVIDERS AND PROFESSIONAL SOCIETIES

DHMS, with the support of Discovery Health, partners with medical professionals to meet the challenge of increasing access to quality, cost-effective healthcare services and caring for our members' health and wellness.

In an environment of increasing healthcare demand and limited resources, the development of a value-based approach to healthcare creates a virtuous cycle in which patients, their healthcare providers and funders work together to optimise the outcomes for each party as well as for the broader healthcare system.

In 2018, our partnerships with medical professionals were aimed at accelerating the shift towards value-based healthcare provision. This included encouraging adoption of the latest digital health technologies to facilitate, support and improve care coordination and quality healthcare delivery.

Clinical teams are critical to achieving quality healthcare goals premised on the concept of value-based care. We continue to look to professional societies and individual professionals for their leadership in supporting this objective. To date, we have co-created a number of models of care and financial reimbursement that are already resulting in quality improvements, with scope for greater impact in future.

Members are also key to the move to value-based care initiatives as they take a more active role in their own care through better access to information and increased involvement in feedback. The ability to measure and share data on experience and outcomes enables objective peer discussions, continuous improvement and increased transparency. Through HealthID, we offer digital platforms for both clinicians and patients to record information, share results and track their progress.

Ongoing engagements with healthcare providers and professional services include:

- Extensive communication to update health professionals on pertinent Scheme and Discovery Health changes.
- Ongoing engagement with societies and representative bodies in the sector.
- Articles published in medical journals and the press to showcase quality of care improvement initiatives and collaboration with doctors.

KEY SHARED VALUE PROJECT ACTIVITIES DURING 2018

Premier Plus GP Network

The Premier Plus GP Network focuses on members diagnosed with one or more of the identified major chronic illnesses. With improved quality and cost-effective care, savings can be shared with Premier Plus Network GPs who are actively engaged in developing and operating comprehensive care management programmes.

Once members are registered with HealthID, care is tracked digitally to achieve the best possible outcomes while also maximising benefits for those patients who need them most. These benefits include additional consultations, one extended consultation a year and ongoing monthly remuneration for the Premier Plus Network GP for achieving defined quality of care standards.

HEALTHCARE PROVIDERS AND PROFESSIONAL SOCIETIES *continued*

Recent additions to the Premier Plus GP Network include the GP having the option to enrol any DHMS member newly diagnosed with first onset major depression or recurrence of episodic major depression in the Mental Health Programme. Eligibility criteria for enrolment on the programme are based on defined clinical criteria, and the programme sets out additional required benefits to assist eligible members.

As part of the existing DiabetesCare Programme, Discovery Health provided Premier Plus GPs with access to a diabetes coach to assist them with effective out-of-office monitoring, education and support of members with diabetes registered on the DiabetesCare Programme. This change recognises the value that can be added by appropriately skilled health practitioners to support members diagnosed with chronic diseases.

Hip and Knee Arthroplasty Network

Discovery Health's Centres of Arthroplasty Excellence seek to optimise health outcomes for members through a value-based alternative reimbursement model. The contracting and engagement process has resulted in over 90% of joint arthroplasty surgeries being performed within the selected network facilities. Hospital networks are encouraged to remain flexible in the reimbursement models available to the surgical teams. The current focus of the network is on sharing quality and outcomes data to further improve health outcomes for joint arthroplasty patients.

Obstetric Quality Network

Following extensive engagement in 2018, January 2019 saw the launch of a joint effort to improve obstetric care delivery through a programme led by The South African Society of Obstetricians and Gynaecologists and the Gynaecology Management Group (SASOG-GMG) in collaboration with the Scheme and Discovery Health. Through this initiative, DHMS, Discovery Health and SASOG-GMG commit to working together to enhance maternity care in South Africa, while strengthening and sustaining the profession of obstetrics, including through enhanced remuneration.

In support of this initiative, an electronic maternity record system based on SASOG-GMG and international guidelines is available on HealthID. Obstetricians can elect to initially complete a simple discharge summary and move to a more comprehensive clinical record as the practice becomes more proficient with the electronic interface.

We anticipate that this programme will continue to grow in 2019, which will benefit both members and doctors through data sharing and improved care.

Vitality Active Rewards for Doctors (VARD)[1]

In support of medical professionals who provide care to Scheme members, Discovery Health launched the second phase of its Vitality Active Rewards for Doctors (VARD) initiative. Support includes providing all doctors who interact with DHMS with free and exclusive access to a suite of Vitality services and benefits.

To date, over 3 700 doctors have activated VARD, representing about one third of all doctors claiming from DHMS. Given the growing body of research[2] demonstrating that doctors who themselves are managing their lifestyles are more effective in "prescribing wellness" for their patients, the VARD initiative may well improve doctors' ability to manage their patients at risk of or living with non-communicable diseases – the biggest driver of morbidity and mortality globally and in South Africa.

Regulatory change

To clarify and address concerns on some of the proposals contained in the NHI Bill, the MSAB and the HMI Provisional Report, Discovery Health conducted engagements with medical professionals in all major urban centres in South Africa. Over 2 000 medical professionals attended these engagements, with positive feedback received regarding the engagements.

1 *Provided by Vitality. Vitality is not part of Discovery Health Medical Scheme. Vitality is a separate wellness product, sold and administered by Discovery Vitality (Pty) Ltd, registration number 1999/007736/07, an authorised financial services provider.*

2 *For example: "When physicians are unwell, the performance of the health-care systems can be suboptimum. Physician wellness might not only benefit the individual physician, it could also be vital to the delivery of high-quality health care." Source: Lemair, Wallance & William, Lancet 2009; 374: 1714-21. Preliminary research by Discovery Health also indicates that members who visit doctors engaged in VARD are more engaged themselves than are patients who visit non-engaged doctors.*

FINANCIAL ADVISERS (BROKERS)

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

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.

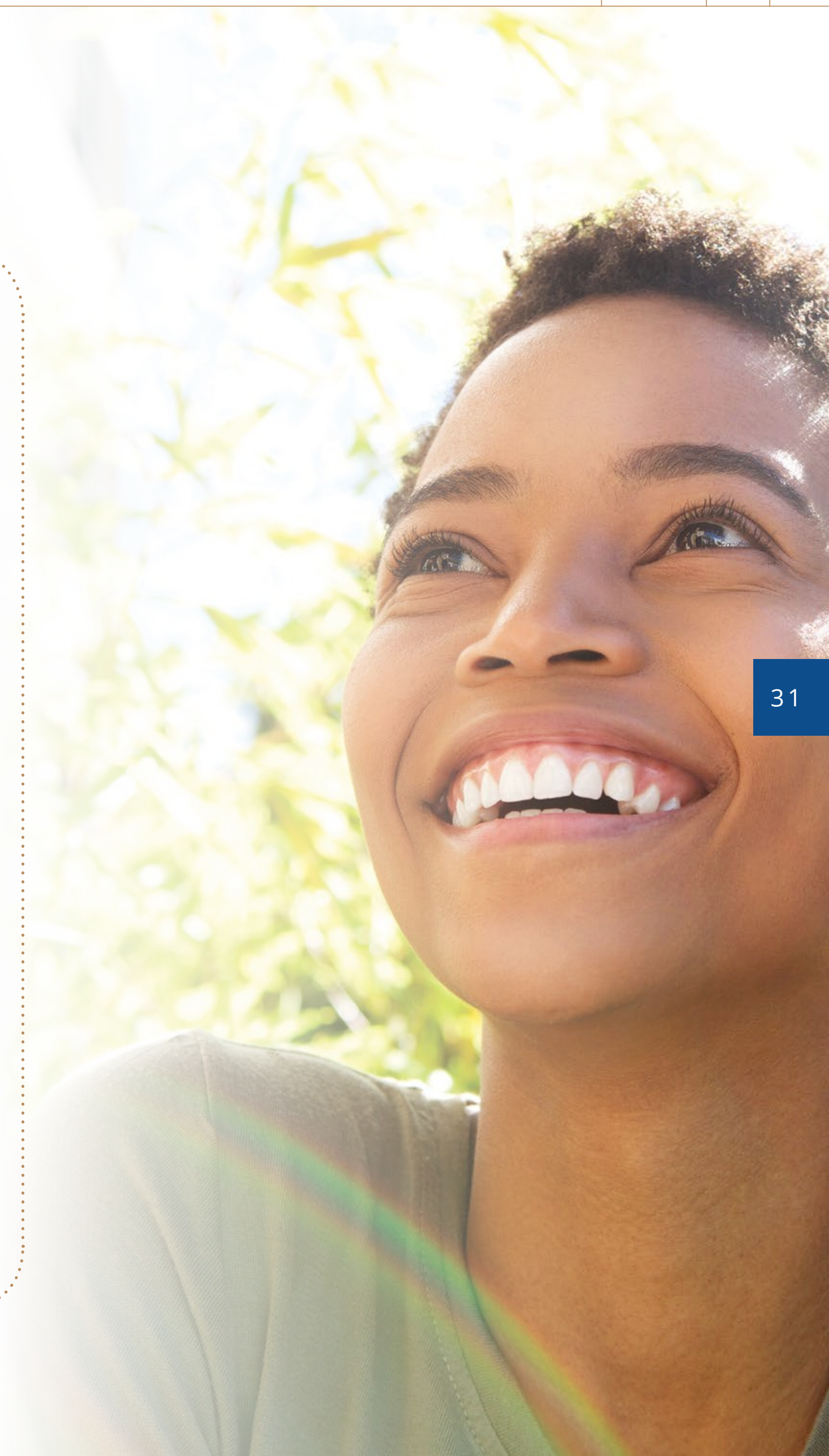
Financial advisers are reimbursed by the Scheme for their services according to legislated fees and their contractual arrangements with the Scheme – members do not pay them directly. Financial advisers must be registered with and are regulated by the Financial Services Board, and must comply with the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

Discovery Health engages extensively with financial advisers on the Scheme's behalf. In-depth training and assessment sessions are supplemented by annual product launches and updates to support advisers. The Scheme focuses 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.

Perception surveys were conducted to establish how satisfied financial advisers are with the service they receive. The overall perception score by brokers of Discovery Health for the year was 8.77 out of 10, slightly up from 8.67 in 2017.

ENGAGEMENTS IN 2018 INCLUDED:

- The annual update on the Scheme's product and benefit enhancements for the coming year was provided in a national rollout to over 200 business consultants and agents, and presented and broadcast to more than 8 200 financial advisers from the annual product launch event. Following the product update, approximately 60 sessions were held nationwide with business consultants and financial advisers.
- National presentations to corporate brokerages at two different times in the year provided information on the Scheme's strategies, industry position, financial results and risk management initiatives.
- Broker consultants received training and were assessed on their knowledge of the Scheme's products, the private healthcare sector, and sales and presentation skills.



DISCOVERY HEALTH (PTY) LTD

Discovery Health is a leading administrator and managed care provider for medical schemes in South Africa, providing services to over 3.5 million lives. This includes DHMS, the largest open scheme in South Africa, as well as 18 restricted schemes.

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 the Vested® model, which focuses on outcomes and is characterised by a shared vision and aligned objectives to ensure that both organisations work for 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 are responsible for ensuring that Discovery Health meets agreed strategic and operational requirements.

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

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

In 2017, DHMS renewed its Administration and Managed Care Contracts with Discovery Health. The agreements provided for the formation of the new Relationship Management and Innovation Committees, to support enhanced governance and relational dynamics relating to the Vested relationship between DHMS and Discovery Health and provide scope for continued innovation. These committees met during 2018 and have identified opportunities to enhance the working relationship, which includes the further implementation of the DHMS operating model to clarify accountabilities. This work has commenced in 2019.

OUR EMPLOYEES

The Scheme is committed to protecting the dignity, safety and health of our employees, providing decent work, fair remuneration and opportunities for training and development, and treating them equitably and ethically in accordance with good employer practices, and with the corporate citizenship framework we have adopted as part of our strategy.

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

The Scheme employs a small team that is essential to its effective operation and sustainability by 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 assessments and audits of the Scheme's value proposition to employees support staff satisfaction and retention, and regular performance discussions help employees stay on track in terms of their role objectives, alignment to the objectives of the Scheme, and career development.

In addition to planned development interventions, during 2018 Scheme Office employees participated in workshops to support better personal work management and deepen interpersonal skills. The team also spent time developing a shared understanding of behaviours aligned to the Scheme's values. A revised performance management framework is being developed and we aim to implement it during 2019.

REGULATORY BODIES

The Scheme and Discovery Health are required to adhere to strict legislation. The Scheme is primarily governed by the Medical Schemes Act (the Act).

Maintaining constructive relationships with industry 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 relevant authorities.

The Scheme and Discovery Health continue to engage the National Department of Health, the CMS and the Competition Commission on other matters affecting the sustainability of the broader industry, including advocating for access to more affordable health technology, in particular innovative medicines.

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; and
- Working with the Department of Health regarding regulatory and policy interventions.

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

In 2018, the CMS published 65 circulars and the Scheme submitted responses to those where required, as well as to other ad hoc and formal enquiries from the CMS. The CMS also publishes an annual report covering activity across the private healthcare industry.

THE NATIONAL DEPARTMENT OF HEALTH

The Scheme interacts with the National Department of Health whenever required. On 21 June 2018, the draft NHI Bill was published in the Government Gazette no. 41725. The NHI, as a healthcare financing mechanism that seeks to achieve universal health coverage for South Africa, has significant implications for South Africa and the medical scheme industry. The Scheme has therefore taken a deep interest in developments around the NHI Bill and has participated actively in NHI-related processes wherever possible. This includes the CMS-led review of Prescribed Minimum Benefits (PMBs) which is proposed to align to NHI.

The draft MSAB was also released at the same time as the NHI Bill, and the Scheme submitted detailed commentary on both.

The Scheme supports the objectives of universal health coverage and looks forward to opportunities to collaborate with the Department of Health and other stakeholders to determine how best the sector can achieve the objectives of quality and equitable healthcare. We also support the need to update the Act to reflect the current environment with its socioeconomic and demographic challenges, and will continue to engage with the Ministry in the interests of our members.

DHMS is a member of the Health Funders Association (HFA), which is an industry body representing stakeholders involved in the funding of private healthcare in South Africa. The HFA similarly submitted commentary on the draft bills from an industry perspective, and engaged on its members' behalf with the Department of Health on the proposed interim single exit price of medicines adjustment as well as the industry's concern about high-cost medications.

THE COMPETITION COMMISSION

The ongoing HMI is a general investigation of the state and types of competition in the private healthcare sector, and does not relate to any specific organisation. One of the aims of the HMI is to promote competition to benefit consumers.

The HMI's Provisional Report was published during 2018 and DHMS submitted substantial commentary on it. The Scheme is supportive of many of the recommendations made in this report. We believe that the reduced fragmentation of the healthcare system and lower overall costs which should result from the implementation of these recommendations will be positive for consumers. This outcome aligns with the Scheme's objectives. In addition, the HMI's recommendations promote competition and innovation in the industry, which is essential for improving healthcare in South Africa.

During 2018, the Scheme engaged regularly with the HMI process wherever possible and will continue to do so in 2019.

OUR CHAIRPERSON'S STATEMENT

The current state and future shape of the South African healthcare sector, both public and private, remained a pressing issue in 2018.

The healthcare reform agenda saw the draft National Health Insurance (NHI) Bill and Medical Schemes Amendment Bill (MSAB) released during the year. The Scheme participated actively in the consultation processes, motivating for positive outcomes for our members, other stakeholders and the sector as a whole.

Within a fluid regulatory context, the Trustees' key concern is affordability, with many of our members facing challenges in relation to the cost of living, including paying their scheme contributions. We are deeply concerned about ongoing healthcare inflation which, coupled with difficult economic conditions, rising costs and job losses, constrain our members' ability to continue accessing high quality healthcare. These conditions are slowing the growth in scheme membership, albeit off a very high base, with a concomitant impact on future affordability and sustainability.

Each year the Trustees critically review the Scheme's benefit plans and pricing. We try to ensure that our range of plans caters for our diverse membership; with over 2 819 000 beneficiaries at the end of 2018, this is no small task but we consider it one of our most important. At the end of each year, the Council for Medical Schemes (CMS) approves DHMS's benefit plans for the coming year.

GOVERNANCE AND LEADERSHIP

04

It is essential that DHMS continues to provide a discernibly better value proposition to our members than other schemes do. The Scheme remains highly competitive with average contributions for 2018 being 16.4% lower on a plan type for plan type comparison basis than the next eight open schemes by size, and 16.6% lower for 2019. We also try to shield our members from the impact of the economic environment as best we can; for example we decided to absorb the impact of the VAT increase during 2018 to delay its effect on our members.

Annually, the Trustees assess the service and value provided to our members by our Administrator and Managed Care Provider, Discovery Health. The independently assured assessment done in 2018, for 2017, showed that for every R1.00 paid to Discovery Health by the Scheme, value of R2.02 was received (slightly up from R2.00 for 2016). Discovery Health's extensive work to optimise the functioning of the private healthcare system has a significant impact on supporting our members' ability to access high quality care for the lowest possible contributions. Further, the risk management interventions and efforts to combat fraud, waste and abuse in healthcare that the Scheme and Discovery Health put in place are central to protecting the value we offer our members.

Of concern for the whole sector is how to extend access to quality healthcare to all South Africans – the focus of the Presidential Health Summit convened late in 2018. Representatives from civil society, government, unions, academia and the private sector attended the Summit to grapple with the theme of "strengthening the South African health system towards an integrated and unified health system".

The critical role of the private sector in realising the aims of the NHI was acknowledged and the call was made for the Summit's inclusive approach to be adopted in developing healthcare policy that achieves its intended aims. We welcome this shift in approach and will play our part in achieving the aim of universal health coverage in South Africa.

The Trustees note the appointment of Dr Sipho Kabane to the permanent position of chief executive and registrar of the CMS, after a year in an acting capacity. We wish him every success in the role.

As a function of our focus on best practice governance, in 2018 the Trustees put in place measures to balance independence of oversight and retention of institutional knowledge within the legislated restrictions of the Scheme. The Scheme's Rules hold that members elect at least half the Trustees at any given time. The Board appoints additional Trustees to fill knowledge, experience and skills gaps as required. Trustees serve a term of three years and are eligible for subsequent re-election or re-appointment, but may not serve more than two consecutive terms. The terms of our Independent Board Committee members have now been aligned to this requirement.

Ms Daisy Naidoo, an elected Trustee, will reach the end of her second term in June 2019 and will be leaving us. Ms Naidoo is a highly experienced and conscientious Trustee who has exercised her position on the Board with great care and diligence, for which we thank her. The first terms of three other elected Trustees, Mr David King, Dr Dhesan Moodley and myself, will also end in June 2019 and elections will be held to fill these three positions. We thank Mr King and Dr Moodley for their dedication and hard work in the last three years, and, along with Ms Naidoo, for fulfilling their fiduciary duties in an exemplary manner.

Some Independent Board Committee members will also leave us in 2019: Mr Imtiaz Ahmed who served as the Chair of the Investment Committee, and Dr Zephne van der Spuy who has served as a long-standing member of the Clinical Governance Committee. Once suitable replacements have been found for Mr Barry Stott, Chair of the Audit and Risk Committees and a member of the Investment Committee, and Mr Steven Green, a member of the Audit and Risk Committees, they too will step down. We thank these exceptional Independent Board Committee members for their service to the Scheme and wish them well.

My thanks to my other colleagues on the Board, the Principal Officer, Dr Nozipho Sangweni, and her team at the Scheme Office, without whom we could not keep our promise to care for our members through thick and thin.

Neil Morrison
CHAIRPERSON

The critical role of the private sector in realising the aims of the NHI was acknowledged and the call was made for the Summit's inclusive approach to be adopted in developing healthcare policy that achieves its intended aims. We welcome this shift in approach and will play our part in achieving the aim of universal health coverage in South Africa.

HOW WE ARE GOVERNED

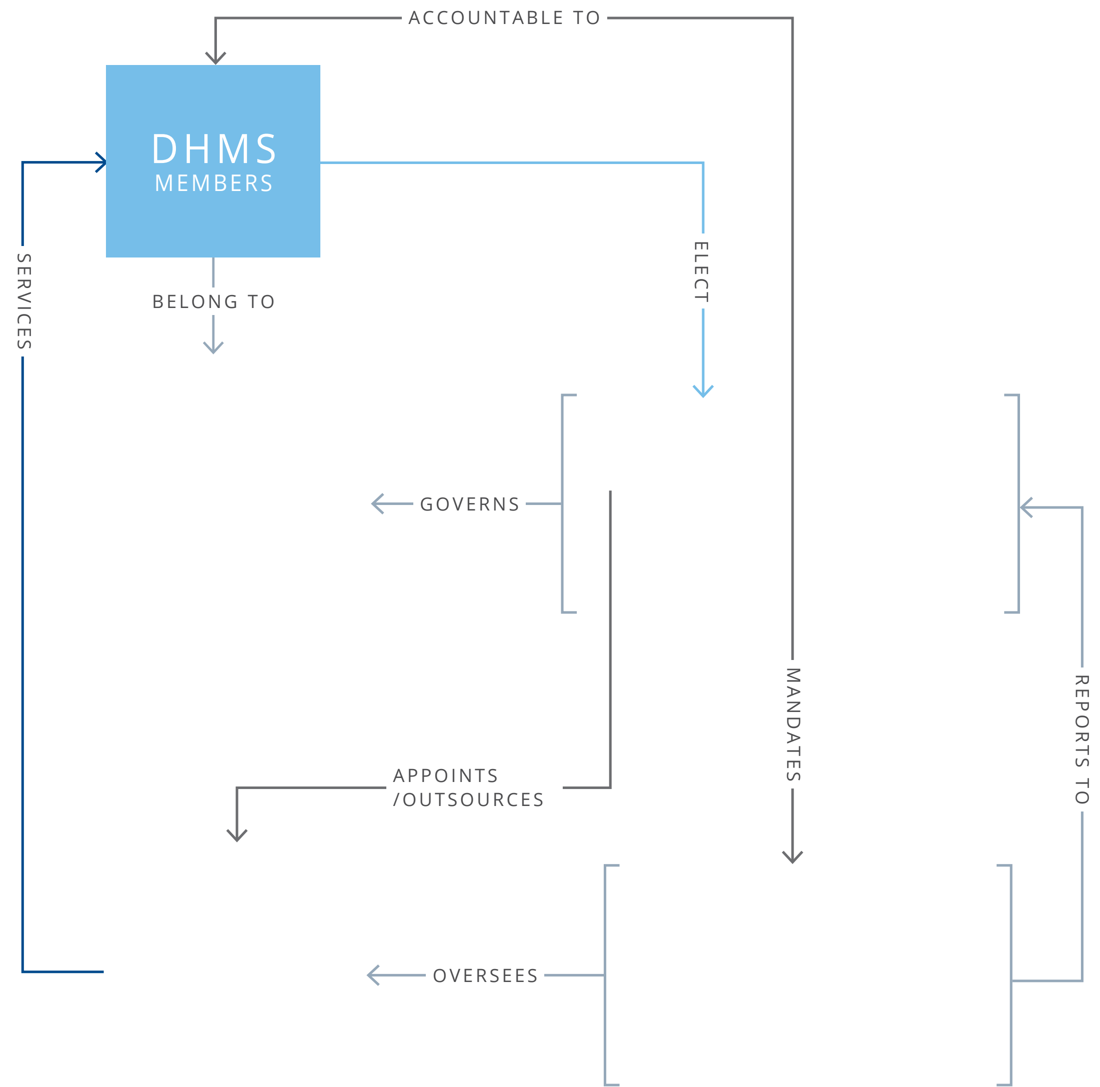
All medical schemes in South Africa are governed by the Act. The Scheme Rules are developed in accordance with the Act and approved annually by the CMS.

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

- An ethical culture
- Good performance
- Effective control
- Legitimacy

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

OUR GOVERNANCE STRUCTURES



The Board of Trustees

DHMS is governed by an independent Board of Trustees, which is responsible for the oversight of the business of the Scheme. The Trustees hold the decision-making power of the Scheme and are ultimately responsible for oversight of the Scheme's material matters, the development and implementation of the Scheme's strategy and the sound management of its business, including Scheme policies.

The Board's overriding objective is to ensure that the best interests of Scheme members are served equitably and in the context of the sustainability of DHMS. The Trustees are accountable to the Scheme's members.

According to the Scheme Rules, the affairs of the Scheme must be managed according to these Rules by a Board of fit and proper members (i.e. 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 Trustees.

Trustees serve a term of three years and are eligible for subsequent re-election or re-appointment, but may not serve more than two consecutive terms.

At least 50% of Trustees on the Board are elected by members at any given time, which means that the Scheme has no influence over the re-election of these Trustees. In terms of its limited succession planning ability, the Board may also appoint additional Trustees to fill knowledge, experience and skills gaps if required or re-appoint a Trustee, taking into account their performance and the skills and knowledge that are required on the Board.

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

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

The Board comprises independent, highly skilled 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. Our Trustees have expertise in legal, actuarial, accounting, economics, governance, clinical, financial, financial reporting, investment and human resources.

THE **ROLE OF THE TRUSTEES** IS TO:

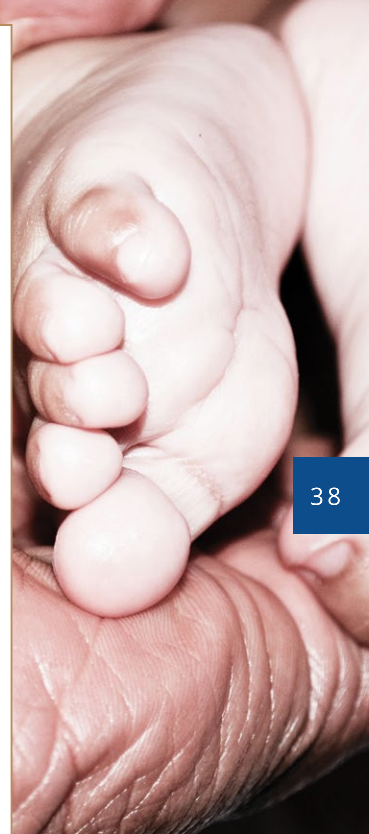
- Evaluate, direct and monitor the Scheme's strategy, ensuring that it is aligned with the purpose and value drivers of the Scheme, and the legitimate interests and expectations of stakeholders;
- Review the sustainability of the Scheme and evaluate whether the services offered by the Administrator and 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; and
- Consider stakeholder perceptions and their impact on the Scheme's reputation.

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

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

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



BOARD EVALUATIONS

The Board is assessed regularly by either external independent parties or through self-appraisals. In January 2018, DHMS appointed the Institute of Directors in Southern Africa (IoDSA) to facilitate its Board appraisal. IoDSA conducted an objective and independently facilitated self-assessment process, which considered the views of the individual Trustees on the performance of:

- The Board of Trustees as a whole;
- The eight Committees of the Board;
- Individual Trustees through peer appraisal; and
- The Chairperson through Trustee appraisal.

Performance was evaluated quantitatively based on information from the completed questionnaire and qualitatively based on the comments from Trustees in interviews held. These evaluations assessed the following: Board composition, Board responsibilities, Committees of the Board, Relationship with the Scheme Office, stakeholder relationships, and Board meetings. According to the assessments the Board of Trustees is performing at a "meets best practice" level according to the views of the Trustees. The Board also exceeded the IoDSA benchmark in all six categories.

The Board is satisfied that the diversity of skills and experience of the Trustees enables it to carry out its duties in a competent way that fulfils its responsibility to the Scheme's members. In addition, the Board is satisfied that it has fulfilled its mandate in accordance with its charter and carried out its duties in an ethical, responsible and equitable manner during the year.

OUR TRUSTEES

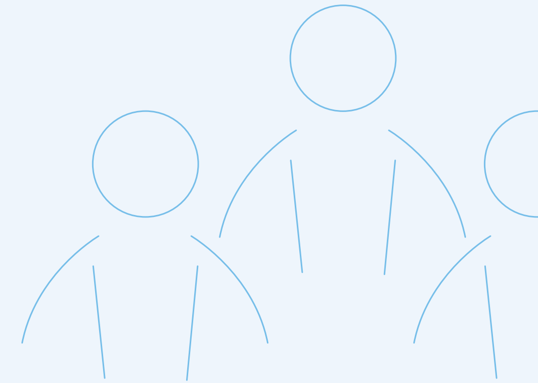
Mr Neil Morrison (62)

BSc (Hons) Physics; MA (Economics)

CHAIRPERSON

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

Mr Morrison was elected as a Trustee in 2016 and currently serves on the Stakeholder, Remuneration, Investment and Non-healthcare Expenses Committees. He was elected Chairperson of the Board on 14 August 2017.



Ms Joan Adams SC (55)

B.IURIS LLB; (FP) SA[1]

Ms Adams SC has been an advocate for 31 years. She was previously a Senior State Advocate and Senior Family Advocate. She served for five years on two presidentially elected Commissions of Inquiry involving fraud and corruption. She was appointed Senior Counsel in early 2018.

She is a full and accredited forensic practitioner (Institute for Commercial Forensic Practitioners, RSA) and a member of the Gauteng Society of Advocates.

Ms Adams SC has considerable experience in medical law and ethics and has chaired numerous professional conduct inquiries. She was elected as a Trustee in 2017 and serves on the Clinical Governance, Audit and Risk Committees.

1 Forensic Practitioner, South Africa.
Note: all ages as at 31 December 2018.

Dr Susette Brynard (62)

BSc (Sciences); PhD (Education)

Dr Brynard is a research fellow at the University of the Free State, specialising in education management. She was formerly part of the management team of the Bloemfontein College of Education. She is currently a director of SAMBA, a co-operative buy-aid, a position she has held for the last 25 years. She attained her post graduate degrees cum laude and is doing ground-breaking work on the education and development of learners with Down syndrome internationally.

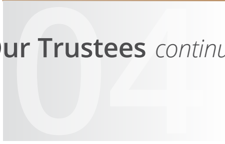
Dr Brynard was elected as a Trustee in 2017 and currently serves on the Remuneration, Stakeholder Relations and Ethics and Product Committees.

Mr John Butler SC (52)

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

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

Mr Butler SC was appointed as a Trustee on 14 June 2017. He serves on the Stakeholder Relations and Ethics, Non-healthcare Expenses and Remuneration Committees.



Our Trustees *continued*

Mr Johan Human (48)

B.Bus.Sc; FIA[2]; FASSA[3]

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

Mr Human was appointed to the Board on 14 August 2017 after being co-opted as an Independent Co-opted member to the Board on 5 September 2016. He currently chairs the Product Committee and serves on the Investment, Audit and Risk Committees, and has previously served on the Non-healthcare Expenses Committee.

Mr David King (55)

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

Mr King is a seasoned business executive with over 25 years' multinational experience. He spent 12 years as Human Resources Director of Brandhouse Beverages and was instrumental in 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 chairs the Remuneration Committee and serves on the Non-healthcare Expenses and Stakeholder Relations and Ethics Committees. He previously served on the Audit, Risk and Stakeholder Relations Committees as an independent member.

Dr Dhesan Moodley (56)

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 that focuses on HIV and chronic conditions in the public sector. In the past, he was president of Alexander Proudfoot, CEO of Bluepeter Consulting, partner of Ethos Private Equity Technology Fund, associate partner at Accenture and principal at Gemini Consulting. He has deep expertise in health insurance and healthcare. His past and present affiliations include the 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 between 2001 and 2011. In 2016, he was re-elected as a Trustee and currently chairs the Clinical Governance and Investment Committees while serving on the Product and Stakeholder Relations and Ethics Committees.

Ms Daisy Naidoo (46)

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 and Product Committees, and chairs the Non-healthcare Expenses Committee.

2 Fellow of the Institute of Actuaries UK.
3 Fellow of the Actuarial Society of South Africa.
Note: all ages as at 31 December 2018.

Board independence, composition, rules and attendance[1]

The Trustees have considered the tenures of Mr Barry Stott, Chair of the Audit and Risk Committees, and Mr Steven Green, Independent member of the Audit and Risk Committees and, in line with new governance requirements regarding the terms of Independent Committee members, will be conducting a search for suitable replacements for both during the course of 2019.

Name of Trustee or Board Committee member	Current trustee	Designation	Appointed/ elected	Start of term	End of term
Daisy Naidoo	●	Trustee	Elected 1st term	20 Jun 13	19 Jun 16
		Trustee	Elected 2nd term	23 Jun 16	22 Jun 19
Neil Morrison	●	Trustee – Chair	Elected	23 Jun 16	22 Jun 19
David King	●	Trustee	Elected	23 Jun 16	22 Jun 19
Dhesan Moodley	●	Trustee	Elected	23 Jun 16	22 Jun 19
John Butler SC		Independent Co-opted member	Appointed	05 Sep 16	13 Jun 17
	●	Trustee	Appointed	14 Jun 17	13 Jun 20
Johan Human		Independent Co-opted member	Appointed	05 Sep 16	13 Aug 17
	●	Trustee	Appointed	14 Aug 17	13 Aug 20
Joan Adams SC	●	Trustee	Elected	22 Jun 17	21 Jun 20
Susette Brynard	●	Trustee	Elected	22 Jun 17	21 Jun 20
Barry Stott[2]		Trustee	Elected	24 Jun 10	20 Jun 13
		Chair of the Audit and Risk Committees, Independent Investment Committee member	Appointed	04 Jul 13	
Imtiaz Ahmed		Chair of the Investment Committee	Appointed	20 Jan 16	19 Jan 19
Zephne van der Spuy		Trustee	Elected 1st term	24 Jun 10	20 Jun 13
		Trustee	Elected 2nd term	20 Jun 13	23 Jun 16
		Independent Clinical Governance Committee member	Appointed	04 Jul 16	03 Jul 19
Mike Sathekge		Independent Clinical Governance Committee member	Appointed	01 Jan 16	15 Mar 18
Selma Smith		Independent Clinical Governance Committee member	Appointed	01 Jan 16	31 Dec 18
			Reappointed	01 Jan 19	31 Dec 21

● CURRENT TRUSTEE

Name of Trustee or Board Committee member	Designation	Appointed/ elected	Start of term	End of term
Philile Maphumulo	Independent Audit and Risk Committees member	Appointed	19 Jan 16	18 Jan 19
		Reappointed	20 Jan 19	19 Jan 22
	Independent Investment Committee member	Appointed	12 Sep 17	11 Sep 20
Sue Ludolph	Independent Audit and Risk Committees member	Appointed	19 Jan 16	19 Jan 19
		Reappointed	20 Jan 19	19 Jan 22
Steven Green[2]	Independent Audit and Risk Committees member	Appointed	11 Dec 01	
Peter Goss[3]	Chair of the Nomination Committee	Appointed	22 Oct 15	22 Jun 17
		Reappointed	28 Aug 18	19 Jun 20
Tom Wixley[3]	Nomination Committee member	Appointed	22 Oct 15	22 Jun 17
		Reappointed	28 Aug 18	19 Jun 20
Roy Shough[3]	Nomination Committee member	Appointed	22 Oct 15	22 Jun 17
		Reappointed	28 Aug 18	19 Jun 20

According to the Scheme's Rules, the Board may consist of a minimum of five and a maximum of eight Trustees (Rule 17.1) and at least 50% of the Board must be elected by members (Rule 17.3). The balance of the Trustees may be elected by members or appointed by the Trustees provided not more than two[4] Trustees are appointed.

1 *Due to the variation of Disputes Committee panellists, members are not listed.*
Each Disputes Panel consists of three Independent members drawn from the greater Disputes Committee, each of whom have either legal or medical expertise. Dispute Hearings are scheduled as and when required, and draw from the legal and medical panellists available at the time. The Committee can be constituted several times a week if required to attend to increased caseloads.
2 *Term will end when a suitable replacement is found.*
3 *The Board constitutes the Nomination Committee when required by the timing of Trustee elections, in order to oversee Trustee nominations processes. These Committee member terms are therefore not for a fixed three year period.*
4 *An amendment to the Scheme Rules to allow for the appointment of a maximum of three Trustees is pending registration by the CMS.*

Board independence, composition, rules and attendance *continued*

Board meetings attendance in 2018		21 Feb	22 Feb	12 Apr	18 Apr[A]	08 Jun	27 Aug[A]	28 Aug	05 Sep[A]	15 Nov
Trustees	Mr Neil Morrison (Chair)	✓	✓	✓	✓	✓	✓	✓	✓	✓
	Ms Daisy Naidoo	✓	✓	✓	✓	✓	✓	✓	✓	✓
	Mr Dave King	✓	✓	✓	✓	✓	✓	✓	✓	✓
	Mr Dhesan Moodley	✓	✓	✓	✓	✓	–	✓	✓	✓
	Adv Joan Adams	✓	✓	✓	✓	✓	–	✓	✓	✓
	Johan Human	✓	✓	✓	✓	✓	–	✓	✓	✓
	John Butler	✓	✓	✓	✓	✓	✓	✓	✓	✓
	Dr Susette Brynard	✓	✓	✓	✓	✓	–	✓	✓	✓
Chairperson: Audit and Risk Committee	Mr Barry Stott	✓	✓	✓	✓	✓	✓	x	✓	✓
Attendee	Mr Imtiaz Ahmed*	✓	✓	–	–	–	–	–	–	–

A Ad hoc meetings:
Ad hoc meetings may be shorter than scheduled Board or Committee meetings. Trustees and Committee members are remunerated according to the duration of such meetings.

- *The meeting of 05 September 2018 included the Audit and Product Committees to debate and approve the DHMS Actuarial Valuation Report.*
- *The meeting of 18 April 2018 was held to discuss the outstanding NHE feedback from the Board agenda of the meeting held on 12 April 2018.*
- *The meeting of 27 August 2018 was a working meeting to discuss succession planning.*

** Invited by the Chairperson to provide Investment Committee feedback.*
– Not required to attend.
x Apology tendered.

BOARD COMMITTEES

In compliance with the Act, 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 ten Board Committees, which are constituted and structured according to the needs of the Scheme and to assist the Board to fulfil its fiduciary and oversight duties effectively. Board Committee members consist of both Trustees and Independent members. Independent Board Committee members serve a term of three years and are eligible for subsequent re-appointment for a further three years, but may not serve more than two consecutive terms. Committee members are remunerated for their services in terms of the Scheme's Remuneration Policy.

The Committees 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, and 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 the approval of any decisions to be taken.

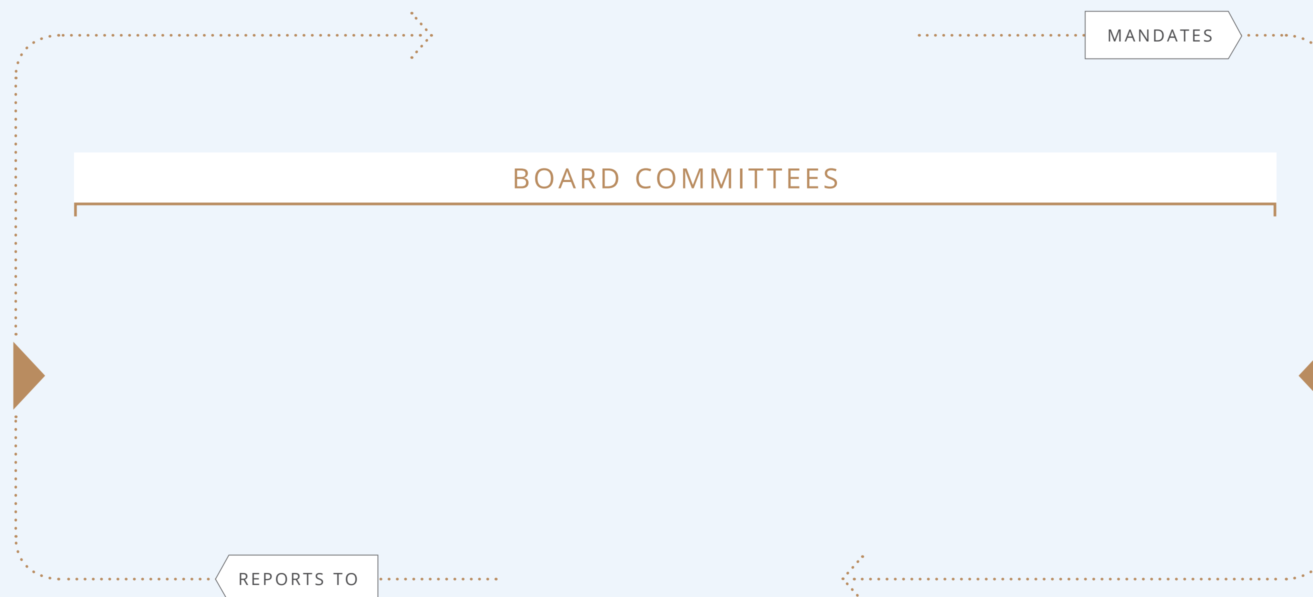
BOARD COMMITTEE EVALUATIONS

The Board evaluation process undertaken in January 2018 by IoDSA included appraisals of the Board Committees. The process considered the views of the individual Committee members on the performance of the Committee.

The assessments covered areas such as:

- Committee composition;
- Roles and responsibilities;
- Interaction with the Scheme Office; and
- Committee meetings.

Overall, the Committees were highly rated in terms of their composition, the specialist work that they do and the report back to the Board. Matters identified as areas for consideration which do not include any material weaknesses are being dealt with by each Committee respectively.



INDEPENDENT BOARD COMMITTEE MEMBERS

MR IMTIAZ AHMED (53)

CA(SA)

Chairperson of the Investment Committee[1].

Detailed 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.

PROF PETER GOSS (51)

(FP) SA, Professor of Practice (Governance and Forensics), College of Business and Economics, University of Johannesburg; MA: Criminal Justice

Chairperson of the Nomination Committee.

Extensive expertise as a managing director in business consulting and advisory services; crisis management, corporate governance, forensic audit and medical schemes board elections expert.

MR STEVEN GREEN (47)

BSc (Hons) Information Systems; BSc Computer Science

Member of the Audit and Risk Committees.

Extensive 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 in South Africa and internationally.

MRS SUE LUDOLPH (55)

CA(SA)

Member of the Audit and Risk Committees.

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

MR NDUMISO LUTHULI (43)

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

Member of the Remuneration Committee.

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

MRS PHILILE MAPHUMULO (37)

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

Member of the Audit, Risk and Investment Committees.

More than 13 years' experience in corporate finance and private equity; founder of Heritage Capital, a private equity fund focused on funding small to medium enterprises. Mrs Maphumulo has served as a non-executive director on company boards in various sectors in South Africa.

1 Stepped down as Chairperson on 18 April 2018, after which Dr Dhesan Moodley was appointed from amongst Committee members as Chairperson on 23 April 2018.

2 Bachelor of Civil Law.

Note: all ages as at 31 December 2018.

Independent Board Committee members *continued*

DR NONKULULEKO MLABA (47)
MBBCh; MPH; PGDHE
Member of the Clinical Governance Committee.

A healthcare professional with a medical degree and post-graduate public health and health economics qualifications; seasoned professional with a deep understanding of managed healthcare, healthcare regulation and clinical research.

PROF SELMA SMITH (57)
MBChB; M Prax Med[6]; FCFP(SA)[7]
Member of the Clinical Governance Committee.

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

PROF MIKE SATHEKGE[3] (49)
MBChB; MMed; FAMS; PhD
Member of the Clinical Governance Committee.

Specialist nuclear physician and expert in the design and innovative point-of-care diagnostics and therapies in nuclear medicine; an internationally acclaimed and rated researcher by the National Research Foundation.

MR BARRY STOTT (70)
CA(SA)
Chairperson of the Audit and Risk Committees and member of the Investment Committee.

Deep understanding of the financial services industry; member of audit, risk and investment committees, and independent non-executive director at financial services institutions; more than 40 years' experience in accounting and auditing.

MR ROY SHOUGH (68)
CA(SA); HDip BDP; CISA[4] (Lapsed); CIA[5]
Member of the Nomination Committee.

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 board committees, and senior executives in governance and risk management.

PROF ZEPHNE VAN DER SPUY (71)
MBChB; MRCOG[8]; PhD; FRCOG[9]; FCOG (SA)[10]
Member of the Clinical Governance Committee.

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

MR TOM WIXLEY (78)
BCom; CA(SA)
Member of the Nomination Committee.

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

3 Resigned 15 March 2018.
4 Certified Information Systems Auditor.
5 Certified Internal Auditor.
6 Masters in Family Medicine.
7 Fellow of the College of Physicians of South Africa.
8 Member of the Royal College of Obstetricians and Gynaecologists.
9 Fellow of the Royal College of Obstetricians and Gynaecologists.
10 Fellow of the College of Obstetricians and Gynaecologists of South Africa.
Note: all ages as at 31 December 2018.

Audit Committee

The Audit Committee is a statutory committee established in terms of Sections 36 (10) to (13) of the Act. This Committee 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.

The Committee supports 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 the effectiveness and appropriateness of the combined assurance model;
- Monitoring matters relating to the sustainability of the Scheme to the extent that it has an impact on the financial results; and
- Recommending annual contribution increases for approval by the Board.

Combined assurance

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

1. **First Line** – Scheme management.
2. **Second Line** – Group Risk Management, Compliance and Forensics.
3. **Third Line** – 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 2018 benefit year. The Trustees are comfortable with the level and type of assurance the Scheme obtains.

Activities during 2018

The Committee continued to support the Trustees in fulfilling their governance and oversight responsibilities during the year. It is satisfied that its activities, reporting and recommendations to the Board during 2018 have fulfilled its responsibilities in accordance with its terms of reference.

Composition and meetings in 2018

The Audit Committee comprises highly skilled and experienced members with extensive actuarial, legal, financial and IT skills. At the end of 2018, the Committee comprised three Trustees and four Independent members, one of whom chaired the 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 Managed Care Provider and Scheme management present. Committee members 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, attend all Committee meetings by invitation and have unrestricted access to the Chairperson of the Audit Committee. The heads of the outsourced administration functions also attend the meeting to provide the Committee with insight and comfort regarding the outsourced functions.

Audit Committee attendance in 2018		22 Mar	06 Apr[A]	18 Apr[A]	14 Aug	21 Aug	05 Sep[A]	09 Oct
Independent member/ Chairperson	Mr Barry Stott	✓	✓	✓	✓	x	✓	✓
Committee members	Ms Daisy Naidoo (Trustee)	✓	✓	✓	✓	✓	✓	✓
	Adv Joan Adams (Trustee)	✓	✓	✓	✓	✓	✓	✓
	Mr Johan Human (Trustee)	✓	✓	✓	x	✓	✓	✓
	Ms Susan Ludolph (Independent Member)	✓	✓	✓	✓	✓	✓	✓
	Mr Steven Steven (Independent Member)	✓	x	✓	✓	✓	x	✓
	Ms Philile Maphumulo (Independent Member)	✓	✓	x	✓	✓	✓	✓
Attendee	Mr Imtiaz Ahmed (Independent Member)	–	–	✓	–	–	–	–

A *Ad hoc meetings:*

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

- *The meeting of 05 September 2018 included the Audit and Product Committees to approve the DHMS Actuarial Valuation Report.*
- *The meeting of 06 April 2018 was held for the Audit Committee and Stakeholder Relations and Ethics Committee to discuss the disclosure of regulatory matters in the 2017 Integrated Report ("IR").*
- *The meeting of 18 April 2018 was held as part of a consultative process for input into the Chief Financial Officer role. Mr Ahmed was invited to attend to provide input from the perspective of the Investment Committee.*

x *Apology tendered.*

FUTURE FOCUS AREAS

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

Clinical Governance Committee

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

The Committee comprises members with the requisite skills to consider the clinical complexities in healthcare funding. It oversees the functions performed by Discovery Health in terms of the managed care agreement. In this regard, it has insight into clinical and utilisation risk management, funding policies and protocols, management of clinical exceptions and ex-gratia requests and decisions, clinical pilot projects, member complaints, appeals and disputes, research and development of clinical best practice, and health benefit formulation.

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 complies with its managed care mandate to offer members the highest level of appropriate, affordable quality care, 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 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 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.

The Committee also engages with Health Quality Assessment (HQA), an independent industry body that performs an annual assessment of clinical quality offered by medical schemes according to specific quality indicators, which it provides to a participating scheme in an annual scheme-specific report. This report assists the Committee in fulfilling its mandate to oversee and improve the quality of healthcare received by Scheme members.

Activities during 2018

The Committee continued its focused strategy to oversee the development and implementation of strategic risk management interventions, which are designed to mitigate the impact of demand and supply side utilisation factors contributing to healthcare inflation above the rate of consumer price inflation. At the same time, the Committee took cognisance that these interventions did not unduly impact members and healthcare providers in terms of quality of healthcare accessible to members and provider interests, including professional autonomy and fair remuneration respectively.

The Committee met four times during 2018 and considered strategic risk management plans and reports. The Committee supported and monitored the impact of various in – and out-of-hospital, health professionals and health technology risk management initiatives deployed by Discovery Health to manage increased utilisation that is contributing to escalating medical inflation.

A key theme interrogated by the Committee during the year was the trends observed in oncology (cancer) epidemiology and the Scheme's growing prevalence and claims experience. The Committee considered relevant interventions from a benefit design and patient experience perspective, some of which have been approved for 2019 product enhancements. In addition, a centralised oncology service model was implemented. A further focus area was psychiatry, which also had a benefit enhancement approved for 2019.

The Committee approved and monitored the development of new value-based care initiatives, including the introduction of the GP Value Based Multiplier (VBM) which rewards General Practitioners adopting value-based care principles, as measured on performance on three parameters (access, efficiency and quality). The Committee also considered the 2017 HQA results for the Scheme, which are benchmarked against industry performance, and approved related plans for continuous improvement.

In line with the adoption of the value-based care model, the Committee monitored the implementation of new governance projects, being the joint arthroplasty network and the obstetric governance project, which both launched in July 2018. The Committee provided oversight to ensure sufficient stakeholder engagement and collaboration with healthcare professionals and the regulator (being the Health Professions Council of South Africa), and adequate access for the members to the joint arthroplasty network.

The Committee continued to provide oversight in relation to the approval and monitoring of new and on-going pilot projects. These include pilots testing supply side re-engineering to promote delivery of healthcare through multi-disciplinary care teams and care-coordination in different contexts, within a defined population and for members with complex care needs. Other initiatives considered and supported by the Committee are alternative settings for delivery of care where appropriate, including in the home environment.

The Committee also continues to monitor and engage in developments in the private healthcare market and regulatory reform initiatives, including considering the provisional findings and recommendations report issued by the Health Market Inquiry (HMI), the National Health Insurance (NHI) Bill, Medical Schemes Act Amendment Bill, and the Prescribed Minimum Benefits (PMB) Review project.

The Committee is satisfied that the activities it has conducted and the manner in which it has reported and recommended to the Board during 2018 have fulfilled its responsibilities in accordance with its terms of reference.

Composition and meetings in 2018

At the end of 2018, Committee members included two Trustees, one of whom chaired the Committee, and three Independent members and the Chief Medical Officer of the Scheme.

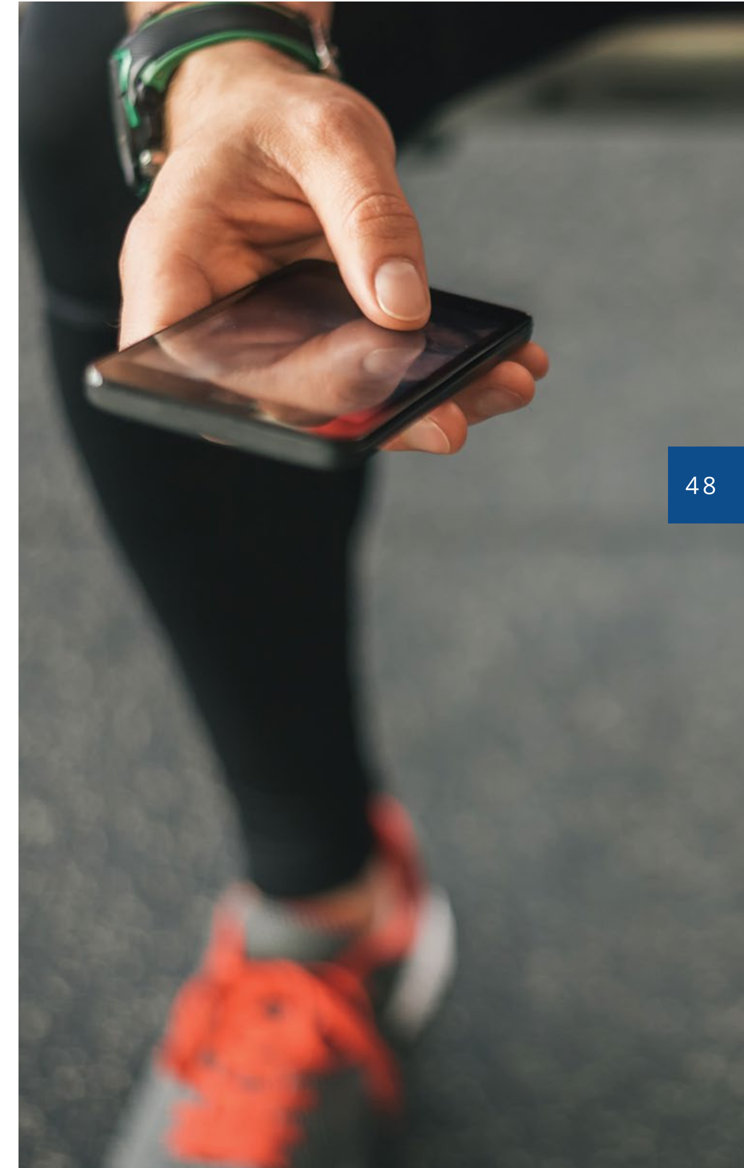
Regular attendees of Committee meetings include experts from Discovery Health's clinical and risk management teams. The Committee also hosts occasional external speakers on specific topics of interest to the Committee.

Clinical Governance Committee attendance in 2018		27 Mar	05 Jun	25 Sep	08 Nov
Trustee/ Chairperson	Dr Dhesan Moodley	✓	✓	✓	✓
Committee members	Adv Joan Adams (Trustee)	✓	✓	✓	✓
	Prof Zephne van der Spuy (Independent member)	✓	✓	✓	✓
	Prof Mike Sathekge (Independent member)#	–	–	–	–
	Prof Selma Smith (Independent member)	✓	x	✓	✓
	Dr Nonkululeko Mlaba (Independent Member)*	–	–	✓	✓
	Dr Unati Mahlati (Chief Medical Officer)%	✓	✓	✓	✓

 # Resigned as Independent Member on 15 March 2018
** Appointed as Independent Member on 10 September 2018*
% Scheme Executive. All other Committee members are non-executive.
– Not required to attend.
x Apology tendered.

FUTURE FOCUS AREAS

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



Disputes Committee

The Trustees established an independent Disputes Committee to hear and rule on all formally lodged member disputes in an open, transparent and equitable manner.

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

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

The Committee's responsibilities are to:

- Receive submissions from Scheme members and the Scheme's representatives, which may be made in person, by telephone or in writing;
- Ensure that it has sufficient information regarding the dispute to adjudicate the case objectively;
- Adjudicate the dispute and draft a ruling with due regard for all facts presented at the hearing and in line with relevant legislation and the Scheme Rules; and
- Ensure that the process at hearings and in adjudicating disputes is handled as efficiently as possible and without undue delay.

Activities during 2018

The Committee heard a total of 72 disputes. Although 724 disputes were lodged in 2018, 503 of these were resolved prior to a hearing, indicating the efficacy of the dispute resolution process.

Oversight of the Committee's activities, on behalf of the Board, was moved from the Clinical Governance Committee to the Stakeholder Relations and Ethics Committee as the scope of the Committee's work is broader than only medical matters, and may cover a full spectrum of stakeholder concerns.

The Committee is satisfied that the activities it has conducted during 2018 have fulfilled its responsibilities in accordance with its operating framework.

Composition and meetings in 2018

Each Disputes Panel consists of three members drawn from the greater Disputes Committee, each of whom have either legal or medical expertise. Each Panel presiding over all Dispute Hearings requires at least one legal expert and at least one medical expert.

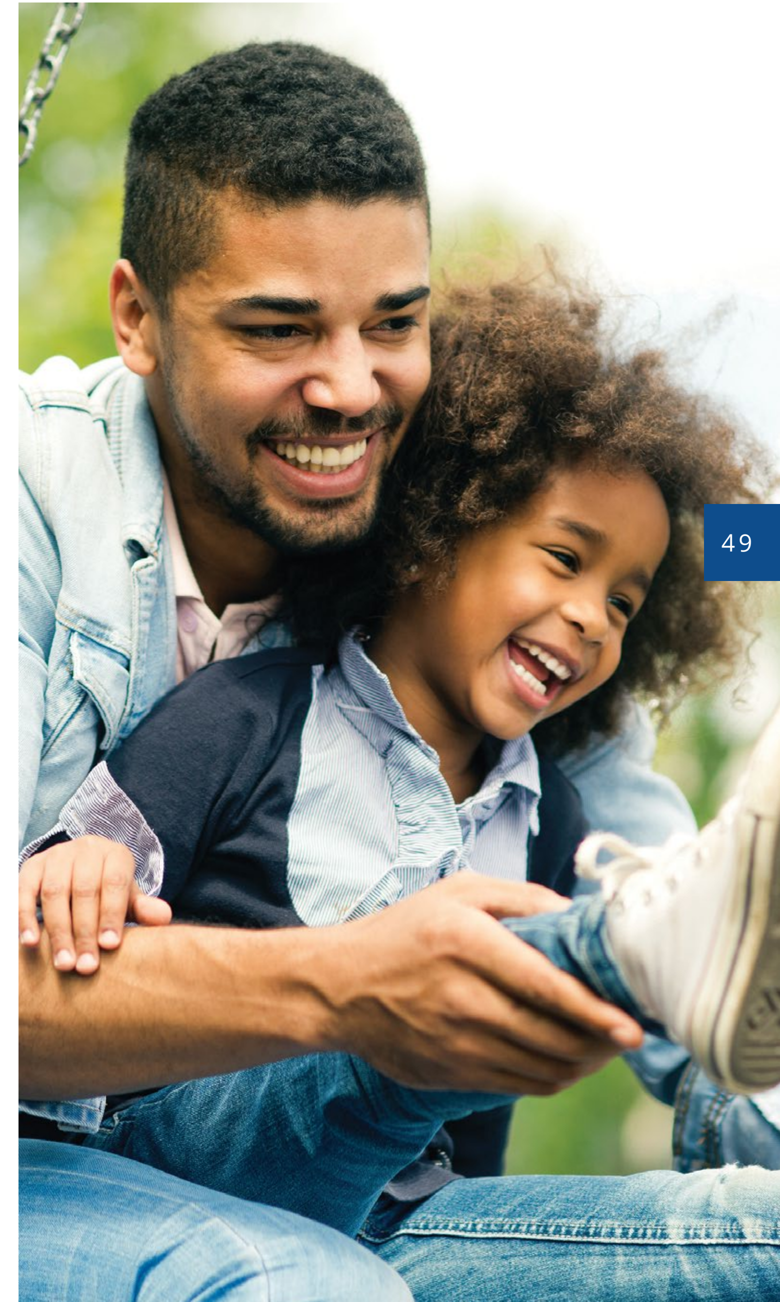
The Chairperson of all Dispute Hearings is always a practising attorney. While not employed by the Scheme, Committee members are remunerated for their time and input in objectively hearing and adjudicating cases, regardless of the outcome of the hearings.

Dispute Hearings are scheduled as and when required, and draw from the legal and medical panellists available at the time. The Committee can be constituted several times a week if required to attend to increased caseloads.

Due to the frequency of hearings and variation of panellists, an attendance register is not shown. During 2018, every hearing was properly constituted.

FUTURE FOCUS AREAS

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



Investment Committee

The Investment Committee recommends and oversees the implementation and maintenance of investment policies and mandates. It advises the Trustees on strategic and operational matters regarding investing the Scheme's reserves to ensure that investments made are in the best interest of members and within the risk appetite of the Scheme, as determined by the Trustees.

The Committee's responsibilities are to:

- Recommend to the Trustees an investment policy for the Scheme, having regard to the requirement that the assets invested should maximise returns while maintaining solvency;
- 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;
- 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; and
- Assist the Trustees in preparing their annual report on investment performance and compliance.

Activities during 2018

- Considered the Scheme's strategic investment strategy as well as the tactical asset allocations that take account of current market conditions.
- Oversaw the implementation of the updated long-term asset allocation plan.
- Recommended an updated Investment Policy Document to the Board for approval.
- Reviewed the results of the Scheme's annual due diligence exercise conducted across its asset managers, which included on-site visits by the Scheme.
- Reviewed the performance of asset managers.
- Agreed to allocate a portion of the investments to a portfolio that aims to extract additional returns by investing in longer-term securities.
- Reviewed the Treasury Management Function.
- Reviewed the effectiveness of services provided by the investment consultant.

The Committee is satisfied that the activities it has conducted and the manner in which it has reported and recommended to the Board during 2018 have fulfilled its responsibilities in accordance with its terms of reference.

Composition and meetings in 2018

At the end of 2018, the Committee consisted of four Trustees and three Independent members. The Committee receives investment advice and quarterly reports from the Scheme's investment consultants, Riscura, who attend all Committee meetings. Asset managers are invited to attend meetings on a rotational basis to report on their strategy and performance.

Investment Committee attendance in 2018		12 Feb	18 Apr[A]	16 May	07 Aug	06 Nov
Independent member/ Chairperson	Mr Imtiaz Ahmed[#]	✓	✓	✓	✓	✓
Committee members	Dr Dhesan Moodley (Trustee)*	✓	✓	✓	✓	✓
	Ms Daisy Naidoo (Trustee)	✓	✓	✓	✓	✓
	Mr Johan Human (Trustee)	✓	✓	✓	✓	✓
	Mr Neil Morrison (Trustee)	✓	✓	✓	✓	✓
	Mr Barry Stott (Independent member)	✓	✓	x	✓	✓
	Ms Philile Maphumulo (Independent member)	✓	x	✓	x	✓

A *Ad hoc meetings:*
Ad hoc meetings may be shorter than scheduled Board or Committee meetings. Trustees and Committee members are remunerated according to the duration of such meetings.

- *The meeting of 18 April 2018 was a discussion of the IoDSA appraisal results and a review and confirmation of the Board's delegation of authority to the Committee.*

Resigned as Chairperson on 19 April 2018.
* *Appointed from amongst Committee members as Chairperson on 23 April 2018.*
– *Not required to attend.*
x *Apology tendered.*

FUTURE FOCUS AREAS

During 2019, the Committee will review the Scheme's asset allocation to account for changes in the market conditions and the Scheme's risk appetite.

Non-healthcare Expenses Committee

The Committee oversees the optimisation and management of the Scheme's non-healthcare expenses[1] and the outsourcing of the administration and managed healthcare services based on the Scheme's Vested® outsourcing model (Vested model).

The Committee's responsibilities are to:

- Support and endorse key principles that the Scheme Office will use in negotiating the contractual terms of the outsourced administration and managed services based on Vested® principles, and recommend the contractual terms to the Trustees for consideration and approval;
- Recommend the fee model to be used for the calculation of the outsourced administration and managed care fees to the Trustees for consideration and approval;
- Set and monitor service levels for the outsourced Administrator and Managed Care Provider services;
- Monitor the value the Scheme and its members receive from the Administrator and Managed Care Provider relative to the fees paid;
- Monitor and evaluate the level of investment in innovation by the Administrator and Managed Care Provider for the Scheme;
- Recommend the non-healthcare expenses budget to the Trustees for consideration and approval, and monitor actual non-healthcare expenses incurred against the approved budget; and
- Recommend the Scheme's Procurement Policy to the Trustees for consideration and approval, and monitor procurement decisions.

Activities during 2018

- Reviewed and monitored reports on the service levels achieved by Discovery Health and approved changes 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 2019 budget to the Trustees for approval.

The Committee is satisfied that the activities it has conducted and the manner in which it has reported and recommended to the Board during 2018 have fulfilled its responsibilities in accordance with its terms of reference.

Composition and meetings in 2018

At the end of 2018, the Committee comprised four Trustees, one of whom chaired the Committee, and the Principal Officer. Committee meetings are attended by the DHMS Chief Operations Officer, who is responsible for oversight of the outsourced administration and managed healthcare services, as well as the Head of Legal and Ethics. Executive management of Discovery Health attend when required by the Committee.

Non-healthcare Expenses Committee attendance in 2018		26 Mar	31 Jul	17 Oct
Trustee/ Chairperson	Ms Daisy Naidoo (Trustee)	✓	✓	✓
Committee members	Mr Dave King (Trustee)	✓	✓	✓
	Mr John Butler (Trustee)	✓	x	✓
	Mr Neil Morrison (Trustee)	✓	✓	✓
	Dr Nozipho Sangweni (Principal Officer)%	✓	✓	x

% Scheme Executive. All other Committee members are non-executive.
x Apology tendered.

FUTURE FOCUS AREAS

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

1 The sum of non-healthcare fees paid to the Administrator, financial adviser commissions and other operating expenses (which include staff costs, bad debts, impairments etc.).

Nomination Committee

The Committee oversees the nomination process to elect and appoint suitably fit and proper persons as Trustees. In terms of the Scheme Rules, the Trustees may appoint an independent third-party service provider to assist the Nomination Committee in carrying out its functions. For the 2019 election, the Trustees have approved the appointment of PwC's Forensic Services division as the independent third-party service provider to assist the Nomination Committee.

Activities during 2018

The following activities were initiated by the Committee for the 2019 Trustee elections. This process will continue into 2019:

- Oversee the procedural aspects of the nominations process in terms of approving communications to members.
- Ensure that the Independent Electoral Body (IEB) applies a vetting process to ensure that candidates who stand for election are fit and proper. During the vetting process, each nominee is subject to strict vetting criteria.
- Review and discuss the draft candidate list compiled by the IEB, and thereafter present the final list to the Trustees in terms of the candidates that will stand for election.

The Committee will report to the Board on its activities for the 2019 election and fulfil its responsibilities in accordance with its terms of reference.

Composition and meetings in 2018

The Board, after discussion at their meeting held on 28 August 2018, approved the reconstitution of the Nomination Committee for the purposes of the 2019 and 2020 nominations and elections processes. The Committee comprises three Independent members who are independent of the Board and Board Committees. Committee meetings are attended by the IEB and its representatives.

In preparation for the 2019 nominations process for the election to be held at the June 2019 annual general meeting (AGM), two Nomination Committee meetings were held on 16 October 2018 and 26 November 2018, respectively.

Nominations Committee attendance in 2018		19 Jul*	16 Oct	26 Nov
Independent Member/ Chairperson	Mr Peter Goss	✓	✓	✓
Committee members	Mr Roy Shough (Independent member)	✓	✓	✓
	Mr Tom Wixley (Independent member)	✓	✓	✓

* *The meeting of 19 July 2018 was a working meeting to discuss a request for information regarding an independent electoral body service.*

FUTURE FOCUS AREAS

Trustee elections will be held in 2019 and 2020 and the Nomination Committee will oversee this process from a governance perspective in terms of its mandate.

Product Committee

While there is no statutory requirement for this Committee, it was established in terms of Scheme Rule 19.3, as the Trustees consider it necessary for ensuring compliance to the legislative and regulatory requirements of the Act, and to comply with best practice governance principles pertaining to benefit and product development.

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

The Committee ensures that benefit proposals are assessed against the following factors every year:

- Clinical appropriateness and best practice;
- Financial affordability and sustainability;
- Balancing the interests of stakeholders according to principles of fairness;
- Value and appropriateness to members; and
- The Scheme's marketing and communication policies.

Activities during 2018

- Considered the Scheme's 2017 annual and 2018 quarterly financial performance and related factors.
- Reviewed the impact of the benefit changes made for 2018, comparing actual versus expected utilisation and cost measures.
- Considered the marketing strategy and plan.
- Reviewed the performance of all benefit plans based on specific performance metrics.
- Reviewed and recommended the 2019 product and benefit amendments to the Trustees for approval.
- Considered changes to the Scheme Rules.

The Committee collaborated with the Audit Committee and Clinical Governance Committee in considering the financial impact, actuarial valuation and clinical appropriateness of the product design and benefit amendments for 2019, prior to making the final recommendations to the Board for approval.

The Committee is satisfied that the activities it has conducted and the manner in which it has reported and recommended to the Board during 2018 have fulfilled its responsibilities in accordance with its terms of reference.

Composition and meetings in 2018

At the end of 2018, the Committee comprised four Trustees, one of whom chaired the Committee, and the Principal Officer. The Committee obtains regular reports and presentations from Discovery Health, and the relevant individuals are regularly invited to Committee meetings for this purpose.

The Product and Audit Committees jointly considered the actuarial valuation and contribution increases, and invited the Scheme's external auditors, PwC, and the Scheme's independent actuaries, Insight Actuaries & Consultants, to attend the meeting. The Committee also hosted external speakers on specific topics of interest to the Committee.

Product Committee attendance in 2018		11 Apr	24 Jul	21 Aug
Trustee/ Chairperson	Mr Johan Human (Trustee)	✓	✓	✓
Committee members	Dr Dhesan Moodley (Trustee)	✓	✓	✓
	Ms Daisy Naidoo (Trustee)	✓	✓	✓
	Dr Susette Brynard (Trustee)	✓	x	✓
	Dr Nozipho Sangweni (Principal Officer)%	✓	✓	✓

% Scheme Executive. All other Committee members are non-executive.
x Apology tendered.

FUTURE FOCUS AREAS

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

Remuneration Committee

The Committee assists the Trustees in overseeing the Scheme's remuneration and other human resources strategies and policies, and ensuring 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 is followed for appointing senior staff.

The Committee's responsibilities are to:

- Review staff remuneration, including that of senior executives, Trustees and Board Committee members, as well as any retirement and termination payments;
- Ensure that remuneration policies are established and administered in the Scheme's long-term interests; and
- 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.

Activities during 2018

- Recommended Trustee and Committee member remuneration to the Trustees for approval, considering the non-profit status of the Scheme.
- Recommended Scheme Office senior staff remuneration to the Trustees for approval, based on market benchmarking conducted by independent remuneration practice experts.
- Reviewed training and development requirements for Scheme staff and recommended appropriate training and development initiatives to the Trustees for approval.

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.

With the support of the Committee, the Scheme presented its Trustee Remuneration Policy to members at its 2018 AGM for a non-binding advisory vote, which received 96% approval. The Scheme also presented its Trustee remuneration, which received 85% approval. The formal approval of Trustee remuneration by members is a standing agenda item at each AGM.

The Committee is satisfied that the activities it has conducted and the manner in which it has reported and recommended to the Board during 2018 have fulfilled its responsibilities in accordance with its terms of reference.

Composition and meetings in 2018

At the end of 2018, the Committee comprised four Trustees and an Independent member. The Principal Officer attends Committee meetings by invitation.

The Committee makes regular use of independent remuneration experts from PwC, and engaged Spencer Stuart for recruitment assistance during 2018. Individuals from these organisations are occasionally invited to Committee meetings.

Remuneration Committee attendance in 2018

		20 Feb	18 Apr[1]	24 May	26 Oct
Trustee/ Chairperson	Mr Dave King (Trustee)	✓	✓	✓	✓
Committee members	Mr John Butler (Trustee)	✓	✓	✓	✓
	Mr Neil Morrison (Trustee)	✓	✓	✓	✓
	Dr Susette Brynard (Trustee)	✓	✓	✓	✓
	Mr Ndumiso Luthuli (Independent member)*	–	–	✓	✓
Attendee	Daisy Naidoo (Trustee)∞	–	✓	–	–

** Appointed as Independent Committee Member on 12 April 2018.*
∞ Requested by Chairperson to attend meeting of 18 April 2018.
– Not required to attend.

1 The meeting of 18 April 2018 was held as part of a consultative process for input into the Chief Financial Officer role as well as to approve the Remuneration Policy and to appoint Mr Luthuli.

FUTURE FOCUS AREAS

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

Risk Committee

The Committee oversees risk management, compliance, IT governance, fraud, ethics, whistleblowing, legal and regulatory matters.

The Committee's responsibilities 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 compliance incidents;
- 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; and
- Review significant cases of conflict of interest, misconduct or fraud, or any other unethical activity.

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 Committee.

Risk management

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

Activities during 2018

- Participated in the annual risk assessment, which included representatives of the Committee, the Scheme Office and the Administrator and Managed Care Provider.
- Regularly reviewed risk management reports and key risk indicators, and performed the annual review of the risk management framework that was recommended to the Trustees for approval.
- Regularly reviewed compliance reports and monitored exposure and actions taken to mitigate compliance risks, as well as performed the annual review of the Compliance Policy. The Committee considered the policy and subsequently recommended it to the Trustees for approval.
- Received reports to assist in delivering the Scheme's IT governance obligations and recommended the IT Governance Framework to the Board for approval. This included a focus on cybersecurity and business continuity.
- Approved the Scheme's fraud risk management strategy.

The Committee is satisfied that the activities it has conducted and the manner in which it has reported and recommended to the Board during 2018 have fulfilled its responsibilities in accordance with its terms of reference.

Composition and meetings in 2018

At the end of 2018, the Committee comprised three Trustees and four Independent members, one of whom chaired the Committee. Members of the Scheme Office management are also members of the Committee.

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

Risk Committee attendance in 2018		06 Mar	26 Jul[A]	14 Aug	09 Oct
Independent member/ Chairperson	Mr Barry Stott	✓	✓	✓	✓
Committee members	Ms Daisy Naidoo (Trustee)	✓	✓	✓	✓
	Adv Joan Adams (Trustee)	✓	✓	✓	✓
	Mr Johan Human (Trustee)	✓	✓	✓	✓
	Ms Susan Ludolph (Independent member)	x	✓	✓	✓
	Mr Steven Green (Independent member)	✓	✓	✓	✓
	Ms Philile Maphumulo (Independent member)	✓	✓	✓	✓
Scheme Management	Dr Nozipho Sangweni (Principal Officer)	x	✓	✓	✓

A Ad hoc meetings:
Ad hoc meetings may be shorter than scheduled Board or Committee meetings. Trustees and Committee members are remunerated according to the duration of such meetings.
- *The meeting on 26 July 2018 was a workshop.*

x Apology tendered.

FUTURE FOCUS AREAS

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

Stakeholder Relations and Ethics Committee

The purpose of the Stakeholder Relations and Ethics Committee is to assist the Trustees in the oversight of:

Ethics and society:

- Assist the Board of Trustees to ensure that the Scheme has an ethical culture and is a good corporate citizen;
- Oversee, monitor and evaluate the ethics of the Scheme in a way that supports the establishment of an ethical culture;
- Oversee, monitor and evaluate the corporate citizenship of the Scheme such that the Scheme is, and is seen to be, a responsible corporate citizen; and
- Oversee and monitor the development of adequate processes and procedures for the management of the Scheme's ethics and corporate citizenship.

Stakeholder relations:

- Identify material stakeholder groupings and individuals as well as their legitimate needs, interests and expectations;
- Oversee, monitor and evaluate the management of and engagement with DHMS's material stakeholders; and
- Oversee and monitor the development of adequate processes and procedures for engagement with DHMS's material stakeholders.

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

Activities during 2018

- Reviewed reports relating to its social and ethics mandate, overall stakeholder engagement and risk, social media engagement, disputes and complaints, and high-risk cases.
- Reviewed Discovery Health's fraud and forensic recoveries activities, conducted on behalf of the Scheme.
- Reviewed the Scheme and Discovery Health's readiness and plans for catering for new information privacy requirements.
- Reviewed plans for engagement with stakeholders with regard to the Scheme's AGM and Trustee nominations and elections.
- Reviewed health professional engagement strategies to encourage participation in quality of care, alternative reimbursement mechanisms and centres of excellence initiatives in development by Discovery Health.
- Reviewed responses by stakeholders to year-end benefit changes, and the plans for engagement with these stakeholders where required.
- Considered the recommendation that oversight of the Disputes Committee, previously overseen by the Clinical Governance Committee, be moved to the Stakeholder Relations and Ethics Committee, and approved the move.
- Recommended to the Board that its terms of reference be amended to allow for the appointment of an Independent Committee member, should succession planning and knowledge gaps indicate the requirement for an additional member and, subsequent to Board approval, adopted a revised terms of reference in this regard.
- Considered the results of a review of its effectiveness conducted by an independent third party, identified gaps and implemented improvements.

The Committee is satisfied that the activities it has conducted and the manner in which it has reported and recommended to the Board during 2018 have fulfilled its responsibilities in accordance with its terms of reference.

Composition and meetings in 2018

At the end of 2018, the Committee comprised five Trustees, one of whom chaired the Committee, and the Principal Officer. The Committee requires that one of its members is a member of the medical profession.

Committee meetings are attended by the Head: Special Projects and Stakeholder Relations. In addition, 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. External experts are also occasionally invited to address the Committee.

Stakeholder Relations and Ethics Committee attendance in 2018		27 Feb	06 Apr[A]	24 May[A]	17 Jul	25 Oct
Trustee/ Chairperson	Mr John Butler SC (Trustee/Chairperson)	✓	✓	✓	✓	✓
Committee members	Dr Dhesan Moodley (Trustee)	✓	✓	✓	✓	✓
	Mr Dave King (Trustee)	✓	✓	✓	✓	✓
	Dr Susette Brynard (Trustee)	✓	✓	✓	✓	✓
	Mr Neil Morrison (Trustee)	✓	✓	✓	✓	✓
	Dr Nozipho Sangweni (Principal Officer)[%]	✓	✓	x	✓	✓

A *Ad hoc meetings:*
Ad hoc meetings may be shorter than scheduled Board or Committee meetings. Trustees and Committee members are remunerated according to the duration of such meetings.
- *The meeting of 06 April 2018 was held for the Audit Committee and Stakeholder Relations and Ethics Committee to discuss the disclosure of the regulatory matters in the 2017 Integrated Report ("IR")*
- *The meeting of 24 May 2018 was held to discuss the Statement of Intent: Requisite Ethical Conduct.*

x *Apology*
% *Scheme Executive. All other Committee members are non-executive.*

FUTURE FOCUS AREAS

The Committee will be engaging further with The Ethics Institute and with Discovery Group's corporate social responsibility initiatives in a continued expansion of its ethics and society mandate.

OUR REMUNERATION POLICY

The Board of Trustees is responsible for the development and implementation of a Remuneration Policy for the Board of Trustees and Board Committee members. The Board of Trustees has delegated the responsibility of Scheme remuneration oversight to a Remuneration Committee (Remco). Remco consists of four Trustees and an Independent member.

It is important to note that Remco uses independent expert consultants and independent market benchmarking to assist the Committee in terms of best remuneration practices.

Trustee remuneration disclosure occurs in three forums:

- At the annual general meeting (AGM);
- To the CMS, the Scheme's Regulator; and
- In the Scheme's Integrated Report.

Trustee remuneration is based on a professional hourly rate, discounted to take into account that the Scheme is a non-profit entity. This is the building block of all Trustee and Board Committee remuneration, and is the rate that members are required to vote on via ballot at this meeting.

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

The Remuneration Policy is based on the requirement set out by the CMS in Circular 41 of 2014 and was presented to members for the first time at the 2014 AGM, where it was approved by a majority of members in attendance.

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

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

It is important to note that Trustees are also members of Board Committees and that each Board Committee differs with regard to preparation time, duration of meetings, and number of meetings in the year.

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

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

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

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

For 2018, the Scheme has made additions to the Remuneration Policy in order to clarify certain eventualities which were not clearly defined previously (such as Independent Board Committee member remuneration and the treatment of unplanned meetings). The changes made to the Policy do not deviate from the methodology and structure of fees as set out in the submission made to the CMS on 24 November 2014.

SCHEME EXECUTIVE MANAGEMENT

The Trustees, as one of their fiduciary duties, appoint and delegate accountability for the day-to-day management of the Scheme to the Principal Officer and the Scheme Office.

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

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

Guided by the Act, its Regulations, the Scheme Rules, the Board delegation of authority, and applicable laws, codes and standards, the Principal Officer is supported by an executive management team to execute the strategic objectives of the Scheme. The team works in collaboration with the Administrator and Managed Care Provider, Discovery Health, in implementing strategy. The management team's diverse expertise includes medical, actuarial, risk management, accounting, business management, strategic development, financial management, investment, legal, ethics, compliance and research capabilities.

REMUNERATION AND HUMAN RESOURCES PLANNING

The Trustees and the Remuneration Committee direct and oversee remuneration for the employees of the Scheme Office, which is based on best practice, and carefully structured and independently benchmarked according to the experience and skills required. This aims to attract and retain high-calibre staff.

In 2018, the Scheme Office consisted of twelve staff members, with a team of five[1] executives reporting to the Principal Officer and supported by a Scheme Secretariat department and an administration department. This very lean employee complement makes succession planning challenging. As a result, the operational model applied by the Scheme Office requires significant overlap in the capabilities of the executive team. This must be supported by a mature knowledge management and retention strategy to mitigate this risk in various ways, including sufficiency in the notice period for scarce skills to allow for transition.

STAFF MOVEMENTS AND ORGANISATION REDESIGN DURING 2018/9

During the course of 2018, the Chief Risk and Operations Officer continued as acting Chief Financial Officer. The role title was amended to Chief Operations Officer and role responsibilities now incorporate the investment portfolio. From 1 March 2019, Ms Mbewu-Sanqela joined the Scheme Office as the new Chief Financial Officer and Mr Kahlberg's acting role in this regard ended.

Mrs Yashmita Mistry, Head: Governance and Compliance, resigned on 30 September 2018, and recruitment for a replacement is underway.

SCHEME SECRETARIAT

Within its operational structure, the Scheme has a secretariat function that is appropriately qualified and experienced to provide the Trustees with support regarding their duties, responsibilities and powers. In addition, the secretariat function ensures that accurate minutes of all Board and Committee meetings are prepared, distributed and stored appropriately.

DELEGATION OF AUTHORITY

The Board has implemented a formal delegation of authority that defines the authority, roles and responsibilities required for the optimal operation of the Scheme. The delegation of authority is reviewed and updated whenever necessary to ensure relevance to operating requirements and alignment with the accountabilities and authorities of Scheme employees.

1 *The Chief Financial Officer role was vacant during this period.*

PRINCIPAL OFFICER
Dr Nozipho Sangweni
MBChB; MBA; PGDip Occupational Health; PGDip Civil Aviation Management

Accounting Officer of the Scheme, Council member of iFHP[1], and a board member of the HFA[3].

5

HEAD: LEGAL AND ETHICS
Mr Howard Snoyman
LLB; MSc. Med (Bioethics and Health Law); Certified Deal Architect[4]; Dip Sports Management; Adv Dip Sports Management.

President and board member of the Corporate Counsel Association of South Africa[2]; board member of the Marketing Code Authority.

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

3

HEAD: SPECIAL PROJECTS AND STAKEHOLDER RELATIONS
Ms Michelle Culverwell
BA (Hons); MBA in Executive Management

Member of the HFA[5] Technical Advisory Committee

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

1

CHIEF OPERATIONS OFFICER
Mr Selwyn Kahlberg
ACTING CHIEF FINANCIAL OFFICER (from 1 January 2018)
BSc (Hons) Actuarial; CFA; FASSA; FIA

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

4

CHIEF MEDICAL OFFICER
Dr Unati Mahlati
MBChB; FCPHM[6]; MMed

Board member of HQA[7].

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

Not shown

HEAD: GOVERNANCE AND COMPLIANCE
Mrs Yashmita Mistry[8]
LLB

This role provides a central source of guidance to the Scheme on governance matters. Ensures the management, coordination and responsibility for the Scheme Secretariat function, as well as compliance with the Scheme's legislative and regulatory universe.

2

CHIEF FINANCIAL OFFICER
Ms Charlotte Mbewu-Sanqela
BCom (Hons) Accounting; CA (SA)

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

1 *iFHP: International Federation of Health Plans.*
2 *Resigned 31 March 2019.*
3 *HFA: Health Funders Association.*
4 *The Vested Certified Deal Architect (CDA) programme, offered by the University of Tennessee, is for individuals who want to become an expert in the field of crafting strategic partnerships based on Vested agreements.*
5 *HFA: Health Funders Association.*
6 *Fellow of the College of Public Health Medicine of South Africa.*
7 *HQA: Health Quality Assessment.*
8 *Resigned 30 September 2018.*

REGULATORY AND INDUSTRY MATTERS
DEALT WITH IN 2018

CIRCULAR 42 OF 2018: DRAFT MEDICAL SCHEMES CONSOLIDATION FRAMEWORK

Issued on 19 September 2018, Circular 42 of 2018 invited comments from stakeholders on a proposed approach to reducing risk-pool fragmentation while strengthening financial risk protection and improving social solidarity through cross-subsidies in the current medical schemes environment. The approach took into consideration the provisions of the current Medical Schemes Act, Medical Schemes Amendment Bill, draft National Health Insurance Bill and the provisional findings of the Competition Commission's Health Market Enquiry (HMI), as well as national health policy.

DHMS supports measures to protect members of medical schemes and ensure the sustainability of schemes. DHMS submitted comments to the Council for Medical Schemes (CMS) on 20 November 2018, expressing its support for the overall goals of the Circular, and in addition pointing out some possible barriers to implementation and related industry interventions to be considered. DHMS also suggested some alternative mechanisms for addressing the problem as expressed in the Circular.

CMS MATTERS

Certain provisions of Rule 11 of the Scheme Rules remain unregistered with the CMS. Rule 11 deals with preventing members from re-joining the Scheme immediately after committing fraud or deliberate non-disclosure against it. In order to protect the Scheme's greater membership, the Scheme believes that such members should be prohibited from re-joining for a certain time period. During 2016, the Scheme appealed the non-registration of the relevant provisions of Rule 11 in terms of Section 49 and subsequently Section 50 of the Act. The Scheme was unsuccessful in both appeals.

Following legal advice, on 17 May 2017 the Trustees lodged a High Court Application to Review in terms of the Promotion of Administrative Justice Act, in conjunction with an Application for a Declarator confirming that the Act does not, on a proper interpretation, prohibit a medical scheme from imposing a timeframe within which those persons whose membership is terminated on account of fraud or non-disclosure may not re-apply for scheme membership. Separately, the Scheme is seeking confirmation that such period does not in fact constitute a "waiting period" as defined in S29A of the Act. This application is progressing.

The 2015 iteration of Scheme Rule 14.7, dealing with the rejection of claims from providers where they have placed the Scheme at risk, remains registered by the CMS in light of subsequent iterations of the Rule not having been registered. In this regard, the concern of the Scheme relates to fraudulent or illegal behaviour. At the time of writing, the 2019 iteration of Rule 14.7, as well as the rest of the main body of Scheme Rules, was still pending registration by the CMS.

When the Prescribed Minimum Benefits (PMB) Code of Conduct was established in 2010, it was acknowledged that a coordinated, consultative process would need to take place 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.

The CMS continues to periodically publish PMB Benefit Definitions for various PMB conditions, and the Administrator on behalf of the Scheme continues to review and submit comments and recommendations on the draft definitions, particularly in relation to contentious services, health technology or healthcare products which may not be cost-effective for schemes to fund.

A revision of the 2010 PMB Code of Conduct was initiated by the CMS in March 2017. Following stakeholder workshops and submissions, the CMS presented a draft revised PMB Code of Conduct for public comment through Circular 74 of 2017, published in November 2017. The Scheme and Discovery Health contributed to the Health Funders Association (HFA) submission in this regard. There has been no feedback or update from the CMS in this regard, thus the Scheme continues to fund PMBs in accordance with the 2010 Code of Conduct.

CMS Circulars 83 of 2016 and 1 of 2017 proposed a review of the PMBs. A PMB Review Project commenced in November 2017, following the appointment of industry stakeholder representatives to the PMB Review Advisory Committee and Costing Committee in October 2017. The Scheme is represented in these discussions through HFA representatives appointed to the two Committees. The Advisory Committee, working together with the Costing Committee, will ultimately make recommendations to the Joint Steering Committee for a comprehensive, affordable and sustainable service benefit package.

In February 2018, the CMS published Circular 6 of 2018, in which it proposed a draft framework for designing the service benefits package, and inviting stakeholders to make further inputs on the proposed framework. The proposed framework was essentially an expansion of the proposal contained in Circular 83 of 2016. The HFA submitted a response to the CMS, indicating its concern with this approach.

Following this submission, the Advisory Committee has made progress culminating in the adoption of a priority setting framework, namely the Multi-Criteria Decision Analysis (MCDA). In developing the new package, the Committee will endeavour to align this work with that underway to develop an NHI benefit package.

The Costing Committee hosted stakeholder engagements in November 2018, to obtain input from stakeholders regarding the PMB costing methodology. The Scheme, Administrator and HFA participated and provided input during the engagement with Funders.

Another CMS initiative supported by the Scheme and Administrator is the Industry Technical Advisory Panel's (ITAP) Managed Care Task Team, which is responsible for developing indicators to measure quality, outcomes and the value proposition of managed care interventions. The Scheme and Administrator attended working group meetings and provided inputs on the various minimum reporting data specifications published by the CMS during 2018.

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

COMPETITION COMMISSION'S HEALTH MARKET INQUIRY INTO THE PRIVATE HEALTHCARE SECTOR

The HMI seeks to determine whether there are aspects of the South African private healthcare market that distort, restrict or prevent competition. The Scheme supports the HMI and has cooperated fully and extensively with the HMI Panel. The Competition Commission's provisional HMI report was published in July 2018, and DHMS submitted extensive comments in response. The final report is expected to be published by 30 September 2019, as per the HMI's timetable published in February 2019.

NATIONAL HEALTH INSURANCE AND THE DRAFT MEDICAL SCHEMES AMENDMENT BILL

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

The NHI policy was approved by Cabinet in June 2017 and the draft NHI Bill was approved by Cabinet for release for consultation and published in the government gazette in June 2018.

The draft Medical Schemes Amendment Bill was released at the same time as the NHI Bill. The Bill proposes some significant changes to the Medical Schemes Act. While the Minister of Health indicated that these two Bills were intended to be "twinned", there seem to be inconsistencies in some provisions, including those relating to the exact role of private healthcare funders within an NHI environment. The Scheme submitted comments on both Bills in September 2018 and continues to participate and make relevant contributions to the process through various opportunities and forums open to stakeholders, including through Business Unity South Africa (BUSA) and the National Economic Development and Labour Council (Nedlac).

PERSONAL MEDICAL SAVINGS ACCOUNTS

On 6 June 2017, the Constitutional Court handed down judgement on the matter of "Genesis Medical Scheme v Registrar of Medical Schemes and Another". The judgement has implications on the technical accounting treatment of the funds in members' Medical Savings Accounts (MSAs). Issued by the CMS on 14 July 2017, Press Release 12 of 2017 provides an explanation of how the MSA funds are affected by the ruling. As a result of the ruling and the press release, the reflection of MSAs as trust assets has changed and are now reflected as Scheme assets, which affects how interest on accounts with positive balances is paid. The Scheme's Rules have been amended with effect from 1 January 2018 to reflect this position and to pay interest at its discretion and according to the MSA balance. With effect from 1 January 2018, these balances no longer reflect as trust assets and liabilities in the Scheme's Annual Financial Statements.

OUR PERFORMANCE

05

OUR PRINCIPAL OFFICER'S REVIEW OF THE YEAR

Performance overview

Despite many challenges over the past year, DHMS has been able to fulfil our purpose of caring for our members' health and wellness while also safeguarding their funds. We ended the year in a very solid position across all key measures for the growth and sustainability of the Scheme.

Our final net healthcare result for the year was a negative R352 million (2017: positive healthcare result of R968 million). This operating result was affected by absorbing the impact of higher Value Added Tax (VAT) on behalf of our members, and supported by effective risk management interventions that mitigated the financial impact of higher utilisation during the year. The 1% point increase in VAT drove claims and other expenditure up unexpectedly by approximately R350 million, which shows that in the absence of the VAT increase, the Scheme's net healthcare result would have been at break-even.

Another year of satisfactory investment performance, despite volatile markets, bolstered the Scheme's financial position. Investment income of R1 465 million (2017: R1 433 million) contributed to a net surplus for the year of R816 million. While the net surplus was down substantially from R2 450 million in 2017, member funds therefore remained robust at R17.6 billion (2017: R16.7 billion) and the Scheme achieved a solvency level of 27.3% (2017: 27.44%), above the required minimum of 25%. With solvency at this level, the Scheme has an intended adequate buffer against unexpected poor claims experience or low investment returns. The Scheme is careful to balance the need for adequate solvency levels in the short and medium term against allowing solvency to grow too large as this could result in an inefficient use of members' financial resources.

Managing difficult trade-offs for sustainability

The affordability constraints our members are experiencing in relation to their medical cover are of deep concern to us. While current economic conditions are forcing our members to make difficult decisions about how they allocate their income, the absence of medical cover can result in devastating consequences for families should unforeseen life events occur. Also, gaps in cover may result in a longer-term negative financial impact as schemes may impose late joiner penalties in these instances, to protect their risk pools.

Our first consideration in delivering the best possible value to our members, notwithstanding affordability concerns, is to continue to enhance the benefits they pay for wherever and whenever we can. An example during the year was enhancing our maternity benefit to provide comprehensive maternity and post-birth benefits to families, with guidance and support specifically focused on young families delivered through the member app.

Healthcare inflation continues, stubbornly, to outpace the consumer price index (CPI). To manage this risk, we focus on containing healthcare costs in every way we can. Wherever possible, we push for value-based contracting to optimise access to quality care at the lowest possible cost. This migration from the traditional fee-for-service payment model is critical in delivering sustainable value to our members, with multidisciplinary healthcare teams delivering less fragmented and better health outcomes for our members.

In this regard we also monitor global healthcare trends, which inevitably affect our members more over time. Already a grave public health concern is the presence of antibiotic-resistant infections – so called "superbugs" – which are stimulated by the overuse of antibiotics, and result in escalating claims costs. We consider minimising the impact of such concerning trends to be core to our responsibility to our members, and to greater society.

A more specific intervention during the year, to ease the financial burden on our members, was the Board's decision not to implement an interim contribution increase during 2018 but rather to absorb the cost increase due to higher VAT. Mindful that medical scheme contributions already make up a high proportion of our members' monthly expenses, the Trustees decided that the Scheme's strong financial position made it possible to absorb the VAT impact for 2018.

During the early months of 2018, the Scheme continued to experience a high hospital admission rate. These appeared to be largely short length of stay medical admissions, linked in part to higher occurrences of seasonal viral infections in particular among our more vulnerable members, including children. Interventions were introduced to ensure clinically appropriate hospital admissions and to manage the claims risk to the Scheme. Health benefit specialists were placed in key hospitals to assist members and providers in understanding and accessing member benefits, to balance appropriate levels of care with the Scheme's financial stability.

We are conscious that certain of our risk management interventions may be disruptive for some of our stakeholders, and we do whatever we can to balance the needs of all of our stakeholders in implementing them. Our duty of care as a medical scheme, however, requires that we make use of evidence-based healthcare delivery models that continually improve the quality of care as cost-effectively as possible.

For example, going into 2019, we introduced the use of a day surgery network for certain procedures on certain plans. The South African private healthcare sector lags behind other developed healthcare systems in the use of same-day surgery. In the US, for example, over 85% of eligible hospital admissions occur on a same-day basis. In South Africa, the rate is below 20%, with the vast majority of procedures carried out in general acute hospitals. Shifting a higher proportion of suitable patients to same-day surgery centres is a well-proven approach to improving quality of care and patient convenience, and to reducing cost.

Fraud, waste and abuse are unfortunately all too common in healthcare. They drive inflationary pressure in the system, and the misappropriation of limited resources ultimately has an adverse effect on the members and the sustainability of schemes. The Council for Medical Schemes (CMS) estimates that up to 15% of all claims in our sector are fraudulent, which amounts to a negative impact of an estimated R25 billion. In effect, this staggering amount is stolen from honest scheme members, reducing their funds and ability to access healthcare. DHMS is determined to combat this scourge to the best of our ability.

In 2018, the Scheme's savings and recoveries totalled approximately R500 million. We estimate our fraud and waste prevention strategies have resulted in a 'halo effect' of benefit to the Scheme of an estimated R4 billion in the past five years. Our Administrator and Managed Care Provider, Discovery Health, has invested significantly in proprietary forensic skills and assets that enable continuous monitoring of claims and identification of unusual claims patterns. We also continue to work closely with all stakeholders in reaching a common understanding of the drivers of fraud and waste. We are grateful to our regulator, the Council for Medical Schemes (CMS) and our industry body, the Health Funders Association (HFA), for their leadership in this regard, specifically the initiatives resulting from the Fraud, Waste and Abuse Industry Charter recently signed by sector stakeholders.

Contributing to positive healthcare reform

As our Chairperson has noted, healthcare reform gathered pace in the year. Our approach at this critical juncture in the development of the South African healthcare environment is to be found in our vision, in which the Scheme commits to collaborating with all relevant stakeholders to shape an inclusive and complete healthcare system in South Africa. In particular, we fully support the objectives of universal health coverage, and will continue to work with all parties to achieve it.

While we agree with the Minister of Health, Dr Aaron Motsoaledi, that addressing the challenges in the public healthcare system is crucial, retaining the role of the private sector in building a truly equitable and inclusive healthcare system is an absolute imperative. As such, we continue to engage and submit comments and contributions to all health reform initiatives.

We note that the Medical Schemes Amendment Bill (MSAB) appears to be on hold pending the release of the final Health Market Inquiry (HMI) Report, due in September 2019. We support the many positive recommendations in the Provisional HMI Report, which we believe will improve the functioning of the private healthcare market, including reinforcing the need for rigorous and excellent governance of schemes by fit and proper and highly competent trustees.

In another development, the proposed amendments to the Competition Act will influence the nature of competition in the South African economy. The amendments promote further inclusion of small and medium enterprises and those with historically disadvantaged ownership. Similarly, while we support the principle of the amendments, care must be taken to ensure effective competition that will stimulate and grow the economy at the levels we need to achieve dramatically higher levels of employment and socioeconomic equity.

Closing and appreciation

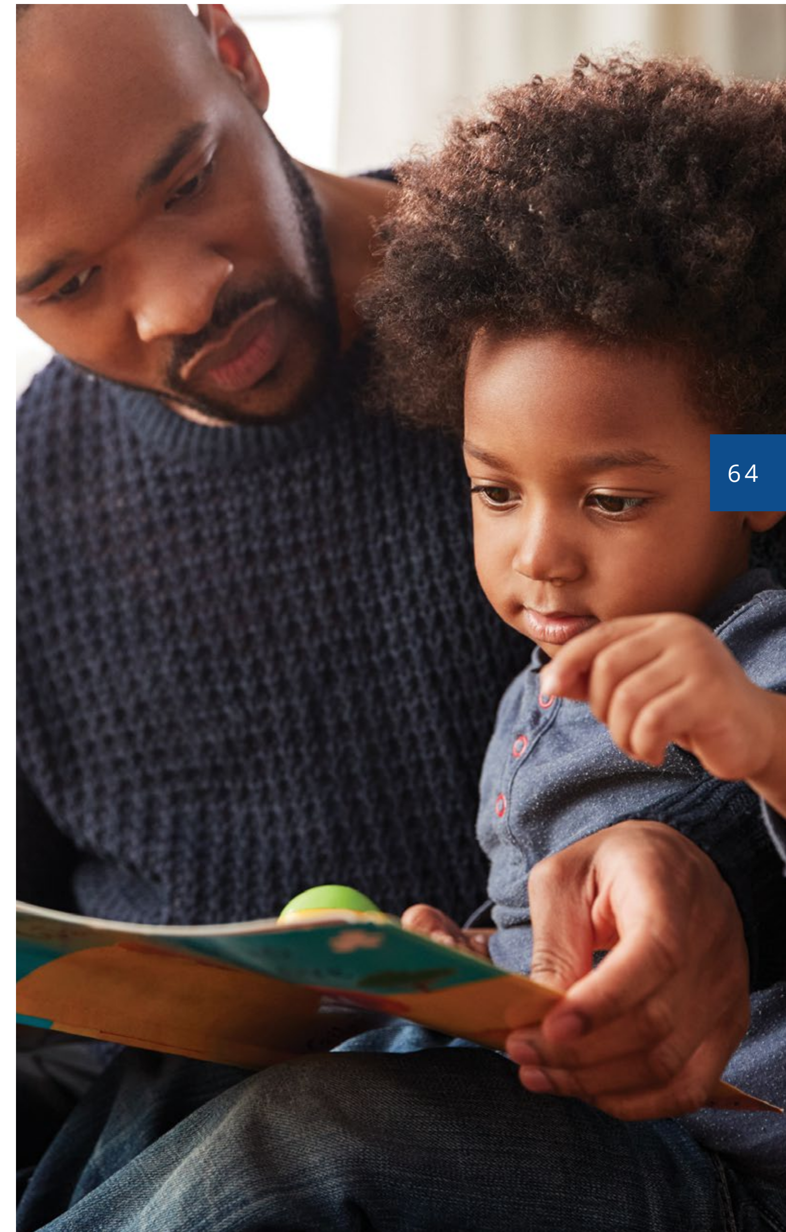
The Scheme Office welcomes our new Chief Financial Officer, Ms Charlotte Mbewu-Sanqela, who joined DHMS on 1 March 2019. Ms Mbewu-Sanqela has extensive experience in the medical schemes environment. Our Chief Operations Officer, Mr Selwyn Kahlberg, ably held the position in the interim and I thank him for being a safe pair of hands in what has been a challenging period for the Scheme.

My gratitude to the Trustees, Independent Committee members and to the Scheme Office team for their thought leadership and hard work in protecting and growing the Scheme despite the operational constraints and financial pressures.

Our members can rest assured that their funds, and their Scheme, are secure and sustainable and will be able to provide for their healthcare needs into the future.

Nozipho Sangweni

Dr Nozipho Sangweni
PRINCIPAL OFFICER



OUR PERFORMANCE

Overview

DHMS delivered a negative net healthcare result (contribution income less claims and all other Scheme expenses) of R352 million for the year ended 31 December 2018 (2017: positive healthcare result of R968 million).

The year-on-year reduction in the result was mainly attributable to the impact of the Value Added Tax (VAT) increase, as well as to higher claims costs due to increased utilisation of in-hospital and out-of-hospital health services over the period.

The rollout of enhanced and expanded risk management initiatives through the year successfully stemmed the increased utilisation. The increase in the rate of VAT from 14% to 15% from 1 April 2018 also had a material impact on the Scheme, resulting in an unbudgeted increase in claims costs and other expenses of approximately R350 million over the year. In the absence of the VAT increase, the Scheme would have had a break-even net healthcare result for 2018.

Despite volatile investment markets, the Scheme generated healthy investment income of R1 465 million (2017: R1 433 million), contributing to the net surplus for the year of R816 million (2017: R2 450 million).

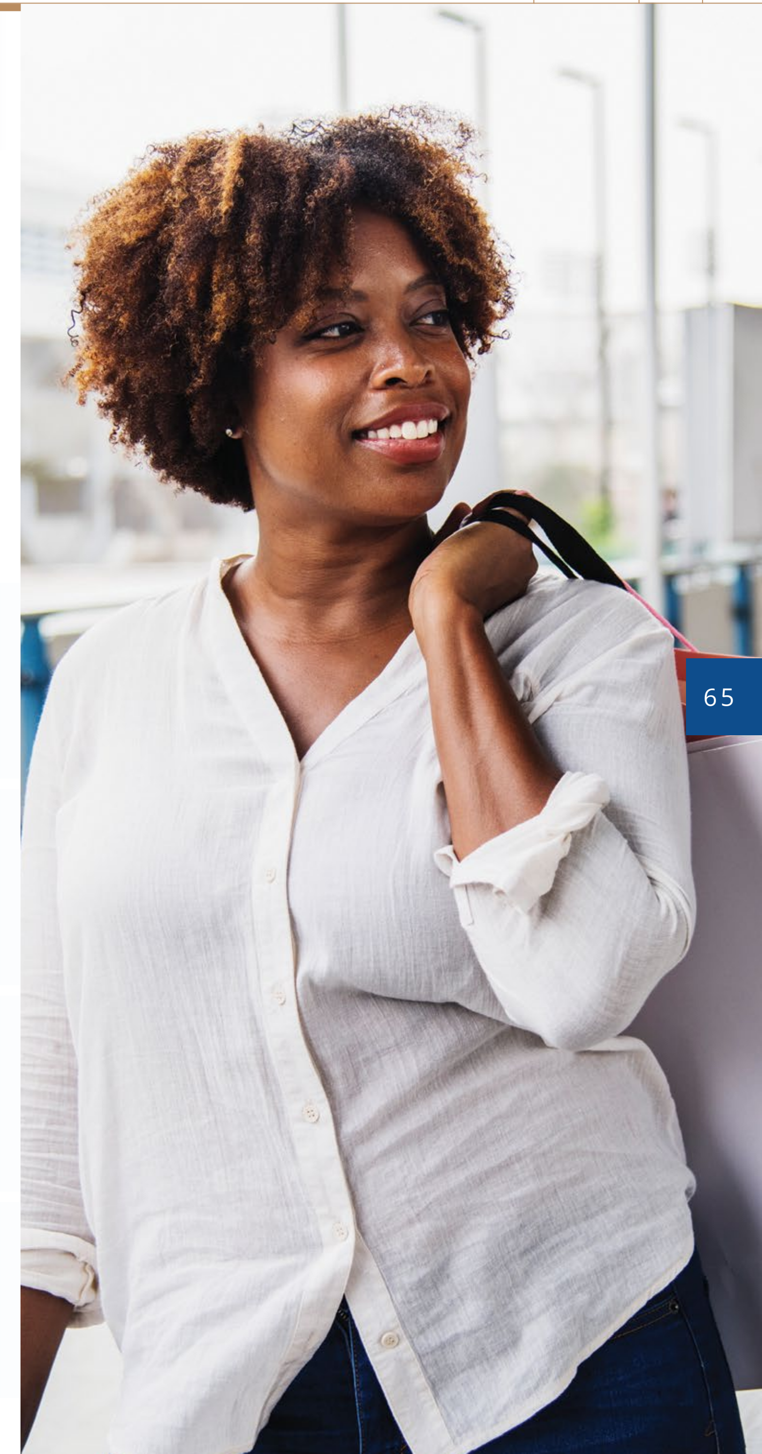
This solid financial performance increased members' funds to R17.6 billion (2017: R16.7 billion) with a solvency level of 27.3% (2017: 27.44%), versus the regulatory requirement of 25%. The Scheme's financial strength and ability to pay claims was once again confirmed with a credit rating of AAA from the independent credit rating agency, Global Credit Rating Co (GCR). This is the 18th consecutive year the Scheme has achieved the highest possible rating for a medical scheme in South Africa. In the Trustees' view, DHMS ended 2018 in a strong financial position despite a challenging year, and is well positioned to continue to meet its members' needs going forward.

THE SCHEME GENERATED A **HEALTHY INVESTMENT INCOME OF**
R1 465 million
(2017: R1 433 million)

NET SURPLUS FOR THE YEAR
R816 million
(2017: R2 450 million).

MEMBERS' FUNDS INCREASED TO
R17.6 billion
(2017: R16.7 billion)

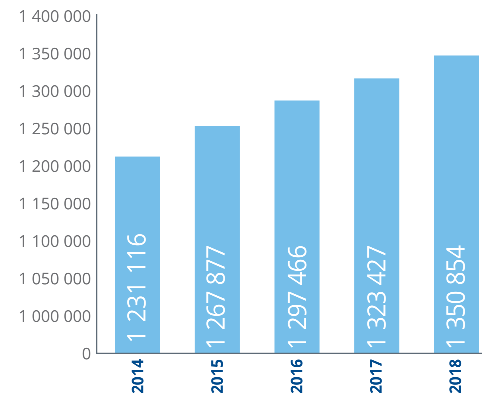
SOLVENCY LEVEL
27.3%
(2017: 27.44%)

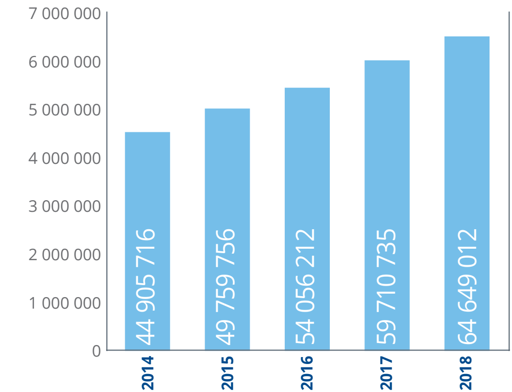


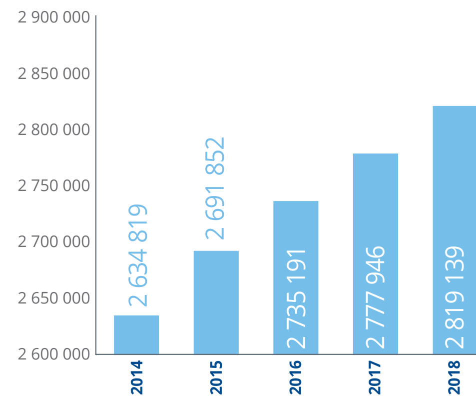
KEY PERFORMANCE
INFORMATION

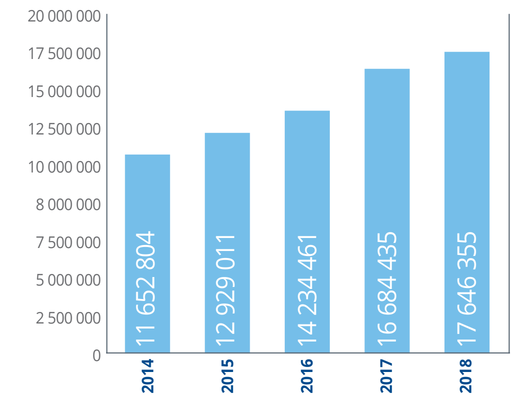
Historical performance indicators

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









1 *Year-on-year change (2017 – 2018).*

Ensuring the Scheme's sustainability

The Scheme's financial strength, its ability to pay claims, and its sustainability over the long term, are of critical importance to its members. A summary of key outcomes metrics for the Scheme's sustainability appears below:

GROWTH AND SUSTAINABILITY

RELATIVE CONTRIBUTION LEVELS

Reflects value for money for members, effective risk management and value added by the Administrator.

AVERAGE CONTRIBUTIONS
16.5%
lower[1] than the next
EIGHT LARGEST OPEN SCHEMES
(2017: 16.4%)

MEMBERSHIP SIZE

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

2 819 139
BENEFICIARIES
as at 31 December 2018
(2017: 2 777 946)

56.6%[2]
SHARE OF OPEN SCHEME MARKET
(2016: 55%)

MEMBERSHIP GROWTH

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

AVERAGE NET MEMBERSHIP GROWTH
2.07%
(2017: 2.08%)[3]

AVERAGE BENEFICIARY GROWTH
1.48%
(2017: 1.59%)[3]

AVERAGE AGE AT YEAR END
34.91
(2017: 34.50)[4]

9.83%
PENSIONER RATIO
(2017: 9.33%)

5%
ANNUALISED LAPSE RATE
(2017: 5%)

PLAN MOVEMENTS

Indicates member satisfaction, stability in benefit design and appropriate pricing.

94.24%
PLANS DID NOT CHANGE IN 2018
(2017: 93.86%)

3.24%
PLANS WERE UPGRADED
(2017: 2.91%)

2.52%
PLANS WERE DOWNGRADED
(2017: 3.23%)

1 *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 dependant and one child dependant (i.e. a family of three). These average contributions are then weighted (for DHMS and the next eight largest open schemes) according to the distribution of members across DHMS plans. This ensures that plans with similar benefits are being compared on a like-for-like basis, thereby providing a reasonable estimate of the lower contribution that a typical member of DHMS pays relative to members of similar options in competitor schemes.*

2 *Based on beneficiaries, according to the Council for Medical Schemes Quarterly Reports for the Period ending 30 September 2018 (www.medicalschemes.com/Publications.aspx).*

3 *Membership growth across medical schemes is currently constrained by affordability and a challenging economic climate, including stagnant job growth.*

4 *An increase of less than one year per annum is favourable as it indicates that young people are joining the Scheme.*

FINANCIAL STRENGTH AND MANAGEMENT

ABSOLUTE RESERVES

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

ACCUMULATED FUNDS
EXPRESSED AS A PERCENTAGE OF GROSS ANNUAL CONTRIBUTIONS
27.3%
(2017: 27.44%)
exceeding the statutory solvency requirement of
25%

AAA INDEPENDENT CREDIT RATING
for claims paying ability[1]
(2017: AAA)

PRICING SUFFICIENCY

Surplus year-on-year reflects contribution levels that are in line with expected membership and claims, notwithstanding the impact of the increase in VAT from 14% to 15% during the year.

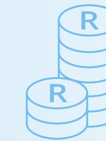
NET SURPLUS
FOR THE YEAR OF
R816 MILLION
(2017: R2 450 million)

PRUDENT INVESTMENT MANAGEMENT

Ensuring that investment returns are maximised within an acceptable and conservative level of risk.

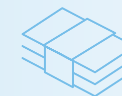
5.85%
GROSS RETURN ON INVESTMENTS
(2017: 10.00%)

VALUE-ADDED ADMINISTRATION AND MANAGED CARE



FOR EVERY R1.00 SPENT BY DHMS ON ADMINISTRATION AND MANAGED CARE FEES IN 2017, MEMBERS OF DHMS RECEIVED
R2.02 (2016: R2.00)
in value from the activities of Discovery Health (Pty) Ltd.

THIS IS EQUIVALENT TO NOMINAL ADDED VALUE OF
R6.24 BILLION in 2017
(2016: R5.56 billion).



ADMINISTRATION FEES
7.54%
OF GROSS CONTRIBUTIONS
(2017: 7.56%)

MANAGED CARE FEES
2.56%
OF GROSS CONTRIBUTIONS
(2017: 2.57%)

1 How many times the Scheme is able to cover its monthly claims expense with its liquid investments.

DHMS PLANS
AND BENEFICIARY DISTRIBUTION

EXECUTIVE SERIES
- Executive

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

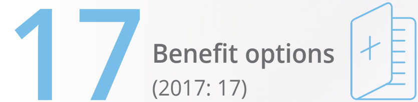
CORE SERIES
- Classic Core
- Essential Core
- Coastal Core
- Classic Delta* Core
- Essential Delta* Core

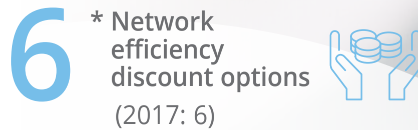
SAVER SERIES
- Classic Saver
- Essential Saver
- Coastal Saver
- Classic Delta* Saver
- Essential Delta* Saver

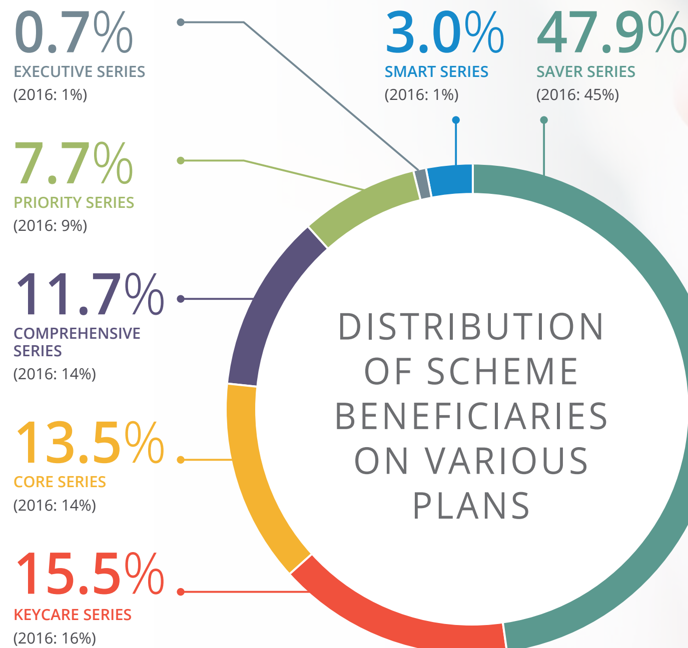
PRIORITY SERIES
- Classic Priority
- Essential Priority

KEYCARE SERIES
- KeyCare Plus
- KeyCare Core
- KeyCare Access

SMART SERIES
- Classic Smart
- Essential Smart







Gross contribution income

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

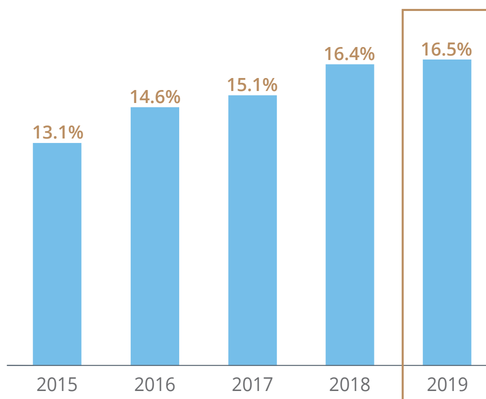
The Scheme remained highly competitive with average contributions for 2019 being 16.5% lower[1] on a plan for plan basis (for 2018: 16.4%) than the next eight open schemes by size, largely due to our ability to contain the impact of medical inflation. The Scheme's members experienced contribution increases lower than the weighted average across the next eight largest open schemes.

The Scheme's high levels of efficiency resulted in 87.9% of contributions being used for members' direct benefit by funding claims and reserves (to meet regulatory solvency requirements). The remainder is utilised to fund activities to support and benefit members in areas such as innovation, managed care, administration, financial advisers and the daily operations of the Scheme.

Gross contribution income rose 8.27% to R64.6 billion (2017: R59.7 billion), driven by contribution increases and net membership growth of 2.07%. The most significant net membership growth was recorded in the mid to low tier options, where the Saver series and Smart series recorded net membership growth of 24 930 and 19 383 respectively. The Comprehensive series of plans experienced the largest decline in principal membership of 8 769.

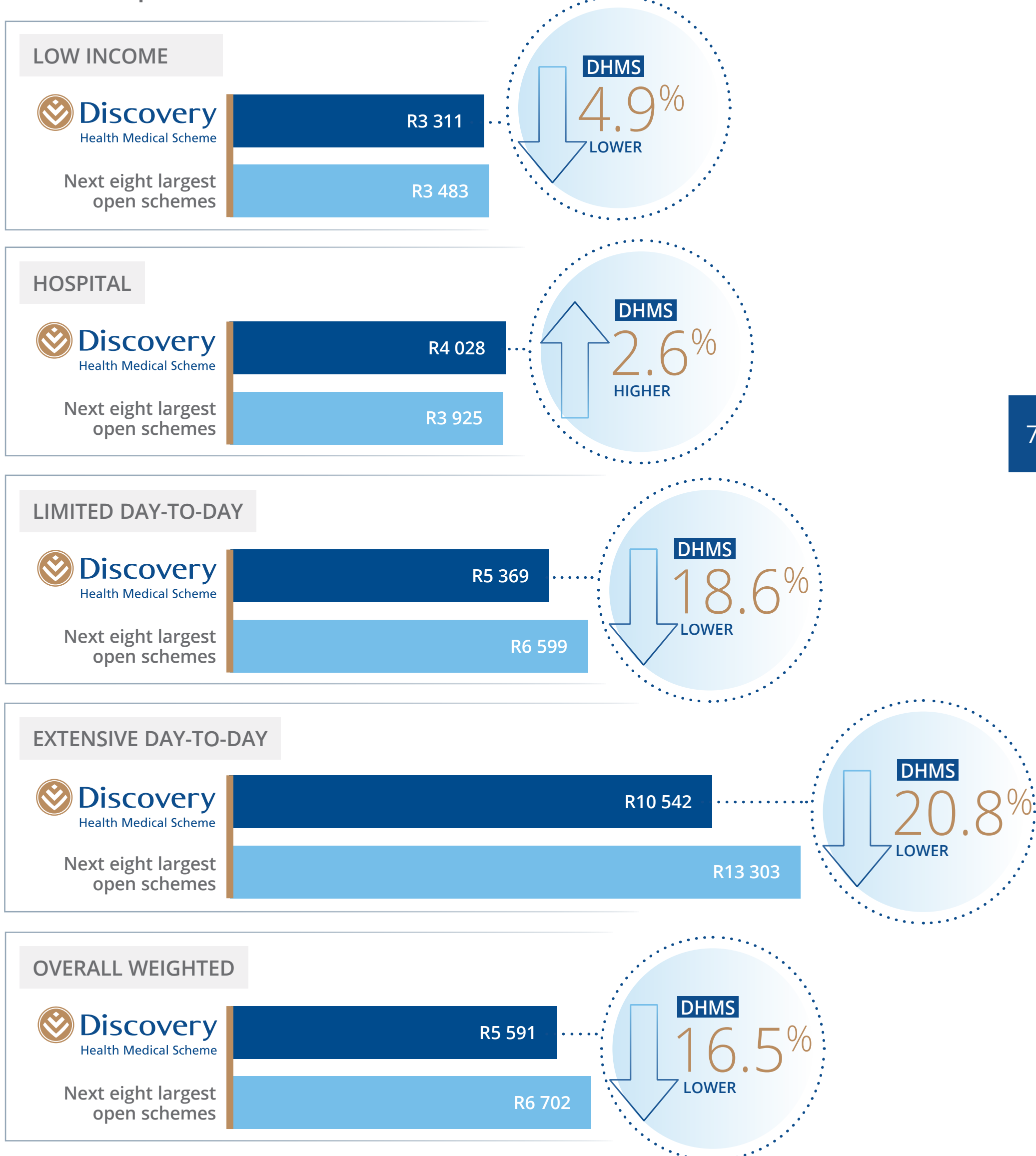
AFFORDABILITY:
DHMS CONTRIBUTIONS ARE
16.5% lower than the next eight largest open schemes in 2019

Continued widening of contribution differential



Sources: Published contributions for 2019

Average contribution differential for a principal member + adult dependant + child dependant for 2018



1 *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 dependant and one child dependant (i.e. a family of three). These average contributions are then weighted (for DHMS and the next eight largest open schemes) according to the distribution of members across DHMS plans. This ensures that plans with similar benefits are being compared on a like-for-like basis, thereby providing a reasonable estimate of the lower contribution that a typical member of DHMS pays relative to members of similar options in competitor schemes.*

Net claims incurred

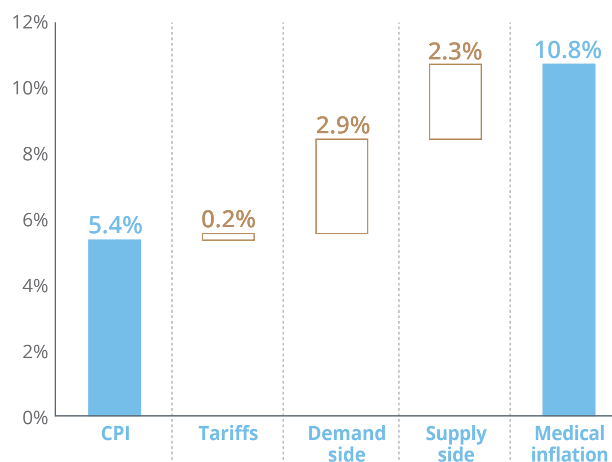
Net claims incurred rose 12.1% to R45.1 billion (2017: R40.2 billion), a higher rate of increase than in the prior year.

Escalating healthcare costs remain a concern to medical schemes, with healthcare inflation consistently above consumer price index (CPI) inflation.

The main driver of healthcare inflation is higher utilisation of healthcare services due to demand-side and supply-side effects, with a limited contribution from tariff increases. Supply-side utilisation is driven by an increase in available services, such as new hospitals, and technological developments in healthcare; demand-side utilisation pertains to the deterioration in the demographic profile of beneficiaries, specifically a higher ratio of older and chronically ill members who need more, higher priced healthcare services. A summary of the composition of medical inflation (annualised over the period 2010 to 2018) is illustrated in the diagram below.

Despite these cost pressures, the Scheme was able to contain the gross claims ratio[1] to 88% (2017: 86%) due to robust risk management interventions implemented by the Scheme's Administrator and Managed Care Provider, Discovery Health.

AVERAGE ANNUALISED INFLATION RATE (2010 – 2018)



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

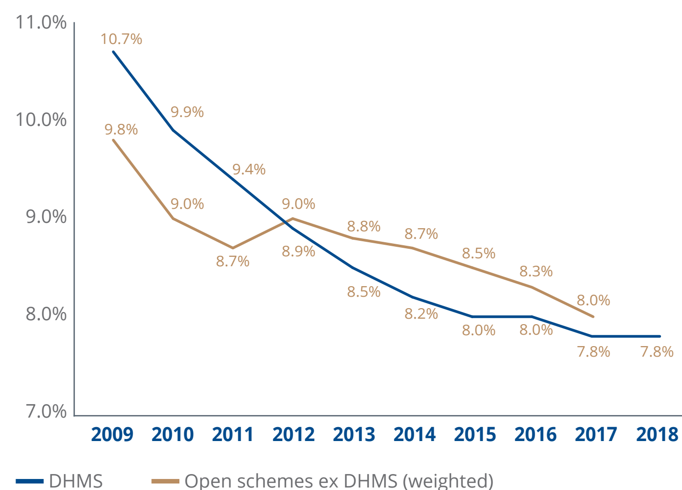
Gross administration expenditure

Gross administration expenditure consists of administration fees and other operational Scheme expenditure, of which the most significant component is administration fees paid to the Scheme's Administrator, Discovery Health. The gross increase in administration fees of 8.07% to R4.9 billion (2017: R4.5 billion) was attributable to the administration fee per member rate increase of 5.7%, and growth in average Scheme membership of 2.07%. The administration fee per average member per month increased by 5.7% from R288.05 to R304.33, which reflects the impact of an annual CPI increase as well as the increase in VAT during the year.

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

The Scheme's analysis of the CMS Annual Report 2017-2018 shows that, at 7.8% for 2017, DHMS continued to rank below the weighted average gross administration expenditure for open schemes when considered as a proportion of gross contribution income, which was 8.0% excluding the Scheme. This means that the Scheme's gross administration expenditure is the sixth lowest out of 21 open medical schemes in the market.

Gross administration expenditure as % of gross contribution income



Accredited managed care services costs

The increase in accredited managed care services costs of 7.8% to R1.7 billion (2017: R1.5 billion) was attributable to both the increase of 5.4% in accredited managed care costs per member per month and growth in average Scheme membership of 2.07%.

Managed care costs per average member per month increased by 5.4%, from R97.96 to R103.24, which reflects the impact of an annual CPI increase as well as the increase in VAT during the year. Managed care costs as a percentage of gross contribution income continued to decline with the 2018 ratio at 2.56% (2017: 2.57%).

An analysis of the CMS Annual Report 2017–2018 shows that the Scheme's managed care cost as a proportion of gross contribution income was 2.57%, compared to the weighted average of 2.28% excluding the Scheme. Although the managed care costs may appear slightly higher than other open schemes, it does not consider the complexity of the Scheme's benefits, the breadth of managed care services offered, or the claims cost savings generated by the managed care services. In 2017[1], claims cost savings of R171.51 (2016: R153.29) per average beneficiary per month were realised through claims review processes, implemented protocols, price negotiations and drug utilisation reviews. This equates to a saving of R2.68 (2016: R2.53) for every Rand paid in managed care costs – an exceptional return on investment of 268%.

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

Investment results

The Scheme's investment portfolio is suitably diversified and managed to optimise returns within our approved risk appetite. Asset allocation is managed and monitored from an asset and liability perspective, while ensuring sufficient liquid funds are available to meet claims and other liabilities as they fall due. Given the short-term nature of Scheme liabilities, a significant portion of our assets are invested in money market and cash investments, with smaller allocations to bonds (local and foreign) and equities. During 2018, the Scheme reallocated assets that had previously been accounted for as trust assets until 31 December 2017, to better align these assets to the long-term asset allocation strategy used for the balance of the Scheme's assets.

The Scheme earned a gross investment return of 5.85% for 2018 (2017: 10.00%). The Scheme's diversified investment strategy resulted in outperformance of its strategic benchmark.

Member disputes and CMS complaints

We thoroughly investigate and review all formal disputes lodged by members with the Scheme. We aim to resolve as many as possible internally, prior to members resorting to laying complaints with the CMS.

The number of CMS complaints reduced by more than 21% to 609 in 2018 (2017: 763), a fraction of the 55 460 282 claims made by Scheme members in 2018. The ratio of internal disputes to CMS complaints has continued to improve from 39% in 2015, to 51.7% in 2016, 97% in 2017 and ultimately to 119% in 2018.

The internal disputes mechanism continues to be effective in reaching an amicable solution in the majority of cases, with a high rate of withdrawals and settlements achieved without a hearing being required by the member. In 2018, 724 disputes were lodged in terms of Rule 27[2], with 503 or 70% of disputes being settled or withdrawn prior to a hearing. Only 72 cases (10%) proceeded to a hearing before the Disputes Committee.

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

Solvency

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

At 31 December 2018, the Scheme's solvency level of 27.3% (2017: 27.44%) of gross annual contributions was R1.5 billion (2017: R1.5 billion) more than the statutory solvency requirement.

Calculation of regulatory capital requirement	**December 2018 R'000**	December 2017 R'000
Total members' funds	**17 646 355**	16 684 435
Less cumulative net gain on re-measurement of investments	**–**	(298 722)
Total net assets (Regulation 29)	**17 646 355**	16 385 713
Gross annual contributions	**64 649 012**	59 710 735
Solvency ratio	**27.30%**	**27.44%**
Average accumulated funds per member at year end	**13 063**	**12 859**

Prudent financial management

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

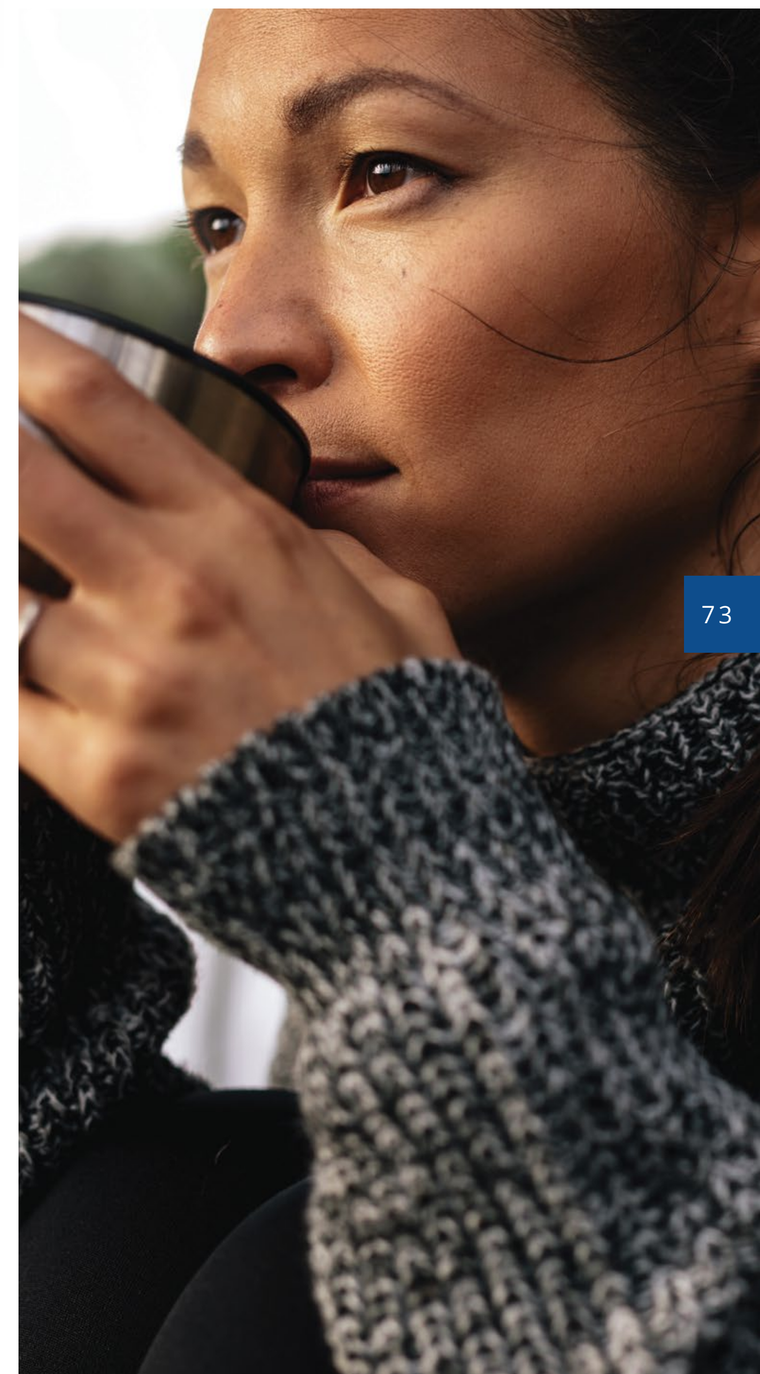
Year ended	**December 2018 R'000**	December 2017 R'000
Gross contributions	**64 649 012**	59 710 735
Total outstanding – excluding December contributions	**32 602**	23 120
% outstanding	**0.05%**	0.04%

Due application of the Scheme Rules

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

Ensuring statutory and regulatory compliance

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



Matters of non-compliance

for the year ended 31 December 2018

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

During 2018, the Scheme did not comply with the following Sections and Regulations of the Act:

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Reserve accounts

Outstanding claims

Personal Medical Savings Accounts

Personal Medical Savings Accounts (PMSAs) enable members to manage their day-to-day healthcare expenses. If members select a plan with a PMSA, they pay either 15% or 25% of their gross contributions, depending on their plan choice, into their PMSA. The Scheme advances the full annual amount to members for immediate use, although members only contribute monthly. PMSAs provide a variety of benefits to members for medical expenses such as day-to-day medicines, visits to general practitioners and specialists, dental care and optometry.

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

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

During the prior year, the assets backing PMSAs were invested as trust assets and were accounted for separately from the Scheme's assets. Following a Constitutional Court judgement, as well as a change in the Scheme's Rules, with effect from 1 January 2018 the assets backing the PMSAs are combined with the balance of the Scheme's assets.

Going concern

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

Auditor independence

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

OPERATIONAL STATISTICS PER BENEFIT PLAN

for the year ended 31 December 2018

December 2018	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 CompZero MSA	Classic Smart	Essential Smart	Total
Number of members at the end of the accounting period	9 813	134 349	50 279	302 177	89 861	15 653	42 305	128 611	6 384	184 540	81 100	232 791	14 561	4 599	915	30 607	22 309	**1 350 854**
Number of beneficiaries at the end of the accounting period	21 082	297 212	108 239	663 032	203 166	29 249	91 012	270 854	13 017	417 639	181 951	406 661	23 309	6 573	1 990	58 281	25 872	**2 819 139**
Average number of members for the accounting period	10 086	137 597	49 812	301 250	91 394	15 995	40 343	124 268	6 426	184 229	80 846	227 771	13 644	4 507	929	27 947	18 049	**1 335 093**
Average number of beneficiaries for the accounting period	21 734	305 549	107 439	659 519	206 262	30 020	86 838	261 327	13 121	417 251	181 288	397 742	21 800	6 403	2 015	53 406	20 870	**2 792 583**
Average risk contributions per member per month (R')	7 745	6 212	3 546	3 354	4 257	5 309	2 818	2 760	3 808	2 994	2 931	1 807	1 529	1 195	6 158	2 524	1 374	**3 297**
Average risk contributions per beneficiary per month (R')	3 594	2 798	1 644	1 532	1 886	2 829	1 309	1 313	1 865	1 322	1 307	1 035	957	841	2 841	1 321	1 188	**1 576**
Average net claims incurred per member per month (R')	10 042	6 390	2 686	2 597	3 589	4 744	1 954	1 783	2 224	2 509	2 493	1 760	1 075	535	5 400	1 607	649	**2 815**
Average net claims incurred per beneficiary per month (R')	4 660	2 878	1 245	1 186	1 590	2 527	908	848	1 089	1 108	1 112	1 008	673	376	2 491	841	561	**1 346**
Average administration costs per member per month (R')	334	333	334	334	334	333	334	334	334	334	334	181	97	116	334	333	334	**304**
Average administration costs per beneficiary per month (R')	155	150	155	152	148	178	155	159	163	147	149	104	61	82	154	174	289	**146**
Average managed care: Management services per member per month (R')	103	103	103	103	103	103	103	103	103	103	103	103	103	103	103	103	103	**103**
Average managed care: Management services per beneficiary per month (R')	48	46	48	47	46	55	48	49	51	46	46	59	65	73	48	54	89	**49**
Average family size at 31 December	2.15	2.21	2.15	2.19	2.26	1.87	2.15	2.11	2.04	2.26	2.24	1.75	1.60	1.43	2.17	1.90	1.16	**2.09**
Loss ratio (%)	131%	105%	79%	81%	87%	91%	73%	68%	61%	87%	89%	102%	77%	53%	90%	67%	56%	**88%**
Total non-healthcare expenses as a percentage of risk contributions (%)	6%	7%	12%	13%	11%	9%	15%	16%	12%	15%	15%	14%	11%	14%	7%	17%	29%	**12%**
Average non-healthcare expenses per member per month	447	448	432	444	448	449	426	433	443	439	429	252	160	171	447	420	392	**403**
Average non-healthcare expenses per beneficiary per month	207	202	200	203	199	239	198	206	217	194	191	144	100	120	206	220	339	**193**
Average age of beneficiaries (years)	44.91	41.56	39.18	32.54	38.47	43.57	35.96	30.37	37.76	34.65	38.68	29.64	35.53	33.10	40.05	30.80	33.81	**34.91**
Pensioner ratio (beneficiaries over 65 years)	24%	18%	14%	7%	13%	22%	10%	5%	13%	8%	13%	7%	12%	7%	13%	4%	4%	**10%**
Average relevant healthcare expenses per member per month	10 151	6 503	2 789	2 700	3 692	4 856	2 057	1 886	2 327	2 612	2 596	1 845	1 178	635	5 520	1 689	767	**2 916**
Average relevant healthcare expenses per beneficiary per month	4 711	2 928	1 293	1 233	1 636	2 587	956	897	1 140	1 153	1 158	1 057	738	447	2 546	884	663	**1 394**
Net surplus/(deficit) per benefit plan	(337 379)	(1 110 523)	246 407	998 019	199 678	13 262	204 151	756 292	85 085	17 494	(6 029)	(558 058)	45 394	25 719	3 104	168 028	65 139	**815 783**

Operational statistics per benefit plan *continued*

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

Statement of responsibility by the Board of Trustees

FOR THE YEAR ENDED 31 DECEMBER 2018

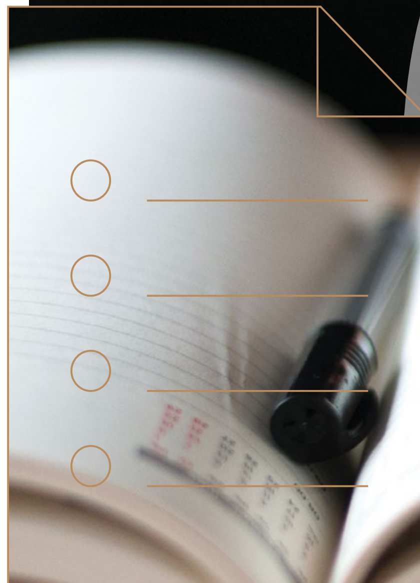
The Board of Trustees is responsible for ensuring that adequate accounting records are maintained and for the preparation, integrity and fair presentation of the Annual Financial Statements of Discovery Health Medical Scheme (the Scheme).

The Annual Financial Statements comprise the Statement of Financial Position as at 31 December 2018, and the Statement of Comprehensive Income, the Statement of Changes in Funds and Reserves and the Statement of Cash Flows for the year then ended, and Notes to the financial statements, including a summary of significant accounting policies. The Annual Financial Statements have been prepared in accordance with International Financial Reporting Standards and the Medical Schemes Act, No 131 of 1998, as amended (the Act), and include amounts based on judgements and reasonable estimates.

The Trustees consider that in preparing the Annual Financial Statements they have used the most appropriate accounting policies, consistently applied, and that all applicable International Financial Reporting Standards have been followed. The Trustees are satisfied that the information contained in the Annual Financial Statements fairly presents the results of operations for the year and the financial position of the Scheme at year end. The Trustees 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 has occurred during the year under review.



06 FINANCIALS

The Board of Trustees has reviewed the Scheme's budget for the year ending 31 December 2019. 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 80 to 82. The Annual Financial Statements, which are presented on pages 83 to 154, were approved by the Board of Trustees on 9 April 2019 and are signed on its behalf by:

N Morrison	J Human	Dr N Sangweni
CHAIRPERSON	**TRUSTEE**	**PRINCIPAL OFFICER**

Report of the Audit Committee

for the year ended 31 December 2018

We are pleased to present our report for the financial year ended 31 December 2018. The Audit Committee (the Committee) is an independent statutory committee. Duties are delegated to the Committee by the Board of Trustees.

Audit Committee terms of reference and assessment

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

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

The Committee conducts self-assessments to evaluate its effectiveness. The Committee was satisfied with the results of the assessments, and no significant matters of concern were identified.

Audit Committee members, meeting attendance and assessment

The membership and attendance of the members of the Committee has been set out on page 44.

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 on 24 August 2018, for the financial period 1 January 2018 to 31 December 2018, in accordance with section 36(2) of the Medical Schemes Act 131 of 1998.

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 2018. The Committee approved the actual audit fees for the year ended 31 December 2017.

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

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

Internal Auditors (IA)

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

The Committee considered and approved the IA Charter.

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

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

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

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

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

Financial statements and accounting 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 Act 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.

Report of the Audit Committee continued

for the year ended 31 December 2018

This included a formal documented review by the IA function of the design, implementation and effectiveness of the Administrator's system of internal financial controls pertaining to the Scheme. Based on the results of this review, it is the view of the Committee that 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 acting Chief Financial Officer. During the course of 2018, the Chief Operations Officer performed the duties of the 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 relevant legal and regulatory obligations. The Committee is satisfied that there has been no material non-compliance with laws and regulations, except for the matters of non-compliance with the Act as detailed in Note 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.

Due to the Audit Committee's responsibility for ensuring that appropriate systems are in place for the monitoring of risk and compliance with laws, regulations and codes of conduct, the members of the Audit Committee also serve as members of the Risk Committee.

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 2018, as well as the budget for the year ending 31 December 2019. Total members' funds exceeded R17.6 billion with a solvency level of 27.3% as at 31 December 2018. Further, the Scheme had sufficient financial resources (cash and cash equivalents and financial assets at fair value through profit or loss) as at 31 December 2018 to cover monthly claims expenditure 5.60 times.

On the basis of this review and taking note of the current net surplus of R816 million, the Committee considers that:

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

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

Mr B Stott
CHAIRPERSON: AUDIT COMMITTEE

9 April 2019

Independent Auditor's report

To the members of Discovery Health Medical Scheme

Report on the financial statements

Opinion

We have audited the financial statements of Discovery Health Medical Scheme (the Scheme), set out on pages 83 to 154, which comprise the statement of financial position as at 31 December 2018, and the statement of comprehensive income, the statement of changes in funds and reserves and the statement of cash flows for the year then ended, and notes to the financial statements, including a summary of significant accounting policies.

In our opinion, these financial statements present fairly, in all material respects, the financial position of the Scheme as at 31 December 2018, 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 judgement, were of most significance in our audit of the financial statements of the current period. These matters were addressed in the context of our audit of the financial statements as a whole, and in forming our opinion thereon, and we do not provide a separate opinion on these matters.

Key audit matter	How our audit addressed the key audit matter
Outstanding claims provision The outstanding claims provision of R1,499 billion at year-end, as described in Note 7 to the financial statements, is a provision recognised for the estimated cost of healthcare benefits that have been incurred prior to year-end but that were only reported to the Scheme after year-end. The outstanding claims provision, as included in the financial statements, is calculated by the Scheme's actuaries. The financial statements are reviewed by the Audit Committee and recommended to the Board of Trustees for approval. The Scheme's actuaries use an actuarial model, based on the Scheme's actual claim development patterns throughout the year, to project the year-end provision. This model applies a combination of the Basic Chain Ladder (BCL) and Cost Per Event (CPE) methods. The claim service date, processing date and amount are used to derive claim development patterns. These historical patterns are then used to estimate the outstanding claims provision. We identified this to be a matter of most significance to the audit because of the uncertainty in the projected claims pattern. A change in the projected claims pattern can cause a material change to the amount of the provision.	We obtained an understanding from the Scheme's actuaries regarding the process to calculate the outstanding claims provision. The actuarial methods applied by the Scheme are generally applied within the medical schemes industry. We obtained the actual claims data from the member administration system covering the year ended 31 December 2018. For a sample of actual claims received by the Scheme in the 31 December 2018 financial year, we tested the accuracy of the service and process dates. No material inconsistencies were noted. We substantively tested a sample of claims against the relevant Scheme Rules and assessed completeness of the claims data. The claims data that was included in the Scheme's actuarial model was agreed to the above actual claims data with no material inconsistencies noted. To assess the reasonableness of the Scheme actuaries' estimation process, we compared the actual claim results in the current year to the prior year provision. Based on our assessment, the estimation process was considered reasonable. Our internal actuarial experts independently calculated the Scheme's outstanding claims provision, taking into account the claims data tested above. We compared our results with that of the Scheme and found the amounts to approximate each other.

Independent Auditor's report continued

Other information

The Scheme's trustees are responsible for the other information. The other information comprises the information included in the Discovery Health Medical Scheme Integrated Report as at 31 December 2018. The other information does not include the financial statements and our auditor's report thereon.

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

In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit, or otherwise appears to be materially misstated. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact. We have nothing to report in this regard.

Responsibilities of the Scheme's Trustees for the financial statements

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

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

Auditor's responsibilities for the audit of the financial statements

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

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

- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, design and perform audit procedures responsive to those risks, and obtain audit evidence that is sufficient and appropriate to provide a basis for our opinion. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control.
- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Scheme's internal control.
- Evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by the Scheme's Trustees.
- Conclude on the appropriateness of the Scheme's Trustees' use of the going concern basis of accounting and based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the Scheme's ability to continue as a going concern. If we conclude that a material uncertainty exists, we are required to draw attention in our auditor's report to the related disclosures in the financial statements or, if such disclosures are inadequate, to modify our opinion. Our conclusions are based on the audit evidence obtained up to the date of our auditor's report. However, future events or conditions may cause the Scheme to cease to continue as a going concern.
- Evaluate the overall presentation, structure and content of the financial statements, including the disclosures, and whether the financial statements represent the underlying transactions and events in a manner that achieves fair presentation.

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

Independent Auditor's report continued

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 instance 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.

Audit tenure

As required by the Council for Medical Schemes' Circular 38 of 2018, Audit Tenure, we report that PricewaterhouseCoopers Inc. has been the auditor of Discovery Health Medical Scheme for 18 years. The engagement partner, Corlia Volschenk, has been responsible for Discovery Health Medical Scheme's audit for 7 years.

PricewaterhouseCoopers Inc.

Director: C. Volschenk
Registered Auditor
Waterfall

09 April 2019

Statement of Financial Position

As at 31 December 2018

R'000	Notes	2018	2017
ASSETS			
Non-current assets		**22 377**	4 417
Property and equipment	1	**14 116**	–
Long Term Employee Benefit Plan asset		**8 261**	4 417
Current assets		**28 796 006**	25 728 677
Financial assets at fair value through profit or loss	3	**20 519 767**	14 005 644
Derivative financial instruments	8	**142 856**	85 857
Trade and other receivables	4	**2 357 902**	1 147 665
Cash and cash equivalents			
– Personal Medical Savings Account trust assets	5	**–**	4 609 149
– Medical Scheme assets	6	**5 775 481**	5 880 362
Total assets		**28 818 383**	25 733 094
FUNDS AND LIABILITIES			
Members' funds		**17 646 355**	16 684 435
Accumulated funds		**17 646 355**	16 684 435
LIABILITIES			
Non-current liabilities		**10 316**	–
Leases	2	**10 316**	–
Current liabilities		**11 161 712**	9 048 659
Leases	2	**1 600**	–
Outstanding claims provision	7	**1 499 227**	1 240 063
Derivative financial instruments	8	**–**	86 445
Personal Medical Savings Account liabilities	9	**5 040 832**	4 656 633
Trade and other payables	10	**4 620 053**	3 065 518
Total funds and liabilities		**28 818 383**	25 733 094

Statement of Comprehensive Income

for the year ended 31 December 2018

R'000	Notes	2018	2017
Risk contribution income	11	**52 828 931**	48 702 024
Relevant healthcare expenditure		**(46 718 953)**	(41 747 808)
Net claims incurred	12	**(45 099 436)**	(40 228 057)
Claims incurred	12	**(45 186 030)**	(40 371 417)
Third party claim recoveries	12	**86 594**	143 360
Accredited managed healthcare services (no risk transfer)	13	**(1 653 972)**	(1 534 311)
Net profit on risk transfer arrangements	14	**34 455**	14 560
Risk transfer arrangement fees		**(382 719)**	(392 023)
Recoveries from risk transfer arrangements		**417 174**	406 583
Gross healthcare result		**6 109 978**	6 954 216
Broker service fees	15	**(1 313 741)**	(1 214 205)
Expenses for administration	26	**(4 875 746)**	(4 511 596)
Other operating expenses	16	**(272 952)**	(260 461)
Net healthcare result		**(352 461)**	967 954
Other income		**1 457 721**	1 893 686
Investment income	22	**1 465 105**	1 433 187
Net (losses)/gains on financial assets	23	**(69 315)**	458 753
Sundry income	24	**61 931**	1 746
Other expenditure		**(289 456)**	(411 666)
Expenses for asset management services rendered		**(71 366)**	(44 428)
Finance costs	25	**(218 090)**	(367 238)
Net surplus for the year		**815 804**	2 449 974
Other comprehensive income		**–**	–
Total comprehensive income for the year		**815 804**	2 449 974

Statement of Changes in Funds and Reserves

for the year ended 31 December 2018

R'000	Notes	2018 Accumulated funds	2017 Accumulated funds
Balance at beginning of the year		**16 684 435**	14 234 461
Total comprehensive income for the year		**815 804**	2 449 974
Transfer of reserves from other medical schemes	30	**146 116**	–
Total member funds end of the year		**17 646 355**	16 684 435

Statement of Cash Flows

for the year ended 31 December 2018

R'000	Notes	2018	2017
CASH FLOWS FROM OPERATING ACTIVITIES			
Cash flows generated from operations before working capital changes	28	**(254 606)**	1 017 921
Working capital changes:			
(Increase)/decrease in trade and other receivables	28	**(1 313 257)**	822 739
Increase in outstanding claims provision		**259 164**	118 669
Increase in Personal Medical Savings Account liabilities		**384 199**	452 590
Increase in trade and other payables	28	**1 554 535**	1 759 273
Cash generated by operations		**630 035**	4 171 192
Payments for financial assets	3	**(9 618 505)**	(2 953 775)
Proceeds from sale of financial assets	28	**2 891 623**	1 669 533
Increase in Long Term Employee Plan asset		**(7 371)**	(3 848)
Cash transferred from other medical schemes		**146 116**	–
Interest received	22	**1 302 974**	1 349 125
Dividend income	22	**162 131**	84 062
Interest paid	25	**(217 415)**	(367 238)
Net cash (outflow)/inflow from operating activities		**(4 710 412)**	3 949 051
CASH FLOWS FROM INVESTING ACTIVITIES			
Payment for property and equipment	28	**(2 844)**	–
Net cash outflow from investing activities		**(2 844)**	–
CASH FLOWS FROM FINANCING ACTIVITIES			
Payment of lease liabilities	2	**(774)**	–
Net cash outflow from investing activities		**(774)**	–
NET (DECREASE)/INCREASE IN CASH AND CASH EQUIVALENTS		**(4 714 030)**	3 949 051
Cash and cash equivalents at beginning of the year		**10 489 511**	6 540 460
CASH AND CASH EQUIVALENTS AT THE END OF THE YEAR		**5 775 481**	10 489 511
Cash and cash equivalents compromise			
Personal Medical Savings Account trust assets	5	**–**	4 609 149
Medical Scheme assets	6	**5 775 481**	5 880 362
		5 775 481	10 489 511

Accounting policies

for the year ended 31 December 2018

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 9 April 2019.

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 detailed accounting policies have been set out in the respective Note to the Annual Financial Statements, with the general accounting policies applied in the preparation of these Annual Financial Statements set out below. These policies have been consistently applied to all years presented, except for changes required by the mandatory adoption of new and revised IFRS.

The preparation of financial statements in conformity with IFRS requires the use of certain critical accounting estimates. It also requires management to exercise its judgement in the process of applying the Scheme's accounting policies. The areas involving a higher degree of judgement, or areas where estimates are significant to the 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.

2 Implementation of new standards

IFRS 9: Financial Instruments

IFRS 9 replaces IAS 39: *Financial Instruments: Recognition and Measurement* and comprises guidance on Classification, Measurement, Impairment, Hedge Accounting and Derecognition. IFRS 9 introduces a new approach to the classification of financial assets, which is driven by the business model in which the asset is held and its cash flow characteristics. A new business model was introduced which allows certain financial assets to be categorised as "fair value through other comprehensive income" in certain circumstances.

The requirements for financial liabilities are mostly carried forward from IAS 39. Some changes were made to the fair value option for financial liabilities to address the issue of own credit risk allowing the recognition of these changes in other comprehensive income for liabilities designated as fair value through profit or loss.

The standard changes the impairment model from an incurred loss model, and introduces a single "expected credit loss" impairment model for the measurement of financial assets within the scope of IFRS 9.

The standard contains a new model for hedge accounting that aligns the accounting treatment with the entity's risk management activities. Enhanced disclosures will provide better information about risk management and the effect of hedge accounting on the financial statements.

The Scheme previously classified its financial assets at "fair value through profit or loss" or "amortised cost". The changes introduced by this standard have had no impact on the Scheme's financial assets at fair value through profit or loss. For financial assets measured at amortised cost, the majority of these assets are Insurance Receivables accounted for in terms of accounting policies adopted under IFRS 4: *Insurance Contracts*, which are scoped out of IFRS 9. As part of the IFRS 9 implementation, the Scheme assessed the classification between Insurance Receivables and Loans and Receivables with certain reclassifications being made from Loans and Receivables to Insurance Receivables. Details of the reclassifications have been included in Note 4.

The Scheme does not apply hedge accounting and the hedge accounting changes introduced have no impact on the Scheme.

Accounting policies continued
for the year ended 31 December 2018

2 Implementation of new standards *continued*

IFRS 9: Financial Instruments *continued*

The introduction of the expected credit loss model and the requirement for the loss allowance to be measured at an amount equal to the lifetime expected credit losses has been assessed and deemed appropriate to be applied in determining impairment of Loans and Receivables. In determining impairment of Insurance Receivables, the incurred loss model adopted under IFRS 4: *Insurance Contracts*, has been assessed and is reasonable and appropriate to determine impairment of Insurance Receivables. This model will continue to be applied and the expected credit loss model is not adopted to determine impairment of Insurance Receivables.

This Standard shall be applied for annual reporting periods beginning on or after 1 January 2018. The Scheme has applied this Standard from the effective date of 1 January 2018. The Scheme did not apply the temporary exemption from IFRS 9 granted to insurers to defer the implementation of IFRS 9.

IFRS 16: Leases

The Standard introduces a single lessee accounting model and requires a lessee to recognise assets and liabilities for all leases with a term of more than 12 months, unless the underlying asset is of low value.

A lessee is required to recognise a right-of-use asset representing its right to use the underlying asset, and a lease liability representing its obligation to make lease payments. Right-of-use assets are measured similarly to other non-financial assets (such as property and equipment) and lease liabilities similarly to other financial liabilities.

As a consequence, a lessee recognises depreciation on the right-of-use asset and interest on the lease liability, and also classifies cash repayments of the lease liability into a principal and interest portion and presents them in the Statement of Cash Flows.

This Standard shall be applied for annual reporting periods beginning on or after 1 January 2019. Earlier adoption is permitted and the Scheme made the decision to early adopt this Standard for the reporting period beginning on 1 January 2018.

IFRS 15: Revenue from Contracts with Customers

The Standard requires entities to recognise revenue to depict the transfer of promised goods or services to customers in an amount that reflects the consideration to which the entity expects to be entitled in exchange for those goods or services.

This Standard shall be applied for annual reporting periods beginning on or after 1 January 2018.

The Scheme's contracts with members are accounted for under IFRS 4: *Insurance Contracts*. The Scheme does not have any contracts with customers which are required to be accounted for under IFRS 15. The implementation of this Standard has had no impact on the Scheme.

Accounting policies continued

for the year ended 31 December 2018

2 Implementation of new standards *continued*

New standards, amendments and interpretations not yet effective and relevant to the Scheme:

The following new standards, amendments and interpretations to the existing standards have been published and are not yet effective for the current financial year. The Scheme has not early adopted them and it is not expected that they will have any material impact on the Scheme's assets, liabilities and results but may result in additional disclosure in the financial statements.

Standard	Scope	Effective date
IFRS 17: *Insurance Contracts*	The Standard was issued in May 2017 and supersedes IFRS 4: *Insurance Contracts*. The Standard creates one accounting model for all insurance contracts and establishes principles for the recognition, measurement, presentation and disclosure of insurance contracts issued. The Standard requires insurance contracts to be measured using updated estimates and assumptions that reflect the timing of cash flows and takes into account any uncertainty relating to insurance contracts. The Standard provides for a simplified approach ("premium allocation approach") for the measurement of a group of insurance contracts only if, at the inception of the group, the entity reasonably expects that the simplification will produce measurement of the liability for remaining coverage that would not differ materially from that produced using the general measurement model and if the coverage period is one year or less. Potential impact: The coverage period for the Scheme's contracts is one year or less allowing for the premium allocation approach to be applied resulting in similar treatment to the current accounting treatment with the most notable exception being the treatment of onerous contracts.	1 January 2021
IAS 1: *Presentation of Financial Statements*	Disclosure Initiative: The amendments clarify and align the definition of 'material' and provide guidance to help improve consistency in the application of that concept whenever it is used in IFRS.	1 January 2020
IAS 8: *Accounting Policies, Changes in Accounting Estimates and Errors*	Disclosure Initiative: The amendments clarify and align the definition of 'material' and provide guidance to help improve consistency in the application of that concept whenever it is used in IFRS.	1 January 2020

Accounting policies continued

for the year ended 31 December 2018

3 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.

4 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. Loans and receivables are receivables other than those arising from insurance contracts and include sundry accounts receivable and interest receivable. Loans and receivables are disclosed under Trade and other receivables.

The classification depends on the purpose for which the financial instruments are acquired. Management determines the classification of financial instruments at initial recognition. All purchases and sales of financial instruments are recognised on the trade date, which is the date on which the Scheme commits to purchase the financial asset or assume financial liability.

Offsetting financial instruments

This applies where a legally enforceable right to set off exists for recognised financial assets and financial liabilities, and there is an intention to realise the asset, and settle the liability simultaneously or to settle on a net basis.

The Scheme will disclose the net asset or liability in the Statement of Financial Position or accompanying notes if the above conditions are met.

Derecognition of financial assets and liabilities

The Scheme derecognises a financial asset or part of a financial asset when:

- The contractual right to the cash flows from the asset expires.
- The Scheme retains the contractual right to receive cash flows of the asset, but assumes the obligation to pay one or more third parties the cash flow without material delay.
- The Scheme 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.

5 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.

6 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.

7 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.

Accounting policies continued

for the year ended 31 December 2018

8 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.

9 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.

10 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.

11 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.

12 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.

13 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.

Accounting policies continued

for the year ended 31 December 2018

14 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. The investment strategy does not include the use of leverage.

These funds are managed by independent asset managers who apply various investment strategies to accomplish their respective investment objectives.

The change in fair value of each fund is included in the Statement of Comprehensive Income in 'Net fair value gains/(losses) on financial assets at fair value through profit or loss'.

Notes to the Annual Financial Statements

for the year ended 31 December 2018

1 Property and equipment

Accounting policy:

Property and equipment are stated at historical cost less depreciation and impairment. Historical cost includes expenditure that is directly attributable to the acquisition of the items.

Subsequent costs are included in the asset's carrying amount or recognised as a separate asset, as appropriate, only when it is probable that future economic benefits associated with the item will flow to the Scheme, and the cost of the item can be measured reliably. All other repairs and maintenance are charged to the surplus or deficit during the financial period in which they are incurred.

Property and equipment are depreciated using the straight-line method to allocate their cost to their residual values over their estimated useful lives, as follows:

Right-of-use asset – Land and Buildings:	Shorter of estimated life or period of lease
Leasehold improvements:	Shorter of estimated life or period of lease

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

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

Note:

R'000 Non-current	Right-of-use asset land and buildings	Leasehold improvements	Total
Balance as at 1 January 2018	**–**	**–**	**–**
Additions	**12 015**	**2 844**	**14 859**
Depreciation charge	**(601)**	**(142)**	**(743)**
Balance as at 31 December 2018	**11 414**	**2 702**	**14 116**

Leased assets

The Right-of-use asset arises from the lease agreement for the Scheme's offices (refer to Note 2 for further details).

2 Leases

Accounting policy:

At inception of a contract, the Scheme assesses whether a contract is, or contains, a lease. A contract is, or contains, a lease if the contract conveys the right to control the use of an identified asset for a period of time in exchange for consideration. To assess whether a contract conveys the right to control the use of an identified asset, the Scheme assesses whether:

- the contract involves the use of an identified asset – this may be specified explicitly or implicitly, and should be physically distinct or represent substantially all of the capacity of a physically distinct asset. If the supplier has a substantive substitution right, then the asset is not considered to be an identified asset;
- the Scheme has the right to obtain substantially all of the economic benefits from the use of the asset throughout the period of use;
- the Scheme has the right to direct the use of the asset. The Scheme has this right when it has the decision-making rights that are most relevant to changing how, and for what purpose the asset is used. In rare cases, where all the decisions about how and for what purposes the asset is used are predetermined, the Scheme has the right to direct the use of the asset if either:
  - the Scheme has the right to operate the asset; or
  - the Scheme designed the asset in a way that predetermines how and for what purpose it will be used.

At inception, or on reassessment of a contract that contains a lease component, the Scheme allocates the consideration in the contract to each lease component on the basis of their relative stand-alone prices.

The Scheme recognises a right-of-use asset and a lease liability at the lease commencement date.

Notes to the Annual Financial Statements continued

for the year ended 31 December 2018

2 Leases *continued*

Right-of-use asset

The right-of-use asset is initially measured at cost, which comprises the initial amount of the lease liability adjusted for any lease payments made at of before the commencement date, plus any initial direct costs incurred. An estimate of the costs to dismantle and remove the underlying asset or to restore the underlying asset or the site on which it is located are also included in the cost. The total cost is reduced by any lease incentives received.

The right-of-use asset is subsequently depreciated using the straight line method from the commencement date to the earlier of the end of the useful life of the right-of-use asset or the end of the lease term. The estimated useful lives of right-of-use assets are determined on the same basis as those of property and equipment. In addition, the right-of-use asset is periodically reduced by impairment losses, if any, and adjusted for certain remeasurements of the lease liability.

Lease liability

The lease liability is initially measured at the present value of the lease payments that are not paid at the commencement date, discounted using the interest rate implicit in the lease or, if that rate cannot be readily determined, the Scheme's incremental borrowing rate. Generally, the Scheme uses its incremental borrowing rate as the discount rate.

Lease payments included in the measurement of the lease liability comprise fixed payments, increasing annually at a rate set out in the lease agreement.

The lease liability is measured at amortised cost using the effective interest method. The lease liability is remeasured by discounting the revised lease payments using a revised discount rate if there is a change in the lease term, or if the Scheme changes its assessment of whether it will exercise an extension option.

When the lease liability is remeasured in this way, a corresponding adjustment is made to the carrying amount of the right-of-use asset, or is recorded in the surplus or deficit if the carrying amount of the right-of-use asset has been reduced to zero.

Leases of low-value assets

The Scheme has elected not to recognise right-of-use assets and lease liabilities for leases of low-value assets.

Disclosure

The Scheme represents right-of-use assets in "property and equipment" and lease liabilities in "leases" in the Statement of Financial Position. The Scheme recognises the lease payments associated with short term leases and leases of low-value assets as an expense on a straight line basis over the lease term.

Effective date

IFRS 16: Leases is effective for year ends commencing on 1 January 2019, early adoption is permitted. The Scheme has early adopted this Standard with effect from 1 January 2018.

Note:

NATURE OF LEASING ACTIVITIES

The Scheme leases land and buildings for its office space. The lease for the office space is effective from 1 July 2018 with an initial period of 5 years and includes an option to renew the lease for an additional period of the same duration, after the end of the initial term. It is reasonably certain that the renewal option will be exercised and the term of this lease has been determined as 10 years when assessing the term under IFRS 16. The lease payments are fixed and increase annually at a rate set out in the lease agreement.

This lease includes non-lease components and provides for the payment by the Scheme of operational costs incurred by the lessor and rates and taxes levied on the lessor. These amounts are determined annually and are recognised as an expense in the period incurred. Detail of this lease is presented below.

The Scheme leases IT equipment and certain office equipment with contract terms of one to two years. These leases are leases of low-value items. The Scheme has elected not to recognise right-of-use assets and lease liabilities for these leases.

Notes to the Annual Financial Statements continued

for the year ended 31 December 2018

R'000	Land and buildings	Total
2 Leases *continued*		
RIGHT-OF-USE ASSET		
Balance as at 1 January 2018	–	–
Additions	12 015	12 015
Depreciation charge for the year	(601)	(601)
Balance as at 31 December 2018	**11 414**	**11 414**
LEASE LIABILITY		
Balance as at 1 January 2018	–	–
Additions	12 015	12 015
Interest expense	675	675
Lease payments	(774)	(774)
Balance as at 31 December 2018	**11 916**	**11 916**

R'000	2018	2017
MATURITY ANALYSIS – CONTRACTUAL UNDISCOUNTED CASH FLOWS		
Less than one year	1 600	–
One to five years	7 604	–
More than five years	11 388	–
Total undiscounted lease liabilities at 31 December	**20 592**	–
LEASE LIABILITIES INCLUDED IN THE STATEMENT OF FINANCIAL POSITION AT 31 DECEMBER		
Non-current	10 316	–
Current	1 600	–
	11 916	–
AMOUNTS RECOGNISED IN THE STATEMENT OF COMPREHENSIVE INCOME		
Depreciation	601	–
Interest on lease liabilities	675	–
Expenses relating to leases of low-value assets	52	–
AMOUNTS RECOGNISED IN THE STATEMENT OF CASH FLOWS		
Total cash outflow for leases	774	–

Notes to the Annual Financial Statements continued

for the year ended 31 December 2018

3 Financial assets at fair value through profit or loss

Accounting policy:

The Scheme's investment strategy ("business model objective") is determined by means of an allocation across different asset classes and grouping of financial assets into specific portfolios. Independent asset managers manage these portfolios under fully discretionary, active mandates with performance evaluated at portfolio level on a fair value basis. All asset managers are remunerated based on the fair value of the portfolios under management. The business model objective is achieved through the selling of assets per the documented strategy for realisation of gains with the collection of contractual cash flows being incidental to the primary business model objective. The financial assets are managed together and grouped into specific portfolios. Based on the business model objective the financial assets are measured at fair value through profit or loss.

Financial assets at fair value through profit or loss are initially recognised at fair value and the transaction costs are expensed in the surplus or deficit section of the Statement of Comprehensive Income.

The fair value of the financial instruments traded in an active market is determined by using quoted market prices or dealer quotes. The fair value of financial instruments not traded in an active market is determined by using valuation techniques that maximise the use of observable market data and rely as little as possible on entity specific estimates.

Gains or losses arising from subsequent changes in fair value are recognised under Other income in the Statement of Comprehensive Income within the period in which they arise.

Note:

R'000	2018	2017
The Scheme's financial assets at fair value through profit or loss are summarised by measurement classes as follows:		
Current assets	**20 519 767**	14 005 644
– Offshore bonds	**847 314**	1 463 064
– Equities	**4 038 399**	3 378 331
– Yield-enhanced bonds	**5 631 601**	3 721 190
– Inflation-linked bonds	**1 104 552**	792 666
– Money market instruments	**8 324 805**	4 268 369
– Listed property	**573 096**	382 024
	20 519 767	14 005 644
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	**14 005 644**	12 211 677
Acquisitions	**9 618 505**	2 953 775
Disposals	**(2 816 057)**	(1 571 646)
Net (losses)/gains on revaluation of financial assets at fair value through profit or loss (Note 23)	**(288 325)**	411 838
At the end of the year	**20 519 767**	14 005 644

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

Notes to the Annual Financial Statements continued

for the year ended 31 December 2018

4 Trade and other receivables

Accounting policy:

Receivables are non-derivative financial assets with fixed or determinable payments that are not quoted in an active market, other than those the Scheme intends to sell in the short term.

Receivables are initially recognised at fair value, plus transaction costs. The Scheme holds its insurance receivables and loans and receivables with the objective to collect the contractual cash flows and measures them subsequently at amortised cost using the effective interest method, less provision for impairment.

Trade and other receivables comprise insurance receivables, arising from the Scheme's insurance contracts with its members and loans and receivables. As part of the implementation of IFRS 9: *Financial Instruments*, the classification between insurance receivables and loans and receivables was reassessed. Based on the reassessment, the balance due by Discovery Third Party Recovery Services (Pty) Ltd, relating to third party recoveries and forensic receivables, previously classified under loans and receivables, as part of sundry accounts receivables, were reclassified to insurance receivables.

Impairment of insurance receivables

The Scheme assesses at each reporting date whether there is objective evidence that an insurance receivable is impaired. An insurance receivable, or group of insurance receivables is impaired, and impairment losses are incurred if, and only if, there is objective evidence of impairment as a result of one or more events that occurred after the initial recognition of the insurance receivable (a "loss event") and that loss event (or events) has an adverse impact on the estimated future cash flows of the insurance receivable that can be reliably estimated.

Objective evidence that an insurance receivable or group of insurance receivables is impaired includes observable data that comes to the attention of the Scheme regarding the following loss events:

- Significant financial difficulty of service 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.
- Adverse changes in the payment status of members of the Scheme.
- National or local economic conditions that correlate with non-payment of debtor contributions.

The Scheme first assesses whether objective evidence of impairment exists, individually for insurance receivables that are individually significant, such as service provider debtors. In the case of insurance receivables which are not individually significant, such as contribution debtors, receivables are grouped on the basis of similar credit characteristics, such as type of receivable and past due status. These characteristics are used in the estimation of future recoverable cash flows.

If there is objective evidence that an impairment loss on an insurance receivable has been incurred, the amount of the loss is measured as the difference between the carrying amount and the present value of estimated future cash flows. The carrying amount of the receivable is reduced and the amount of the loss is recognised in the Statement of Comprehensive Income.

When a receivable is uncollectable, it is written off against the related provision for impairment. Such receivables are written off after all the necessary collection procedures have been completed and the amount of the loss has been determined. Where a provision for impairment has not been raised, the receivable is written off directly to the Statement of Comprehensive Income. Subsequent recoveries of amounts previously written off decrease the amount of the provision for impairment in the Statement of Comprehensive Income.

If, in a subsequent period, the amount of the impairment loss decreases and the decrease can be related objectively to an event occurring after the impairment was recognised, the previously recognised impairment loss is reversed by adjusting the allowance account. The amount of the reversal is recognised in the Statement of Comprehensive Income.

Notes to the Annual Financial Statements continued

for the year ended 31 December 2018

4 Trade and other receivables *continued*

Impairment of loans and receivables

Prior to the implementation of IFRS 9, the Scheme applied an incurred loss model to assess impairment of loans and receivables. Following the implementation of IFRS 9, the Scheme applied the IFRS 9 simplified approach to measure expected credit losses which uses a lifetime expected loss allowance for loans and receivables. To measure the expected credit losses, loans and receivables are grouped based on shared credit risk characteristics and days past due. Note 32 sets out information about impairment of loans and receivables.

Note:

R'000	2018	2017
Insurance receivables		
Contribution receivables	**2 005 164**	751 192
Contributions outstanding	**2 019 897**	762 685
Less: Provision for impairment	**(14 733)**	(11 493)
Member and service provider claims receivables	**98 899**	94 025
Amount due	**403 991**	361 566
Less: Provision for impairment	**(305 092)**	(267 541)
Other risk transfer arrangements	**5 498**	11 796
Recoveries due from other risk transfer arrangements	**4 076**	3 660
Share of outstanding claims provision (Note 7)	**1 422**	8 136
Broker fee receivables	**214**	743
Amounts due from brokers	**1 478**	1 690
Less: Provision for impairment	**(1 264)**	(947)
Other insurance receivables	**39 097**	52 045
Balance due by related party	**14 387**	18 616
Discovery Third Party Recovery Services (Pty) Ltd (Note 26)	**14 387**	18 616
Forensic receivables	**186 328**	204 120
Amount due	**197 638**	214 089
Less: Provision for impairment	**(11 310)**	(9 969)
Total receivables arising from insurance contracts	**2 349 587**	1 132 537
Loans and receivables		
Sundry accounts receivable	**5 294**	11 114
Interest receivable	**3 021**	4 014
Total receivables arising from loans and receivables	**8 315**	15 128
	2 357 902	1 147 665

At 31 December 2018, the carrying amounts of Trade and other receivables approximate their fair values due to the short-term maturities of these assets. Interest is not charged on overdue balances. The estimated future cash flow receipts have not been discounted as the effect would be immaterial.

Notes to the Annual Financial Statements continued

for the year ended 31 December 2018

R'000	2018	2017
5 Cash and cash equivalents – Personal Medical Savings Account trust assets		
(Monies managed by the Scheme on behalf of members)		
Note:		
PERSONAL MEDICAL SAVINGS ACCOUNT TRUST PORTFOLIO (Managed by Aluwani Capital Partners (Pty) Ltd)		
Balance at beginning of the year	**2 304 818**	2 071 391
Net (withdrawal)/additional Investments	**(2 395 237)**	55 608
Interest Income	**90 419**	177 819
Balance at the end of the year	**–**	2 304 818
PERSONAL MEDICAL SAVINGS ACCOUNT TRUST PORTFOLIO (Managed by Taquanta Asset Managers (Pty) Ltd)		
Balance at beginning of the year	**2 304 331**	2 071 281
Net (withdrawal)/additional Investments	**(2 381 615)**	61 143
Interest Income	**77 284**	171 907
Balance at the end of the year	**–**	2 304 331
Total Personal Medical Savings Account trust assets	**–**	4 609 149

Effective from 1 January 2018, the Scheme Rules were amended and Personal Medical Savings Account (PMSA) assets are no longer defined and treated as trust assets and these assets now form part of the Scheme assets and are included as part of the Scheme Cash and cash equivalents. In the prior year, these funds were treated as trust 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 were invested separately from the Scheme's assets. The difference between total Personal Medical Savings Account assets and Personal Medical Savings Account liabilities (Note 9) arose from timing of cash flows to and from the portfolios and was reconciled monthly. The average rate earned on the Personal Medical Savings Account Trust assets during 2017 was 8.33%.

6 Cash and cash equivalents – medical scheme assets

Accounting policy:

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

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.

Note:

R'000	2018	2017
Current accounts	**3 863 605**	3 891 038
Money market instruments	**1 911 876**	1 989 324
	5 775 481	5 880 362

At 31 December 2018 cash and cash equivalents are carried at amortised cost, which approximates fair value.

Notes to the Annual Financial Statements continued
for the year ended 31 December 2018

7 Outstanding claims provision

Accounting policy:

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

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

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

Note:

R'000	2018	2017
Outstanding claims provision – not covered by risk transfer arrangements	**1 497 805**	1 231 927
Outstanding claims provision – covered by risk transfer arrangements (Note 4)	**1 422**	8 136
	1 499 227	1 240 063
Analysis of movement in outstanding claims		
Balance at beginning of the year	**1 240 063**	1 121 394
Payments in respect of prior year	**(1 252 366)**	(1 117 213)
(Under)/over provision in prior year (Note 12)	**(12 303)**	4 181
Outstanding claims provision raised in current year	**1 511 530**	1 235 882
Not covered by risk transfer arrangements	**1 510 108**	1 227 746
Covered by risk transfer arrangements (Note 4)	**1 422**	8 136
Balance at end of the year	**1 499 227**	1 240 063
Analysis of outstanding claims provision		
Estimated gross claims	**1 587 327**	1 323 263
Less:		
Estimated recoveries from savings plan accounts (Note 9)	**(88 100)**	(83 200)
Balance at end of the year	**1 499 227**	1 240 063

Notes to the Annual Financial Statements continued

for the year ended 31 December 2018

R'000	2018	2017
8 Derivative financial instruments		
Note:		
Financial assets held at fair value through profit or loss		
Current assets		
– Derivative financial instruments	**142 856**	85 857
Financial liabilities held at fair value through profit or loss		
Current liabilities		
– Derivative financial instruments	**–**	(86 445)
Derivative financial asset/(liability) at the end of the year	**142 856**	(588)
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	**(588)**	50 384
Net realised gain on derivative financial instruments (Note 28)	**(28 303)**	(89 802)
Realised gains on derivative financial instruments	**(28 303)**	(91 869)
– Equity portfolio derivatives	**(26 202)**	–
– Zero-cost currency collars	**(2 101)**	(91 869)
Realised losses on derivative financial instruments	**–**	2 067
– Bond portfolio derivatives	**–**	2 067
Net fair value gain on derivative financial instruments (Note 23)	**171 747**	38 830
Gains on revaluation of derivative financial instruments to fair value	**252 649**	179 148
– Equity portfolio derivatives	**59 917**	–
– Zero-cost equity fences	**190 339**	–
– Zero-cost currency collars	**–**	174 851
– Bond portfolio derivatives	**2 393**	4 297
Losses on revaluation of derivative financial instruments to fair value	**(80 902)**	(140 318)
– Zero-cost equity fences	**–**	(138 329)
– Zero-cost currency collars	**(80 902)**	–
– Bond portfolio derivatives	**–**	(1 988)
Derivative financial asset /(liability) at the end of the year	**142 856**	(588)

The Trustees approved a strategy to protect the value of the Scheme's investments by entering into zero-cost equity fences which protects the Scheme's equity portfolios against a fall in equity markets and zero-cost currency collars to protect the Scheme's offshore US dollar denominated bond portfolios against rand appreciation.

Some of the Scheme's equity managers entered into future contracts to generate an equity-related return on cash held in the equity portfolios.

Some of the Scheme's bond managers entered into bond futures to hedge the bond portfolios and provide protection against market risk.

Details of the Scheme's derivatives and the impact of these instruments on investment return are set out in the Financial Risk Management Report (Note 32).

Notes to the Annual Financial Statements continued
for the year ended 31 December 2018

9 Personal Medical Savings Account liabilities

Accounting policy:

The Scheme Rules for Personal Medical Savings Accounts (PMSAs) were amended, effective from 1 January 2018. The effect of the amendment is that a trust relationship is no longer established. In the prior reporting period, PMSAs were disclosed as trust liabilities. Following the Rule amendment these liabilities are no longer trust liabilities and no longer disclosed as trust liabilities. There were no other changes to the valuation or classification of PMSAs.

Members' PMSAs represent savings contributions (which are a deposit component of the insurance contracts), and accrued interest thereon, net of any savings claims paid on behalf of members in terms of the Scheme's registered Rules. The deposit component has been unbundled since the Scheme can measure the deposit component separately and the Scheme's accounting policies do not otherwise require recognition of all obligations and rights arising from the deposit component.

The savings accounts contain a demand feature and are initially measured at fair value plus transaction costs, which is the amount payable to a member on demand, discounted from the first date that the amount could be required to be paid. Subsequent to initial measurement, the liability is measured at amortised cost using the effective interest rate method.

Unspent savings at year end are carried forward to meet future expenses for which the members are responsible. In terms of the Act, balances standing to the credit of members are refundable only in terms of Regulation 10 of the Act.

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

Interest payable on members' PMSAs is expensed when incurred.

Note:

R'000	2018	2017
Balance on Personal Medical Savings Accounts at the beginning of the year	**4 656 633**	4 204 043
Add:		
Personal Medical Savings Accounts contributions received or receivable	**11 820 081**	11 008 711
For the current year (Note 11)	**11 820 081**	11 008 711
Interest on Personal Medical Savings Accounts (Note 25)	**220 294**	367 238
Transfers received from other medical schemes	**24 393**	31 784
Less:		
Claims paid to or on behalf of members (Note 12)	**(11 279 740)**	(10 602 298)
Refunds on death or resignation	**(400 829)**	(352 845)
Balance due to members on Personal Medical Savings Accounts at the end of the year	**5 040 832**	4 656 633

It is estimated that claims to be paid out of members' PMSAs in respect of claims incurred in 2018 but not reported will amount to approximately R88 100 000 (2017: R83 200 000) (Note 7).

As at 31 December 2018 the carrying amount of the members' PMSAs were deemed to be equal to their fair values, which is the amount payable on demand.

Interest is determined from time to time by the Scheme at its discretion and added to the funds allocated to the member's PMSA in terms of the Scheme Rules. The Scheme does not charge interest on negative (overdrawn) PMSA balances.

Notes to the Annual Financial Statements continued

for the year ended 31 December 2018

10 Trade and other payables

Accounting policy:

Trade payables are obligations to pay for goods or services that have been acquired in the ordinary course of business from suppliers. Trade payables are classified as current liabilities if payment is due within one year or less. If not, they are presented as non-current liabilities.

Trade payables are recognised initially at fair value and subsequently measured at amortised cost using the effective interest rate method.

Unallocated funds

Unallocated funds arise on the receipt of unidentified deposits in favour of the Scheme.

Unallocated funds that have legally prescribed, that is funds older than three years, are written back and 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.

Note:

R'000	2018	2017
Insurance payables		
Contributions received in advance	**153 229**	1 851 573
Contribution refunds due to employers	**1 867**	1 110
Reported claims not yet paid	**628 147**	562 086
Balance at the beginning of the year	**562 086**	548 257
Net movement for the year	**66 061**	13 829
Broker fee creditors	**88 483**	111 819
Accredited brokers	**88 483**	111 819
Total liabilities arising from insurance contracts	**871 726**	2 526 588
Financial liabilities		
Balances due to related parties (Note 26)	**592 543**	513 720
Discovery Health (Pty) Ltd	**585 452**	513 571
Discovery Life Limited	**51**	149
Discovery Vitality (Pty) Ltd	**3 768**	–
Discovery Central Services (Pty) Ltd	**3 272**	–
Unallocated funds	**3 130 793**	8 943
Total accruals	**24 991**	16 267
General accruals	**24 861**	16 168
Leave pay provision	**130**	99
Total arising from financial liabilities	**3 748 327**	538 930
	4 620 053	3 065 518

At 31 December 2018 the carrying amounts of insurance and other payables approximate their fair values due to the short-term maturities of these liabilities.

Notes to the Annual Financial Statements continued

for the year ended 31 December 2018

11 Risk contribution income

Accounting policy:

Gross contributions comprise risk contributions and Personal Medical Savings Account contributions. Contributions on member insurance contracts are accounted for monthly when their collection in terms of the insurance contract is reasonably assured. Risk contributions represent gross contributions after the deduction of Personal Medical Savings Account contributions. Risk contributions are earned from the date of attachment of risk, over the indemnity period on a straight-line basis. The earned portion of risk contributions received is recognised as revenue.

Risk contributions are shown before the deduction of broker service fees.

Note:

R'000	2018	2017
Gross contributions per registered Scheme Rules	**64 649 012**	59 710 735
Less:		
Personal Medical Savings Account contributions (Note 9)	**(11 820 081)**	(11 008 711)
	52 828 931	48 702 024

12 Net claims incurred

Accounting policy:

Claims incurred

Gross claims incurred comprises of the total estimated cost of all claims arising from healthcare events that have occurred in the year and for which the Scheme is responsible, whether or not reported by the end of the year.

Risk claims incurred comprise:

- Claims submitted and accrued for services rendered during the year.
- Payments under provider contracts for services rendered to members.
- Over or under provisions relating to prior year claims estimates.
- Claims incurred but not yet reported.
- Claims settled in terms of risk transfer arrangements.

Net of:

- Claims from members' Personal Medical Savings Accounts.
- Recoveries from members for co-payments.
- Recoveries from third parties.
- Discount received from service providers.

Anticipated recoveries under risk transfer arrangements are disclosed separately as assets, and are assessed in a manner similar to the assessment of the outstanding claims provision and claims reported not yet paid.

Notes to the Annual Financial Statements *continued*

for the year ended 31 December 2018

12 Net claims incurred *continued*

Reimbursements from the Road Accident Fund

The Scheme grants assistance to its members in defraying expenditure incurred in connection with the rendering of any relevant health service. Such expenditure may be in connection with a claim that is also made against the Road Accident Fund, administered in terms of the Road Accident Fund Act No 56 of 1996. If the member is reimbursed by the Road Accident Fund, they are obliged, contractually, to cede that payment to the Scheme to the extent that they have already been compensated.

Due to the uncertainty around the confirmation and measurability of the Road Accident Fund amounts, the Scheme accounts for these amounts on a cash basis. These amounts are recognised as a reduction of net claims incurred.

Note:

R'000	2018	2017
Current year claims per registered Scheme rules	**56 206 607**	50 855 045
Claims not covered by risk transfer arrangements	**55 789 433**	50 448 462
Claims covered by risk transfer arrangements (Note 14)	**417 174**	406 583
Movement in outstanding claims provision	**259 163**	118 670
Under/(Over) provision in prior year (Note 7)	**12 303**	(4 181)
Adjustment for current year	**246 860**	122 851
	56 465 770	50 973 715
Less:		
Claims charged to members' Personal Medical Savings Accounts (Note 9)	**(11 279 740)**	(10 602 298)
Claims incurred	**45 186 030**	40 371 417
Third party claim recoveries	**(86 594)**	(143 360)
	45 099 436	40 228 057

Risk transfer arrangements

During 2018 the Scheme had five risk transfer arrangements in place compared to six during 2017. The arrangement relating to cover for in-hospital and out-of-hospital benefits for certain members on the KeyCare Plus and KeyCare Access plans was cancelled effective from 1 January 2018. The methodologies used to determine the claims covered by these arrangements are set out below.

- **Risk transfer arrangement covering in-hospital and out-of-hospital benefits for certain members on the KeyCare Plus and KeyCare Access plans.**
  This arrangement was cancelled with effect from 1 January 2018.

  The claims experience for members on the KeyCare Plus and KeyCare Access plans for the 2017 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 in 2017 under this arrangement, the average 2017 PLPM rate is multiplied by the lives exposure for this arrangement's membership.

- **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.

12 Net claims incurred *continued*

- **Risk transfer arrangement providing dentistry services to members on the KeyCare Plus and KeyCare Access plans.**
  The cost of the group of dental 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.

- **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.

- **Risk transfer arrangement providing acute medication dispensing services to members on the Smart plan.**
  The Scheme contracted with two providers to provide acute medication dispensing services for Smart Plan members and remunerates 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.

Notes to the Annual Financial Statements continued

for the year ended 31 December 2018

13 Accredited managed healthcare services (no risk transfer)

Accounting policy:

Accredited managed healthcare services (no risk transfer) fees comprise amounts paid or payable to a third party for managing the utilisation, costs and quality of healthcare services to the members of the Scheme and are expensed as incurred.

Accredited managed healthcare services are part of healthcare expenditure as they directly impact on the delivery of cost-effective and appropriate healthcare benefits to beneficiaries of the Scheme.

Note:

R'000	2018	2017
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	**532 673**	494 155
Hospital Benefit Management Services	**494 141**	458 289
Managed Care Network Management Services and Risk Management Services	**459 294**	426 180
Pharmacy Benefit Management Services	**167 864**	155 687
	1 653 972	1 534 311

14 Net profit on risk transfer arrangements

Accounting policy:

Risk transfer arrangements are contractual arrangements entered into by the Scheme and third parties who undertake to indemnify the Scheme against all or part of the loss that the Scheme may incur as a result of carrying on the business of a medical scheme. Risk transfer arrangements do not reduce the Scheme's primary obligations to its members and their dependants. The arrangements only decrease the loss the Scheme may incur as a result of carrying on the business of a medical scheme.

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

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

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

Amounts recoverable under risk transfer arrangements are assessed for impairment at each reporting date. These assets are deemed impaired if there is objective evidence, as a result of an event that occurred after its initial recognition, that the Scheme may not recover all amounts due and that the event has a reliably measurable impact on the amounts that the Scheme will receive under the risk transfer arrangement. The Scheme gathers the objective evidence that a risk transfer arrangement asset is impaired using the same process adopted for insurance receivables. The impairment loss is also calculated following the same method used for these receivables. These processes are described in Note 4.

Note:

R'000	2018	2017
The Scheme operated the following risk transfer arrangements during the year:		
Risk transfer arrangement fees	**(382 719)**	(392 023)
Recoveries under risk transfer arrangements (Note 12)	**417 174**	406 583
	34 455	14 560

Notes to the Annual Financial Statements continued

for the year ended 31 December 2018

15 Broker service fees

Accounting policy:

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

Note:

R'000	2018	2017
Brokers' fees	**1 313 741**	1 214 205
	1 313 741	1 214 205

16 Other operating expenses

Accounting policy:

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

Note:

R'000	2018	2017
Association fees	**1 900**	1 359
Audit fees	**6 023**	9 066
Audit services for the year ended 2018	**1 881**	–
Audit services for the year ended 2017	**3 270**	1 759
Audit services for the year ended 2016	**–**	3 084
Other services	**872**	4 223
Audit Committee and Risk Committee fees (Note 17)	**1 983**	2 001
Audit Committee	**1 419**	1 458
Risk Committee	**564**	543
Bank charges	**9 591**	9 817
Clinical Governance Committee fees (Note 17)	**629**	662
Council for Medical Schemes	**51 699**	44 103
Debt collecting fees	**3 818**	2 789
Depreciation	**743**	–
Dispute Committee fees	**1 467**	636
Fidelity Guarantee Insurance	**249**	285
General meeting costs	**4 271**	9 989
Investment Committee fees (Note 17)	**749**	701
Investment reporting fees	**4 142**	3 669
Legal fees	**812**	476
Net impairment losses (Note 18)	**103 020**	87 604
Non-healthcare Expenses Committee fees (Note 17)	**–**	131
Nomination Committee fees (Note 19)	**131**	285
Office operating costs	**1 795**	–
Other expenses	**28 387**	25 951
Principal Officer fees – Remuneration	**5 963**	5 128
Principal Officer fees – Unvested Long Term Employee Benefit	**1 676**	1 803
Printing, postage and stationery	**214**	839
Product Committee fees	**–**	73
Professional fees	**8 584**	10 517
Remuneration Committee fees (Note 17)	**88**	106
Scheme office costs	**4 385**	5 658
Staff costs (Note 20)	**20 823**	28 723
Sundry amounts written off	**54**	100
Stakeholder Relations and Ethics Committee fees (Note 17)	**–**	156
Trustees' remuneration and consideration expenses (Note 21)	**9 756**	7 834
	272 952	260 461

Notes to the Annual Financial Statements continued

for the year ended 31 December 2018

17 Board committee fees and considerations

The following table records the remuneration and consideration paid to Independent Members of Board Committees during the year:

Note:

31 December 2018 R'000	Audit	Risk	Clinical Governance	Investment	Non-Healthcare Expenses	Product	Remuneration	Stakeholder Relations and Ethics	Total
I Ahmed	–	–	–	291	–	–	–	–	291
S Green	218	131	–	–	–	–	–	–	349
S Ludoplh	260	119	–	–	–	–	–	–	379
N Luthuli	–	–	–	–	–	–	88	–	88
P Maphumulo	214	131	–	206	–	–	–	–	551
N Mlaba	–	–	84	–	–	–	–	–	84
M Sathekge	–	–	54	–	–	–	–	–	54
S Smith	–	–	198	–	–	–	–	–	198
B Stott	727	183	–	252	–	–	–	–	1 162
Z Van Der Spuy – fees	–	–	237	–	–	–	–	–	237
Z Van Der Spuy – travel	–	–	56	–	–	–	–	–	56
Total	**1 419**	**564**	**629**	**749**	**–**	**–**	**88**	**–**	**3 449**

31 December 2017 R'000	Audit	Risk	Clinical Governance	Investment	Non-Healthcare Expenses	Product	Remuneration	Stakeholder Relations and Ethics	Total
I Ahmed	–	–	–	350	–	–	–	–	350
J Butler – fees	–	–	–	–	–	–	–	130	130
J Butler – travel	–	–	–	–	–	–	–	26	26
D Eriksson	–	–	–	–	–	–	106	–	106
S Green	213	125	–	–	–	–	–	–	338
J Human – fees	–	–	–	–	89	66	–	–	155
J Human – travel	–	–	–	–	42	7	–	–	49
S Ludoplh	225	137	–	–	–	–	–	–	362
P Maphumulo	202	125	–	104	–	–	–	–	431
M Sathekge	–	–	171	–	–	–	–	–	171
S Smith	–	–	209	–	–	–	–	–	209
B Stott	818	156	–	247	–	–	–	–	1 221
Z Van Der Spuy – fees	–	–	239	–	–	–	–	–	239
Z Van Der Spuy – travel	–	–	43	–	–	–	–	–	43
Total	1 458	543	662	701	131	73	106	156	3 830

For detail of the Chairperson of the respective Committee refer to pages 39 to 40 and 44 to 45.

R'000	2018	2017

18 Net impairment losses

Note:

	2018	2017
Insurance receivables		
Contributions that are not collectable	**3 240**	1 734
Movement in provision	**3 240**	1 734
Members' and service providers' portions that are not recoverable	**98 973**	85 688
Movement in provision	**98 973**	85 688
Amounts due by brokers that are not recoverable	**317**	82
Movement in provision	**317**	82
Payables/receivables written off directly to the Statement of Comprehensive Income	**490**	111
Less:		
Previously written off receivables recovered	**–**	(11)
	103 020	87 604

Notes to the Annual Financial Statements continued

for the year ended 31 December 2018

R'000	2018	2017

19 Other committee fees

Note:

	2018	2017
Nomination Committee fees		
P Goss – Independent Member (Chairperson)	**44**	89
T Wixley – Independent Member	**44**	89
R Shough – Independent Member	**43**	107
	131	285

20 Staff costs

Accounting policy:

Pension obligations

All employees of the Scheme are members of defined contribution plans. Defined contribution plans are plans under which the Scheme pays fixed contributions to separate legal entities.

The Scheme has no legal or constructive obligation to pay further contributions if the funds do not hold sufficient assets to pay all employees the benefits relating to employee service in the current and prior periods. The Scheme has no further payment obligations once the contributions have been paid. Contributions to the defined contribution funds are recognised in the net surplus or deficit for the year in which they are incurred.

Other post-employment obligations

The Scheme has no liability for the post-retirement medical benefits of employees.

Other long term employee benefit

The Long Term Employee Benefit plan refers to awards made to qualifying employees.

The amount recognised in the Statement of Financial Position in respect of the defined benefit plan is the present value of the defined benefit obligation at the end of the reporting period less the fair value of plan assets out of which the obligations are to be settled directly. The defined benefit obligation is calculated using the Projected Unit Credit Method.

Leave pay accrual

The Scheme recognises in full employees' rights to annual leave entitlement in respect of past service.

Bonuses

Management and staff bonuses are recognised as an expense in staff costs as incurred.

Note:

R'000	2018	2017
Salaries and bonuses	**17 055**	23 099
Pension costs – defined contribution plans	**1 123**	1 497
Medical and other benefits	**755**	846
Long Term Employee Benefit service cost	**1 852**	3 242
Increase in leave pay accrual	**38**	39
	20 823	28 723
Number of employees at 31 December	**12**	12

21 Trustees' remuneration and considerations

Note:

The following table records the remuneration and consideration paid to Trustees during the year:

31 December 2018 R'000	Services as Trustee	Committee fees								Travel	Total
		Audit	Risk	Investment	Clinical Governance	Product	Non-healthcare Expenses	Remuneration	Stakeholder Relations and Ethics		
N Morrison (Chairperson)	**850**	**–**	**–**	**261**	**–**	**–**	**128**	**145**	**140**	**–**	**1 524**
D Moodley	**466**	**–**	**–**	**288**	**274**	**130**	**3**	**–**	**143**	**33**	**1 337**
D King	**441**	**–**	**–**	**–**	**–**	**–**	**114**	**151**	**132**	**84**	**922**
D Naidoo	**506**	**224**	**150**	**268**	**–**	**125**	**165**	**31**	**–**	**–**	**1 469**
J Adams SC	**506**	**224**	**150**	**–**	**246**	**8**	**4**	**–**	**–**	**–**	**1 138**
J Butler SC	**479**	**–**	**–**	**–**	**–**	**–**	**118**	**141**	**188**	**91**	**1 017**
J Human	**484**	**211**	**150**	**266**	**–**	**173**	**4**	**–**	**–**	**154**	**1 442**
S Brynard	**441**	**–**	**–**	**–**	**–**	**108**	**3**	**103**	**132**	**120**	**907**
Total	**4 173**	**659**	**450**	**1 083**	**520**	**544**	**539**	**571**	**735**	**482**	**9 756**

The following table records the remuneration and consideration paid to Trustees during the prior year:

31 December 2017 R'000	Services as Trustee	Committee fees								Travel	Total
		Audit	Risk	Investment	Clinical Governance	Product	Non-healthcare Expenses	Remuneration	Stakeholder Relations and Ethics		
N Morrison (Chairperson)	625	90	51	222	–	11	136	38	51	–	1 222
M Van Der Nest SC[1]	573	–	–	–	–	–	–	49	66	1	689
G Waugh	180	67	45	–	–	56	92	–	–	7	447
D Moodley	486	–	–	222	241	114	–	–	114	18	1 195
D King	488	–	–	–	–	–	136	76	114	90	904
D Naidoo	521	210	139	247	–	113	155	–	–	–	1 385
J Adams SC	231	115	84	–	115	–	–	–	–	–	545
J Butler SC	248	–	–	–	–	–	54	43	85	36	466
J Human	202	78	63	104	–	70	–	–	–	53	569
S Brynard	202	–	–	–	–	63	–	38	63	44	410
Total	3 756	560	382	795	356	427	573	244	493	249	7 834

1 *Term as a Trustee and Chair ended on 14 August 2017 and Mr Neil Morrisson was appointed by the Board as Chair on 6 April 2017, which appointment took effect on 14 August 2017 when Michael van der Nest SC's term as a Trustee/ Chair ended.*

Notes to the Annual Financial Statements continued

for the year ended 31 December 2018

22 Investment income

Accounting policy:

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

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

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

Note:

R'000	2018	2017
Financial assets at fair value through profit or loss:	**1 443 882**	1 383 773
Dividend income	**162 131**	84 062
Interest income	**1 281 751**	1 299 711
Cash and cash equivalents interest income	**21 223**	49 414
Investment income per Statement of Comprehensive Income	**1 465 105**	1 433 187
The Scheme's total interest income is summarised below.		
Financial assets not at fair value through profit or loss:		
Cash and cash equivalents interest income	**21 223**	49 414
Financial assets at fair value through profit or loss:		
Interest income	**1 281 751**	1 299 711
Total interest income	**1 302 974**	1 349 125

23 Net (losses)/gains on financial assets

Note:

R'000	2018	2017
Net fair value (losses)/gains on financial assets at fair value through profit or loss (Note 3):	**(288 325)**	411 838
Fair value gains on financial assets at fair value through profit or loss:	**277 606**	529 340
– Equities	**–**	435 490
– Money market instruments	**55 204**	27 814
– Offshore bonds	**142 889**	–
– Listed property	**–**	29 476
– Yield-enhanced bonds	**79 513**	36 560
Fair value losses on financial assets at fair value through profit or loss:	**(565 931)**	(117 502)
– Equities	**(399 790)**	–
– Offshore bonds	**–**	(96 851)
– Inflation-linked bonds	**(41 826)**	(14 592)
– Listed property	**(124 315)**	(14 592)
– Yield-enhanced bonds	**–**	(6 059)
Net fair value gains on derivative financial instruments (Note 8):	**171 747**	38 830
Fair value gains on derivative financial instruments:	**252 649**	179 148
Fair value losses on derivative financial instruments:	**(80 902)**	(140 318)
Net fair value gains on cash and cash equivalents	**47 263**	8 085
	(69 315)	458 753

Notes to the Annual Financial Statements continued
for the year ended 31 December 2018

R'000	2018	2017
24 Sundry income		
Note:		
Prescribed amounts written back	**72 677**	24 951
(Reversal of stale cheques written back)/Stale cheques written back	**(10 746)**	(23 205)
	61 931	1 746
25 Finance costs		
Note:		
Financial assets not at fair value through profit or loss:		
Interest on Personal Medical Savings Accounts (Note 9)	**220 294**	367 238
Interest paid to Administrator (Note 26)	**(2 879)***	–
Interest paid	**217 415**	367 238
Interest on lease liability (Note 2)	**675**	–
	218 090	367 238

* *During the year under review an amount of R2,8 million was refunded to the Scheme by Discovery Health (Pty) Ltd relating to interest charged in prior periods on balances owed to the Administrator.*

26 Related party transactions

The Scheme is governed by the Board of Trustees, the majority of which are elected by the members of the Scheme.

Key management personnel and their close family members

Key management personnel are those persons having authority and responsibility for planning, directing and controlling the activities of the Scheme. Key management personnel include the non-executive Board of Trustees and the Executive Officers of the Scheme. The disclosure deals with full-time Executive Officers who are compensated on a salary basis, and non-executive Board of Trustees who are compensated on a fee basis.

Close family members include close family members of the Board of Trustees and Executive Officers of the Scheme.

Parties with significant influence over the Scheme

ADMINISTRATOR

Discovery Health (Pty) Ltd has significant influence over the Scheme, as Discovery Health (Pty) Ltd participates in the Scheme's financial and operating policy decisions, but does not control the Scheme. Discovery Health (Pty) Ltd provides administration, managed care services and wellness programmes. As Discovery Health (Pty) Ltd is a related party, its subsidiaries and fellow subsidiaries within the Discovery Ltd group are related parties to the Scheme. Discovery Ltd's Annual Report provides detail of its group structure.

Notes to the Annual Financial Statements continued

for the year ended 31 December 2018

26 Related party transactions *continued*

Parties with significant influence over the Scheme *continued*

TRANSACTIONS WITH RELATED PARTIES

The following provides the total amount in respect of transactions, which have been entered into with related parties for the relevant financial year.

Transactions with key management personnel and their close family members which includes Trustees and Executive Officers:

R'000	2018	2017
Statement of Comprehensive Income transactions		
Compensation		
Short term employee benefits	**(30 379)**	(35 683)
Unvested Long Term Employee Benefit	**(3 527)**	(5 045)
Contributions and claims		
Gross contributions received	**991**	761
Claims paid from the Scheme	**(308)**	(454)
Claims paid from the Personal Medical Savings Account	**(222)**	(182)
Interest paid on Personal Medical Savings Accounts	**(1)**	(1)
Statement of Financial Position transactions		
Long Term Employee Benefit Plan asset	**8 261**	4 417
Plan asset	**15 167**	8 981
Plan liability	**(6 906)**	(4 564)
Contribution debtors	**72**	57
Personal Medical Savings Account balances	**(32)**	(12)

The terms and conditions of the related party transactions were as follows:

Transactions	Nature of transactions and their terms and conditions
Compensation	This constitutes remuneration and consideration paid to Trustees and Executive Officers, short-term employee benefits and unvested long-term employee benefits.
Contributions received	This constitutes the contributions paid by the related party as a member of the Scheme, in their individual capacity. All contributions were on the same terms as applicable to other members.
Claims incurred	This constitutes amounts claimed by the related parties, in their individual capacity as members of the Scheme. All claims were paid out in terms of the rules of the Scheme, as applicable to other members.
Contribution debtors	This constitutes outstanding contributions receivable. The amounts are due immediately. No impairment provisions have been raised on these amounts.
Personal Medical Savings Account balances	The amounts owing to the related parties relate to Personal Medical Savings Account balances to which the parties have a right. In line with the terms applied to other members, the balances earn monthly interest on an accrual basis, at interest rates determined by the Scheme from time to time at its discretion. The amounts are all current and would need to be payable on demand as applicable to other members.

Notes to the Annual Financial Statements continued

for the year ended 31 December 2018

26 Related party transactions *continued*

Transactions with entities that have significant influence over the Scheme

R'000	2018	2017
Discovery Health (Pty) Ltd – Administrator		
Statement of Comprehensive Income transactions		
Administration fees paid	**(4 875 746)**	(4 511 596)
Interest refund received on monthly balances (Note 25)	**2 879**	–
Statement of Financial Position transactions		
Balance due to Discovery Health (Pty) Ltd (Note 10)*	**(446 372)**	(384 681)
Discovery Health (Pty) Ltd – Managed care organisation		
Statement of Comprehensive Income transactions		
Accredited managed healthcare services (no risk transfer) (Note 13)	**(1 653 972)**	(1 534 311)
Statement of Financial Position transactions		
Balance due to Discovery Health (Pty) Ltd at year end (Note 10)*	**(139 080)**	(128 890)
Discovery Health (Pty) Ltd – Lifestyle and health assessments		
Statement of Comprehensive Income transactions		
Claims paid from the Scheme	**(15 821)**	(16 489)
Statement of Financial Position transactions		
Claims due to provider	**(589)**	(2)
Transactions between Discovery Health (Pty) Ltd's subsidiaries and the Scheme are provided below		
Discovery Third Party Recovery Services (Pty) Ltd		
Statement of Comprehensive Income transactions		
Third party collection fees	**(24 275)**	(21 827)
Statement of Financial Position transactions		
Balance due to the Scheme at year end (Note 4)	**14 387**	18 616
Southern RX Distributors (Pty) Ltd		
Statement of Comprehensive Income transactions		
Claims paid from the Scheme	**(242 068)**	(202 254)
Statement of Financial Position transactions		
Claims due to provider	**(2 389)**	(1 916)
Grove Nursing Services (Pty) Ltd		
Statement of Comprehensive Income transactions		
Claims paid from the Scheme	**(11 851)**	(7 862)
Statement of Financial Position transactions		
Claims (due to)/ from provider	**(101)**	(153)

* *Total amount due to Discovery Health (Pty) Ltd for the current financial year is R585 million (2017: R514 million), disclosed in Note 10 .*

Notes to the Annual Financial Statements *continued*

for the year ended 31 December 2018

R'000	2018	2017
26 Related party transactions *continued*		
Transactions with entities that have significant influence over the Scheme *continued*		
Transactions between Discovery Health (Pty) Ltd's fellow subsidiaries and the Scheme are provided below.		
Discovery Life Ltd		
Statement of Financial Position transactions		
Balance due to Discovery Life Limited at year end (Note 10)	**(51)**	(149)
Discovery Vitality (Pty) Ltd		
Statement of Financial Position transactions		
Balance due to Discovery Vitality (Pty) Ltd at year end (Note 10)	**(3 768)**	(4)
Discovery Connect Distribution Services (Pty) Ltd		
Statement of Comprehensive Income transactions		
Broker fees paid	**(58 830)**	(40 772)
Discovery Central Services (Pty) Ltd		
Statement of Comprehensive Income transactions		
Contractual lease payments	**(2 568)**	–
Statement of Financial Position transactions		
Balance due to Discovery Central Services (Pty) Ltd at year end (Note 10)	**(3 272)**	–

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 for a five year period effective from 1 January 2018. The Scheme and the Administrator shall be entitled to terminate the agreement by giving the other party at least 12 calendar months' written notice.

The administration fees are an all-inclusive fee, calculated on a Per Member Per Month basis. The total expense for administration cost changes in line with membership growth and inflation.

The main categories of service provided can be broken down as follows:

- Member and provider servicing;
- Marketing and advertising;
- Financial and actuarial services; and
- Governance, risk, compliance and internal audit.

Notes to the Annual Financial Statements *continued*

for the year ended 31 December 2018

26 Related party transactions *continued*

Managed healthcare agreement

Managed healthcare means clinical and financial risk assessment and management of healthcare, with a view to facilitating appropriateness and cost-effectiveness of relevant health services within the constraints of what is affordable, through the use of rules-based and clinical management-based programmes.

The Scheme has contracted with the Administrator to provide accredited managed healthcare services (no risk transfer). These services include bill review, specialist and hospital referrals, case management, disease management (where healthcare benefits are not included in the contract), peer review, claims audits and statistical analysis.

This agreement is in accordance with instructions given by the Board of Trustees. The agreement is for a five year period and effective from 1 January 2018. The Scheme and Discovery Health (Pty) Ltd shall be entitled to terminate the agreement by giving the other party at least 12 calendar months' written notice.

The accredited services provided by the managed care organisation include:

- Active Disease Risk Management Services and Disease Risk Management Support Services
- Hospital Benefit Management Services
- Managed Care Network Management Services and Risk Managed Services
- Pharmacy Benefit Management Services

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 2018 to 31 December 2018 to Discovery Third Party Recovery Services (Pty) Ltd for the amount of R14 million (2017: R15 million).

Specialist Pharmaceutical Services

The Scheme is contracted with Southern RX Pharmacy, a wholly owned subsidiary of Discovery Health (Pty) Ltd to provide specialist pharmaceutical services to members of the Scheme.

Lifestyle and health assessments

Discovery Health (Pty) Ltd provides wellness experiences through lifestyle and health assessments to Scheme members with the use of information technology and on-site medical evaluations of key health indicators.

Home-based nursing services

The Scheme is contracted with Grove Nursing services also known as Discovery HomeCare 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 Connect Distribution Services (Pty) Ltd to provide broker services directly to the consumer. The amounts were determined and paid based on the terms and conditions applicable to other brokers.

Contractual lease payments

The Scheme has contracted with Discovery Central Services (Pty) Ltd, a wholly owned subsidiary of Discovery Health (Pty) Ltd, to lease land and buildings for its office space. The lease for the office space is effective from 1 July 2018 with an initial period of 5 years. The lease payments are fixed and increase annually at a rate set out in the lease agreement.

This lease includes non-lease components and provides for the payment by the Scheme of operational costs incurred by the lessor and rates and taxes levied on the lessor. These amounts are determined annually and are recognised as an expense in the period incurred.

Notes to the Annual Financial Statements continued

for the year ended 31 December 2018

27 Surplus/(deficit) from operations per benefit plan

2018 R'000	Executive	Classic Comp	Classic Comp Zero MSA	Classic Core	Classic Saver	Classic Priority	Essential Comp	Essential Saver	Essential Core
Risk contribution income	**937 324**	**10 257 684**	**68 673**	**2 119 838**	**12 124 262**	**4 668 227**	**1 018 948**	**4 116 330**	**1 364 223**
Net claims incurred	(1 215 340)	(10 551 200)	(60 221)	(1 605 487)	(9 386 512)	(3 935 812)	(910 483)	(2 658 364)	(945 775)
Claims incurred	(1 215 969)	(10 559 812)	(60 280)	(1 608 710)	(9 405 883)	(3 941 572)	(911 486)	(2 666 608)	(948 487)
Third party claim recoveries	629	8 612	59	3 223	19 371	5 760	1 003	8 244	2 712
Net (expense)/income on risk transfer arrangements	(783)	(15 047)	(183)	–	–	–	(1 789)	–	–
Risk transfer arrangement fees	(10 720)	(145 231)	(1 317)	–	–	–	(14 875)	–	–
Recoveries from risk transfer arrangements	9 937	130 184	1 134	–	–	–	13 086	–	–
Accredited managed healthcare services (no risk transfer)	(12 494)	(170 451)	(1 151)	(61 709)	(373 197)	(113 217)	(19 814)	(153 955)	(49 982)
Relevant healthcare expenditure	**(1 228 617)**	**(10 736 698)**	**(61 555)**	**(1 667 196)**	**(9 759 709)**	**(4 049 029)**	**(932 086)**	**(2 812 319)**	**(995 757)**
Gross healthcare result	**(291 293)**	**(479 014)**	**7 118**	**452 642**	**2 364 553**	**619 198**	**86 862**	**1 304 011**	**368 466**
Broker service fees	(11 571)	(160 984)	(1 069)	(48 530)	(336 003)	(106 886)	(18 957)	(122 714)	(36 574)
Expenses for administration	(40 377)	(550 532)	(3 720)	(199 325)	(1 205 874)	(365 781)	(63 942)	(497 534)	(161 525)
Other operating expenses	(2 103)	(28 649)	(192)	(10 204)	(61 867)	(18 974)	(3 330)	(25 111)	(8 101)
Net healthcare result	**(345 344)**	**(1 219 178)**	**2 137**	**194 583**	**760 809**	**127 557**	**633**	**658 652**	**162 266**
Investment income	11 069	151 016	1 020	54 664	330 588	100 300	17 554	136 357	44 268
Net fair value (losses)/gains on financial assets at fair value through profit or loss	(511)	(6 972)	(48)	(2 577)	(15 631)	(4 660)	(813)	(6 518)	(2 126)
Sundry income	476	6 493	44	2 316	14 014	4 296	754	5 702	1 844
Other income	**11 034**	**150 537**	**1 016**	**54 403**	**328 971**	**99 936**	**17 495**	**135 541**	**43 986**
Expenses for asset management services rendered	(537)	(7 322)	(49)	(2 662)	(16 087)	(4 869)	(852)	(6 661)	(2 166)
Interest paid	(2 532)	(34 540)	2	83	(75 676)	(22 946)	(4 015)	(31 240)	64
Other expenditure	**(3 069)**	**(41 862)**	**(47)**	**(2 579)**	**(91 763)**	**(27 815)**	**(4 867)**	**(37 901)**	**(2 102)**
Net (deficit)/surplus for the year	**(337 379)**	**(1 110 502)**	**3 106**	**246 407**	**998 017**	**199 678**	**13 261**	**756 292**	**204 150**

Notes to the Annual Financial Statements continued

for the year ended 31 December 2018

27 Surplus/(deficit) from operations per benefit plan *continued*

2018 R'000	Essential Priority	Coastal Saver	Coastal Core	KeyCare Plus	KeyCare Core	KeyCare Access	Classic Smart	Essential Smart	Total
Risk contribution income	**293 648**	**6 618 810**	**2 843 896**	**4 937 863**	**250 388**	**64 637**	**846 532**	**297 648**	**52 828 931**
Net claims incurred	(171 517)	(5 546 618)	(2 418 126)	(4 809 473)	(176 025)	(28 928)	(539 023)	(140 532)	(45 099 436)
Claims incurred	(171 926)	(5 558 448)	(2 423 325)	(4 824 396)	(176 958)	(29 223)	(540 985)	(141 962)	(45 186 030)
Third party claim recoveries	409	11 830	5 199	14 923	933	295	1 962	1 430	86 594
Net income/(expense) on risk transfer arrangements	–	–	–	48 170	–	152	7 131	(3 196)	34 455
Risk transfer arrangement fees	–	–	–	(188 082)	–	(3 033)	(15 651)	(3 810)	(382 719)
Recoveries from risk transfer arrangements	–	–	–	236 252	–	3 185	22 782	614	417 174
Accredited managed healthcare services (no risk transfer)	(7 961)	(228 227)	(100 153)	(282 177)	(16 904)	(5 584)	(34 627)	(22 369)	(1 653 972)
Relevant healthcare expenditure	**(179 478)**	**(5 774 845)**	**(2 518 279)**	**(5 043 480)**	**(192 929)**	**(34 360)**	**(566 519)**	**(166 097)**	**(46 718 953)**
Gross healthcare result	**114 170**	**843 965**	**325 617**	**(105 617)**	**57 459**	**30 277**	**280 013**	**131 551**	**6 109 978**
Broker service fees	(7 095)	(196 271)	(75 597)	(148 772)	(7 602)	(2 018)	(23 730)	(9 368)	(1 313 741)
Expenses for administration	(25 726)	(737 465)	(323 576)	(494 182)	(15 888)	(6 297)	(111 712)	(72 291)	(4 875 746)
Other operating expenses	(1 329)	(37 875)	(16 614)	(46 251)	(2 712)	(914)	(5 470)	(3 256)	(272 952)
Net healthcare result	**80 020**	**(127 646)**	**(90 170)**	**(794 822)**	**31 257**	**21 048**	**139 101**	**46 636**	**(352 461)**
Investment income	7 052	202 170	88 721	249 955	14 973	4 944	30 661	19 793	1 465 105
Net fair value gains on financial assets at fair value through profit or loss	(332)	(9 497)	(4 165)	(11 896)	(742)	(244)	(1 514)	(1 069)	(69 315)
Sundry income	**301**	**8 581**	**3 768**	**10 521**	**619**	**206**	**1 248**	**748**	**61 931**
Other income	**7 021**	**201 254**	**88 324**	**248 580**	**14 850**	**4 906**	**30 395**	**19 472**	**1 457 721**
Expenses for asset management services rendered	(343)	(9 836)	(4 317)	(12 189)	(734)	(242)	(1 509)	(991)	(71 366)
Interest paid	(1 614)	(46 276)	135	372	21	7	42	23	(218 090)
Other expenditure	**(1 957)**	**(56 112)**	**(4 182)**	**(11 817)**	**(713)**	**(235)**	**(1 467)**	**(968)**	**(289 456)**
Net surplus/(deficit) for the year	**85 084**	**17 496**	**(6 029)**	**(558 059)**	**45 394**	**25 719**	**168 029**	**65 140**	**815 804**

Notes to the Annual Financial Statements continued

for the year ended 31 December 2018

27 Surplus/(deficit) from operations per benefit plan *continued*

2017 R'000	Executive	Classic Comp	Classic Comp Zero MSA	Classic Core	Classic Saver	Classic Priority	Essential Comp	Essential Saver	Essential Core
Risk contribution income	**925 588**	**10 127 604**	**60 524**	**1 999 904**	**10 690 234**	**4 470 174**	**1 008 291**	**3 495 369**	**1 193 011**
Net claims incurred	(1 193 107)	(10 161 581)	(57 558)	(1 457 631)	(7 977 065)	(3 565 076)	(861 544)	(2 156 717)	(784 339)
Claims incurred	(1 194 229)	(10 177 005)	(57 652)	(1 463 164)	(8 008 290)	(3 575 217)	(863 324)	(2 169 553)	(788 666)
Third party claim recoveries	1 122	15 424	94	5 533	31 225	10 141	1 780	12 836	4 327
Net income/(expense) on risk transfer arrangements	(572)	(12 956)	(199)	–	–	–	(1 995)	–	–
Risk transfer arrangement fees	(10 080)	(138 895)	(1 169)	–	–	–	(14 420)	–	–
Recoveries from risk transfer arrangements	9 508	125 939	970	–	–	–	12 425	–	–
Accredited managed healthcare services (no risk transfer)	(12 446)	(171 435)	(1 038)	(59 452)	(335 991)	(111 187)	(19 830)	(133 479)	(44 975)
Relevant healthcare expenditure	**(1 206 125)**	**(10 345 972)**	**(58 795)**	**(1 517 083)**	**(8 313 056)**	**(3 676 263)**	**(883 369)**	**(2 290 196)**	**(829 314)**
Gross healthcare result	**(280 537)**	**(218 368)**	**1 729**	**482 821**	**2 377 178**	**793 911**	**124 922**	**1 205 173**	**363 697**
Broker service fees	(11 547)	(161 712)	(960)	(46 371)	(299 770)	(105 070)	(18 837)	(105 091)	(32 258)
Expenses for administration	(40 220)	(554 028)	(3 356)	(192 226)	(1 085 766)	(359 412)	(64 086)	(431 333)	(145 337)
Other operating expenses	(2 114)	(29 123)	(176)	(10 092)	(57 056)	(18 884)	(3 369)	(22 649)	(7 631)
Net healthcare result	**(334 418)**	**(963 232)**	**(2 763)**	**234 132**	**934 586**	**310 545**	**38 630**	**646 100**	**178 471**
Investment income	11 628	160 198	971	55 540	313 841	103 886	18 534	124 636	41 999
Net fair value gains on financial assets at fair value through profit or loss	3 669	50 511	309	17 733	100 334	32 929	5 840	40 376	13 594
Sundry income	11	153	–	66	375	108	20	180	61
Other income	**15 308**	**210 862**	**1 280**	**73 339**	**414 550**	**136 923**	**24 394**	**165 192**	**55 654**
Expenses for asset management services rendered	(359)	(4 961)	(31)	(1 723)	(9 729)	(3 219)	(572)	(3 864)	(1 303)
Interest paid	(4 536)	(62 479)	–	–	(122 291)	(40 501)	(7 228)	(48 529)	–
Other expenditure	**(4 895)**	**(67 440)**	**(31)**	**(1 723)**	**(132 020)**	**(43 720)**	**(7 800)**	**(52 393)**	**(1 303)**
Net surplus/(deficit) for the year	**(324 005)**	**(819 810)**	**(1 514)**	**305 748**	**1 217 116**	**403 748**	**55 224**	**758 899**	**232 822**

Notes to the Annual Financial Statements *continued*

for the year ended 31 December 2018

27 Surplus/(deficit) from operations per benefit plan *continued*

2017 R'000	Essential Priority	Coastal Saver	Coastal Core	KeyCare Plus	KeyCare Core	KeyCare Access	Classic Smart	Essential Smart	Total
Risk contribution income	**296 693**	**6 144 961**	**2 711 384**	**4 620 954**	**239 426**	**61 615**	**528 258**	**128 035**	**48 702 024**
Net claims incurred	(187 054)	(4 849 658)	(2 191 449)	(4 267 578)	(150 219)	(25 603)	(297 584)	(44 294)	(40 228 057)
Claims incurred	(187 801)	(4 869 552)	(2 200 521)	(4 293 000)	(151 800)	(26 132)	(299 905)	(45 606)	(40 371 417)
Third party claim recoveries	747	19 894	9 072	25 422	1 581	529	2 321	1 312	143 360
Net income/(expense) on risk transfer arrangements	–	–	–	32 924	–	(267)	(2 375)	–	14 560
Risk transfer arrangement fees	–	–	–	(215 369)	–	(2 954)	(9 136)	–	(392 023)
Recoveries from risk transfer arrangements	–	–	–	248 293	–	2 687	6 761	–	406 583
Accredited managed healthcare services (no risk transfer)	(8 146)	(216 145)	(98 103)	(268 094)	(16 434)	(5 511)	(22 359)	(9 686)	(1 534 311)
Relevant healthcare expenditure	**(195 200)**	**(5 065 803)**	**(2 289 552)**	**(4 502 748)**	**(166 653)**	**(31 381)**	**(322 318)**	**(53 980)**	**(41 747 808)**
Gross healthcare result	**101 493**	**1 079 158**	**421 832**	**118 206**	**72 773**	**30 234**	**205 940**	**74 055**	**6 954 216**
Broker service fees	(7 252)	(184 488)	(72 897)	(139 717)	(7 303)	(1 937)	(14 980)	(4 015)	(1 214 205)
Expenses for administration	(26 325)	(698 495)	(317 029)	(468 790)	(15 445)	(6 213)	(72 250)	(31 285)	(4 511 596)
Other operating expenses	(1 384)	(36 705)	(16 655)	(45 484)	(2 784)	(933)	(3 789)	(1 633)	(260 461)
Net healthcare result	**66 532**	**159 470**	**15 251**	**(535 785)**	**47 241**	**21 151**	**114 921**	**37 122**	**967 954**
Investment income	7 612	201 923	91 649	250 408	15 350	5 147	20 864	9 001	1 433 187
Net fair value losses on financial assets at fair value through profit or loss	2 418	64 268	29 191	80 559	4 957	1 669	6 969	3 427	458 753
Sundry income	8	225	103	324	22	7	42	41	1 746
Other income	**10 038**	**266 416**	**120 943**	**331 291**	**20 329**	**6 823**	**27 875**	**12 469**	**1 893 686**
Expenses for asset management services rendered	(237)	(6 260)	(2 842)	(7 760)	(476)	(159)	(650)	(283)	(44 428)
Interest paid	(2 967)	(78 707)	–	–	–	–	–	1	(367 238)
Other expenditure	**(3 204)**	**(84 967)**	**(2 842)**	**(7 760)**	**(476)**	**(159)**	**(650)**	**(282)**	**(411 666)**
Net surplus/(deficit) for the year	**73 366**	**340 919**	**133 352**	**(212 254)**	**67 094**	**27 815**	**142 146**	**49 309**	**2 449 974**

Notes to the Annual Financial Statements continued

for the year ended 31 December 2018

R'000	2018	2017
28 Cash flows from operations before working capital changes		
Net surplus for the year	**815 804**	2 449 974
Adjustments for:		
Impairment losses (Note 18)	**103 020**	87 604
Depreciation (Note 1)	**743**	–
Interest received (Note 22)	**(1 302 974)**	(1 349 125)
Dividend income (Note 22)	**(162 131)**	(84 062)
Interest paid (Note 25)	**218 090**	367 238
Unvested Long Term Employee Benefit	**3 527**	5 045
Net losses/(gains) on financial assets (Note 23)	**69 315**	(458 753)
	(254 606)	1 017 921
Reconciliation of movements in the cash flow statement		
(Increase)/decrease in trade and other receivables	**(1 313 257)**	822 739
Opening balance	**1 147 665**	2 058 008
Closing balance (Note 4)	**(2 357 902)**	(1 147 665)
Impairment losses	**(103 020)**	(87 604)
Increase in trade and other payables	**1 554 535**	1 759 273
Opening balance	**(3 065 518)**	(1 306 245)
Closing balance (Note 10)	**4 620 053**	3 065 518
Proceeds from sale of financial assets	**2 891 623**	1 669 533
Financial assets at fair value through profit or loss (Note 3)	**2 816 057**	1 571 646
Derivative financial instruments (Note 8)	**28 303**	89 802
Cash and cash equivalents (Note 23)	**47 263**	8 085
Payments for property and equipment	**2 844**	–
Additions to leasehold improvements (Note 1)	**2 844**	–

29 Events after the reporting period

No significant events occurred between the reporting date and the date the financial statements were authorised for issue.

Notes to the Annual Financial Statements continued

for the year ended 31 December 2018

30 Amalgamations

Accounting policy:

Scheme amalgamations are accounted for by applying the acquisition method.

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

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

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

Section 63(14) of the Act prescribes that relevant assets and liabilities of the party effecting the transfer shall vest in and become binding upon the party to which transfer is effected.

No goodwill is recognised on the amalgamation of schemes.

Note:

University of the Witwatersrand Staff Medical Aid Fund

An amalgamation between the Scheme and University of the Witwatersrand Staff Medical Aid Fund ("WitsMed") was confirmed and effective from 1 January 2018. The disclosures provided below have been provided to enable users to evaluate the nature and financial effect of the amalgamation.

WitsMed was a not-for-profit restricted medical scheme registered in terms of the Act. Membership of the Scheme was open to all current and retired employees of the University of the Witwatersrand, its subsidiaries and associates. Retired employees of subsidiaries and associates, which have been disposed of, were able to continue their membership if they so elected.

In terms of the Act, medical schemes do not have equity therefore the Scheme did not acquire any voting equity interest.

The members of the Scheme and WitsMed voted that the amalgamation of WitsMed with the Scheme would be in the best interest of the WitsMed members.

The Scheme obtained control of WitsMed by means of the exposition requirements as set out in Section 63 of the Act.

On the date of the amalgamation 2 604 principal members and 4 920 beneficiaries joined the Scheme.

No goodwill was recognised as a result of this transaction.

Notes to the Annual Financial Statements continued

for the year ended 31 December 2018

30 Amalgamations *continued*

The acquisition date fair value of the total consideration transferred and the acquisition date fair value of each major class of assets and liabilities was:

R'000	2018	2017
University of the Witwatersrand Staff Medical Aid Fund		
Reserves effectively transferred:		
(Acquisition date fair value of WitsMed members' interest)	149 191	–
Net recognised values of WitsMed identifiable assets and liabilities:	149 191	–
Current assets	156 989	–
Available for sale investments	1 762	–
Cash and cash equivalents	151 584	
Member and service provider claims receivables	1 370	–
Provision for impairment	(1 158)	
Interest receivable	767	–
Other accounts receivable	2 664	–
Current liabilities	(7 798)	–
Outstanding claims provision	(4 400)	–
Reported claims not yet paid	(2 188)	–
Contribution in advance	(159)	–
Unallocated funds	(40)	–
Discovery Health (Pty) Ltd	(468)	–
General accruals	(543)	–
Movement subsequent to amalgamation	(3 075)	
Closing balance	146 116	–

Movements subsequent to the amalgamation date generally relate to contributions, claims and operating expenses adjustments.

As a result of the amalgamation, the Scheme acquired the following receivables, information of which is set out below.

R'000	2018	2017
Fair value of receivables acquired:	3 463	–
Insurance receivables	2 876	–
Members claim debtors	211	–
Service provider claim debtors	1 159	–
Other accounts receivable	2 664	–
Provision for impairment	(1 158)	–
Loans and receivables	767	–
Interest receivable	767	–
Gross contractual amounts receivable:	4 801	
Insurance receivables	4 034	–
Member claim debtors	211	–
Service provider claim debtors	1 159	–
Other accounts receivable	2 664	–
Loans and receivables	767	–
Interest receivable	767	–

Notes to the Annual Financial Statements *continued*
for the year ended 31 December 2018

30 Amalgamations *continued*

R'000	2018	2017
Best estimate at the acquisition date of the contractual cash flows not expected to be collected are:		
Insurance receivables	**(1 158)**	–
Member claim debtors	**(178)**	–
Service provider claim debtors	**(980)**	–
The amounts recognised as of the acquisition date for each major class of assets acquired and liabilities assumed.		
Non-current assets	**–**	–
Available for sale investments	**–**	–
Current assets	**156 989**	–
Available for sale investments	**1 762**	–
Cash and cash equivalents	**151 584**	
Member claim debtors	**33**	–
Service provider claim debtors	**179**	–
Interest receivable	**767**	–
Other accounts receivable	**2 664**	–
Current liabilities	**(7 798)**	–
Outstanding claims provision	**(4 400)**	–
Reported claims not yet paid	**(2 188)**	–
Contribution in advance	**(159)**	
Unallocated funds	**(40)**	–
Discovery Health (Pty) Ltd	**(468)**	–
General accruals	**(543)**	–
	149 191	–

Notes to the Annual Financial Statements continued

for the year ended 31 December 2018

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

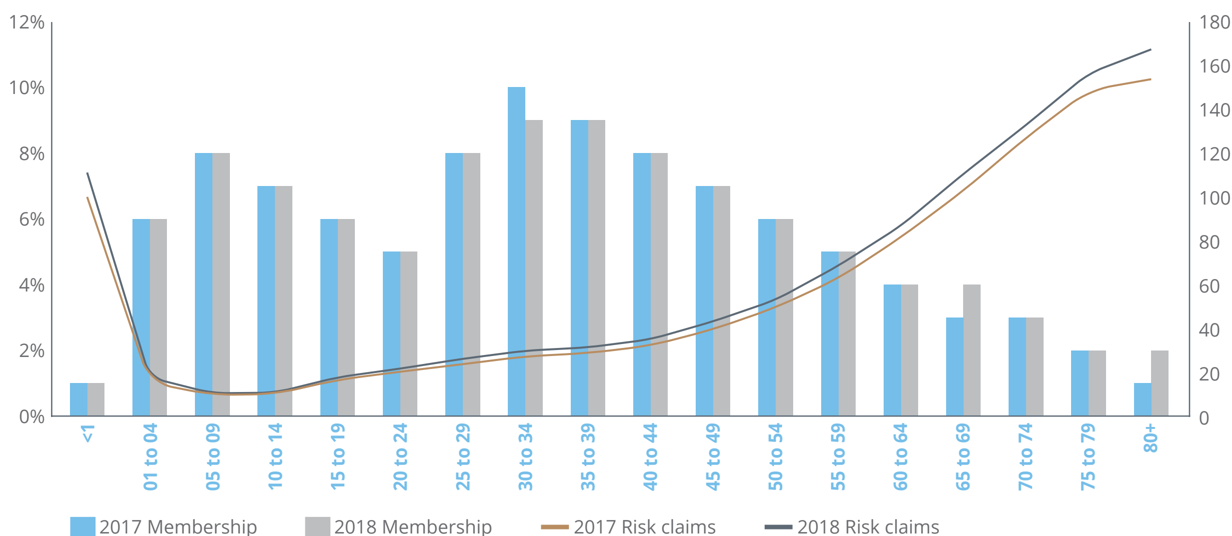
The risk under any insurance contract can be expressed as the probability that an insured event occurs, multiplied by the expected amount of the resulting claim. Insurance events are random and therefore the actual number and size of events during any year are unknown and vary from those estimated. The 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.

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 graph below sets out the distribution of beneficiaries by age band for 2017 and 2018 on the left hand y-axis, as well as the risk claims paid for each age band on the right hand y-axis. The risk claims are indexed to a value of 100 for the "<1" age band in 2017. There has been an increase in the proportions of members older than 45 over the past year.

The graph also illustrates that claims are expected to increase with age. In the absence of mandatory membership and a continuous inflow of young, healthy lives, the average age of lives covered by the Scheme is expected to increase year-on-year. The increases expected from demographic changes are allowed for in the annual contribution rate reviews, but the actual increase in claims may differ from the expected increase.

Membership distribution and risk claims (claims indexed to age band "<1" 2017 = 100)



The risks that the Scheme faces can be discussed for the three main benefit types offered by the Scheme as follows:

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 Day-to-day Extender Benefit and Above Threshold Benefit (ATB). The Scheme does not carry risk for PMSA benefits.

Notes to the Annual Financial Statements continued

for the year ended 31 December 2018

31 Insurance risk management report *continued*

Insurance risk *continued*

CHRONIC BENEFITS

The Chronic Illness Benefit (CIB) covers approved medication and treatment for up to 61 listed conditions, including the 27 Prescribed Minimum Benefit (PMB) chronic conditions. These include conditions such as HIV/AIDS, high blood pressure, cholesterol and asthma.

The risks associated to the Scheme with the types of benefits offered to members are addressed below:

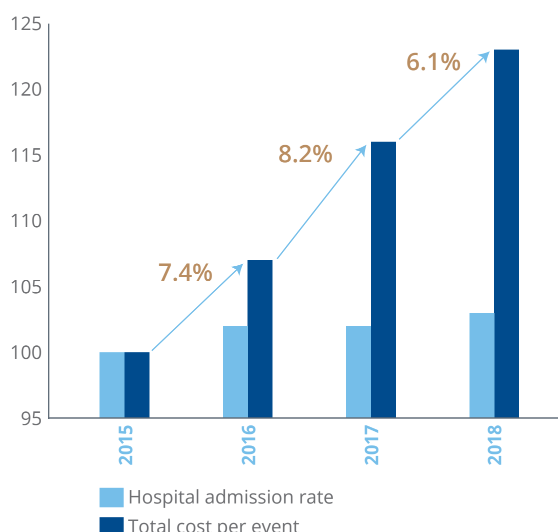
HOSPITAL BENEFIT RISK

The main factors impacting the frequency and severity of hospital claims are the number of admissions and the cost per event. An increase in the frequency and severity of claims result in an increase in the cost of claims.

An increase in the admission rate is often linked to increases in the number of beneficiaries at older ages or with chronic conditions. The increase in cost per event is driven by annual tariff and other cost increases. An increased cost per event can also be caused by an increased case-mix, severity of admissions and the introduction of new hospital-based technologies.

The hospital claims experience graph alongside indicates the change in the admission rate over the past four years as well as the impact on the cost per event. This graph is indexed to a value of 100 as at 2015.

Hospital claims experience (indexed to 2015 = 100)



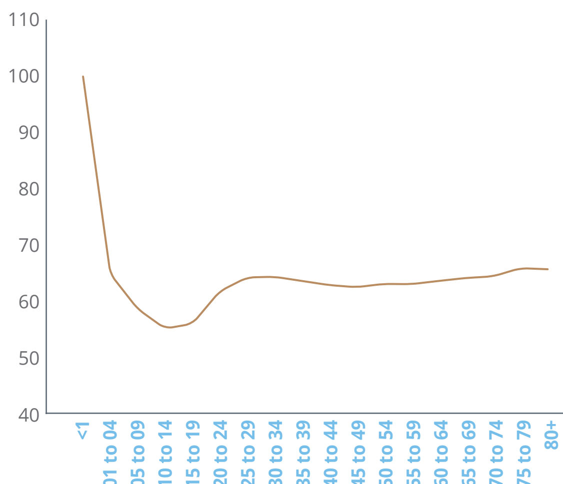
DAY-TO-DAY BENEFITS RISK

The frequency and severity of claims are driven by the number and disease burden of claimants. The mix of members between the different benefit plans as well as an increase in the number of claims categorised as PMB claims will also have an impact on the claims.

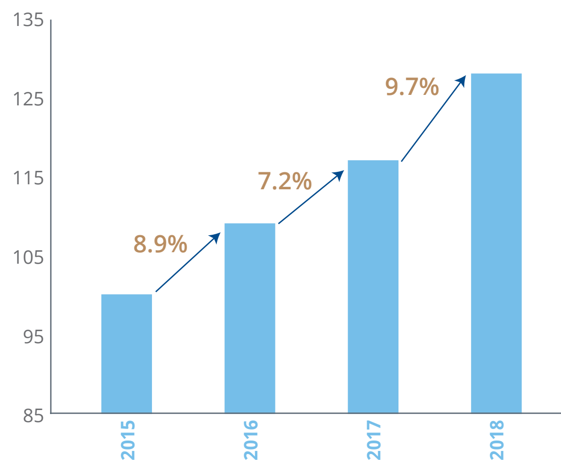
The first graph below shows that the frequency of out of hospital claims are materially higher for babies under 1-year old, and then drops off sharply until age 19 after which a stable but increasing trend is apparent.

The second graph below indicates the change in the claims cost per out of hospital claimant over the past four years. This graph is indexed to a value of 100 as at 2015.

2018 utilisation of out of hospital risk benefits (indexed to age band "<1" 2018 = 100)



Cost per out of hospital claimant (indexed to 2015 = 100)



Notes to the Annual Financial Statements continued

for the year ended 31 December 2018

31 Insurance risk management report *continued*

Insurance risk *continued*

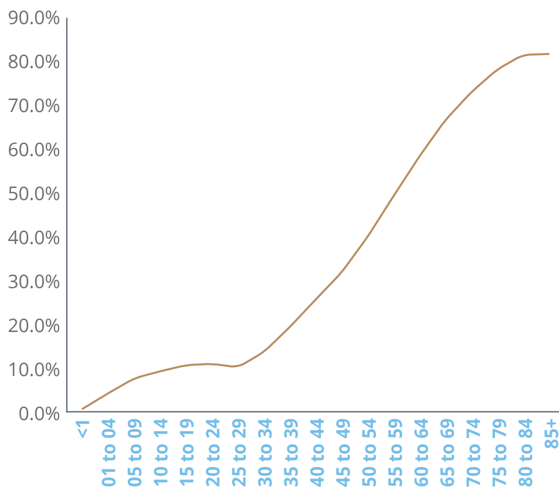
CHRONIC BENEFITS RISK

The main factors impacting the frequency and severity of chronic claims are the number of claimants and the cost per claimant respectively.

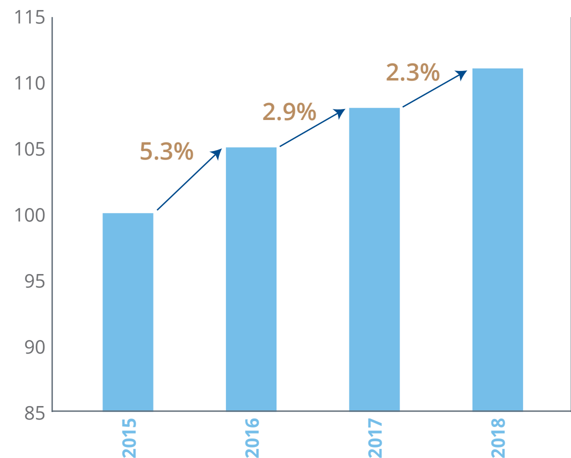
Higher increases in chronic claimants are linked to increases in the number of beneficiaries at older ages. In addition, changes relating to the eligibility for chronic benefits will also impact costs. An increase in the number of items per claimant will drive up the costs of chronic claims per claimant. Increases in the regulated prices for chronic medication, the Single Exit Price, and increases in dispensing fees will also result in an increase in costs per claim. The mix between the various chronic conditions will have an impact on the frequency and the presence of multiple chronic conditions per person will have an impact on the severity of the claims.

The following graphs indicate the percentage of chronic registrations by age band for 2018, as well as the change in the cost per claimant over the past four years. The cost per claimant graph is indexed to a value of 100 as at 2015.

Proportion of chronic registrations by age band



Cost per chronic claimant (indexed to 2015 = 100)



Notes to the Annual Financial Statements *continued*

for the year ended 31 December 2018

31 Insurance risk management report *continued*

Insurance risk *continued*

CHRONIC BENEFITS RISK *continued*

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 planned and non-emergency 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 Centre for Clinical Excellence evaluates the effectiveness of new technologies and recommends whether the Scheme should cover these.
- The development of protocols around various high cost conditions, such as lower back surgery.
- A dedicated unit to focus on reducing surgical consumable spend.
- The profiling of statistically significant outlier doctors on admission rate and generated costs as well as peer reviewing them.
- A Coordinated Care Programme (CCP) which 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.
- An Advanced Illness Benefit Programme dedicated to managing care during the end of life stage for patients that are terminally ill.
- A disease management unit dedicated to managing high risk beneficiaries with complex diseases.
- Alternative reimbursement contracts exist with hospitals to mitigate the risk of additional utilisation above that which is expected for the demographics of the Scheme and severity of admissions.
- Managing and mitigating the risks associated with chronic illness benefits through an extensive managed care programme, involving detailed drug policy interventions, medicine protocols and benefit rules, all of which comply with the Regulations on Prescribed Minimum Benefits. In addition, the Centre for Clinical Excellence is involved in evaluating the effectiveness of new drugs and recommends whether the Scheme should cover these drugs or not.

Notes to the Annual Financial Statements continued

for the year ended 31 December 2018

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.

RISK TRANSFER ARRANGEMENTS

During 2018 the Scheme had five risk transfer arrangements in place compared to six during 2017. The arrangement relating to cover for in-hospital and out-of-hospital benefits for certain members on the KeyCare Plus and KeyCare Access plans was cancelled effective from 1 January 2018. Under these risk transfer agreements, suppliers are paid to provide certain minimum benefits to Scheme members, as and when required by the members. These arrangements are also known as capitation arrangements and fix the cost to the Scheme of providing these benefits.

The first risk transfer arrangement covers out-of-hospital benefits for certain members on the KeyCare Plus and KeyCare Access plans. There are 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 arrangement covers Smart Plan 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 the estimated cost per event method, which uses pre-authorised admissions, is also followed.

The estimation of the outstanding claims provision as at 31 December 2018 was made in accordance with Advisory Practice Note 304 of the Actuarial Society of South Africa. In accordance with this guidance note, the following factors are considered to determine whether they would have any impact on the outstanding claims provision estimate:

- The homogeneity of claims data.
- The credibility of claims data.
- Changes in emergence and settlement patterns.
- The impact of seasonality.
- The impact of re-opened or adjusted claims.
- The impact of benefit limits and changes.
- External influences.
- The demographic profile of the Scheme.

Based on the processing patterns and claims development up to the end of December 2018 in respect of treatment dates during 2018, the provision for outstanding claims as at 31 December 2018 is R1 499 million (2017: R1 240 million).

Notes to the Annual Financial Statements continued

for the year ended 31 December 2018

31 Insurance risk management report *continued*

Concentration of insurance risk *continued*

CLAIMS DEVELOPMENT *continued*

The total claims incurred (including the provision for outstanding claims) for the most significant claims categories are as follows:

R'000	2018	2017
Total estimate of incurred claims		
In-hospital claims incurred	**33 386 416**	29 475 556
Chronic claims incurred	**2 703 488**	2 474 427
Out-of-hospital risk claims incurred	**8 925 462**	8 240 285

The table below outlines the sensitivity of insured liability estimates to slower claims processing. If processing is slower than expected, a larger claims provision for unprocessed claims will be required. It should be noted that this is a deterministic approach with no correlations between the key variables.

R'000	Change in variable %	Impact on outstanding claims provision 2018	Impact on outstanding claims provision 2017
In-hospital claims incurred	1% slower claims processing	**370 810**	326 614
Chronic claims incurred	1% slower claims processing	**11 475**	10 364
Out-of-hospital risk claims incurred	1% slower claims processing	**85 277**	89 670

Liquidity risk

The main component of the Scheme's insurance liabilities is the outstanding claims provision. These are generally settled in a short period of time. Approximately 98% of this provision is settled within three months after the claim was incurred and the balance is settled within six months. The remaining insurance liabilities are generally settled within 30 days.

Assumption risk

The Scheme's reserves and therefore solvency are most sensitive to changes in claims development patterns. Another relevant assumption is medical inflation. Other assumptions that are considered, include utilisation trends, the impact of new technology and the expected demographic profile of the Scheme membership.

Notes to the Annual Financial Statements continued
for the year ended 31 December 2018

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.

The Scheme manages the financial risks as follows:

- The Investment Committee, a Committee of the Board of Trustees, recommends the Scheme's investment policy to the Board of Trustees for approval. The Investment Committee meets at least quarterly and reports back to the Board of Trustees on the matters included in its terms of reference.
- The Scheme has appointed reputable external asset managers to manage its investments and their performance is monitored regularly.
- An external asset consulting company has been appointed to assist in formulating the investment strategy and to provide ongoing reporting and monitoring of the asset managers.
- Asset management agreements and mandates are concluded and reviewed by the Scheme's in-house legal counsel.
- Independent valuation of the Scheme's investments is performed by a third party.

Market risk

Market risk is the risk that changes in market variables, such as foreign exchange rates, interest rates and equity prices, will affect the Scheme's income or the value of its holdings in financial instruments. The objective of market risk management is to manage and control market risk exposures within acceptable parameters, while optimising the return on risk.

The table below summarises the primary risks affecting the Scheme's financial assets at fair value through profit or loss exposure to market risk.

R'000	Total	Currency risk	Price risk	Interest rate risk
31 December 2018				
Investments	**20 519 767**			
Offshore bonds	**847 314**	✓		✓
Equities	**4 038 399**		✓	
Yield enhanced bonds	**5 631 602**			✓
Inflation linked bonds	**1 104 552**			✓
Money market instruments	**8 324 805**			✓
Listed property	**573 096**		✓	
31 December 2017				
Investments	14 005 644			
Offshore bonds	1 463 064	✓		✓
Equities	3 378 331		✓	
Yield enhanced bonds	3 721 190			✓
Inflation linked bonds	792 666			✓
Money market instruments	4 268 369			✓
Listed property	382 024		✓	

The Scheme's insurance liabilities are settled within one year and the Scheme does not discount insurance liabilities. Consequently changes in market interest rates would not affect the Scheme's surplus or deficit arising from changes in the insurance liability.

Notes to the Annual Financial Statements continued

for the year ended 31 December 2018

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 continued to invest in offshore bond portfolios (reference currency is the US dollar). During the year under review, a tactical asset allocation decision was taken to reduce the weighting to this asset class. Derivative financial instruments are utilised by bond managers within these portfolios for risk mitigation and efficient portfolio construction. At 31 December 2018, R847 million (2017: R1,46 billion) (Note 3) was invested in these portfolios.

- CURRENCY DERIVATIVES FINANCIAL INSTRUMENT (ZERO-COST CURRENCY COLLARS)

The Scheme enters into zero-cost currency collar arrangements with South African banks to hedge exposure to changes in the rand/US dollar exchange rate with respect to its offshore bond portfolios. The following table provides detail of the open contracts at year end.

			2018		
Contract	Expiry date	Nominal USD value $'000	**USD put ("floor")**	**USD call ("cap")**	**% above floor**
1	26/09/2019	$60 000	**R14.27**	**R16.19**	**13.45%**

The zero-cost currency collars are categorised as at fair value through profit or loss.

At the time of expiry of the zero-cost currency collars the following transactions could occur depending on the rate at which the rand is trading against the US dollar:

- If the spot rate is higher than the cap, the Scheme would be required to pay the difference between the cap and the spot rate to the counterparty.
- If the spot rate is trading lower than the cap but higher than the floor, no action would take place.
- If the spot rate is trading lower than the floor, the counterparty would be required to pay the difference between the floor and the spot rate to the Scheme.

The fair value of these contracts have been included in financial assets. Gains and losses on these arrangements are included in the Net Surplus (Note 8).

- CURRENCY RISK SENSITIVITY ANALYSIS

The sensitivity of the rand appreciating and depreciating against the US dollar is presented below. This impact would be recognised in the Net Surplus. The potential outcomes of the sensitivity is based on the assumption that the rand has strengthened or weakened against the US dollar by 5% *(increase or decrease of R0.72)* or 15% *(increase or decrease of R2.16)* from a spot level of R14.39 to the US dollar, with all other variables held constant. The analysis is presented including and excluding the impact of the zero cost currency collars, valued at year-end, based on the underlying valuation variables. The actual outcome of the impact of the zero cost currency collars would be based on the exchange rate at the date of expiry of the respective contracts.

R'000	15% rand appreciation	5% rand appreciation	5% rand depreciation	15% rand depreciation
(Loss)/gain arising from rand appreciation/depreciation *before zero cost currency collars*	(127 097)	(42 366)	42 366	127 097
(Loss)/gain arising from rand appreciation/depreciation after *zero cost currency collars*	(32 463)	(11 376)	18 037	44 541

32 Financial risk management report *continued*

Price risk

The Scheme is exposed to equity securities price risk due to equity investments held by the Scheme that are classified as at fair value through profit or loss. The value of the Scheme's equity investments amounted to R4.0 billion (2017: R3.4 billion) (Note 3).

The Scheme manages the price risk arising from investments in equity securities, through the diversification of its investment portfolios. Diversification of the portfolios is performed by asset managers in accordance with the mandate set by the Scheme. The strategy implemented during the previous financial year, to manage price risk, by limiting exposure to any constituent of the benchmark to a maximum weight of 15% remains in place.

The Scheme purchased derivative financial instruments to protect the solvency of the Scheme as a result of fluctuations in the equity market. The derivative strategy considers the impact of the decision to limit the maximum exposure to 15% of any constituent of the benchmark.

- EQUITY DERIVATIVE FINANCIAL INSTRUMENT (ZERO-COST EQUITY FENCE)

The Scheme entered into zero-cost equity fence arrangements to hedge approximately 100% of the exposure to changes in market prices for investments in the equity portfolios. The contracts provide downside protection of up to 15% after a reduction in equity prices of 5% (ie. the Scheme is at risk for the first 5% drop in equity prices but protected for the next 15%). To achieve this, the Scheme agreed to forego upside benefit from an increase in equity prices above the pre-determined level (the cap). The cap for these contracts range between 14% and 18% above the pre-determined level. These contracts expire during 2019.

	2018					
Contract	Nominal value R'000	Index level	Index level at trade date	Short put level ("lower floor")	Long put level ("upper floor")	Call level ("cap")
1	**240 500**	**DTOP[2]**	**10 952**	**80.00%**	**95.00%**	**116.50%**
2	**721 500**	**DCAP[3]**	**17 116**	**80.00%**	**95.00%**	**114.36%**
3	**250 000**	**DTOP**	**11 113**	**80.00%**	**95.00%**	**116.68%**
4	**750 000**	**DCAP**	**17 215**	**80.00%**	**95.00%**	**114.19%**
5	**250 000**	**DTOP**	**11 141**	**80.00%**	**95.00%**	**116.76%**
6	**750 000**	**DCAP**	**17 361**	**80.00%**	**95.00%**	**114.33%**
7	**141 000**	**DTOP**	**11 033**	**80.00%**	**95.00%**	**117.62%**
8	**329 000**	**DCAP**	**17 505**	**80.00%**	**95.00%**	**115.54%**
9	**90 000**	**DTOP**	**10 929**	**80.00%**	**95.00%**	**116.68%**
10	**210 000**	**DCAP**	**17 163**	**80.00%**	**95.00%**	**114.48%**
11	**198 000**	**DTOP**	**10 136**	**80.00%**	**95.00%**	**118.20%**
12	**462 000**	**DCAP**	**15 994**	**80.00%**	**95.00%**	**115.22%**

2 DTOP – FTSE/JSE SWIX TOP 40 Index
3 DCAP – FTSE/JSE CAPPED SWIX TOP 40 Index

The zero-cost equity fences are categorised as at fair value through profit or loss.

At the time of expiry the following transactions could occur depending on the level at which the equity index trades:

- If the index level is higher than the cap, the Scheme would be required to pay the difference between the cap and the index level to the counterparty.
- If the index level is trading lower than the cap but higher than the upper floor, no action would take place.
- If the index level is trading between the upper floor and the lower floor, the counterparty would be required to pay the difference between the index level and the lower floor to the Scheme.
- If the index level is trading lower than lower floor, the Scheme would be required to pay the difference between the lower floor and the index level minus 15% to the counterparty.

The fair value of these contracts have been included in financial assets and financial liabilities. Gains and losses on these arrangements are included in the Net Surplus (Note 8).

Notes to the Annual Financial Statements *continued*

for the year ended 31 December 2018

32 Financial risk management report *continued*

Price risk *continued*

- EQUITY PRICE RISK SENSITIVITY ANALYSIS

The analysis reflecting the impact of increases or decreases in equity prices has been presented below. This impact would be recognised in the Net Surplus. The potential outcomes of the sensitivity is based on the assumption that equity prices had increased or decreased by 5% or 15%, spot reference levels of 10,219 (DTOP) and 16,126 (DCAP) respectively, with all other variables held constant. The analysis is presented including and excluding the impact of the zero cost equity fences, valued at year-end, based on the underlying valuation variables. The actual outcome of the impact of the zero cost equity fences would be based on the reference level at the date of expiry of the respective contracts.

The following table indicates the 5% or 15% change in the respective index.

Index	5% increase or decrease	15% increase or decrease
DTOP	**511**	**1 533**
DCAP	**806**	**2 419**

R'000	15% price decrease	5% price decrease	5% price increase	15% price increase
(Loss)/gain arising from price decrease/increase before zero cost equity fences	**(605 760)**	**(201 920)**	**201 920**	**605 760**
(Loss)/gain arising from price decrease/increase after zero cost equity fences	**(192 351)**	**59 604**	**305 530**	**555 445**

The analysis reflecting the impact of increases or decreases in prices of the listed property portfolio has been presented below. This impact would be recognised in the Net Surplus. The potential outcomes of the sensitivity is based on the assumption that prices had increased or decreased by 5% or 15%, with all other variables held constant. The Scheme has not hedged this portfolio.

R'000	15% price decrease	5% price decrease	5% price increase	15% price increase
(Loss)/gain arising from price decrease/increase	**(84 964)**	**(28 655)**	**28 655**	**84 964**

Notes to the Annual Financial Statements *continued*

for the year ended 31 December 2018

32 Financial risk management report *continued*

Interest rate risk

The Scheme is exposed to interest rate risk as it places funds in short dated investments, money market accounts and bonds. The risk is managed by maintaining an appropriate mix between fixed and floating rate investments within the Scheme's money market investment portfolio as well as additional fixed and call deposit investments. The bond managers have made use of bond futures and other derivative instruments within these portfolios to manage duration risk.

The table summarises the Scheme's exposure to interest rate risks. Included in the table are the Scheme's investments at carrying amounts, categorised by the earlier of contractual repricing or maturity dates.

As at 31 December 2018 R'000	**0 – 3 Months**	**3 – 12 Months**	**> 12 Months**	**Total**
Cash and cash equivalents	**5 775 481**	**–**	**–**	**5 775 481**
Money market instruments carried at fair value through profit or loss	**–**	**8 324 805**	**–**	**8 324 805**
Yield enhanced bonds carried at fair value through profit or loss	**–**	**5 631 601**	**–**	**5 631 601**
Inflation linked bonds carried at fair value through profit or loss	**–**	**1 104 552**	**–**	**1 104 552**
Offshore bonds carried at fair value through profit or loss	**–**	**847 314**	**–**	**847 314**

As at 31 December 2017 R'000	0 – 3 Months	3 – 12 Months	> 12 Months	Total
Cash and cash equivalents	5 880 362	–	–	5 880 362
Money market instruments carried at fair value through profit or loss	–	4 268 369	–	4 268 369
Yield enhanced bonds carried at fair value through profit or loss	–	3 721 190	–	3 721 190
Inflation linked bonds carried at fair value through profit or loss	–	792 666	–	792 666
Offshore bonds carried at fair value through profit or loss	–	1 463 064	–	1 463 064

- INTEREST RATE RISK SENSITIVITY ANALYSIS

A sensitivity analysis indicating results of increases in interest rates has been presented below. This impact would be recognised in the Net Surplus. The sensitivity is based on the assumption that local or foreign interest rates had increased or decreased by 1% or 2%, with all other variables held constant.

Gains/(losses) arising from changes in: R'000	**2% interest rate decrease**	**1% interest rate decrease**	**1% interest rate increase**	**2% interest rate increase**
Local portfolios	**108 834**	**46 780**	**(41 876)**	**(85 797)**
Foreign portfolios	**69 603**	**34 801**	**(34 801)**	**(69 603)**

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.

Notes to the Annual Financial Statements *continued*

for the year ended 31 December 2018

32 Financial risk management report *continued*

Legal risk

Legal risk is the risk that the Scheme will be exposed to contractual obligations which have not been provided for. At 31 December 2018, the Scheme did not consider there to be any significant concentration of legal risk and no provision has been raised.

Investment risk

Investment risk is the risk that the investment returns on accumulated assets will not be sufficient to cover future liabilities.

The Scheme's Investment Committee oversees that the funds are invested in line with the Act.

The investment philosophy is to hold a diversified pool of assets. The assets are selected as being most appropriate given the liquidity and solvency requirements of the Scheme. In contemplating solvency, the return goals of the Scheme, as well as the risk associated with all assets and asset classes are considered. Diversification is across securities, issuers, asset classes, geographic regions as well as managers within asset classes where practical. The Scheme diversifies its investment portfolio by investing in short-term deposits, money market, bond, listed property and equity portfolios managed by reputable asset managers.

The Scheme's investment objective statement is:

- Maximise targeted investment returns, which is dependent on contribution increases implemented over the next year and the evaluation of the solvency level above the statutory minimum requirement from time to time.
- The return target will be reviewed at the end of every year taking into account the actual returns achieved, projected operating surplus and finalised contribution increases.
- The return target is subject to a low risk appetite for:
  - solvency reducing below 25% due to poor investment returns; or
  - achieving returns in any year that are lower than the return assumed by the actuary in the pricing budget.

The Investment Committee monitors the performance of the Scheme's asset managers to ensure performance in accordance with the agreed mandates.

Breakdown of investments

The investments are split between the following in the Annual Financial Statements:

- Investments carried at fair value through profit and loss; and
- Cash and cash equivalents.

R'000	Segregated funds	Collective investment schemes	Policy of insurance	Total
31 December 2018				
Investments	**19 672 453**	**526 801**	**320 513**	**20 519 767**
Offshore bonds	**–**	**526 801**	**320 513**	**847 314**
Equities	**4 038 399**	**–**	**–**	**4 038 399**
Yield enhanced bonds	**5 631 601**	**–**	**–**	**5 631 601**
Inflation linked bonds	**1 104 552**	**–**	**–**	**1 104 552**
Listed property	**573 096**	**–**	**–**	**573 096**
Money market instruments	**8 324 805**	**–**	**–**	**8 324 805**
Cash and cash equivalents	**3 863 605**	**1 911 876**	**–**	**5 775 481**
	23 536 058	**2 438 677**	**320 513**	**26 295 248**
31 December 2017				
Investments	12 542 580	901 589	561 475	14 005 644
Offshore bonds	–	901 589	561 475	1 463 064
Equities	3 378 331	–	–	3 378 331
Yield enhanced bonds	3 721 190	–	–	3 721 190
Inflation linked bonds	792 666	–	–	792 666
Listed property	382 024	–	–	382 024
Money market instruments	4 268 369	–	–	4 268 369
Cash and cash equivalents	3 891 038	1 989 324	–	5 880 362
	16 433 618	2 890 913	561 475	19 886 006

32 Financial risk management report *continued*

Breakdown of investments *continued*

MONEY MARKET PORTFOLIOS:

Local portfolios:

The two local money market portfolios are managed by independent asset managers. The investment mandate is for an actively managed portfolio of financial instruments aimed at maximising return on the investments, on a long-term basis, with due regard to the relevant risks and the constraints imposed by the mandates.

For the first portfolio, the mandate stipulates liquidity requirements that 5% of the assets must be available within 24 hours and 15% within 5 working days. The weighted modified duration of the portfolio may not exceed 180 days. The weighted term to maturity of the portfolio shall not exceed 2 years. The term of each individual instrument is also limited. The average weighted credit rating of this portfolio will not be less than A+.

The liquidity requirements of the second portfolio also stipulate that 5% of the assets must be available on 24 hours' notice and an additional 15% within 5 working days. The average portfolio duration is limited to 180 days. There are a number of additional liquidity requirements included in the mandate such as requiring that all investments with a maturity longer than 18 months must be of a negotiable nature. The key feature of being of a negotiable nature is that the instrument can be sold by the holder of that instrument to another party without requiring explicit consent from the issuer of the instrument.

The performance benchmark for these portfolios is measured against STeFI + 130 basis points per annum over rolling one year periods.

The local money market portfolios comprise approximately 41% (2017: 30%) of the Scheme's financial assets at fair value through profit or loss.

BOND PORTFOLIOS:

Local portfolios:

The Scheme has two bond portfolios, managed by independent asset managers.

The one portfolio uses a specialist fixed income strategy with South African exposure and invests in a broad spectrum of listed and unlisted fixed income instruments. The instruments are typically investment grade and include but are not limited to asset types such as listed bonds, credit-linked notes, floating rate notes, interest rate swaps and bond futures. The benchmark for this portfolio is STeFI 3 month index + 150 basis points per annum.

The second portfolio is a specialist yield-enhanced bond portfolio with moderate risk limits that seeks diversity, reasonable yield enhancement, moderate liquidity and relatively low volatility due to constrained interest rate positions. This is achieved by investing in a broad spectrum of fixed interest and yield-enhanced debt instruments. The benchmark for this portfolio is STeFI.

The 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 27% (2017: 27%) of the Scheme's financial assets at fair value through profit or loss.

Offshore portfolios:

The Scheme has two offshore portfolios managed by independent asset managers.

The first portfolio aims to produce a positive total return, consisting of both income and capital gains, over rolling 3 year periods, regardless of market conditions, by investing primarily in fixed interest bearing instruments and related derivatives. The majority of these assets are denominated in major currencies and exposure to minor currencies is managed on a cautious basis. The fund is benchmarked against 3 month USD LIBOR.

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 investing in fixed income instruments. The benchmark for this portfolio is the Barclays Capital Global Aggregate.

These portfolios comprise approximately 4% (2017: 10%) 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 2018

32 Financial risk management report *continued*

Breakdown of investments *continued*

Inflation linked bonds:

The Scheme has two inflation-linked bond portfolios, each managed by an independent asset manager.

The primary mandate of the first portfolio is aimed at generating inflation-linked bond returns on initial capital invested. The benchmark is the JSE Composite Inflation-Linked Index (CILI).

The second portfolio is a fully discretionary, actively managed portfolio of inflation-linked and fixed income instruments. The portfolio only invests funds in domestic instruments. The benchmark for this portfolio is the JSE Bond Exchange and Actuarial Society of South Africa (JSE BEASSA IGOV Index).

These portfolios comprise approximately 5% (2017: 6%) of the Scheme's financial assets at fair value through profit or loss.

Equity portfolios:

The primary goal is to maximise long-term investment performance with due regard to the relevant risks, including volatility of returns, risk of capital loss and liquidity. These risks are mitigated by blending investment mandates across different manager styles and sectors.

The portfolios may only be invested in South African equities and are to be as fully invested as can practically be achieved at all times. One portfolio has a maximum cash allocation of 2% and the remaining portfolios a maximum allocation of 5%. The portfolios must comply with the Act and are prohibited from investing in Discovery Ltd. The Scheme has mitigated exposure to any single benchmark constituent by limiting investment in any single benchmark constituent to a maximum of 15%.

The Scheme considers responsible investing in all its investments. Managers are required to exclude tobacco manufacturers and related exposures by utilising negative screening. This includes all direct investments and indirect investments greater than 5%.

The performance of the actively managed portfolios is measured against the benchmark, which is the FTSE/JSE Shareholder Weighted Index (SWIX) adjusted to exclude tobacco (as per the Scheme's responsible investment policy) and capping the exposure of any benchmark constituent to 15%. The performance of the passive portfolio is measured against the FTSE/JSE SWIX 40 (J400) adjusted to exclude tobacco (as per the Scheme's responsible investment policy) and capping the exposure of any benchmark constituent to 15%.

These portfolios comprise approximately 20% (2017: 24%) of the Scheme's financial assets at fair value through profit or loss.

Listed property:

The primary objective of this mandate is to deliver consistent and incremental out-performance of the benchmark over a long-term period. Prior to July 2018 the benchmark was the FTSE/JSE SA Listed Property Index. From July 2018, the benchmark was changed to a custom benchmark being the FTSE/JSE SA All Property Index.

The mandate does not permit investment in foreign listed shares or direct property investments and requires that there will always be more than 6 holdings in the portfolio.

This portfolio comprises approximately 3% (2017: 3%) 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 2018

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.

R'000	Financial assets and liabilities at fair value through profit and loss	Loans and receivables	Insurance receivables and (payables)	Financial liabilities at amortised cost	Total carrying amount	Fair value amount
31 December 2018						
Investments						
– Offshore bond portfolio	**847 314**	**–**	**–**	**–**	**847 314**	**847 314**
– Listed equities	**4 038 399**	**–**	**–**	**–**	**4 038 399**	**4 038 399**
– Yield-enhanced bond portfolio	**5 631 601**	**–**	**–**	**–**	**5 631 601**	**5 631 601**
– Inflation-linked bond portfolio	**1 104 552**	**–**	**–**	**–**	**1 104 552**	**1 104 552**
– Listed property	**573 096**	**–**	**–**	**–**	**573 096**	**573 096**
– Money market portfolios	**8 324 805**	**–**	**–**	**–**	**8 324 805**	**8 324 805**
Cash and cash equivalents:						
Medical Scheme assets	**–**	**5 775 481**	**–**	**–**	**5 775 481**	**5 775 481**
Personal Medical Savings Account trust assets		**–**	**–**	**–**	**–**	**–**
Trade and other receivables	**–**	**8 315**	**2 349 587**	**–**	**2 357 902**	**2 357 902**
Personal Medical Savings Accounts	**–**	**–**		**(5 040 832)**	**(5 040 832)**	**(5 040 832)**
Trade and other payables	**–**	**–**	**(871 726)**	**(3 748 327)**	**(4 620 053)**	**(4 620 053)**
Derivative financial instruments	**142 856**	**–**	**–**	**–**	**142 856**	**142 856**
	20 662 623	**5 783 796**	**1 477 861**	**(8 789 159)**	**19 135 121**	**19 135 121**

R'000	Financial assets and liabilities at fair value through profit and loss	Loans and receivables	Insurance receivables and (payables)	Financial liabilities at amortised cost	Total carrying amount	Fair value amount
31 December 2017						
Investments						
– Offshore bond portfolio	1 463 064	–	–	–	1 463 064	1 463 064
– Listed equities	3 378 331	–	–	–	3 378 331	3 378 331
– Yield-enhanced bond portfolio	3 721 190	–	–	–	3 721 190	3 721 190
– Inflation-linked bond portfolio	792 666	–	–	–	792 666	792 666
– Listed property	382 024	–	–	–	382 024	382 024
– Money market portfolios	4 268 369	–	–	–	4 268 369	4 268 369
Cash and cash equivalents:						
Medical Scheme assets	–	5 880 362	–	–	5 880 362	5 880 362
Personal Medical Savings Account trust assets		4 609 149	–	–	4 609 149	4 609 149
Trade and other receivables	–	15 128	1 132 537	–	1 147 665	1 147 665
Personal Medical Savings Accounts	–	–		(4 656 633)	(4 656 633)	(4 656 633)
Trade and other payables	–	–	(2 526 588)	(538 930)	(3 065 518)	(3 065 518)
Derivative financial instruments	(588)	–	–	–	(588)	(588)
	14 005 056	10 504 639	(1 394 051)	(5 195 563)	17 920 081	17 920 081

Notes to the Annual Financial Statements *continued*

for the year ended 31 December 2018

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).

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.

Provision for impairment

INSURANCE RECEIVABLES

For insurance receivables, the Scheme establishes an allowance for impairment that represents its estimate of incurred losses. The provision is based on the expected difference between the current carrying amount and the amount recoverable from the counterparty.

The main components of this provision are:

- A specific loss component that relates to individually significant exposures; and
- A collective loss component established for groups of similar assets in respect of losses that have been incurred but not yet identified.

The collective loss allowance is determined based on historical data of payment statistics for similar financial assets.

LOANS AND RECEIVABLES

The Scheme applies the IFRS 9 simplified approach to measuring expected credit losses which uses a lifetime expected loss allowance for loans and receivables.

To measure the expected credit losses associated with loans and receivables, these have been grouped based on shared credit risk characteristics and the days past due. Loans and receivables comprise sundry accounts receivable and interest receivable and are all current and not in a past due status. No expected loss rate is assigned to receivables that are not past due. Any loss associated to these receivables is neglible and no provision raised. No further analysis is presented.

31 December 2018 R'000	Current	Total
Expected loss rate	0%	
Gross carrying amount – loans and receivables	**8 315**	**8 315**
Sundry accounts receivable	5 294	5 294
Interest receivable	3 021	3 021

Notes to the Annual Financial Statements *continued*

for the year ended 31 December 2018

32 Financial risk management report *continued*

Credit risk *continued*

The movement in the provision for impairment, for each component of insurance receivables has been presented below:

R'000	Contribution receivables	Member and service provider claims receivables	Other risk transfer arrangements	Broker fee receivables	Forensics receivables	Total
Balance as at 1 January 2017	9 759	257 283	–	864	961	268 867
Increase in provision for impairment	1 734	85 688	–	82	9 008	96 512
Amounts utilised during the year	–	(75 430)	–	1	–	(75 429)
Balance as at 31 December 2017	11 493	267 541	–	947	9 969	289 950
Balance as at 1 January 2018	**11 493**	**267 541**	**–**	**947**	**9 969**	**289 950**
Increase in provision for impairment	**3 240**	**98 972**	**–**	**317**	**1 341**	**103 870**
Amounts utilised during the year	**–**	**(61 421)**	**–**	**–**	**–**	**(61 421)**
Balance as at 31 December 2018	**14 733**	**305 092**	**–**	**1 264**	**11 310**	**332 399**

Notes to the Annual Financial Statements *continued*

for the year ended 31 December 2018

32 Financial risk management report *continued*

Credit risk *continued*

	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	Forensics receivables	Related party	Loans and receivables	Total
31 December 2018												
Not past due	4 542	7 247	3 062	14 851	1 987 295	5 498	126	39 097	63 743	14 387	8 315	2 133 313
Past due 30 – 60 days	3 951	8 959	2 271	15 181	14 630	–	11	–	15 112		–	44 934
Past due 61 – 90 days	4 529	9 625	5 537	19 691	5 946	–	7	–	4 604		–	30 248
Past due 91 – 120 days	3 466	11 176	2 009	16 651	11 068	–	5	–	5 647		–	33 371
Past due 121 – 150 days	3 252	11 729	1 341	16 322	958	–	20	–	11 566		–	28 866
Past due 151 – 180 days	2 987	12 378	838	16 203	–	–	45	–	707		–	16 955
181 days to more than one year	39 103	225 686	40 303	305 092	–	–	1 264	–	96 259		–	402 614
Gross receivables	61 830	286 800	55 361	403 991	2 019 897	5 498	1 478	39 097	197 638	14 387	8 315	2 690 301
Provision for impairments	(39 103)	(225 686)	(40 303)	(305 092)	(14 733)	–	(1 264)	–	(11 310)	–	–	(332 399)
Trade and other receivables neither past due nor impaired	22 727	61 114	15 058	98 899	2 005 164	5 498	214	39 097	186 328	14 387	8 315	2 357 902
31 December 2017												
Not past due	4 011	7 822	5 149	16 982	739 565	11 796	80	52 045	214 089	18 616	15 128	1 068 301
Past due 30 – 60 days	3 650	8 037	2 419	14 106	9 875	–	587	–	–	–	–	24 568
Past due 61 – 90 days	3 425	8 118	2 214	13 757	2 927	–	58	–	–	–	–	16 742
Past due 91 – 120 days	3 369	9 458	675	13 502	4 457	–	5	–	–	–	–	17 964
Past due 121 – 150 days	4 342	12 302	2 291	18 935	5 861	–	9	–	–	–	–	24 805
Past due 151 – 180 days	3 370	9 896	3 461	16 727	–	–	4	–	–	–	–	16 731
181 days to more than one year	36 628	207 642	23 287	267 557	–	–	947	–	–	–	–	268 504
Gross receivables	58 795	263 275	39 496	361 566	762 685	11 796	1 690	52 045	214 089	18 616	15 128	1 437 615
Provision for impairments	(36 628)	(207 642)	(23 271)	(267 541)	(11 493)	–	(947)	–	(9 969)	–	–	(289 950)
Trade and other receivables neither past due nor impaired	22 167	55 633	16 225	94 025	751 192	11 796	743	52 045	204 120	18 616	15 128	1 147 665

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 page 142 can be assessed by reference to historical information about counterparty default.

CONTRIBUTION DEBTORS

The Scheme collects over 95% of outstanding contributions in the month following the contributions being due. Therefore we can establish that the credit quality of contribution debtors is high and no additional disclosure of the credit quality is provided.

ACTIVE MEMBER CLAIMS DEBTORS

A provision for impairment covering 63% (2017: 62%) 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 79% (2017: 79%) 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 thereby 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	2018	2017
– Offshore bonds	**847 314**	1 463 064
– Yield enhanced bonds	**5 631 601**	3 721 190
– Inflation linked bonds	**1 104 552**	792 666
– Money market instruments	**8 324 805**	4 268 369
– Cash and cash equivalents	**5 775 481**	5 880 362
– Derivative financial instruments	**142 856**	–
	21 826 609	16 125 651

Exposure to credit risk

The Scheme manages credit risk on its investment portfolios through the appointment of reputable and appropriate asset managers, extensive diversification and ongoing monitoring and management of credit risk exposures and portfolio holdings.

Cash and cash equivalents comprise cash deposits with financial institutions. The risks associated with these deposits are managed by monitoring the Scheme's exposure to external financial institutions against approved deposit limits per institution. Information regarding the credit quality of cash and cash equivalents is provided on page 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.

Notes to the Annual Financial Statements *continued*

for the year ended 31 December 2018

32 Financial risk management report *continued*

Exposure to credit risk *continued*

CREDIT RATING SCALES

Credit ratings provide an opinion on the relative ability of an entity to meet its financial commitments, such as interest, dividends or the repayment of capital invested. They are used as indicators of the likelihood of receiving the amounts owed in accordance with the terms on which they were invested.

Definitions of the symbols are presented below.

LONG-TERM RATING SCALES

AAA: Highest credit quality

AAA ratings denote the lowest expectation of default risk and are assigned only in cases of exceptionally strong capacity for payment of financial commitments. This capacity is highly unlikely to be adversely affected by foreseeable events.

AA: Very high credit quality

AA ratings denote expectations of very low default risk and indicate very strong capacity for payment of financial commitments. This capacity is not significantly vulnerable to foreseeable events.

A: High credit quality

A ratings denote expectations of low default risk. The capacity for payment of financial commitments is considered strong. This capacity may, nevertheless, be more vulnerable to adverse business or economic conditions than is the case for higher ratings.

BBB: Good credit quality

BBB ratings indicate that expectations of default risk are currently low. The capacity for payment of financial commitments is considered adequate but adverse business or economic conditions are more likely to impair this capacity.

BB: Speculative

BB ratings indicate an elevated vulnerability to default risk, particularly in the event of adverse changes in business or economic conditions over time, however business or financial flexibility exists which supports the servicing of financial commitments.

B: Highly speculative

B ratings indicate that material default risk is present, but a limited margin of safety remains. Financial commitments are currently being met, however capacity for continued payment is vulnerable to deterioration in the business and economic environment.

CCC: Possibility of default

Obligations for which there is a current perceived possibility of default. Timely repayment of principal and interest is dependent on favourable business economic or financial conditions.

CC: Very high levels of credit risk

Default of some kind appears probable.

Notes to the Annual Financial Statements *continued*
for the year ended 31 December 2018

32 Financial risk management report *continued*

Exposure to credit risk *continued*

The following table discloses the Scheme's asset credit ratings using official credit ratings where available, or the asset manager's rating and is presented using a Fitch national scale rating. The credit risk policy limits investments in non-investment grade instruments to a maximum of 10% after considering official credit ratings and asset manager assigned internal credit ratings where official ratings are not available. Less than 1% (2017: 2%) of the instruments are invested in non-investment grade instruments after consideration of internally assigned credit ratings.

		Long-term rating									
R'000	Total	Govt	AAA	AA+ to AA-	A+ to A-	BBB- to BBB+	BB- to BB+	B- to B+	CCC+ to CCC-	CC+	Not rated
2018											
At fair value through profit or loss:	**15 908 272**	**848 086**	**2 513 284**	**10 122 846**	**843 034**	**128 160**	**59 490**	**38 135**	**–**	**–**	**1 355 237**
– Offshore bond portfolio	**847 314**	**–**	**106 662**	**33 387**	**120 238**	**43 064**	**59 490**	**37 186**	**–**	**–**	**447 287**
– Yield enhanced bond portfolio	**5 631 601**	**–**	**1 510 232**	**3 048 027**	**118 253**	**57 460**	**–**	**949**	**–**	**–**	**896 680**
– Inflation linked bond portfolio	**1 104 552**	**848 086**	**38 436**	**213 613**	**4 417**	**–**	**–**	**–**	**–**	**–**	**–**
– Money market portfolios	**8 324 805**	**–**	**857 954**	**6 827 819**	**600 126**	**27 636**	**–**	**–**	**–**	**–**	**11 270**
Cash and cash equivalents	**5 775 481**	**–**	**3 396 132**	**1 717 095**	**37 315**	**–**	**–**	**–**	**–**	**–**	**624 939**
Total*	**21 683 753**	**848 086**	**5 909 416**	**11 839 941**	**880 349**	**128 160**	**59 490**	**38 135**	**–**	**–**	**1 980 176**
% of assets at fair value through profit or loss per rating band		**3.9%**	**27.3%**	**54.6%**	**4.1%**	**0.6%**	**0.3%**	**0.2%**	**0.0%**	**0.0%**	**9.1%**
2017											
At fair value through profit or loss:	10 245 289	401 511	1 296 569	6 269 204	508 718	246 993	102 274	84 548	3 251	–	1 332 221
– Offshore bond portfolio	1 463 064	–	231 344	284 611	79 924	122 725	102 274	60 967	3 251	–	577 968
– Yield enhanced bond portfolio	3 721 190	–	698 624	2 036 167	185 757	84 617	–	23 581	–	–	692 444
– Inflation linked bond portfolio	792 666	373 927	–	410 154	8 585	–	–	–	–	–	–
– Money market portfolios	4 268 369	27 584	366 601	3 538 272	234 452	39 651	–	–	–	–	61 809
Cash and cash equivalents	5 880 362	–	4 037 907	1 655 954	29 089	101 169	15 141	–	–	–	41 102
Total*	16 125 651	401 511	5 334 476	7 924 158	537 807	348 162	117 415	84 548	3 251	–	1 373 323
% of assets at fair value through profit or loss per rating band		2.9%	33.1%	49.1%	3.6%	2.2%	0.7%	0.6%	0.0%	0.0%	9.5%

* *Excludes derivative financial instruments*

The Scheme's investments in securitisations and collective investment schemes ("funds") are subject to the terms and conditions of the respective funds' offering documentation and are susceptible to market price risk arising from uncertainties about future values of those funds. The investment manager makes investment decisions after extensive due diligence of the underlying fund, its strategy and the overall quality of the underlying funds' managers.

All of the funds in the investment portfolio are managed by portfolio managers who are compensated by the respective funds for their services. Such compensation generally consists of an asset-based fee and a performance-based incentive fee and is reflected in the valuation of the investment in each of the funds.

These investments are included in financial assets at fair value through profit or loss in the Statement of Financial Position and no other material risks relating to these investments have been identified other than those already disclosed in previous sections of this report.

Notes to the Annual Financial Statements continued

for the year ended 31 December 2018

32 Financial risk management report *continued*

Exposure to credit risk *continued*

The exposure to investments in unconsolidated structured entities is disclosed in the following table:

Name and description	2018 R'000	Authorised programme size	% of authorised programme size	Fair value hierarchy		Debt ranking		Credit rating		Underlying assets	
				Level	%	Ranking	%	Rating	%	Asset	%
Asset backed commercial paper	**46 272**	R3.5 billion	1.32%	Level 2	100%	Senior Secured	100%	AA	100%	Diversified portfolio of money-market instruments	100%
Residential mortgage-backed securitisations	**594 085**	R172.9 billion	0.34%	Level 1	85%	Senior secured	92%	AAA	69%	Residential Mortgages	100%
				Level 2	15%	Secured	8%	AA+	13%		
								A+	3%		
								NR	15%		
Asset backed securitisations	**367 901**	R31.2 billion	1.18%	Level 1	82%	Senior secured	92%	AAA	68%	Equipment leases	21%
				Level 2	18%	Secured	8%	AA- to AA+	12%	Unsecured Loans	17%
								A to A+	7%	Vehicle Loans	61%
								NR	13%		
Commercial mortgage-backed securitisations	**9 091**	R3.0 billion	0.30%	Level 1	100%	Secured	100%	AA	100%	Commercial mortgage loans	100%
Collateralised loan obligations	**19 741**	R3.4 billion	0.58%	Level 1	100%	Senior secured	33%	AAA	67%	Vehicle Loans	100%
						Senior unsecured	67%	AA-	33%		

Notes to the Annual Financial Statements *continued*

for the year ended 31 December 2018

32 Financial risk management report *continued*

Exposure to credit risk *continued*

Name and description	2018 R'000	Portfolio size	% of portfolio size	Fair value hierarchy	Credit rating	Fund
Collective investment schemes	**837 293**	R14.2 billion	5.90%	Level 2	AA+	Nedgroup Investments Money Market Class C2
	584 087	R22 billion	2.65%	Level 2	AA+	Nedgroup Investments Corporate Money Market Fund Class C2
	1 291 547	R40.7 billion	3.17%	Level 2	AA	Nedgroup Investments Core Income Fund Class C2
	1 111	R29 billion	0.00%	Level 2	AA+	Investec Money Market Fund
	700	R39 billion	0.00%	Level 2	AA+	Stanlib Corporate Money Market Fund
	649	R20 billion	0.00%	Level 2	AA+	Investec Corporate Money Market Fund
	3 366	R115 million	2.93%	Level 2	NR	Nedgroup Investments Core Income ABIL Retention Fund Class A
	526 404	R3.08 billion	17.07%	Level 2	A	Investec Target Return Bond Fund

Notes to the Annual Financial Statements continued

for the year ended 31 December 2018

32 Financial risk management report *continued*

Exposure to credit risk *continued*

The exposure to investments in unconsolidated structured entities for the year ended 31 December 2017 is disclosed in the following table:

Name and description	2017 R'000	Authorised programme size	% of authorised programme size	Fair value hierarchy	Debt ranking	Credit rating	Underlying assets
Asset backed commercial paper	1	R25 billion	0.00%	Level 2 – 100%	Senior secured	A+	Instalment sales agreements Corporate loans Credit card receivables Bonds Equipment leases
Residential mortgage-backed securitisations	478 065	R6.39 billion	0.75%	Level 1 – 67.09% Level 2 – 32.91%	Senior secured	AAA: 81.55% Not rated: 18.45%	Residential mortgages
Asset backed securitisations	319 613	R39.5 billion	3.51%	Level 1 – 48.51% Level 2 – 51.49%	Senior secured – 99.14% Junior debt: 0.86%	AA- to AAA- 78.92% Not rated: 21.08%	Vehicle loans Corporate loans Unsecured loans Equipment leases
Commercial mortgage-backed securitisations	19 624	R5.5 billion	0.36%	Level 2 – 100%	Senior secured	AAA	Commercial property
Collateralised loan obligations	41 450	R5 billion	0.83%	Level 1 – 68.63% Level 2 – 31.37%	Senior secured	AAA	Vehicle loans
Collective investment schemes	2 664	R52.8 billion	0.01%	Level 2		AA+	ABSA Money Market Fund
	10 661	R12.6 billion	0.08%	Level 2		AA-	Nedgroup Investments Core Income Fund Class C2
	44 048	R24.4 billion	0.18%	Level 2		AA+	Investec Money Market Fund
	2 627	R26.4 billion	0.01%	Level 2		AA+	Stanlib Corporate Money Market Fund
	5 023	R13.7 billion	0.04%	Level 2		AA+	Investec Corporate Money Market Fund
	901 589	R4.5 billion	0.02%	Level 2		A	Investec Target Return Fund

Notes to the Annual Financial Statements *continued*

for the year ended 31 December 2018

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 98% (R2.1 billion) (2017: 98% – R1.8 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:

R'000	Less than 1 year	Between 1 and 2 years	Between 2 and 5 years
As at 31 December 2018			
Personal Medical Savings Accounts (Note 9)	**5 040 832**	**–**	**–**
Trade and other payables (Note 10)	**3 748 327**	**–**	**–**
	8 789 159	**–**	**–**
As at 31 December 2017			
Personal Medical Savings Accounts (Note 9)	4 656 633	–	–
Trade and other payables (Note 10)	538 930	–	–
	5 195 563	–	–

Fair value estimation

FINANCIAL INSTRUMENTS

The fair value of financial instruments traded in active markets is based on quoted market prices at the reporting date. The quoted market price used for financial assets held by the Scheme is the current closing price.

The fair value of financial instruments that are not traded in an active market is determined by using valuation techniques. These valuation techniques maximise the use of observable market data where it is available and rely as little as possible on entity-specific estimates. Specific valuation techniques used to value financial instruments include quoted market prices or dealer quotes for similar instruments.

The carrying value less impairment provision of trade receivables and payables are assumed to approximate their fair values due to their short-term nature.

PERSONAL MEDICAL SAVINGS ACCOUNTS

The members' Personal Medical Savings Accounts contain a demand feature. In terms of Regulation 10 of the Act, any credit balance on a member's Personal Medical Savings Account must be taken as a cash benefit when the member terminates his or her membership of the Scheme or benefit plan, and enrols in another benefit plan or medical scheme without a savings account or does not enrol in another medical scheme. Therefore the carrying values of the members' Personal Medical Savings Accounts are deemed to be equal to their fair values, which is the amount payable on demand.

Notes to the Annual Financial Statements continued

for the year ended 31 December 2018

32 Financial risk management report *continued*

Fair value hierarchy for financial assets measured at fair value

ASSETS MEASURED AT FAIR VALUE

R'000	Fair value measurement at end of the year using:			
	Total	Level 1	Level 2	Level 3
2018				
Current assets				
– Offshore bonds	**847 314**	**–**	**847 314**	**–**
– Equities	**4 038 399**	**3 846 675**	**191 724**	**–**
– Yield-enhanced bonds	**5 631 601**	**2 860 079**	**2 771 522**	**–**
– Inflation-linked bonds	**1 104 551**	**1 093 806**	**10 745**	**–**
– Listed property	**573 095**	**573 095**	**–**	**–**
– Money market instruments	**8 324 805**	**2 167 161**	**6 157 644**	**–**
	20 519 766	**10 540 816**	**9 978 950**	**–**
2017				
Current assets				
– Offshore bonds	1 463 064	601 503	861 561	–
– Equities	3 378 331	3 313 762	64 569	–
– Yield-enhanced bonds	3 721 190	2 291 984	1 429 206	–
– Inflation-linked bonds	792 666	790 243	2 423	–
– Listed property	382 024	382 024	–	–
– Money market instruments	4 268 369	2 227 191	2 041 178	–
	14 005 644	9 606 707	4 398 937	–

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 2018

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 R'000	Fair value as at 31 December 2018	Fair value as at 31 December 2017	Valuation techniques	Observable Input
Financial assets at fair value through profit or loss:				
Unlisted:				
Debt securities	**3 629 582**	2 293 190	Reference to listed benchmark bond	Risk free yield to maturity curve, risk free zero curve
Money market securities	**6 157 644**	2 041 178	Discounted cash flow valuation Black–Scholes model	Published exchange swap curve, published interest rate curve, published credit spread curve/implied credit spread curve, risk free yield to maturity curve, risk free zero curve, swap yield to maturity curve, swap zero curve
Unlisted equity	**191 724**	64 569	Discounted cash flow valuation	Risk free yield to maturity curve, risk free zero curve
	9 978 950	4 398 937		

Capital management

The Scheme is subject to the capital requirement imposed by Regulation 29 (2) of the Act, which requires a minimum solvency ratio of accumulated funds expressed as a percentage of gross annual contributions of 25%.

The Scheme's objectives when managing capital are to maintain the capital requirements of the Act, and to safeguard the Scheme's ability to continue as a going concern in order to provide benefits for its stakeholders.

The calculation of the regulatory capital requirement is set out below.

R'000	2018	2017
Total members' funds per Statement of Financial Position	**17 646 355**	16 684 435
Less: cumulative unrealised net gain on remeasurement of investments to fair value	**–**	(298 722)
Accumulated funds per Regulation 29	**17 646 355**	16 385 712
Gross annual contribution income	**64 649 012**	59 710 735
Solvency margin		
= Accumulated funds/gross annual contribution income x 100	**27.30%**	27.44%

At 31 December 2018, the Scheme's regulatory capital level of 27.3% (2017: 27.44%) was R1.48 billion (2017: R1.46 billion), more than the statutory capital requirement of 25%.

Notes to the Annual Financial Statements continued

for the year ended 31 December 2018

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 12.

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 4.

34 Non-compliance matters

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

During 2018, the Scheme did not comply with the following Sections and Regulations of the Act.

- **Sustainability of benefit plans**

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

  For the year ended 31 December 2018 the following plans did not comply with Section 33 (2):

R'000	Net healthcare result	Net (deficit)/ surplus
Benefit plan		
Executive	**(345 344)**	**(337 379)**
Classic Comprehensive	**(1 219 176)**	**(1 110 503)**
Coastal Saver	**(127 647)**	**17 494**
Coastal Core	**(90 170)**	**(6 029)**
KeyCare Plus	**(794 822)**	**(558 058)**

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

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

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

- **Investments in employer groups and medical scheme administrators**

  Section 35 (8) (a) 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 has granted DHMS exemption for a period of 12 months effective from 1 April 2018.

34 Non-compliance matters *continued*

- **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 was granted an exemption to invest in offshore derivatives, subject to certain conditions, which expired on to 31 December 2018. The Scheme submitted an exemption application to CMS on 6 November 2018, which at the date of publication of this report is still being considered.

- **Contributions received after due date**

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

- **Broker fees paid**

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

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

- **International travel cover**

  In Section 1 of the Act, the business of a medical scheme is defined as making provision for, granting assistance in defraying expenditure incurred in connection with or rendering a relevant health service in return for a contribution. As part of the Scheme's international cover benefit, amounts relating to the repatriation of mortal remains were funded up to April 2017. The repatriation of mortal remains is no longer offered by the Scheme and payments made by the Scheme related to repatriation have been recovered.

- **Direct or indirect borrowing of money**

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

- **Amounts debited to scheme bank account**

  Section 26(4) of the Act provides that no amount may be debited to a scheme bank account other than

  – payments by a medical scheme of any benefit, payable under the rules of a medical scheme;
  – costs incurred by the medical scheme in the carrying on of the business as a medical scheme; or
  – amounts invested by the Board of Trustees.

  During the year under review a total of R4,614 was debited to the Scheme's bank account that was not related to the Scheme. This debit arose from the incorrect allocation of bank accounts for certain payments. The amount has subsequently been refunded to the Scheme and additional controls implemented to mitigate this occurring again.

Notes to the Annual Financial Statements *continued*

for the year ended 31 December 2018

34 Non-compliance matters *continued*

- **Prescribed Minimum Benefits**

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

- **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".

  Due to a conflict in the payment run dates that were loaded on to the administration system for the generation of cheques to members and providers, 26 claims to the value of R 22,280 were paid after 30 days. The value of exceptions should be considered in the context of approximately 50 million claims processed and net claims incurred of R45 billion in 2018. This error is not expected to re-occur as the Scheme no longer reimburses claims by means of cheque payments.

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RESOURCES

Important sources of information

CONTACT DETAILS

Principal Officer

Email **principalofficer@discovery.co.za** or call **+27 11 529 2888** and ask for the Principal Officer of Discovery Health Medical Scheme (DHMS or the Scheme).

Council for Medical Schemes

DHMS is regulated by the Council for Medical Schemes (CMS). The CMS can be contacted by telephone 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.

COMPLAINTS, COMPLIMENTS OR DISPUTES

DHMS is committed to providing you with the highest standard of service and your feedback is important to us. We encourage you to follow the process on the website.

Feedback on the Scheme's Integrated Report

We welcome any comments or specific feedback on the following:

- Was the Integrated Report (this Report) understandable to you?
- Were you able to find the information you were looking for, and if not, what were you looking for?
- Did this Report cover all the information relevant to your relationship with the Scheme?
- Was this Report presented in a format that worked for you, and if not, what you would prefer?

Email your feedback to **dhms_stakeholders@discovery.co.za.**

Reporting fraud or unethical behaviour

As the Scheme's Administrator and Managed Care Provider, Discovery Health (Pty) Ltd (Discovery Health) provides a fraud hotline and investigates possible instances of fraud. If you even slightly suspect someone of committing fraud or behaving unethically, report all information to the fraud hotline on the number below. You can also email our fraud department at forensics@discovery.co.za to investigate the matter.

You may remain anonymous if you prefer.

- Toll-free call: **0800 0045 00**
- Toll-free fax: **0800 00 77 88**
- Email: **discovery@tip-offs.com**
- Post: **Freepost DN298, Umhlanga Rocks, 4320**

REGISTERED **ADDRESSES**

PRINCIPAL OFFICER
Dr Nozipho Sangweni
Discovery Health Medical Scheme, 1 Discovery Place, Sandton, 2146

REGISTERED OFFICE ADDRESS AND POSTAL ADDRESS
Discovery Health Medical Scheme, Ground Floor, The Ridge, Corner of Rivonia Road and Katherine Street, Sandton, 2146
PO Box 786722, Sandton, 2146

ADMINISTRATOR AND MANAGED CARE PROVIDER
Discovery Health (Pty) Ltd, 1 Discovery Place, Sandton, 2146
PO Box 786722, Sandton, 2146

AUDITORS
PricewaterhouseCoopers Incorporated,
4 Lisbon Lane, Waterfall City, Jukskei View, 2090
Private Bag X36, Sunninghill, 2157

PRINCIPAL BANKERS
Rand Merchant Bank a division of FirstRand Bank Ltd, 1 Merchant Place, Cnr Fredman Drive and Rivonia Road, Sandton, 2196

INVESTMENT **MANAGERS**

ABAX INVESTMENTS (PTY) LTD
Coronation House, The Oval, 1 Oakdale Road, Newlands, 7700

ALUWANI CAPITAL PARTNERS (PTY) LTD
EPPF Office Park, 24 Georgian Crescent East, Bryanston East, 2152

ALLAN GRAY INVESTMENTS (PTY) LTD
1 Silo Square, V&A Waterfront, Cape Town, 8001

FAIRTREE CAPITAL (PTY) LTD
Willowbridge Place, Cnr Carl Cronje Drive & Old Oak Road, Bellville, 7530

FUTUREGROWTH ASSET MANAGEMENT (PTY) LTD
3rd Floor, Great Westerford Building, 240 Main Road, Rondebosch, 7700

INVESTEC ASSET MANAGEMENT (PTY) LTD
36 Hans Strijdom Avenue, Foreshore, Cape Town, 8001
100 Grayston Drive, Sandown, Sandton, 2196

LIBERTY CORPORATE
Libridge Building, 25 Ameshoff Street, Braamfontein, 2001

MAZI ASSET MANAGEMENT (PTY) LTD
4th Floor North Tower, 90 Rivonia Road, Sandton, 2196

SESFIKILE CAPITAL (PTY) LTD
2nd Floor, 18 The High Street, Melrose Arch, Johannesburg, 2076

STANLIB ASSET MANAGEMENT LTD
17 Melrose Boulevard, Melrose Arch, 2076

TAQUANTA ASSET MANAGERS (PTY) LTD
7th Floor, Newlands Terraces, Boundary Road, Newlands, 7700