Discovery
Health Medical Scheme

2024

HIGHLIGHTS OF DISCOVERY HEALTH MEDICAL SCHEME'S RESULTS

Discovery Health Medical Scheme registration number 1125

This document contains highlights of the Scheme's performance for the year ended 31 December 2024, extracted from the 2024 Integrated Report, and audited Annual Financial Statements as audited by Deloitte & Touche (Deloitte). Deloitte issued an unqualified audit opinion on 02 May 2025.

Who we are

Discovery Health Medical Scheme (DHMS or the Scheme) is a non-profit entity governed by the Medical Schemes Act (the Act)[1] and regulated by the Council for Medical Schemes (CMS). The Scheme belongs to its members, and an independent Board of Trustees (the Trustees or the Board) – of which the majority is member-elected – oversees its activities.

DHMS is a registered open medical scheme that any member of the public can join, subject to the Scheme Rules. Covering 2 735 204 beneficiaries at 31 December 2024, DHMS is the largest open medical scheme in South Africa, with an open medical scheme market share of 58.0%[2].

The Scheme outsources its administration and managed care functions to Discovery Health (Pty) Ltd (Discovery Health) through a formal contractual arrangement. In the current challenging socio-economic conditions, and a fragmented and inflationary healthcare system, partnering with Discovery Health and healthcare providers provides access to high-quality care and ensures good health outcomes for our members by integrating services and achieving the highest possible cost efficiency.

In the work we do alongside our service providers, we aspire to fulfil our purpose of providing our members with quality, value-based healthcare that is affordable and equitable, now and into the future. Our approach to everything we do is rooted in our ethics and values-driven culture and our commitment to being an engaged and thoughtful corporate citizen that cares deeply for the wellbeing of our members, our industry and our society.

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

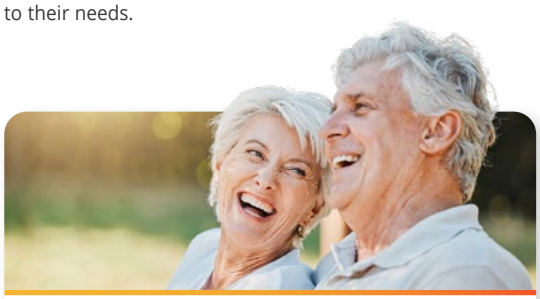
2 *Based on beneficiaries, according to the CMS Industry Report for the year ended December 2023 (https://www.medicalschemes.co.za/download/3768/industry-report-2023/29351/cms-industry-report-2023.pdf). At the end of 2023 there were 16 open schemes registered with the CMS, with approximately 52.7% of the total medical schemes market and 55 restricted schemes, with approximately 47.3% of the market. The Government Employees Medical Scheme is the largest restricted scheme with approximately 2.3 million beneficiaries.*

Why join DHMS?

QUALITY OF CARE IS KEY TO OUR MEMBERSHIP PROPOSITION

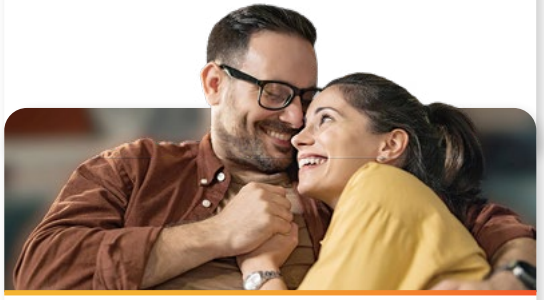
Our members are at the core of what we do, and the Scheme continually strives to ensure that they have access to the most safe, efficient and effective healthcare in South Africa.

Through our partnerships with Discovery Health and other healthcare providers, we enable access to quality of care initiatives and innovations, programmes, professionals, and member-centric care. These are monitored closely and continuously by the Scheme. We drive value-based healthcare, an approach based on placing importance on and reimbursing for better health outcomes for patients rather than only the volume of services delivered. Additionally, we empower our members with information that is current and relevant to their needs.



WE EXIST FOR OUR MEMBERS

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



WE ARE HERE FOR YOU

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

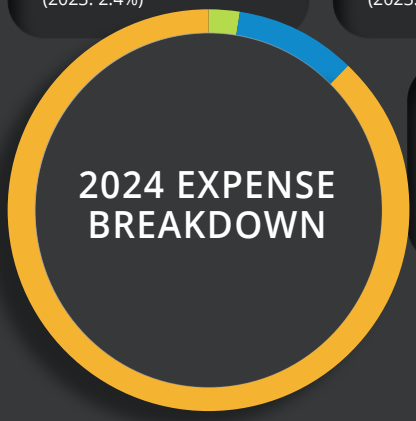
Scan the QR code or click here to access our **2024 Integrated Report**, incorporating our Annual Financial Statements:

WE MAKE SURE YOUR INVESTMENT IN MEMBERSHIP TAKES CARE OF YOU

The Scheme's income is derived only from member contributions and investment returns. All contributions are pooled to fund members' claims, and surplus funds are transferred to Scheme reserves for the security and benefit of members. These reserves are invested to earn returns to bolster the Scheme's financial position.

In setting member contributions for each year, the Scheme aims to ensure sufficient contribution income to pay all claims, and to generate a modest surplus to meet regulated solvency requirements and maintain a cushion against unexpected cost increases[1]. This accords with the fundamental operating principles of a non-profit organisation that must meet the claims needs of its members as well as maintain a minimum statutory level of reserves.

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



2.3%
Financial adviser and Scheme expenses
(2023: 2.4%)

9.9%
Administration and managed care expenses
(2023: 10.0%)

89.7%
Claims
(2023: 90.8%)

(1.9%)
(Loss)/surplus to member reserves
(2023: (3.2%))

WE PROVIDE EXCELLENT COVER TO OUR MEMBERS AND COMPARE WELL TO OTHER SCHEMES

AVERAGE CONTRIBUTIONS FOR 2025

12.7% lower[2]

than the average of the contributions of the next seven largest open medical schemes (2024: 11.1%).

FOR AN AVERAGE RISK CONTRIBUTION OF R2 414 PER MONTH,
R69 billion was paid out in risk claims for the period ending September 2024[3]. This includes:

- **R4 145 per beneficiary with a chronic condition for out of hospital costs (837 153 beneficiaries);**
- **R68 259 per admission (655 161 hospital admissions);**
- **R140 473 per beneficiary undergoing oncology treatment (45 988 beneficiaries).**

15.8% of beneficiaries claimed more than their contributions.

1 *These may relate to various sources of healthcare inflation and include uncertainty about the timing and severity of burden of disease.*

2 *Source: publicly available contribution information for DHMS and the next seven largest open medical schemes. To ascertain the contribution differential between DHMS and competitors, we calculate an average contribution within each plan category for a principal member. These average contributions are then weighted (for DHMS and the next seven 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. Contribution rates on individual plans of other schemes vary and may be cheaper or more expensive than DHMS's equivalent plans.*

3 *All figures are for the period October 2023 to September 2024, with the exception of the number of Scheme members with a chronic condition and number of DHMS members undergoing oncology treatment, where the figures are at September 2024.*

CHARLOTTE MBEWU

Our Principal Officer's Review

The healthcare industry is facing mounting pressure driven by an aging population, rising costs of care, affordability constraints and health policy uncertainty. As life expectancy increases, demand-side pressure is intensifying due to a growing burden of lifestyle-related and chronic diseases, including mental health conditions and cancer. This demographic shift constrains access to appropriate care, as healthcare systems must balance affordability with sustainability. At the same time, the cost of care continues to escalate, driven both by demand-side factors – such as increased utilisation – and supply-side factors such as increasing high-cost medical technology.

The interaction of these factors underscores the need for innovative solutions to enhance healthcare delivery and access, including the development and promotion of preventative mechanisms. Medical schemes must navigate these complexities by leveraging technology, refining benefit structures, and advocating for regulatory frameworks that support long-term viability.

The impacts of chronic disease both on members' health and the financial health of the Scheme are significantly compounded by co-morbid conditions. Our data illustrate that a substantial proportion of members are living with more than one chronic condition, with cardiovascular disease, diabetes, cancer, and mental health conditions frequently co-existing. Notably, members with both chronic conditions and mental health disorders experience the highest health needs, with per-life claims costs nearly 3.8 times higher than those without chronic illnesses. Similarly, hospital admission rates increase markedly as chronic conditions and mental health disorders accumulate, reaching 3.7 times the rate of members without overlapping chronic conditions[1].

These trends highlight the necessity of integrated disease management strategies, enhanced preventative care, and mental health support to improve health outcomes for affected members on a sustained basis, while containing cost escalation. Our Mental Healthcare Programme and new Depression Risk Reduction programmes have demonstrated their effectiveness: members enrolled in the Mental Healthcare Programme have 24% lower hospital admissions than members not on the programme. Members using the internet-based Cognitive Behavioural Therapy (iCBT) programme have shown significant clinical improvement[2]. We continue to promote iCBT as a holistic evidence-based approach to mental health disorders.

We also continue engaging members and healthcare professionals to promote alternative care settings. We are encouraged by members' response to our Virtual Urgent Care benefit, which provides members and their families with additional access to care in a virtual setting. Since its launch at the end of 2023, the platform has facilitated more than 4 700 urgent virtual consultations (by the end of January 2025), helping members who may otherwise have had to travel to casualty units. This reinforces our strong belief in the value of telehealth in bringing care to members in a faster, easier and more accessible way. Further, Hospital at Home enhances care by providing hospital-level treatment at home for suitable conditions, improving comfort and convenience for members. Facilitated through three service providers, it has received a 9/10 satisfaction rating and is achieving positive clinical outcomes[3]. The focus now is to expand its reach.

Preventative care is of utmost importance to the Scheme. Helping our members to live longer, healthier lives and reducing the potential for suffering is top-of-mind for us. We are delighted therefore to be introducing a world first, built on insight and a remarkable set of clinical data, to provide truly personalised guidance to our members on how to safeguard their health. Developed by Discovery Health and underpinned by robust clinical research and data science, Personal Health Pathways (PHP) provides members with clinical and physical recommended actions to improve their health[4]. The artificial intelligence behind PHP allows it to learn and improve continuously, refining its personalised suggestions. Engaging in PHP gives members access to the Scheme's Personal Health Fund, replacing our WELLTH Fund, and providing additional day-to-day benefits. There is deep value for our members and the Scheme in encouraging the development of healthy habits, which PHP is designed to do. Strong versus weak clinical habits[5] show reductions of 13% in relative morbidity and 16% in relative mortality; and strong physical activity habits improve these by 16% and 18% respectively[6]. We encourage all our eligible members to join this journey to better health through this truly innovative programme.

For the year ended 31 December 2024, the Scheme's insurance revenue (previously contribution income) was R 80 673 million (2023: R73 328 million). Taking claims paid on behalf of members and other expenses directly attributable to membership into account, the Scheme generated an insurance service result before amounts attributable to future members of R350 million (2023: negative R2 252 million). This result enables the Scheme to continue to appropriately match member contributions to their rate of healthcare utilisation. In terms of our investment strategy, the Scheme generated investment income of R2 828 million (2023: R2 418 million), which strongly supported our financial position despite challenging and unpredictable market conditions, and allowed us to shield members from healthcare inflation to an extent. Insurance liability to future members (previously member funds) increased to R31.6 billion (2023: R28.7 billion), resulting in solvency of 31.01% (2023: 30.60%) at 31 December 2024 – well above the regulated 25% solvency level. The Scheme remains in a strong position, able to meet members' needs.

Notwithstanding this strong position, it is essential that the Scheme continues to grow to mitigate healthcare inflation. This is challenging in the current economic environment, and we experienced a slight decrease in principal members of 1.05% in 2024. In response, we have closely examined the competitiveness of our benefit plans. In 2025, we introduced the Active Smart plan at an excellent price point, specifically targeting new medical scheme members. We also expanded our KeyCare Regional plan to include additional regions and introduced a new income band, with both changes aimed at increasing access to healthcare.

To attract and retain members, it is important that their healthcare journeys are as frictionless as possible, with information about their benefits readily accessible and funding for their healthcare available when they need it. Taking note of increasing disputes raised and feedback from members, we placed significant scrutiny on our servicing environment in 2024 and introduced new processes to closely monitor member concerns. We have been encouraged since by the feedback received from our members. This will continue to be a heightened area of focus for the Scheme Office.

On the regulatory and policy front, significant movement took place in 2024 with the NHI Act being signed into law. While the NHI Act may not affect medical scheme members for several years, we are concerned about its short-, medium- and long-term implications for the healthcare system. Given the global economic forces which influence the national fiscus and our healthcare system, we are especially concerned about the NHI's affordability. Our concerns are shared by many other stakeholders, with several legal challenges to the NHI Act, or components of it, underway. DHMS is part of the Health Funders Association-led case, while we hope for an agreement to amend the Act to address our concerns and avoid protracted legal action.

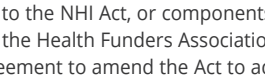
While the challenges to the NHI Act run their course, the Scheme believes that strong – but appropriate – action is urgently needed to safeguard and improve the healthcare system, to achieve equitable access for all. To this end, the Health Market Inquiry (HMI's) very thorough and carefully considered investigation into the functioning of the private healthcare system produced a robust set of recommendations and clear guidance as to how they should be implemented. They are designed to create a concerted improvement rather than a piecemeal and counterproductive effect, and we believe that their implementation as a coherent package would achieve real improvement. The Scheme is committed to participating in the extensive engagement and collaboration needed to achieve the outcomes envisaged by the HMI, and looks forward to engaging with stakeholders on recently published documents in this regard.

On other regulatory matters, we reviewed the long-awaited Low-Cost Benefit Options framework and, through the HFA, made a submission in response. We hold firm to our view that primary care, or low-cost benefit options, offered by schemes would provide significant social protection.

We await the publication of the Section 59 Investigation report[7]. We anticipate that it will vindicate our stance on the importance of implementing effective initiatives to combat fraud, waste and abuse (FWA) to protect members' funds and by extension their continued ability to access healthcare. The interim report found no evidence of intentional or explicit racial bias in any of the processes or methodologies carried out on the Scheme's behalf by Discovery Health, and confirmed that our FWA processes are necessary and justifiable given the significant risk and implications of losses to medical scheme members.

We bade farewell to Dr Sipho Kabane, the Registrar of the Council for Medical Schemes, in August 2024 and welcomed the appointment of Dr Musa Gumede as the new Registrar. We look forward to continued engagement with the office of the Registrar as we work collectively to ensure a sustainable medical scheme environment.

My thanks go to my colleagues in the Scheme Office, whose dedication, diverse views and deep expertise are invaluable to the work of the Scheme. The Scheme's Trustees and Independent Committee Members are highly engaged, and their guidance and steady steer is invaluable to the Scheme in ensuring its continued ability to serve members' needs. We are grateful to key stakeholders and our colleagues in the industry for their vision and collaboration in working to protect our members and the future of healthcare in South Africa. We thank our members for continuing to trust us to meet their healthcare needs.



MS CHARLOTTE MBEWU
Principal Officer

1 *Based on DHMS data, risk-adjusted for age, sex and plan type.*
2 *54% reported a reduction of at least three points on the PHQ-9 depression severity scale, with 35% showing a decrease of at least 50% in their symptoms. Furthermore, 25% of participants who started with mild to severe depression (PHQ-9 score above five) completed the course with a score of five or lower.*
3 *67% lower probability of readmission, and 63% lower probability of an emergency unit visit after discharge.*
4 *Where recommended actions have a cost attached, these are funded according to each member's plan benefits. Please see the description provided per action for more information.*
5 *Such as going for routine screening tests and follow-up consultations, recommended monitoring pathology or radiology tests, and adherence to medicine prescriptions.*
6 *Source: a retrospective mortality study on Discovery Health and Vitality data, conducted by Discovery Health.*
7 *The Section 59 Investigation was an independent inquiry into allegations of unfair treatment and racial discrimination by medical schemes and administrators in South Africa when identifying and penalising healthcare providers for fraud, waste, and abuse (FWA).*

ENSURING THE SCHEME'S SUSTAINABILITY

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

Growth and sustainability

MEMBERSHIP GROWTH

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

NET MEMBERSHIP DECREASE

1.05%

(2023: 0.12% decrease)

NET BENEFICIARY DECREASE

1.90%

(2023: 0.81% decrease)

AVERAGE AGE AT YEAR-END[1]

37.59 (2023: 37.00)

PENSIONER RATIO[2]

13.00%

(2023: 12.32%)

ANNUALISED LAPSE RATE

5.99% (2023: 5.88%)

RELATIVE CONTRIBUTION LEVELS

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

AVERAGE CONTRIBUTIONS FOR 2025 ARE

12.7%

lower than the average of the contributions of the next seven largest open schemes[5] (2024: 11.1%).

MEMBERSHIP SIZE

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

1 359 379

PRINCIPAL MEMBERS AT 31 DECEMBER 2024

(2023: 1 373 864)

2 735 204

BENEFICIARIES AT 31 DECEMBER 2024

(2023: 2 788 242)

58.0%[3]

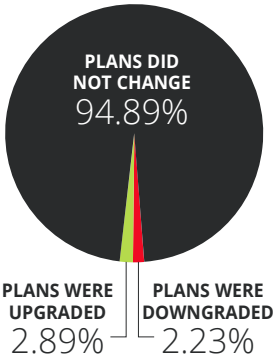
SHARE OF OPEN SCHEME MARKET

(2024: 57.8%)

PLAN MOVEMENTS

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

FROM DECEMBER 2024 – JANUARY 2025[4]:



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

2 *Based on beneficiaries' dates of birth.*

3 *Based on beneficiaries, according to the Council for Medical Schemes (CMS) Industry Report for the year ended December 2023 (https://www.medicalschemes.co.za/download/3768/industry-report-2023/29351/cms-industry-report-2023.pdf). At the end of 2023 there were 16 open schemes registered with the CMS, with approximately 52.7% of the total medical schemes market and 55 restricted schemes, with approximately 47.3% of the market. The Government Employees Medical Scheme is the largest restricted scheme with approximately 2.3 million beneficiaries.*

4 *We monitor plan movements closely, especially when our contributions are increased and members are able to change their plans.*

5 *Source: publicly available contribution information for DHMS and the next seven largest open medical schemes. To ascertain the contribution differential between DHMS and competitors, we calculate an average contribution within each plan category for a principal member. These average contributions are then weighted (for DHMS and the next seven 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, providing a reasonable estimate of the lower contribution that a typical member of DHMS pays relative to members of similar options in competitor schemes. Contribution rates on individual plans of other schemes vary and may be cheaper or more expensive than DHMS's equivalent plans.*

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

31.01%

(2023: 30.60%)

exceeding the statutory solvency requirement of 25%.

AAA

INDEPENDENT CREDIT RATING FOR CLAIMS PAYING ABILITY[1]

(2023: AAA)

PRUDENT INVESTMENT MANAGEMENT

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

GROSS RETURN ON INVESTMENTS

12.47%

(2023: 9.36%)

PRICING SUFFICIENCY

The Scheme's solvency level currently exceeds what the Scheme deems necessary for long-term sustainability. As a result, contributions have been carefully set to gradually reduce solvency from 31.0% at the end of 2024, to a sustainable level still well above 25% in the coming years. This provides some financial relief to our members by passing on the benefit of excess reserves. The Scheme aims to reach an operating break-even, excluding investment income, by 2026.

TOTAL INSURANCE SERVICE RESULT FOR THE YEAR

R350 million

negative

(2023: R2 252 million negative)

TOTAL COMPREHENSIVE INCOME FOR THE YEAR OF

R2 896 million

(2023: R183 million deficit)

VALUE-ADDED ADMINISTRATION AND MANAGED CARE

FOR EVERY R1.00 SPENT BY THE SCHEME ON ADMINISTRATION AND MANAGED CARE FEES IN 2023[2], OUR MEMBERS RECEIVED

R2.08

(2022: R2.08)

in value from the activities of Discovery Health (Pty) Ltd (Discovery Health). This is equivalent to nominal added value, over and above the fees that the Scheme paid to Discovery Health, of R9.6 billion in 2023 (2022: R8.7 billion).

ADMINISTRATION FEES

7.37%

of gross contributions

(2023: 7.41%)

MANAGED CARE FEES

2.52%

of gross contributions

(2023: 2.56%)

1 *Rating affirmed in April 2025; this refers to how many times the Scheme is able to cover its monthly claims expense with its liquid investments.*

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

Extracts from the audited Annual Financial Statements

Statement of Financial Position

AT 31 DECEMBER 2024

	Notes[1]	2024 R'000	2023 R'000
Assets			
NON-CURRENT ASSETS		**26 888 100**	25 022 693
Property and equipment	*1*	**6 024**	7 745
Long-term employee benefit plan assets	*24*	**11 334**	10 206
Financial assets at fair value through profit or loss	*3*	**26 870 742**	25 004 742
CURRENT ASSETS		**12 867 797**	12 281 727
Financial assets at fair value through profit or loss	*3*	**9 711 931**	7 865 155
Derivative financial instruments	*6*	**–**	65 826
Trade and other receivables	*4*	**11 583**	11 967
Reinsurance contract assets	*9*	**1 194**	3 043
Cash and cash equivalents	*5*	**3 143 089**	4 335 736
TOTAL ASSETS		**39 755 897**	37 304 420
Liabilities			
NON-CURRENT LIABILITIES		**30 489 597**	26 924 615
Insurance liability to future members	*10*	**30 485 863**	26 919 793
Lease liability	*2*	**3 734**	4 822
CURRENT LIABILITIES		**9 266 300**	10 379 805
Lease liability	*2*	**1 770**	1 654
Derivative financial instruments	*6*	**29 784**	–
Insurance contract liability	*8*	**8 034 282**	8 525 966
Insurance liability to future members	*10*	**1 100 831**	1 770 453
Trade and other payables	*7*	**99 633**	81 732
TOTAL LIABILITIES		**39 755 897**	37 304 420

*1 See **http://www.discovery.co.za/info/dhmsreports** for the full Integrated Report, incorporating annual financial statements and notes.*

Statement of Comprehensive Income

FOR THE YEAR ENDED 31 DECEMBER 2024

	Notes[1]	2024 R'000	2023 R'000
Insurance revenue	11	**80 673 076**	73 328 203
Insurance service expense	11	**(81 096 469)**	(75 665 705)
Net income from risk transfer arrangements/reinsurance	11	**73 068**	85 723
INSURANCE SERVICE RESULT		**(350 325)**	(2 251 779)
Other income		**4 577 188**	3 378 968
Investment income	18	**2 827 549**	2 417 940
Net gain on financial assets	19	**1 714 147**	924 517
Sundry income	20	**35 492**	36 511
Other expenditure		**(1 330 415)**	(1 309 823)
Other administration fees	12	**(686 987)**	(648 298)
Other operating expenses	13	**(210 659)**	(191 266)
Asset management fees	21	**(93 764)**	(83 041)
Finance costs	22	**(692)**	(922)
Net finance expense from insurance contracts	23	**(338 313)**	(386 296)
Net surplus/(deficit) for the year before mutualisation		**2 896 448**	(182 634)
Amounts attributable to future members[2]	10	**(2 896 448)**	182 634
TOTAL COMPREHENSIVE INCOME FOR THE YEAR		**–**	–

Statement of Cash Flows

FOR THE YEAR ENDED 31 DECEMBER 2024

	Notes[1]	2024 R'000	2023 R'000
Cash flows from operating activities			
CASH RECEIPTS FROM MEMBERS AND PROVIDERS		**94 457 641**	88 566 796
Cash received from members – contributions	8	**94 457 641**	88 566 796
CASH PAID TO PROVIDERS, EMPLOYEES AND MEMBERS		**(96 475 258)**	(91 380 082)
Cash paid to providers and members – claims and directly attributable expenses	8	**(94 752 018)**	(89 714 174)
Cash paid to risk transfer arrangement providers/reinsurers	9	**(314 505)**	(310 596)
Cash paid to providers and employees – other administration fees and operating expenses	26	**(837 296)**	(816 378)
Cash paid to members – savings plan refunds	8	**(571 439)**	(538 934)
CASH USED IN OPERATIONS		**(2 017 617)**	(2 813 286)
Purchase of financial assets	26	**(6 419 310)**	(3 967 570)
Proceeds from disposal of financial assets	26	**4 800 757**	5 383 974
Increase in long-term employee plan asset	24	**(7 130)**	(6 770)
Interest received	26	**2 126 091**	1 802 684
Dividend income	26	**419 990**	397 566
Interest paid	22	**(10)**	–
Asset management fees paid	21	**(93 764)**	(83 041)
NET CASH (OUTFLOW)/INFLOW FROM OPERATING ACTIVITIES		**(1 190 993)**	713 557
Cash flows from financing activities			
Purchases of leasehold improvements	1	**–**	(142)
Payment of lease liabilities	2	**(1 654)**	(1 813)
Net cash outflow from financing activities		**(1 654)**	(1 955)
NET (DECREASE)/INCREASE IN CASH AND CASH EQUIVALENTS		**(1 192 647)**	711 602
Cash and cash equivalents at the beginning of the year		**4 335 736**	3 624 134
CASH AND CASH EQUIVALENTS AT THE END OF THE YEAR		**3 143 089**	4 335 736

1 *See **http://www.discovery.co.za/info/dhmsreports** for the full Integrated Report, incorporating annual financial statements and notes.*

2 *Circular 6 of 2025 issued by the CMS requires medical schemes to present 'Amounts attributable to future members' separate from the "Insurance service expenses" and the "Insurance service result". This resulted in a representation of the prior year affected line items as follows: "Amounts attributable to future members" to the value of 2 896 448 (2023: -182 634), are now being disclosed as a separate line item on the Statement of comprehensive income before the "Surplus/deficit for the year". Insurance service expense in accordance with IFRS 17 includes amounts attributable to future members. Total insurance service result after adjusting for amounts attributable to future members amount to -3 246 773 (2023: -2 069 145).*

Solvency

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 2024, the Scheme's solvency level of 31.01% (2023: 30.60%) of gross annual contributions exceeded the 25% minimum statutory solvency requirement by R5.7 billion (2023: R5 billion).

R'000	**2024**	2023
Insurance contract liability to future members	**31 586 694**	28 690 246
Less: cumulative unrealised net gain on re-measurement of investments	**(2 236 225)**	(1 508 826)
Accumulated funds (Regulation 29)	**29 350 469**	27 181 420
Gross annual contributions	**94 633 158**	88 816 184
Solvency ratio	**31.01%**	30.60%
Average accumulated funds per member at year-end	**21 591**	19 785

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 the respective portfolio level on a fair value basis. All asset managers are remunerated based on the fair value of the portfolio under management.

The business model objective is achieved through the selling of assets per the documented and approved strategy for realisation of gains with the collection of contractual cash flows being incidental to the primary business model objective. The financial assets are managed together and grouped into specific portfolios. Based on the business model objective the financial assets are measured at fair value through profit and loss.

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

The fair value of the portfolios where the underlying financial instruments are traded in an active market is determined by using quoted market prices or dealer quotes of the underlying financial instruments.

The fair value of the portfolios where the underlying financial instruments are not traded in an active market is determined by using valuation techniques that maximise the use of observable market data and rely as little as possible on entity specific estimates.

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

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

Measurement class	Methodology
Offshore cash and bonds	Offshore cash and bonds are in collective investment schemes. The Scheme's intention is not to liquidate these portfolios; however, in the event that operational or strategic requirements require, these portfolios may be liquidated. As a result, these portfolios have been included as open ended.
Equities	The Scheme's intention is not to liquidate these portfolios; however, in the event that operational or strategic requirements require, these portfolios may be liquidated. As a result these portfolios have been included as open ended.
Short duration bonds	The maturity date at instrument level is used to determine the expected settlement. If the maturity date is within 12 months from the reporting date, the instrument is considered to be settled within 12 months. All other instruments are considered open ended.
Flexible fixed income bonds	The maturity date at instrument level is used to determine the expected settlement. If the maturity date is within 12 months from the reporting date, the instrument is considered to be settled within 12 months. All other instruments are considered open ended.
Money market instruments	Assets that are expected to be realised to fund operating activities within 12 months from the reporting date are considered to be settled within 12 months. All other instruments are classified as open ended.
Property	The Scheme's intention is not to liquidate these portfolios; however, in the event that operational or strategic requirements require, these portfolios may be liquidated. As a result these portfolios have been included as open ended.

Operational statistics per benefit plan[1]

FOR THE YEAR ENDED 31 DECEMBER 2024

2024		COMPREHENSIVE			PRIORITY		SAVER		
	EXECUTIVE	CLASSIC COMP	ESSENTIAL COMP	CLASSIC SMART COMP	CLASSIC PRIORITY	ESSENTIAL PRIORITY	CLASSIC SAVER	ESSENTIAL SAVER	COASTAL SAVER
Number of members at the end of the accounting period	7 123	88 307	–	3 057	66 627	4 648	344 957	179 240	154 329
Number of beneficiaries at the end of the accounting period	14 220	177 050	–	5 513	142 968	9 061	744 945	374 130	336 977
Average number of members for the accounting period	7 260	91 370	–	3 157	67 353	4 667	343 059	176 362	156 149
Average number of beneficiaries for the accounting period	14 579	183 863	–	5 761	144 841	9 110	741 203	368 508	341 343
Average insurance revenue per member per month (R')	12 786.47	10 165.11	–	9 114.87	6 774.03	6 056.16	5 293.72	4 289.21	4 966.01
Average insurance revenue per beneficiary per month (R')	6 366.96	5 051.52	–	4 994.39	3 150.00	3 102.34	2 450.15	2 052.74	2 271.73
Average insurance service expenses per member per month (R')	16 809.23	10 906.38	–	7 160.59	6 815.58	4 949.02	5 159.62	3 714.52	5 073.06
Average insurance service expenses per beneficiary per month (R')	8 370.07	5 419.89	–	3 923.56	3 169.33	2 535.19	2 388.08	1 777.71	2 320.70
Insurance service expenses ratio (%)	131.46%	107.29%	16.02%	78.56%	100.61%	81.72%	97.47%	86.60%	102.16%
Average relevant healthcare expenditure per member per month	16 268.43	10 363.00	–	6 623.09	6 270.05	4 403.97	4 613.94	3 179.88	4 526.76
Average relevant healthcare expenditure per beneficiary per month	8 100.78	5 149.86	–	3 629.05	2 915.65	2 255.99	2 135.52	1 521.84	2 070.79
Relevant healthcare expenditure ratio (%)	127.23%	101.95%	9.21%	72.66%	92.56%	72.72%	87.16%	74.14%	91.15%
Average net claims incurred per member per month (R')	16 116.81	10 209.40	–	6 475.17	6 120.91	4 255.66	4 465.81	3 031.22	4 378.86
Average net claims incurred per beneficiary per month (R')	8 025.29	5 073.53	–	3 548.00	2 846.30	2 180.01	2 066.96	1 450.69	2 003.13
Average directly attributable insurance service expenses per member per month (R')	692.42	696.98	–	685.42	694.67	693.36	693.81	683.30	694.20
Average directly attributable insurance service expenses per beneficiary per month (R')	344.79	346.36	–	375.57	323.03	355.18	321.12	327.01	317.57
Directly attributable insurance service expenses ratio (%)	5.33%	6.74%	6.79%	7.39%	10.09%	11.45%	12.89%	15.66%	13.98%
Average administration costs per member per month (R')	456.83	456.84	–	456.85	456.84	456.85	456.84	456.84	456.84
Average administration costs per beneficiary per month (R')	227.48	227.03	–	250.33	212.44	234.03	211.44	218.64	208.98
Average managed care: Management services per member per month (R')	151.81	152.07	–	148.66	149.65	148.78	148.63	148.03	148.74
Average managed care: Management services per beneficiary per month (R')	75.59	75.57	–	81.46	69.59	76.22	68.79	70.84	68.04
Average non-healthcare expenses per member per month	58.05	58.05	–	58.03	58.05	58.07	58.06	58.07	58.05
Average non-healthcare expenses per beneficiary per month	28.91	28.85	–	31.80	26.99	29.75	26.87	27.79	26.56
Total non-healthcare expenses as a percentage of risk contributions (%)	0.45%	0.57%	0.00%	0.64%	0.86%	0.96%	1.10%	1.35%	1.17%
Average family size	2.01	2.01	–	1.83	2.15	1.95	2.16	2.09	2.19
Average age of beneficiaries (years)	48.29	47.07	–	49.36	43.24	41.18	37.30	34.45	38.69
Pensioner ratio (beneficiaries over 65 years)	31.34%	26.84%	–	31.86%	19.82%	16.18%	12.43%	8.81%	13.52%
Net surplus/(deficit) per benefit plan	(334 419)	(613 603)	12 429	82 222	116 362	72 391	1 317 668	1 607 935	147 112

2024	CORE			SMART		KEYCARE			TOTAL
	CLASSIC CORE	ESSENTIAL CORE	COASTAL CORE	CLASSIC SMART	ESSENTIAL SMART	KEYCARE PLUS	KEYCARE CORE	KEYCARE START	
Number of members at the end of the accounting period	43 156	55 027	64 095	71 775	72 191	181 078	17 142	6 627	**1 359 379**
Number of beneficiaries at the end of the accounting period	91 735	119 475	142 961	146 537	85 984	306 614	28 342	8 692	**2 735 204**
Average number of members for the accounting period	43 224	53 578	64 722	69 706	65 044	182 940	16 289	6 332	**1 351 211**
Average number of beneficiaries for the accounting period	92 036	116 518	144 662	142 311	76 833	310 609	26 880	8 266	**2 727 322**
Average insurance revenue per member per month (R')	5 651.31	4 436.75	4 968.83	4 266.41	2 161.69	2 980.80	2 415.25	1 966.68	**4 975.36**
Average insurance revenue per beneficiary per month (R')	2 654.12	2 040.13	2 223.05	2 089.74	1 830.03	1 755.61	1 463.64	1 506.50	**2 464.97**
Average insurance service expenses per member per month (R')	5 680.46	4 272.22	5 371.65	4 075.81	1 919.22	3 492.68	2 405.87	1 421.25	**5 002.16**
Average insurance service expenses per beneficiary per month (R')	2 667.81	1 964.48	2 403.27	1 996.39	1 624.76	2 057.09	1 457.95	1 088.70	**2 478.24**
Insurance service expenses ratio (%)	100.52%	96.29%	108.11%	95.53%	88.78%	117.17%	108.11%	117.17%	**100.54%**
Average relevant healthcare expenditure per member per month	5 142.45	3 743.41	4 837.21	3 548.34	1 427.46	3 101.61	2 156.97	1 078.03	**4 488.44**
Average relevant healthcare expenditure per beneficiary per month	2 415.14	1 721.32	2 164.16	1 738.02	1 208.45	1 826.76	1 307.12	825.79	**2 223.73**
Relevant healthcare expenditure ratio (%)	91.00%	84.37%	97.35%	83.17%	66.03%	104.05%	89.31%	54.81%	**90.21%**
Average net claims incurred per member per month (R')	4 998.44	3 595.44	4 689.36	3 401.19	1 280.43	2 991.26	2 010.91	943.86	**4 345.29**
Average net claims incurred per beneficiary per month (R')	2 347.50	1 653.28	2 098.02	1 665.95	1 083.98	1 761.76	1 218.61	723.01	**2 152.81**
Average directly attributable insurance service expenses per member per month (R')	682.03	676.78	682.29	674.63	638.79	501.42	394.96	477.39	**656.87**
Average directly attributable insurance service expenses per beneficiary per month (R')	320.31	311.20	305.26	330.44	540.78	295.32	239.35	365.69	**325.43**
Directly attributable insurance service expenses ratio (%)	11.87%	15.00%	13.73%	15.81%	29.55%	16.82%	16.35%	24.27%	**13.20%**
Average administration costs per member per month (R')	456.84	456.84	456.84	456.84	456.84	285.02	182.80	285.01	**429.47**
Average administration costs per beneficiary per month (R')	214.55	210.07	204.39	223.77	386.75	167.87	110.77	218.32	**212.77**
Average managed care: Management services per member per month (R')	148.65	148.57	148.63	147.53	147.22	146.06	146.06	146.06	**148.35**
Average managed care: Management services per beneficiary per month (R')	69.81	68.31	66.50	72.26	124.63	86.03	88.51	111.88	**73.50**
Average non-healthcare expenses per member per month	58.05	58.07	58.05	58.06	58.09	41.12	31.04	41.14	**55.36**
Average non-healthcare expenses per beneficiary per month	27.26	26.70	25.97	28.44	49.18	24.22	18.81	31.51	**27.43**
Total non-healthcare expenses as a percentage of risk contributions (%)	1.03%	1.31%	1.17%	1.36%	2.69%	1.38%	1.29%	2.09%	**1.11%**
Average family size	2.13	2.17	2.24	2.04	1.18	1.70	1.65	1.31	**2.02**
Average age of beneficiaries (years)	43.84	40.62	42.84	33.85	36.73	33.15	36.93	36.62	**37.59**
Pensioner ratio (beneficiaries over 65 years)	21.05%	16.76%	19.39%	7.20%	6.22%	10.50%	15.08%	10.68%	**13.00%**
Net surplus/(deficit) per benefit plan	100 352	246 908	(143 010)	342 693	362 756	(531 674)	49 985	60 341	**2 896 448**

1 *Efficiency discount options (Delta, KeyCare Start Regional) are incorporated into their parent plans for operational statistics reporting purposes. For 2025, a new plan, Active Smart, was launched (not shown in the table). For more information on 2024 plans and benefits, see https://www.discovery.co.za/medical-aid/product-benefit-enhancements.*

Matters of non-compliance

for the year ended 31 December 2024

Circular 11 of 2006 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 2024, the Scheme did not comply with the following Sections and Regulations of the Act, and a directive issued by the CMS.

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.

Section 33(2) of the Act pertains to specific financial requirements applicable to medical schemes and outlines the statutory reserves that medical schemes are required to maintain. However, IFRS 17 provides a comprehensive framework for accounting for insurance contracts, including the recognition, measurement, presentation, and disclosure of insurance contracts. In this context, amounts attributable to future members, as determined under IFRS 17, are not subject to the specific provisions of Section 33(2) of the Act, and are excluded from the non-compliance testing related to Section 33(2) of the Medical Schemes Act.

For the year ended 2024 the following plans did not comply with Section 33(2):

Benefit plan	Net healthcare result (R'000)	Net deficit (R'000)
Executive	**(350 427)**	**(334 421)**
Classic Comprehensive	**(814 443)**	**(613 619)**
Classic Core	**(12 718)**	**100 348**
Classic Priority	**(33 170)**	**116 350**
Coastal Core	**(312 251)**	**(143 016)**
Coastal Saver	**(199 005)**	**147 097**
KeyCare Plus	**(1 045 347)**	**(531 658)**

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

When structuring benefit options, the financial sustainability of all the options and the requirements of the CMS are considered. The different financial positions reflect the different disease burdens in each option, among many other factors. The Scheme's strategy for plans' sustainability must 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 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.

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

Investments in employer groups and medical scheme administrators

Section 35(8)(a), (c) and (d) of the Act states that a medical scheme shall not invest any of its assets in the business of an employer who participates in the Scheme, or any administrator or any arrangement associated with the Scheme. The Scheme has investments in certain employer groups and companies associated with medical scheme administration within its diversified investment portfolio. This situation occurs industry-wide and the CMS has granted DHMS exemption for a three-year period effective from 01 December 2022.

Investments in other assets in territories outside the Republic of South Africa

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

Investments in derivatives in territories outside the Republic of South Africa are, however, prohibited in terms of Category 7(b) of Annexure B to the Regulations of the Act. The CMS has granted DHMS exemption for a three-year period effective from 01 December 2022.

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 suspending membership for non-payment.

Claims paid in excess of 30 days

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

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

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 instances where the Scheme did not pay claims in accordance with the scope and level of minimum benefits. The claims are being re-processed to ensure that they are correctly paid.

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 four 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 re-occurrence.

Member confidentiality

Section 57(4)(i) of the Medical Schemes Act mandates that the Board of Trustees must "take all reasonable steps to protect the confidentiality of medical records concerning any member's state of health".

During the financial year, an employee of Discovery Health as our administrator inadvertently sent an email to an external, unrelated third party. This email contained six unprotected Excel files with personal and special personal information of DHMS beneficiaries. This incident represents a breach of both Section 57(4)(i) of the Act and the Protection of Personal Information Act. The recipient has confirmed, via affidavit, that the files were not opened.

In response to this breach, several preventative measures have been implemented, including:

- Stricter controls over external email addresses
- Mandatory use of secure platforms for document sharing
- Enhanced staff training in data protection protocols

Claims payments as per the scheme's registered rules

Regulation 18(2)(b) of the Medical Schemes Act states that:
"The agreement referred to in sub regulation (1) must provide:
(b) that the administrator must on behalf of the medical scheme, administer the business of a medical scheme in accordance with the Act, and as provided for in the rules of the medical scheme."

During the year, system-related issues impacted the correct administration of PMSA allocations, resulting in non-compliance with the Scheme's registered rules. This included incorrect claim funding rates for ophthalmologists, where claims were paid at 2023 rates instead of 2024 rates, affecting 141 members and resulting in a short payment of R129 000. PMSA interest calculation errors due to new business activation faults, claims processing inaccuracies, and plan changes impacted over 19 000 members with a financial impact of R14.2 million.

Corrective actions have been implemented for the identified issues including system fixes, claim reprocessing, and interest recalculations. Preventative measures such as enhanced change control processes, improved system validations, and revised monitoring tools have been introduced to strengthen system controls, improve monitoring, and ensure compliance with scheme rules going forward.

Claims payment errors

Section 29(1)(q)(i) and Section 29(1)(q)(ii) of the Medical Schemes Act require that a medical scheme's rules include provisions for the payment of benefits according to a defined scale, tariff, or recommended guide, and in line with specific directives as prescribed in the rules of the scheme.

During the year, there were two incidents where claims were not paid in accordance with the prescribed rules and tariffs. Pharmaceutical claims were incorrectly funded at the 2025 Discovery Reference Price (DRP) instead of the 2024 scheme-approved rate. As a result, 261 members were required to pay invalid co-payments amounting to R47 000. Additionally, 914 non-pharmacy claims were underpaid by R49 000. The second incident related to anaesthetist claims which were incorrectly paid at 2023 Premier B rates instead of the 2024 rates due to a tariff linkage error. This impacted 10 601 claims resulting in a total short payment of R2.4 million.

Corrective actions were promptly implemented. For the first incident, the system configuration was corrected to apply the 2025 DRP rates from the correct effective date of 01 January 2025. Non-pharmacy claims were reprocessed, and a bulk refund was issued to members affected by invalid co-payments. For the second incident, the incorrect tariff linkage was corrected, 2024 pricing was reloaded, and claims were reprocessed.

Preventative measures included enhanced quality assurance processes, including retrospective audits after each deployment with the aim to strengthen system integrity, prevent recurrence, and ensure ongoing compliance with the Medical Schemes Act.

Misclassification of investment instrument – breach of Regulation 30(1) and Annexure B categorisation

Regulation 30(1) of the Medical Schemes Act requires that medical scheme funds be invested in accordance with the kinds of assets and limits prescribed in Annexure B.

During the financial year, an offshore equity instrument held in an asset manager's equity portfolio was misclassified as a domestic equity instrument. This misclassification resulted in a breach of the prescribed foreign asset exposure limits. To ensure compliance with Regulation 30 this necessitated the disinvestment from this instrument. As a result, the instrument was exited leading to a capital loss which was fully reimbursed to the Scheme by the asset manager.

Preventative controls and classification processes have since been strengthened within the asset manager, including enhanced instrument classification reviews, dual compliance checks, and more robust communication between investment teams and compliance functions to ensure full alignment with regulatory requirements and asset class definitions.

Our Trustees*

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2 *Fellow of the Actuarial Society of South Africa.*
3 *Chartered Enterprise Risk Actuary.*
4 *Institute of Directors in South Africa.*
5 *Fellow of the Actuarial Society of South Africa.*

* *In office during 2024. All ages are as at 31 December 2024.*

Discovery Health Medical Scheme

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