Minutes of the 30th Annual General Meeting of Discovery Health Medical Scheme ("DHMS"/" the Scheme") held virtually on 26 June 2025 at 09:00

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1 Welcome and Quorum

The Chairperson of the Board of Trustees ("the Board"), Ms Michelle Norton, SC welcomed all attendees to the 30th Annual General Meeting ("AGM") of Discovery Health Medical Scheme ("DHMS" or "the Scheme"). She extended a warm welcome to all members of the Scheme and acknowledged the presence of the delegate from the Council for Medical Schemes ("CMS" or "the Regulator"), Ms Boitumelo Matolo.

The Chairperson briefed members on the meeting protocols, as outlined below:

- The meeting was streamed live on the Scheme's official website.
- Principal Members were afforded the opportunity to pose questions relating to the business of the AGM via the chat facility on the online platform.
- It was noted that the platform did not support voice integration functionality.
- Interpreters were made available to translate questions posed in languages other than English.
- Members with questions related to personal claims were advised to contact the Scheme's call centre or to post their queries—without disclosing personal information—on the online chat facility, where a personalised response would be provided after the AGM.
- Questions from Members were scheduled to be addressed following the conclusion of Agenda items 3, 4, and 6.

The Chairperson confirmed that, in order to ensure that the AGM and all related processes were conducted in accordance with the Scheme Rules and to facilitate Member participation, the Scheme had appointed Forvis Mazars as an independent third-party service provider. Forvis Mazars was tasked with overseeing the nominations process, the proxy appointment process, and the voting process at the AGM. It was noted that Forvis Mazars reported directly to the Scheme's independent Nominations Committee.

The Chairperson then called upon Mr Ishan Bhowani from Forvis Mazars to confirm whether the required minimum of 50 Principal Members in good standing was present, thereby confirming that the AGM was quorate in accordance with the Scheme Rules.

Mr Ishan Bhowani, a Director at Forvis Mazars, addressed the meeting and indicated that, in accordance with Scheme Rule 25.1.4, at least 50 Principal Members in good standing were required to constitute a quorum. He informed attendees that, should a quorum not be established within 30 minutes of the scheduled start of the AGM, the meeting would have to be postponed to a date to be determined by the Board of Trustees.

Mr Bhowani then requested the virtual platform provider to display the number of Principal Members present in the meeting. The number displayed represented the total number of Principal Members attending online. A total of 808 online Principal Members were recorded as being connected to the meeting, thereby exceeding the minimum quorum requirement of 50 Principal Members. Mr Bhowani subsequently handed the proceedings back to the Chairperson.

The Chairperson confirmed that the meeting was duly quorate and officially declared the 30th AGM open. She then handed the floor back to Mr Bhowani to explain the voter registration and voting procedures.

Mr Bhowani explained that all virtual attendees' statuses as Principal Members in good standing had been verified prior to the commencement of the AGM and the opening of the voting process. Each verified member had received a secure voting link via email. By clicking on the link, members were able to exercise their right to vote. To cast a vote, members were instructed to select the "Vote" tab located at the top of their screens.

In the event of technical queries, a banner with the contact details of the relevant support agents was displayed on the screen. For AGM-related queries, members were advised to email DHMS2025AGM@forvismazars.com or call 011 547 4212, where service agents were available to assist until the close of voting at 19:00 on 26 June 2025.

Mr Bhowani urged members to vote on all resolutions tabled at the AGM. He further announced that Ms Asanda Booi had withdrawn her candidacy and would no longer be standing for election. He noted that the notice of withdrawal had only been received after the candidate booklets had already been finalised and printed.

Mr Bhowani concluded by reiterating that voting would close strictly at 19:00 on 26 June 2025, after which no further votes would be accepted. He then handed the meeting back to the Chairperson.

Confirmation of the Agenda

The Chairperson proceeded to declare the voting process officially open and moved on to the confirmation of the Agenda as previously communicated to members. The 2025 AGM Agenda was displayed on members' screens.

The Chairperson invited Principal Members to propose the approval of the Agenda and called for another Principal Member to second the proposal, using the chat facility available on the platform. Mr Jacobus Johannes Van Der Merwe proposed the approval of the Agenda, and Ms Busiswa Sizeke seconded the proposal. The Agenda was accordingly approved.

2 Confirmation of the Minutes of the 2024 Annual General Meeting

The Chairperson referred Members to the copy of the minutes of the 2024 AGM, which were made available in the documents tab of the meeting pack and uploaded to the Scheme's webpage. The minutes were displayed on screen, and the Chairperson noted that the Board had reviewed the minutes and considered them to be an accurate reflection of the proceedings of the 2024 AGM. In the absence of any substantive objections, the Chairperson proposed that the minutes be approved and called upon one Principal Member to propose the approval of the minutes and another to second the proposal, using the chat facility on the platform.

Mr Temogo Nkabela proposed the approval of the minutes, and Mr Zaid Parack seconded the proposal. The minutes were thus duly approved.

3 Tabling of the 2024 Integrated Report, including the Scheme's Annual Financial Statements for the financial year ended 31 December 2024

The Chairperson referred Members to the financial statements for the year ending 31 December 2024 and advised that these were laid before the meeting in accordance with Rule 25.1.5 of the Scheme Rules.

The Chairperson informed Members that presentations would be delivered before the floor was opened for questions. A presentation would be delivered by the Principal Officer of Discovery Health Medical Scheme ("DHMS"), Ms Charlotte Mbewu, followed by a presentation by Dr Ryan Noach, the CEO of Discovery Health (Pty) Ltd ("DH"), the administrator of the Scheme.

Before proceeding with the presentations, the Chairperson highlighted key matters the Board of Trustees had addressed during the past year in the course of fulfilling its oversight responsibilities and managing the business of the Scheme. As reported at the previous AGM, the Scheme continued to face persistent

challenges in balancing two fundamental interests of its members: access to high-quality healthcare services, and the long-term sustainability of the Scheme.

The Chairperson noted the following challenges:

1. **Rising Chronic Disease**: A steady increase in the chronic disease profile among members, which contributes to higher utilisation of healthcare services.
2. **Escalating Healthcare Costs**: Healthcare cost inflation remains approximately 4% above the Consumer Price Index (CPI), with new innovative technologies in medicines that come at a significant cost.
3. **Affordability Constraints**: driven by broader economic pressures, both domestic and global, continue to affect members' affordability.

In response to these challenges, the Chairperson noted that the Scheme had implemented several significant initiatives in 2025. These included the launch of the **Personal Health Pathways Programme** in January, offering members personalised recommendations to help reduce the incidence and severity of disease. The Scheme also introduced **new risk-funded personal health fund benefits** for day-to-day medical expenses, and the **Active Smart Benefit Plan**, designed to attract younger and healthier members to the Scheme.

The Chairperson highlighted that among the most difficult issues the Scheme faces is the demand for access to high-cost, life-saving medicines or treatments. As a non-profit entity, the Scheme allocates all contributions and investment returns—beyond what is paid for administration, managed care services, financial advice, and Scheme's expenses—towards funding members' healthcare needs. Consequently, when requests for exceptionally high-cost treatments are declined or not fully covered, it is typically because funding them would compromise the Scheme's ability to meet the healthcare needs of other members equitably.

Turning to regulatory developments, the Chairperson referenced the National Health Insurance ("NHI") Act, which has been signed into law but has not yet come into operation. The Chairperson noted that multiple legal challenges had been launched over the past 18 months. DHMS is a party to the application proceedings initiated earlier in the month by the Health Funders Association. These proceedings challenge the constitutionality of the Act. The Chairperson clarified that the Health Funders Association and its members support the objective of universal health coverage, but contend that the Act, in its current form, is not capable of achieving that objective. Notably, the Minister of Health, in his answering papers to one of the review applications, indicated that full implementation of the Act is expected to take at least 10 to 15 years.

Lastly, the Chairperson addressed an issue that had emerged within the broader geo-political context. In November 2024, the Scheme's administrator, Discovery Health (Pty) Ltd, hosted and participated in a conference on global healthcare initiatives (Future of Health Summit). Among the 80 delegates from more than 15 countries were representatives from an Israeli public hospital. Some organisations objected to DH's participation in the conference due to the ongoing humanitarian and health crisis in Gaza.

This gave rise to two key questions for the Scheme:

1. "Are there any circumstances in which the Scheme could or should determine its own healthcare engagements with members of the global healthcare community on grounds other than the best interest of the Scheme, in particular the best healthcare services for its members."; and
2. "Is there any basis on which the Scheme could require its service providers, including DH, to do the same."

The Chairperson acknowledged that these were complex issues without simple answers. The Board of Trustees had requested that the Scheme's office, along with the Stakeholder Relations and Ethics Committee, develop a framework of considerations to guide future decision-making in this regard. This framework is to

be informed by the Scheme's regulatory obligations, its commitment to human rights, and the importance of wide-ranging engagements to ensure that the Scheme is able to deliver excellent, up-to-date healthcare solutions for its members.

In conclusion, the Chairperson reiterated that in all its decisions, the Board of Trustees remains guided by what is in the best interests of all members.

Following this address, the Chairperson handed over to the Principal Officer of DHMS, Ms Charlotte Mbewu, to deliver her presentation.

3.1 Presentation by Principal Officer of DHMS, Ms Charlotte Mbewu

Ms Mbewu began her presentation by stating that the purpose thereof was to provide an account of the Scheme's performance over the 2024 period, to contextualise the Scheme's current position from a 2025 perspective, and to provide a forward-looking view beyond 2025. She emphasised that all of this is rooted in the core purpose of the Scheme—namely, to ensure the care and wellbeing of its members from both a healthcare and wellness perspective.

Ms Mbewu proceeded to outline the structure of her presentation, noting that it would cover the following key themes:

1. The healthcare environment.
2. Trusted governance and long-term sustainability.
3. Caring for our members; and
4. 2025 and beyond.

The presentation highlighted the following aspects:

The Healthcare Environment

Ms Mbewu acknowledged the various factors contributing to economic pressures on households, which, in turn, have created stagnation within the medical scheme's environment. Firstly, from a household income perspective, since 2011—and particularly following the COVID-19 period—real household income has been constrained and continues to decline, thereby placing strain on members' disposable income. Secondly, unemployment remains relatively high in South Africa, which reduces the number of individuals able to make the choice to join medical schemes. Thirdly, from an industry growth perspective, these factors have collectively contributed to stagnation within the sector—an environment to which DHMS is not immune.

She noted that, as a consequence of high unemployment, the youth segment in South Africa has been particularly affected. As of Quarter 3 of 2025, the unemployment rate among individuals aged 15–34 stands at 33.8%. This has resulted in fewer younger lives joining the medical schemes environment.

Against this economic backdrop, additional complexity arises from a healthcare standpoint. There has been a marked increase in chronic disease prevalence, which adds to the disease burden within medical schemes. While such increases were previously more common among older members—as expected—a notable surge has now been observed among the younger demographic, particularly those aged 18–36. Between 2008 and 2023, there has been a 190% increase in chronic disease prevalence in this age group. This includes increased diagnoses of cancer and mental health conditions.

Given these dynamics, the Scheme must assist its membership in navigating this increasingly complex environment, while also ensuring continued access to healthcare. Ms Mbewu highlighted a rise in the average cost of various treatments. For instance, the average cost per hospital admission for hip and knee

replacements currently stands at R185,000—a 22% increase from 2019. Similar cost increases have been observed in cataract surgeries, fertility treatments, and access to innovative oncology therapies—all aimed at providing members with essential and beneficial healthcare services.

Turning to the regulatory landscape in which medical schemes operate, Ms Mbewu acknowledged that, on the one hand, there has been meaningful engagement aimed at expanding access to affordable healthcare—not only for DHMS members but for the wider South African population. She noted that the Scheme has been actively involved in engagements related to the review and possible revision of the prescribed minimum benefits (PMBs) that all medical schemes and their respective benefit options must cover. According to Ms Mbewu, the Scheme believes that if PMBs are relaxed, benefit options could become more affordable, thereby increasing both scheme membership and access to private healthcare services.

On the issue of Low-Cost Benefit Options (LCBOs), Ms Mbewu reported that the CMS had released a report for public comment, as published by the Minister of Health. DHMS participated in this process by submitting its comments. She indicated that the Scheme supports the development of a basic and consistent benefit package across the industry—particularly one that includes primary care benefits—which would serve both the industry and the general public by enabling access to affordable primary care within the private healthcare setting.

Ms Mbewu also addressed the proposed interim block exemption for healthcare tariffs, as published by the Department of Trade and Industry. She noted that the Scheme is largely supportive of the recommendations made by the Health Market Inquiry (HMI), although some aspects of the framework still require further consideration to ensure alignment with the HMI's original intent.

On the matter of NHI, Ms Mbewu emphasised that DHMS and DH have been engaged in the process since its inception in 2016. The Scheme has participated consistently to support collaboration between public and private healthcare sectors, and to contribute to shaping a healthcare system that serves the broader environment. While DHMS strongly supports the principle of universal health coverage, the Scheme does not believe that the NHI, in its current form, is feasible.

She outlined several concerns in this regard:

- Firstly, the NHI carries significant economic and healthcare system risks, which could negatively impact both the sustainability of medical scheme membership and the broader South African economy.
- Secondly, the NHI would require substantial increases in tax collection and tax rates, placing further economic strain on taxpayers and reducing disposable income, which would, in turn, affect spending in the local economy.
- Thirdly, the Scheme is concerned about the potential exodus of healthcare professionals who may seek employment opportunities abroad, due to perceived constraints within the NHI framework that could hinder their ability to provide appropriate patient care.
- Additionally, the NHI is expected to result in increased healthcare costs and out-of-pocket expenses.

Ms Mbewu noted that these concerns form part of the litigation initiated by the Health Funders Association (HFA), supported by extensive research conducted by Genesis Analytics.

As an alternative, the HFA has proposed a hybrid multi-fund model to replace the currently proposed single-fund model under the NHI. DHMS supports this hybrid model, which would involve offering an NHI benefit package through medical schemes. In this model, schemes would make a form of cross-subsidisation to the NHI fund—both through taxes and direct scheme contributions—while still offering additional and supplementary cover beyond the NHI package. According to research by the HFA, similar models have been

successfully implemented in other countries, and evidence suggests that this structure is more effective than a single-fund model.

Trusted Governance and Long-term Sustainability

Ms Mbewu commenced by contextualising how medical schemes operate and are governed. She explained that medical schemes provide protection against medical expenses within the framework of social solidarity. Specifically, open medical schemes operate under the principle of open enrolment. This means that medical schemes cannot risk-rate an individual applying for membership based on their health status. Risk pooling occurs at the level of a benefit option, and the set contribution is applied uniformly to all applicants for that specific benefit option.

Open enrolment allows any member of the public to join an open medical scheme, subject to the provisions of the Medical Schemes Act, including underwriting protocols.

From a governance perspective, the Scheme is tightly governed by a Board of Trustees, the majority of whom are elected by members. Among the most challenging aspects the Scheme faces are affordability constraints experienced by members, and the imperative of ensuring the long-term sustainability of the Scheme—so that it can continue to operate effectively and meet members' claims as they fall due, while maintaining appropriate benefit offerings.

DHMS fulfils these objectives through a complex ecosystem. Membership belongs to the Scheme, which is overseen by a Board of Trustees, supported by several Board committees. The Board appoints a Principal Officer to manage the Scheme's daily operations. Additionally, the Scheme is subject to oversight and regulation by the CMS, which ensures that medical schemes act in the best interests of members at all times.

The Board of Trustees appoints and mandates service providers. In the case of DHMS, DH serves as both the administrator and the managed care service provider. These relationships, and all activities of the Scheme, are overseen by the Board with the assistance of its committees, the Principal Officer, and the Scheme Office.

The role of the Board of Trustees is critical, as it is the body that exercises strategic oversight and sound management of the Scheme. This includes ensuring that the Scheme operates in accordance with the Medical Schemes Act, that all initiatives and strategic objectives are aligned to members' best interests, and that the Scheme remains sustainable over the long term.

Ms Mbewu referred to the Scheme's financial performance for the 2024 financial year, which had been distributed to members in preparation for the AGM. She presented the key financial highlights, noting their significance in determining the Scheme's sustainability and ability to meet its obligations.

For the 2024 financial year:

- The Scheme collected insurance revenue of **R80.67 billion**.
- Insurance service expenses (including claims and managed care services) totalled **R81.10 billion**, indicating that the full amount collected was used to fund healthcare expenditure.
- Taking into account net income from risk arrangements and reinsurance, the Scheme recorded an insurance service result of **negative R350.33 million**.
- However, due to a prudent investment strategy, the Scheme generated investment income of **R4.54 billion**.
- Including other income and after deducting administration and operating expenses, the Scheme delivered a **surplus of R2.90 billion**, attributable to members.

This surplus was added to the Scheme's reserves to meet future claims obligations and maintain regulatory solvency requirements of 25%. The reserves also serve as assurance that the Scheme is well-positioned to meet its members' future healthcare needs.

Ms Mbewu elaborated on the Scheme's financial position, including its assets—comprising investment income, cash, and cash equivalents—as well as its liabilities as of 31 December 2024. She highlighted that:

- **89.7%** of funds collected were used to pay member claims.
- **9.9%** funded administration and managed care services.
- **2.3%** went toward financial adviser fees and Scheme expenses.
- **1.9%** contributed to member reserves.

She further explained that the majority of claims in 2024 related to day-to-day benefits and hospital services. On average, DHMS processes 55 million healthcare claims per year, either by reimbursing members or paying service providers directly.

Regarding cost management, Ms Mbewu pointed out that DHMS's administration expenditure, as a percentage of contributions, was 7.6% for the 2023 financial year—lower than the industry average of 8.1%, as reported by CMS. In comparison with 16 other open medical schemes, DHMS remained competitive, underscoring its efficiency in managing administrative costs.

To verify that fees paid to DH for managed care and administrative services provide value, an actuarial study was conducted and independently verified by NMG Consulting. For the 2023 financial year, it was determined that for every R1.00 spent on administration and managed care, members received R2.08 in value—indicating that DHMS derives significant value from its service provider.

Ms Mbewu noted that DHMS holds 58% of the open scheme market share—meaning that for every 10 people joining an open medical scheme, six choose DHMS. With a 95% membership stability rate, 3% upgrading, and only 2% downgrading, the figures reflect members' confidence in the Scheme's ability to meet their healthcare needs at an acceptable contribution level.

On solvency, DHMS continues to exceed the minimum regulatory requirement, maintaining a solvency level of 31% compared to the required 25%. Additionally, DHMS has consistently maintained a AAA credit rating for 25 consecutive years.

In terms of investment performance, the Scheme's investment portfolio—comprising its reserves—achieved a return of 12.47% in the 2024 financial year.

Regarding contribution increases, Ms Mbewu highlighted that the weighted average contribution increase for 2025 was 9.3%, one of the lowest in the industry. This reflects the Scheme's commitment to providing high-quality healthcare at the lowest sustainable cost, while also supporting members in managing and improving their health. Well-managed chronic conditions and delayed disease onset benefit both member outcomes and reduce hospitalisation needs.

She added that DHMS is actively exploring alternative care delivery models, such as "hospital at home" initiatives, which enable members to receive certain treatments at home using digital tools. This aligns with the Scheme's goal of minimising contribution increases while maintaining service quality, in recognition of the financial burden on members.

In benchmarking DHMS's contribution levels against the industry across various plan types—including comprehensive and entry-level options—Ms Mbewu noted that DHMS consistently performed below the industry average. In fact, for 2025, DHMS contributions were 12.7% lower than the market average. This

continues to demonstrate that DHMS delivers tangible value to its members compared to other players in the market.

Caring for our Members

Ms Mbewu's presentation included a snapshot of the various initiatives and achievements of DHMS during the 2024 period. She highlighted that 121 mammograms were conducted for members within the Scheme, noting that breast cancer affects not only female members but also the male segment of the population. Additionally, 209,000 prostate tests were conducted. The snapshot demonstrated the breadth of healthcare services accessed by members, ranging from over the counter to prescribed medication, and included the birth of 28,000 babies in the 2024 period. These figures reflected not only the volume of claims processed, as mentioned earlier, but also the wide range of care programmes and initiatives available to DHMS members.

Ms Mbewu reported that the 10 highest claims paid by DHMS in 2024 amounted to a total of R70.5 million. Beyond these, she noted that the Scheme processed 2,108 individual claims for healthcare services exceeding R1 million each. These figures underscore the principle of pooling member contributions to protect against high-cost healthcare needs—especially when those needs are life-changing or life-threatening. For instance, the highest single claim paid amounted to R9.6 million, which would equate to 283 years' worth of contributions from a single member or family to cover that cost. This, she explained, illustrates the value and support provided by the Scheme in times of critical need.

Ms Mbewu then addressed the increasing burden of chronic disease within the DHMS population. She noted that while members in the past may have had one or two chronic conditions, data now indicates a growing prevalence of multiple (three to four) chronic conditions per member. This increase significantly elevates the risk of hospital admissions and results in longer hospital stays. In response, DHMS is actively examining and refining its care programmes to manage member health more holistically—from a population health perspective, rather than focusing on individual chronic conditions alone.

She highlighted that over one million DHMS members are currently living with a chronic condition and are enrolled in a chronic care programme. However, not all members with chronic conditions are registered for the relevant programmes. Those who are not enrolled miss key benefits that these programmes offer. These include:

- Access to a **multidisciplinary care team**, tailored to the specific chronic condition.
- A **condition-specific basket of care**
- **Digital and in-person care modalities** that enable members to monitor their condition while being supported and monitored by the care team.

These initiatives are continuously refined over time in alignment with technological advancements, ensuring that members derive increasing value from their engagement with DHMS.

Focusing on the diabetes care environment, Ms Mbewu shared that members enrolled in the programme have better health outcomes, including a higher likelihood of keeping HbA1c test results within the target range, thus achieving better diabetic control. She noted a 7% improvement in test results for those enrolled in the programme compared to eligible members who were not enrolled. Most notably, there was a 27% reduction in diabetes-related mortality for enrolled members versus non-enrolled members.

In terms of mental health, Ms Mbewu reported that members who used the Internet-Based Cognitive Behavioural Therapy (ICBT) programme experienced meaningful improvement. Specifically, 1 in 3 members using ICBT showed a 50% improvement in their depression scores, signifying better disease management. In addition, DHMS observed a significant reduction in hospital admissions for members living with mental

health conditions. She encouraged all members living with qualifying conditions to register for the appropriate disease management programmes.

Lastly, Ms Mbewu shared member testimonials, displayed on the screen, highlighting real stories of individuals who had received support from DHMS and experienced positive healthcare outcomes as a result. These stories served to reinforce the tangible impact of the Scheme's care initiatives.

2025 and beyond

Ms Mbewu stated that DHMS continues to broaden access to healthcare through its various benefit designs. In 2025, DHMS introduced the Active Smart Plan, which is offered at a monthly contribution of R1,350 per principal member, with a similar contribution required for dependants and beneficiaries registered under the plan. The Scheme continues to expand access to care through technology while ensuring that these tools complement members' care journeys and support the coordination of care, particularly by primary care providers. DHMS also launched female health tools, aimed at enhancing support for women's health throughout various life stages.

She noted that DHMS takes pride in the launch of a world-leading precision and personalisation initiative through the Personal Health Pathways (PHP) programme. This initiative aims to improve members' quality of life by recommending "next best actions" (NBAs), which members are encouraged to follow. The delivery of PHP has been made possible through the Discovery Health App and WhatsApp-based engagement, supporting user-friendly access to care.

These tools are linked to an enriched day-to-day benefit offering through the Personal Health Fund (PHF), which was created to help members cover essential daily healthcare needs. Ms Mbewu highlighted that the PHF plays a significant role in supporting members' ability to access medical services, enhancing value from the benefits received.

With regard to the new Active Smart Plan, she reported that 5% of new business in 2025 has gone into this offering. The uptake aligns with its targeted demographic—younger individuals, confirming that the plan responds to a gap identified by DHMS and is resonating with the market.

The Scheme's digital tools also provide support for both members and their treating service providers. These tools assist doctors and clinicians in managing member healthcare journeys and improving clinical outcomes. Through the Discovery Health App, members can access a doctor immediately, from wherever they are, for non-emergency but urgent care needs. To date, 6,500 consultations have occurred through this channel. The top five conditions treated via this platform include:

- Acute upper respiratory infections
- Gastroenteritis
- Acute lower respiratory infections
- Urinary tract infections
- Headaches

She added that DHMS had previously launched Internet-Based Cognitive Behavioural Therapy (ICBT), specifically targeting depression. Feedback from members who used the programme has been overwhelmingly positive, with 95% of surveyed participants expressing satisfaction with the ICBT tool.

Furthermore, DHMS launched a female health hub, designed to serve as a one-stop platform for female members. The hub supports various healthcare needs, from maternity, family planning, and menopause, to broader women's health matters. In this regard, DHMS has partnered with Parent Sense and Stella to deliver relevant digital tools and care options.

Regarding Personal Health Pathways, since its launch, 209,000 eligible beneficiaries over the age of 18 have activated the programme—representing at least 13% of the Scheme's eligible population. So far:

- **270,000 health actions** have been completed
- **1.1 million exercise actions** have been recorded

The top five NBAs completed include:

1. Getting a flu vaccine
2. Going for a dental check-up
3. Selecting a primary GP
4. Getting a pap smear
5. Going for a health check

DHMS aims to ensure integration between PHP and other tools available to members, service providers, and the advisor community. This integrated approach allows members to independently engage with PHP, while also enabling healthcare providers to support and guide members in executing NBAs. Providers can monitor whether their patients are participating meaningfully in the programme. The PHP also links to the Personal Health Fund, which unlocks day-to-day benefits as members complete their recommended actions.

Ms Mbewu highlighted that members have accumulated R137 million in PHF benefits by completing NBAs. These benefits are in addition to members' medical savings and are funded from the Scheme's risk pool for use toward day-to-day healthcare needs. Members primarily use their PHF benefits in the areas of pharmacy, general practitioner visits, pathology, dentistry, and optometry. This structure enables members to meet their healthcare needs more effectively.

To illustrate the practical benefits of PHP, Ms Mbewu shared the testimony of a mother and daughter duo, whose experience highlighted how PHP and the PHF have empowered them. Their story demonstrates how user-friendly the digital tools are, and how these platforms can unlock real healthcare benefits and encourage meaningful member engagement.

In conclusion, Ms Mbewu emphasised three key points from her presentation:

1. **Safeguarding the Scheme's ability to pay member claims**: Ensuring financial stability remains a core focus of DHMS to guarantee claims are met as they arise.

2. **Delivering high-quality care**: DHMS continues to invest in care programmes supported by data analytics and digital platforms. These tools are designed to place both the member and the provider at the centre of care delivery, ensuring empowerment of all parties involved.

3. **Shaping the future of healthcare through personalisation and precision**: These themes will remain central to DHMS's strategic direction. DHMS aims to keep benefit designs innovative and relevant, unlocking long-term value for members and supporting their health outcomes. This includes the ongoing effort to attract younger lives into the Scheme, facilitating cross-subsidisation between younger and older (or more medically vulnerable) members. DHMS remains aware that care needs tend to increase with age, and it continues to plan accordingly.

3.2 Presentation by the CEO of Discovery Health (Pty) Limited, the Administrator and Managed Care Organisation of the Scheme, Dr Ronald Whelan

Dr Whelan commenced his presentation by providing an overview of the topics he would be covering. The presentation focused on three main aspects: firstly, a managed care and administration overview; secondly, a forward-looking strategy; and thirdly, an overview of the health system and the NHI.

1. Managed care and administration overview

Dr Whelan commenced his presentation by emphasizing the unprecedented scale and complexity of DHMS. With 2.7 million members, DHMS is nearly four times larger than its closest competitor and about nine times larger than the average open medical scheme in the South African market. The KeyCare Plan alone comprises more members than the average open medical scheme, making DHMS a significantly complex scheme to manage, particularly in terms of operational volume.

Annually, the Scheme processes 714,000 hospital admissions, equating to 60,000 per month or roughly 2,000 per day. Furthermore, 29,700 babies are born into the Scheme each year. DHMS collects R89 billion in contributions annually, a substantial fiduciary responsibility that is met with meticulous financial governance.

Operational Structure and Resource Investment

To support this scale, DH has heavily invested in its operating model. This includes:

- 153 actuarial and data science professionals
- 293 managed care and disease management staff
- 3,568 service and operations employees
- 650 digital and systems employees
- 10 policy and regulation professionals
- 31 research and development staff

In total, there are 6,100 DH employees. Additionally, DH collaborates with 1,559 Vitality colleagues and 594 staff in marketing and distribution, excluding the 6,000 brokers and advisers affiliated with DHMS. The investment in marketing and distribution alone stands at R2.1 billion annually. In total, more than 13,000 individuals directly or indirectly support DHMS, reflecting DH's commitment to the Scheme's sustainability.

Operating Environment and Technological Infrastructure

Dr Whelan expanded on DH's integrated system, which connects 2.7 million members, 51,000 healthcare professionals, 7,200 employer groups, and 6,500 financial advisers. DH maintains offices across four provinces: Gauteng, Western Cape, KwaZulu-Natal, and Eastern Cape. On a daily basis, DH manages over 153,309 member interactions and receives 29,675 calls, underscoring its extensive service infrastructure.

Please stop taking things out. All I want you to do is pay attention to sentence construction, ensure that it is professionally written and makes sense. STOP LEAVING THINGS OUT AND ADD EVERYTHING ENSURING ADHERENCE TO PROPER SYNTAX AND SENTENCE CONSTRUCTION!

DH has developed over 40 data science and Artificial Intelligence ("AI") models that optimize member service, including affinity and topic matching tools that align members with the most appropriate service agents. These advancements form part of the "Discover IT" programme, enhancing service efficiency and delivery.

A dedicated Customer Experience Officer leads DH's focus on customer satisfaction, drawing on global best practices, including collaboration with Disney and major retailers. DH has employed over 650 IT professionals and invested R1.4 billion in systems and infrastructure, including R300 million in new claims management systems. Approximately 81 million claims are processed annually, with 95.5% submitted digitally and 99.9%

auto-adjudicated. Claims are generally settled within 7–10 days. DH is investing on a big data platform with over 30 tb and this is the platform that powers PHP and is working with some of the leading providers globally around the data platform.

Digital Ecosystem and Member Experience

DH's digital platforms enable world-class member experiences. The Discovery Health app allows members to manage benefits, track and submit claims, and access services such as virtual doctor consultations and e-scripting. HealthID, present on over 6,000 doctors' desks, provides consent-based access to member medical records, facilitating coordinated care. The integration of PHP, virtual consults, and HealthID enhances service delivery.

Innovation and Research

From 2017 to 2025, DH has made consistent investments in innovation, dedicating over 160,000 hours annually to research and development. These efforts ensure that DHMS remains globally competitive and continues delivering high-quality care.

Managed Care Strategy

Managed care at DH focuses on both efficiency and quality. R9.8 billion in annual managed care savings has been achieved through forensics, billing recoveries, population health management, and policy enhancements. These savings translate to 12.7% lower contributions for DHMS members compared to the next seven open schemes.

DH maintains close partnerships with providers to ensure members experience full-cover healthcare journeys. Coverage statistics include:

- 97.7% of hospital admissions
- 91.8% of specialist treatments
- 99.2% of pathology
- 88.7% of anaesthetics
- 90.6% of dental services
- 99.2% of allied healthcare
- 99.2% of radiology
- 93.5% of GP services

Overall, 96.1% of member hospital costs are covered in full, compared to the industry average of 90.6%. The average hospital admission cost is R70,000.

Provider Networks and Cost Management

DH has developed three primary hospital networks—Smart, Delta, and KeyCare—covering 241 hospitals. These agreements deliver up to 50% tariff discounts. Currently, 1.1 million members (40% of DHMS's base) are on network plans. Additional networks include:

- 6,724 specialist providers
- 145-day surgery centres
- 2,900 pharmacy partners
- 190 oncologists with 52 radiation units and 120 chemotherapy centres

Quality Assurance and Member Feedback

Dr Whelan emphasized quality initiatives, including:

1. **Hospital Care Rating System** – Developed in partnership with international institutions, measuring cost efficiency, patient experience, and clinical outcomes.
2. **Experience Surveys** – Across GPs, pharmacies, hospitals, and renal dialysis centres.
3. **Patient-Reported Outcomes** – Especially for joint replacement surgeries.

Chronic Disease Management and Oncology

Over 1.1 million members are diagnosed with chronic conditions. Using advanced detection models, DH identifies at-risk members and enrolls them in tailored chronic disease management programmes—currently supporting over 323,000 members.

Oncology is another priority, with over 100,000 members registered and 25,000 receiving active treatment. High-cost treatments such as biologicals and immunologicals are assessed for cost-effectiveness. DHMS has paid over R827 million towards the Oncology Innovation Benefit over six years, supporting members with treatments like Darzalex, Keytruda, Tagrisso, Lynparza, and Venclexta.

Fraud, Waste, and Abuse Prevention

DH has implemented a comprehensive fraud, waste, abuse, and errors ("FWAE") management platform. Savings from this programme total R0.6 billion in 2024, rising from R 0.4 billion in 2022 and R0.5 billion in 2023. The halo effect of recoveries is estimated to be eight times the direct savings.

Vitality and Member Demographics

Vitality, DH's behavioural change programme, significantly improves member health outcomes and retention:

- 22% lower admission rates (Diamond vs Blue status)
- 28% shorter hospital stays
- 16% lower healthcare costs
- 63% reduced mortality
- 38% lower withdrawal rates for members with Vitality

Vitality also improves the demographic risk profile, with younger members joining via the programme.

Marketing and Distribution Investment

Discovery invests approximately R700 million annually in marketing and R1.4 billion in advisor-led distribution and training. This supports the acquisition of 290,000 new members per year—more than the total size of some open medical schemes.

Dr Whelan concluded by reaffirming DHMS's leading position in the market and Discovery's ongoing commitment to investing in world-class services, products, and healthcare delivery for DHMS members.

2. The Forward-looking strategy

Dr Whelan began this chapter with the following quote “The patient need for precision and personalisation has finally converged with the data and technology required to achieve it.”

Addressing the Need for Precision and Personalisation in Healthcare

DH is actively addressing the need for healthcare that is both precise and personalised, while acknowledging the inherent complexities of such a transformation. The healthcare sector has always produced substantial amounts of data—according to a statistic from Google, 30% of the world's data originates from healthcare. This staggering figure highlights the complexity of healthcare systems and the challenges of analysing such extensive data sets.

Until just two to three years ago, DH lacked the technological capacity to effectively analyse these vast data sets. However, DH now has both the data and the technology to enable more personalised and precise healthcare. This marks an exciting and transformative moment in the industry.

Global and Local Leadership in Transformative Healthcare

DH is at the forefront of what is globally recognised as transformative in healthcare. The organisation is leveraging big data through machine learning and artificial intelligence (AI) to identify key patterns. These efforts are geared toward achieving more personalised healthcare delivery and improving the overall service experience. The goal is to enhance health outcomes while also improving member services across DH's entire ecosystem.

Dual Platform Empowerment

DH's model is structured to empower both the operating platform and the healthcare delivery platform. During the presentation, Dr Whelan referenced data sets across the Discovery Health ecosystem comprising over 60 million life years. These include a constellation of clinical, behavioural, demographic, and financial data, all anonymised and securely protected. DH has committed to never using this data for any ulterior motives. However, this data holds tremendous potential to support members in living longer and healthier lives. Globally, it stands as one of the most comprehensive healthcare data sets.

The Vitality AI Stack

DH has built an artificial intelligence engine, known as Vitality AI, which ingests this data set with a singular mission: to improve healthcare outcomes and enhance service delivery to DHMS members. This AI-driven engine is a core component of DH's strategy and remains fully focused on these two intertwined objectives.

Enabling Assets Driving Transformation

Key Enabling Components

DH deploys its AI stack alongside its integrated digital health ecosystem, which, together with the unique healthcare data set, serves as a powerful enabling asset. These key enablers are:

1. The healthcare data set
2. Vitality AI
3. The integrated digital ecosystem

These components enable front-end delivery tools for DHMS members, including:

- Personalised products
- Precision marketing and distribution
- Personal health pathways
- Predictive health and claims risk management
- Precise and personalised service and operations

Strategy in Action: PHP

This strategy is already materialising through a range of products and services. One of the core features is the PHP, which provides each DHMS member with a unique health journey based on their clinical data. These pathways are generated using sophisticated AI and machine learning models aimed at improving long-term healthcare outcomes.

There are over seven million potential health pathways per member, which underscores the complexity DH manages on the back end. Yet, for members, this manifests as a simple, user-friendly platform on the front end.

Member Experience and Impact

PHP Integration on Discovery Platforms

Dr Whelan demonstrated how PHP is presented within the Discovery Health App and the Discovery Corporate App. These platforms offer three "next best actions" for members—covering both lifestyle and clinical behaviours. Completing these actions drives behaviour change and rewards members, with the results channelled into the Personal Health Fund (PHF), as referenced earlier by Ms Mbewu.

PHP Usage and Outcomes

- **290,000** members have activated PHP.
- **270,000** have completed health actions.
- **1.1 million** exercise actions have been completed.
- **40,000** members have completed their first lifestyle action.

These figures demonstrate PHP's powerful member impact. Several members have written in to share their experiences with early detection of breast cancer, highlighting the platform's role in improving health outcomes. For instance, Dr Jane Semugga recommended a pap smear via the "next best action" feature, which led to the early-stage detection of cervical cancer.

Conclusion: Transforming Healthcare Through Precision

PHP clearly reflects the delivery of precise and personalised health recommendations, tailored to the unique needs of each individual. This innovation is not only enhancing health outcomes but also reshaping the member experience in a meaningful and impactful way.

3. Health system and NHI overview

Dr Whelan provided members with a comprehensive update on the NHI and the South African health system. He began by reflecting on research conducted by Genesis Analytics in support of the HFA, a coalition comprising more than 20 medical schemes and medical scheme administrators, including DH and DHMS. Genesis Analytics is an independent economic consultancy based in South Africa.

Medical Scheme Membership Demographics in South Africa

Dr Whelan noted that medical scheme membership in South Africa is significantly diverse. Key statistics from the analysis included:

- There are 9.1 million beneficiaries in medical schemes in South Africa, which translates to 6.8% of the population.

- Of these, 6.1 million beneficiaries are Black (including African, Indian, or Coloured).
    - **51% (4.6 million)** are African.
    - **32% (3 million)** are White.

Employment and Union Affiliation

Regarding employment, Dr Whelan explained:

- 67% (2.7 million) of medical scheme members are part of a union.
- 33% (1.04 million) are not unionised.

Income Profile of Members

Dr Whelan reported the following income-related figures:

- 83% of members earn less than R37,500 per month.
- 39% earn between R16,000 and R37,500 per month.

These figures demonstrate that medical scheme members in South Africa are not only racially diverse, but also income-diverse and spread across various employment sectors, providing critical access to care for a broad cross-section of the population.

Tax Contribution and Value of Private Healthcare

Dr Whelan highlighted that:

- Medical schemes contribute approximately R599 billion in personal income tax annually.
- 74% of all personal income tax collected in South Africa is contributed by medical scheme members, who pay for medical scheme benefits using after-tax income.

South Africa's private healthcare system is world-class, offering internationally accredited facilities and highly skilled professionals. Dr Whelan referenced data from the International Federation for Health Plans showing that, on a purchasing power parity (PPP) basis:

- The average healthcare cost per capita in high-income countries is $6,500.
- In South Africa's private sector, it is $4,100, which is 37% lower.

This supports the conclusion that South Africa's private healthcare system delivers exceptional value and quality compared to international benchmarks.

DH's Position on the NHI

Dr Whelan stated that DH's position on the NHI has been clear and consistent:

DH is not opposed to universal healthcare but is calling for amendments to the NHI Act to make it workable and to enable private sector collaboration.

Current Legislative and Litigation Landscape

There are two key avenues being pursued:

1. Engagement, led by Business Unity South Africa (BUSA), with the Presidency regarding the NHI Act.
2. Litigation, led by the HFA and other organisations, against the current version of the Act.

The general sentiment among stakeholders is to reach a workable and amicable solution.

No Immediate Impact on Medical Schemes

Dr Whelan reassured members that, according to the Minister of Health, full implementation of the NHI is expected in 10–15 years, making it a long-term project. As such, there are no foreseeable changes to medical schemes in the near future.

DH will continue to constructively engage with the Presidency, the Minister of Health, and National Treasury to contribute towards finding solutions for universal health coverage in South Africa.

HFA Litigation and Financial Modelling

Genesis Analytics Model

Dr Whelan described the financial and economic model developed by Genesis Analytics to assess various NHI-related scenarios. The model allows stakeholders to simulate outcomes under a variety of assumptions. Key scenarios modelled include:

- Comprehensive Care Model: Everyone in South Africa receives the same level of care currently enjoyed by medical scheme members.
- Shared Resource Model: All healthcare resources (~R532 billion) are pooled and distributed evenly across the population.
- High Efficiency Scenario: Assumes 45% efficiency savings in the private sector—considered an ambitious stretch.
- Low Efficiency Scenario: Assumes only 13% efficiency savings.

Summary of Modelled Scenarios

Dr Whelan presented a 2x2 matrix of scenarios combining the care models (comprehensive vs shared) with efficiency levels (high vs low).

Most Optimistic Scenario: High Efficiency + Shared Resources

- Would require a 47% increase in personal income tax (1.5x current rates).
- Members would receive 43% less healthcare than they currently do through medical schemes.
- From a national budget perspective, 22% of total government expenditure would need to be allocated to healthcare, significantly exceeding global averages.

Comprehensive Care Scenario (High Efficiency)

- Would require a 115% increase in personal income tax.
- The top tax bracket would increase from 45% to 66%.
- This would place pressure on South Africa's narrow tax base, potentially endangering both the economy and public finances.

Low Efficiency Scenario

- Would further exacerbate the above tax burdens, rendering the NHI even less financially feasible.

Dr Whelan emphasised that the modelling highlights the complexity of the challenge. DH remains committed to a strategy-driven and data-informed approach, and the Genesis Analytics model provides a useful tool for engaging with government in identifying viable solutions toward achieving universal health coverage.

The HFA Alternative Model: "NHI and Medical Schemes, Not Or"

Dr Whelan noted that the HFA's alternative model proposes a parallel system where NHI and medical schemes coexist—as opposed to replacing one with the other. This model has precedent in other countries and could deliver wider access and more sustainable outcomes for South Africa.

Summary

1. **Managed Care and Administration**
- DHMS operates at unprecedented scale and complexity.
- Ongoing, significant investment by DH supports DHMS's capabilities.
- DHMS continues to deliver a market-leading member experience and value.
2. **Forward-Looking Strategy**
- DH is leveraging data and technology to drive precision and personalisation in healthcare delivery and service.
3. **Health System and NHI**
- No changes to medical schemes are expected in the foreseeable future.
- The current NHI proposal is fiscally unviable and unworkable without private sector collaboration.
- The preferred approach is "NHI and Medical Schemes, not or".

The Chairperson proceeded to open the floor for questions on the 2024 financial statements and the presentations provided.

1. Question from Eleanor Baker: Increase in Mental Health Conditions

Question:
Has DHMS noticed an increase in mental health conditions and, if so, over what period and why?

Response (Ms Mbewu):
Ms Mbewu confirmed that DHMS has certainly seen an increase in mental illness conditions. Interestingly, as illustrated in the slides presented earlier, the rise in mental illness spans across all age groups — it is not unique to a specific demographic but begins from younger lives.

Additionally, DH is witnessing a high incidence of comorbidities, where members are diagnosed with both a mental health condition and another illness, such as diabetes or other cardiometabolic conditions. If left untreated or unmonitored, these comorbidities result in complications that often require hospitalisation. These hospital admissions are complex and typically lead to increased lengths of stay.

2. Question from Sindiswa Bokhu: Support for Members with Mental Health Conditions

Question:
What is DH doing to assist members with mental health conditions? While additional benefits have been added, the increased administrative burden on members creates anxiety. How is DH engaging with providers to preserve the member experience?

Response (Ms Mbewu):
Ms Mbewu explained that international best practices, and DH's own experience, highlight the benefits of

partnering with coaching programmes. These coaches help members navigate challenges and provide guidance on specific circumstances unique to those diagnosed with mental health conditions.

DH has also partnered with SilverCloud for ICBT (Internet-based Cognitive Behavioural Therapy). These care programmes undergo ongoing refinement — at least annually — informed by data analytics, insights from international service provider engagements (including psychiatrists and psychologists), and clinical best practices. The approach combines data-informed decisions with clinical inputs to offer collaborative, member-focused care.

Dr Whelan emphasised that mental health is a critical focus. He acknowledged that the increase in reported cases may also stem from improved screening efforts. DH is investing significantly in screening and mental health support. Cognitive behavioural therapy, proven internationally for conditions like depression and anxiety, has become central to DH's mental health offering.

3. Question from Nicole May Stevens: Co-Payment for PMB Rheumatoid Arthritis Medication

Question:
Why do I still pay a co-payment for my PMB rheumatoid arthritis medication?

Response (Ms Mbewu):
Ms Mbewu stated that it would be beneficial to engage directly with Ms Stevens to understand her specific treatment plan and medication. Some prescribed drugs, while helpful, may not meet the criteria for Prescribed Minimum Benefit (PMB) level of care. DH will initiate direct engagement to clarify this and offer appropriate guidance.

4. Question from Rick Rolland: PMB Conditions and Contribution Relief

Question:
Which conditions on the PMB list would provide the greatest relief to contribution pricing if removed, and how many members would be affected?

Response (Dr Whelan):
Dr Whelan indicated that a formal PMB review is underway in collaboration with the Council for Medical Schemes. While this process has been active for several years, there is no definitive conclusion yet on which specific conditions would impact contribution pricing the most.

DH is open to collaborating further by leveraging its data analytics and actuarial expertise to support the review process. A broader network of actuaries and data scientists is involved, but this remains a complex, ongoing area of work.

5. Question from Anthony Charles: Retaining Young Members Transitioning from Family Cover

Question:
Younger individuals often begin on family memberships. Later, they may either remain with the scheme or leave. How does DH secure retention of such members as new principal members?

Response (Ms Mbewu):
Ms Mbewu noted that DH has specific strategies to retain members who transition from dependants on a parent's plan to principal membership. DH identifies these members and proactively engages them to explore personalised retention options that encourage continued membership.

6. Question from Sizukile Mabisela: Cover for Dentistry and Optometry

Question:
Why doesn't Discovery cover dentistry and optometry outside of savings? Why not allocate limited funds annually for these services as part of the scheme's risk benefits?

Response (Ms Mbewu):
Ms Mbewu stated that while DHMS has explored the feasibility of offering dentistry and optometry within risk benefits, affordability remains a key barrier. However, certain benefit options do include basic dentistry and an annual eye test. These are intended to support primary care.

More comprehensive dental and optical coverage is limited due to competing financial priorities, including high-cost services such as oncology and mental health, which must also be sustainably funded.

7. Question from Alexander Perez: Special Benefit Package for Retirees

Question:
Given that older members require greater coverage but often move to more affordable plans due to reduced income, is there a possibility of offering a special benefit package for long-time members who are retired?

Response (Chairperson):
The Chairperson noted that, by law, medical schemes may not discriminate among members. This includes offering differentiated benefits based on age.

Ms Mbewu added that all benefit options must be universally available to all members. The only limitation permitted by regulation is within income-based plans such as KeyCare, which uses capitation arrangements.

8. Question from Ms Ngcobo: MSA Limitations and Waiting Periods

Question 1:
Why does DH allocate all funds into the Medical Savings Account (MSA), which is insufficient to cover optometry, two dental visits, a pap smear, and a mammogram — especially for high-risk members?

Question 2:
Why is there a waiting period when transitioning from another medical scheme without interruption?

Response to Question 1 (Ms Mbewu):
Ms Mbewu acknowledged that while optometry and dental benefits have already been discussed, DH does offer mammogram benefits covered from risk — provided services are rendered at agreed rates. Pap smears also have some risk funding. She offered to contact Ms Ngcobo directly to better understand her healthcare profile and support options confidentially.

Response to Question 2 (Dr Whelan):
Dr Whelan explained that medical schemes in South Africa operate under open enrolment with regulated underwriting. Waiting periods are shorter if transitioning directly from another scheme. The length of continuous cover with the previous scheme also influences the waiting period, in line with the principles of open enrolment and community rating under the Medical Schemes Act.

9. Question from Ellen Rebecca: Most Prevalent Mental Health Conditions and Affected Age Groups

Question:
What are the most common mental health conditions DH is seeing, and which age groups are most affected?

Response (Dr Whelan):
Dr Whelan confirmed that the most common mental health conditions are Generalised Anxiety Disorder and Depressive Disorders, including Major Depressive Disorder. These mood disorders dominate across all age groups. Notably, DH is seeing a growing prevalence among younger members. Psychotic disorders represent a much smaller proportion of cases.

10. Question from Tanya Grobelaar: Mammogram Coverage for Men

Question:
Are mammograms covered for men?

Response (Ms Mbewu):
Ms Mbewu responded that she was not certain and would follow up on the matter. However, based on current policy, she does not believe that mammograms are covered for males.

11. Question from Amanda Wild: Implementation of Value-Based Procurement

Question:
Will DHMS implement value-based procurement alongside its strategy for value-based care, and if so, how, and when?

Response (Ms Mbewu):
Ms Mbewu confirmed that DH has a strategy for value-based care and has already implemented it across several areas. Value-based care refers to a reimbursement model that compensates providers based on healthcare outcomes and appropriateness, rather than on a fee-for-service (FIFO) basis. This approach benefits both the scheme and its members as it incentivises improved patient outcomes.

Dr Whelan elaborated that value-based care is central to DH's ethos. It rewards providers who deliver better outcomes efficiently. Over 40% of DH's hospital-based contracts are value-based, using metrics like mortality rates, readmission rates, and hospital-acquired infections. DH also runs a value-based programme for hip and knee surgeries and a shared-value diabetes management programme.

12. Question from Michael Stow: Lack of Member Care During Hospitalisation

Question:
Where is Discovery's member care during hospitalisation? A member recently had a botched operation at a UCT hospital, and the DH PO refused to intervene despite existing relationships.

Response (Ms Mbewu):
Ms Mbewu apologised for the member's experience and expressed her intention to follow up to understand the situation fully. She clarified that DH, as a scheme, does not make clinical decisions. However, there are regulatory mechanisms such as the Health Professions Council of South Africa (HPCSA), and DH has a forensic unit to investigate fraud, waste, or abuse. She offered to engage with Mr Stow directly.

13. Question from Modika Masholane: Lipoma Classification

Question:
Why is a lipoma considered a cosmetic procedure and not covered?

Response (Dr Whelan):
Dr Whelan explained that lipomas are typically benign and often asymptomatic, though they can have

cosmetic implications. If complications arise, processes are in place to evaluate and potentially cover treatment. He offered to engage with the member directly.

14. Question from Michael Stow: Access to Medicine Names on Claims Statements

Question:
Why can't members see the names of their medicine on CTH and claims statements?

Response (Ms Mbewu):
Ms Mbewu stated that claim statements are usually sent to the principal member and may include treatments for dependants. Due to confidentiality, some medication names are withheld. However, members can request specific details for their own claims through formal channels.

15. Question from Diana Montshe: Post-Discharge Medication and Limited Day-to-Day Cover

Question:
Why doesn't the scheme continue covering medication prescribed upon hospital discharge, and why is day-to-day cover for services like optometry, dentistry, and physiotherapy so limited?

Response (Dr Whelan):
Dr Whelan clarified that hospital admissions are the most expensive healthcare costs (averaging R70,000) and are fully covered under risk. However, post-discharge medication is classified under day-to-day care and must be paid from the Medical Savings Account (MSA). Plan selection determines MSA levels, and members are advised to consult financial advisors.

16. Question from Lisa Ntsulumba: Rejected Claims and Claim Data

Question:
Does DH have a view of the population's rejected claims?

Response (Ms Mbewu):
Yes, DH monitors rejected claims by discipline and category. Many rejections occur when members go outside designated networks. DH encourages members to use contracted providers to avoid out-of-pocket expenses.

17. Question from Jainene Canterbury: Basket of Care for IBD and Autoimmune Programme

Question:
Who makes decisions on baskets of care for chronic conditions like IBD? Will DH introduce an autoimmune programme similar to the diabetes programme?

Response (Ms Mbewu):
Basket of care decisions are made in collaboration with expert societies and informed by global clinical research. While it is too early to confirm an autoimmune programme, DH is exploring possibilities through multidisciplinary engagement.

18. Question from Mrs Ngcobo: Points and Services from Public Clinics

Question:
How do points benefit me, and how can I submit services received from public clinics (e.g., flu vaccines, pap smears), especially when I have no remaining funds?

Response (Ms Mbewu):
Ms Mbewu indicated that DH has submission mechanisms for non-claimed services like vaccines and pap smears. She will investigate the specific case further and assist directly.

Additional Comment (Dr Whelan):
Provincial departments may submit claims directly, which may have already been processed in the background.

19. Question from Reshmee (KeyCare Plus Member): Limited Coverage and Maternity Benefits

Question:
What is the purpose of maternity benefits for pensioners on KeyCare Plus? Why are certain medications excluded, and why are procedures like shoulder replacements and root canals not covered?

Response (Ms Mbewu):
Maternity benefits are part of PMBs and must be available to all KeyCare members, regardless of age. Coverage differences across benefit options are due to pricing structures. Higher-tier plans offer more comprehensive benefits. Procedures and medications may not be included in lower cost plans due to affordability constraints.

20. Question from Bilal Sedat: GP Programme Changes and PMB Rejections

Question:
Why was the GP programme changed? Also, why was a physiotherapy session declined under PMB despite available sessions?

Response (Ms Mbewu):
DH welcomes the feedback and will explore ways to improve communication about GP access. Regarding the physiotherapy claim, treatment approval depends on whether it is linked to a qualifying PMB condition. She offered to follow up directly for clarity.

21. Question from Jainene Canterbury: Size of Discovery Clinical Team

Question:
How many employees are in the Discovery Health clinical team?

Response (Dr Whelan):
The strategic clinical team includes over 160 employees, with more than 200 in care services. Additionally, over 50 hospitals have benefit specialists supporting members. These teams are backed by data science and intelligence resources.

22. Question from Maurice Van der Merwe: Holistic and Non-Traditional Healthcare

Question:
What is DH's stance on non-traditional healthcare approaches?

Response (Ms Mbewu):
Ms Mbewu acknowledged the complexity of holistic medicine, noting a lack of clinical trials and evidence in many cases, making it difficult for DH to fund such treatments.

Additional Comment (Dr Whelan):
DH follows an evidence-based approach. Some services from registered homeopaths are covered under MSA, provided they are HPCSA-registered.

23. Question from Yazmeen Hussen: Medication via Virtual Consults

Question:
How is medication issued through virtual doctors or nurses?

Response (Dr Whelan):
Virtual doctors' issue electronic prescriptions that are legally compliant. These can be emailed to the member or directly to a chosen pharmacy.

24. Question from George Bogotso: Inclusion of Board Resolutions in AGM Pack

Question: May I request that you share all resolutions taken by the Board of Trustees year to date? May I also please request that, in future, the resolutions be included in the AGM pack for members' consideration?

Answer (Ms Mbewu): The reason the resolutions were not included in the AGM pack is due to the Board's fiduciary obligations, which include the responsibility to execute such duties independently. As a result, resolutions that relate to the ongoing management and governance of the Scheme fall within the purview of the Trustees and are not routinely shared in member communications. However, this request will be taken under consideration.

Answer (Chairperson): The Integrated Report contains or reflects all significant decisions taken by the Board of Trustees concerning members.

25. Question from Tebogo Malatji: Younger Representation on the Board

Question: For the growing share of younger members, especially those joining low-cost plans like Active Smart, what is the Board doing to ensure that younger voices are represented in strategic decision-making, given the current age and professional profile of Trustees?

Answer (Chairperson): This is not a matter that the Board of Trustees on its own is able to address. While some trustees are elected by members, others are appointed to provide certain skills and expertise not represented among the elected members. It is important for members to nominate and elect younger trustees. The Board is aware of the importance of diverse representation and will consider this in future appointments.

26. Question from Michael Stow: Use of Members' Personal Data

Question: How does the Principal Officer and Board of Trustees justify sharing members' personal data with Vitality and other Discovery commercial operations for data mining and product cross-selling without consent—especially considering the misleading nature of the "free" Vitality three-month promotion that leads to mass cancellations?

Answer (Chairperson): No members' personal data is shared without their explicit opt-in consent for participation in these programs.

Answer (Dr Whelan): Absolutely no data is shared across Discovery's platforms without express member permission. Discovery Health is meticulous in its data governance and applies rigorous protocols to protect personal, healthcare, and financial information in full compliance with relevant laws and regulations.

27. Question from Michael Stow: Conflict of Interest Among Trustees

Question: How many Trustees have connections to Discovery Health Medical Scheme (DHMS) management, Discovery Vitality, or supplier companies?

Answer (Chairperson): None. The Scheme enforces a rigorous conflict of interest policy that is managed throughout the year to ensure objectivity and independence.

28. Question from Michael Stow: Trustee Independence and Competency

Question: How independent are the Trustees, and do they possess the legal, actuarial, and fiduciary expertise to act autonomously without undue influence from Discovery Pty Ltd actuaries and executives?

Answer (Chairperson): The Board of Trustees is highly competent and independent. It comprises two actuaries, two legal professionals, three trustees with clinical backgrounds, and several others with investment and governance expertise. All Trustees are required by the Medical Schemes Act to exercise fiduciary responsibility independently. The Council for Medical Schemes actively monitors the independence of medical schemes' relationships with their administrators. The Principal Officer is appointed by the Board—not by Discovery Pty Ltd—and must be independent under the law.

29. Question from Tebogo Malatji: Governance Mechanisms to Safeguard Board Independence

Question: What governance mechanisms are in place to ensure that the Board maintains full independence of thought and decision-making, particularly when evaluating performance fees and managing potential conflicts of interest with Discovery Health?

Answer (Chairperson): As previously stated, DHMS maintains an arms-length relationship with Discovery Health. The Board of Trustees is supported by independent advisors and conducts annual value-based assessments to evaluate the return on investment from services provided by Discovery Health. These steps are critical in managing potential conflicts of interest.

30. Question from Nolo Khanyisa Machaya: Skills Audit and Governance Gaps

Question: Is there a skills audit in place to identify critical governance gaps on the Board to ensure that the Board composition evolves appropriately? How does the Board compensate for governance gaps, such as in finance oversight?

Answer (Chairperson): As previously mentioned, most Trustees are elected by members. However, should there be any identified skills gaps, the Board has the authority to appoint additional Trustees who possess the required expertise. This ensures a well-rounded and capable governance structure.

31. Question from Jennifer Struven: Position on Assisted Dying (Euthanasia)

Question: Is DHMS engaging in conversations with the government regarding assisted dying or euthanasia? I ask this because I have a rare and incurable disease and would like the option of assisted dying to be available.

Answer (Dr Whelan): DHMS must adhere to the Constitution of South Africa and all applicable regulations. While the global debate on assisted dying is evolving—particularly with recent developments in the UK—the Scheme cannot support or implement such a benefit unless there is a change in South African legislation. Any move in that direction would require legislative amendments and broad legal reform.

32. Question from Siviwe Mazwana: Scheme Investment Performance and Oversight

Question: The Scheme reported gross investment returns of 12.47% and 9.36% respectively over the past two years. While these returns contribute positively to DHMS's financial health, they appear lower than top-quartile returns from similar conservative investment strategies in South Africa.

What measures are in place to:

- Ensure optimal long-term risk-adjusted returns?
- Hold asset managers accountable for underperformance?
- Ensure competitiveness through multi-manager or best-in-class selection strategies?
- Review mandates and manager line-ups regularly?

Answer (Ms Mbewu):
In responding, Ms Mbewu outlined that the Medical Schemes Act mandates at least 20% of Scheme assets be held in qualifying domestic cash instruments, due to the short-term nature of liquidity requirements. DHMS places an additional buffer above this to manage market fluctuations.

Medical schemes are also restricted from investing in global equities and may only hold fixed-income instruments abroad, further limiting the investable universe. Therefore, by the time the investment strategy is formulated, several constraints are already in place due to regulatory limitations.

In developing the Scheme's investment strategy, solvency and the risk appetite of the Scheme are key considerations. The strategy is set in consultation with the Scheme's asset consultants, who provide expert guidance.

The Scheme does not operate a multi-manager or balanced fund strategy but uses a building-block approach. Performance oversight is conducted by the Investment Committee, which conducts regular due diligence on asset managers. Managers are benchmarked against market comparators, and discretionary mandates are structured to avoid direct stock selection by the Scheme.

Where underperformance is observed, managers are monitored closely and may be placed under review. The Scheme also assesses:

- Asset class allocations,
- Fee competitiveness,
- Manager appropriateness, and
- Strategic alignment with the investment policy.

33. Question from Reshmee (KeyCare Plus Member): KeyCare Benefits and Exclusions
Question:

- What is the purpose of the maternity benefit for pensioners over 60 on KeyCare Plus?

- Why are essential medications such as pain and anti-inflammatory medications excluded from the formulary?

- Why are procedures like shoulder replacements not covered?

- Why is the dentistry benefit so limited and excludes root canal treatments?

- Why are braces only covered once and never repeated?

Answer (Ms Mbewu):
The maternity benefit under the KeyCare Plus option is available to the entire KeyCare population and not only to pensioners. KeyCare covers members of varying ages, including those still of childbearing age who require access to maternity services. Furthermore, maternity care is classified as a Prescribed Minimum Benefit (PMB), which the Scheme is legally required to provide in accordance with the Medical Schemes Act.

Regarding the exclusions of certain medications and procedures, these are informed by the structure and price point of the respective benefit option. KeyCare, as a more affordable plan, has limitations aligned with its pricing and risk pool.

Procedures like shoulder replacements and treatments such as root canals may not be covered under KeyCare due to cost constraints but may be available on higher-tier options. The orthodontic benefit (e.g., braces) is designed as a once-off benefit and not a recurring entitlement.

Finance & Governance Questions

1. Board Resolutions Shared with Members

Question from George Bogotso: He requested that all resolutions taken by the Board of Trustees year to date be shared with members. He also asked that, in future, such resolutions be included in the AGM pack for members' consideration.

Answer from Ms Mbewu:

The reason the resolutions were not included in the AGM packs is that the Board has fiduciary obligations, which includes the decision to execute its fiduciary obligations. Ms Mbewu does not think, due to that, resolutions relating to the running of the business and affairs of the Scheme should be included, but it would be for consideration of the Trustees as those who have been entrusted with the running and oversight of the medical scheme.

The Chairperson added:
The Integrated Report will contain or reflect all the significant decisions that have been taken regarding members.

12. Youth Representation in Board Decision-Making

Question from Tebogo Malatji:
With the growing share of younger members, especially those joining low-cost plans like Active Smart, what is the Board doing to ensure that the younger voices are represented in strategic decision-making, given the current age and professional position of trustees?

Answer from the Chairperson:
That is something the Board of Trustees is able to address only when the Board appoints trustees to the

Board. The Board is made up of elected trustees and other trustees are appointed to address or provide certain skills and expertise that are not among the elected trustees. Members need to be nominating and electing younger trustees, and the Board of Trustees certainly will make some appointments to the Board. The Board is very aware of the point that Mr Malatji has raised.

13. Sharing of Personal Data with Discovery Entities

Question from Michael Stow:
How does the Principal Officer and Board of Trustees justify sharing members' personal data with Vitality and other DH commercial operations to mine the data and cross-sell products without consent? The free Vitality three months inevitably leads to mass cancellations when members discover it is not free.

Answer from the Chairperson:
No member's personal data will be shared without them opting in to one or the other of these programmes.

Dr Whelan adds:
There is absolutely no data shared across the environment without the explicit request or permission from members. DH is cautious and rigorous around all of the data management across the business. Healthcare data and financial data are incredibly sensitive data. All of the security controls and protocols are in place to ensure that all data management is strictly in compliance with regulations and laws.

14. Trustee Connections to Discovery Entities

Question from Mr Stow:
How many trustees have a connection to DHMS management, Discovery Vitality, or supplier companies?

Answer from the Chairperson:
The answer is none. DH has a rigorous conflict of interest policy, which is managed throughout the year.

15. Trustee Independence and Qualifications

Question from Mr Stow:
How independent are they and do they have the legal, actuarial, and fiduciary skills to act independently without being guided with rings through their noses pulled by Discovery (Pty) Ltd actuaries and executives?

Answer from the Chairperson:
DH's Board of Trustees comprises two actuaries, two legal professionals, three trustees with clinical backgrounds and several trustees with investment skills and expertise, and a broad range of governance experience. The Board is perfectly able—it has the necessary skills, qualifications, and ability to exercise its fiduciary duties in the best interest of the Scheme. It is required to do so by the Medical Schemes Act, and our regulator, the Council for Medical Schemes, monitors very clearly and carefully the independence of all medical schemes' relationships with their administrators. The Principal Officer is certainly not appointed by Discovery (Pty) Ltd. The Principal Officer is appointed by the Board of Trustees. Once again, the Medical Schemes Act governs the provision of this position and ensures that no person may be Principal Officer of a medical scheme if that person is in any way related to the administrator or any of their related companies.

16. Board Independence in Governance and Oversight

Question from Tebogo Malatji:
What governance mechanisms are in place to ensure that the Board maintains full independence of thought and decision-making, particularly when evaluating performance fees and potential conflicts of interest with Discovery Health?

Answer from the Chairperson:
Our administrator answered that already, by also referencing the steps that we take to ensure that there are no conflicts of interest from a trustee point of view. DHMS has an arm's length relationship with DH, and the relationship is managed carefully. The Scheme continually peer reviews through independent advisors much of what DH provides to the Board. In particular, DH does a value-based assessment every year to assess the value that the Scheme has or that the Scheme derives from the funds that it spends and pays to DH.

17. Skills Audit and Governance Gaps on the Board

Question by Nolo Khanyisa Machaya:
Regarding younger members in trustee roles, she also asks if there is a skills audit in place to identify critical governance gaps to ensure that Board composition evolves accordingly. How does the Board compensate for these gaps—like finance—at a Board oversight level?

Answer from the Chairperson:
The first question has previously been answered. The majority of the trustees at any given time are elected, and if the necessary skills are not found in the trustees who have been elected to the Board, the Board of Trustees is able to ensure that those skills are available to the Board by making its own appointments of trustees to the Board.

18. Euthanasia and Legal Framework

Question by Jennifer Struven:
She asks if DH is driving talks with government about youth euthanasia. She also indicates the reason is that she has a rare disease that is incurable and would like the option to be available.

Answer by Dr Whelan:
DH has to be guided by the South African Constitution and regulations around youth euthanasia. It is clearly an important debate unfolding globally with the recent developments in the UK around assisted dying. As an administrator or a Scheme, we cannot act outside the law. It would require legal changes within South Africa's legal environment for DH to contemplate any benefits and support.

19. Investment Strategy and Manager Accountability

Question from Siviwe Mazwana:
He posted questions regarding the Scheme's investment returns. In the past two years the Scheme reported gross investment returns of 12.47% and 9.36%, respectively. Whilst these returns contribute significantly to the Scheme's financial health and help reduce the burden on members, they appear to be lower than the top quartile returns achieved by similar conservative strategies in the South African asset management universe over the same period. What measures are in place to ensure that, over the long term, DHMS ensures the best possible risk-adjusted returns? What mechanisms are in place to ensure that partner managers are held accountable for underperformance? Does DHMS use multi-manager or best-in-class manager selection to diversify and enhance returns and how often are mandates and manager line-ups reviewed to ensure competitiveness?

Answer from Ms Mbewu:
In responding to the questions, she stated that in relation to the Scheme's investment strategy, it is important to first note that, as a consequence of the Medical Schemes Act—which also considers the short-term nature of liquidity requirements in the medical schemes environment—a medical scheme must have at least 20% of its investment portfolio within qualifying cash assets, which is domestic cash assets. To not

fall foul of the regulations, DHMS places a buffer so that if market movement affects the other investments or asset classes, it will not compromise DHMS's adherence to that 20% requirement.

The second context for the medical scheme environment is that from a global market perspective, medical schemes are restricted to investing in the global environment only to fixed income instruments, and even then, the universe is limited to those which are permissible by the regulator. She was giving context to the fact that, by the time an investment strategy is formulated, there are already certain aspects that cannot be considered within the context of the Scheme's investment strategy because they are simply not permitted in terms of the Medical Schemes Act. Then there are other aspects regarding concentration, which are a lot more stringent than what would be typically available in the retirement funding space.

In setting the Scheme's investment strategy, considerations include the financial performance of the Scheme. A key component is the solvency of the Scheme and what solvency the Scheme can actually put at risk without compromising the ability of the Scheme to meet its solvency requirements. The second aspect is the Scheme's actual risk appetite. Given all of this, that is how the investment strategy is formulated—in partnership with the Scheme's asset consultant giving guidance.

Where the Scheme uses building blocks of asset classes, the Scheme does not have a multi-manager or a balanced fund strategy. Rather, the Scheme has report-backs and due diligence that happen to the Investment Committee of the Board and also due diligences where the respective asset managers are also visited. The Scheme also makes use of benchmarks to assess the performance of various asset managers that have contracts with the Scheme, and such contracts are of a discretionary nature so that the Scheme is not making investment decisions as stock picks as part of the work that is done by asset managers.

Where there are concerns, those managers are also placed under monitoring for additional close and careful consideration. There are also ongoing assessments to see whether the asset manager is still appropriate for the Scheme, including looking at appropriate asset managers and also looking at the percentage of the investment portfolio that is invested within each asset class as a build-up to the Scheme's strategic allocation and investment strategy, also considering the fees that are being charged for a similar mandate with the rest of the market.

20. Administrative Costs

Question by: Cornelius Schutte
Mr Schutte noted that Discovery is ranked 5th lowest in administrative costs and queried whether, given the economies scale with 60% of the market, DHMS could be more cost-effective.

Response:
The Chairperson responded that if it were possible to reduce costs further, Discovery would certainly do so and emphasised that a great deal of attention is placed on cost-effectiveness.

Dr Whelan added that increasing levels of chronic disease affect service costs: over 30% of DHMS members are now diagnosed with a chronic disease, which increases the complexity and frequency of care (hospital admissions, medication, GP, and pharmacy visits). He also highlighted that the scheme's average age is now 38 years and rising, which increases service demands. Individuals with chronic conditions incur 2.6 times higher service loads compared to non-chronic members. Although administration fees are kept largely in line with inflation, this does not fully account for the increased healthcare burden.

21. Investment Returns and Contributions

Question by: Michael Stirr
Mr Stirr asked why DH is the only medical scheme that does not show investment returns when determining contribution increases. He asked how the assets are invested, the start and end value of the investment period, and the real returns for the past year.

Response:
Ms Mbewu noted that this information is provided to members in the Integrated Report. She specified that the investment strategy and asset class allocations are included (approximately on page 123 or Note 3 of the Financial Statements). Additionally, the front sections of the report contain details about the investment strategy and returns.

Regarding contribution setting, Ms Mbewu stated that investment returns are taken into account to some extent. However, only realised returns (such as dividends and interest) are banked. Unrealised market fluctuations are not counted until assets are sold.

22. Administration Fees

Question by: Samantha Bothoa
Ms Bothoa asked for the amount charged in administrative fees by DH per member.

Response:
The Chairperson referred members to the Integrated Report, confirming that the fee is R430.14 per member.

23. Value Calculation Transparency

Question by: Cornelius Schutte
Mr Schutte enquired whether the calculation of the R2.08 value derived for every R1 spent could be made more transparent.

Response:
The Chairperson indicated that the basis for the calculation is included in a footnote in the Integrated Report. If it is not sufficiently clear, the Scheme will consider making the information available.

24. Solvency Levels and Use of Surplus

Questions by: Tebogo Malaji and Cornelius Schutte
Both members questioned whether the Scheme is evaluating options to use surplus reserves to enhance benefits or subsidise contributions.

Response:
The Chairperson highlighted that managing reserves is critical to scheme sustainability. Schemes that overextend reserves can enter financial distress.

Ms Mbewu added that unlocking solvency levels must be done cautiously. Healthcare costs increase annually due to inflation and growing demand. Contribution increases must match this inflation to avoid underpricing.

She noted the use of once-off benefits during COVID (e.g., the Wealth Fund) and explained the PHF, a similar initiative for new members aimed at growing the Scheme. Contribution increases were also delayed during the pandemic to ease financial pressure.

Additional benefits pose a long-term cost and could deplete reserves unless offset by future contribution hikes, which the Scheme aims to avoid. The focus remains on maintaining a sustainable balance between contributions, claims, and potential surplus use.

25. Governance and Financial Questions

The Chairperson noted that questions related to governance and finance had largely been answered. Remaining questions will be responded to in writing. The moderator was asked to upload the remaining set of questions.

Additional Round of Questions

1. Fraud Prosecution

Question by: Anthony Henry Barkhuizen
Mr Barkhuizen asked how many healthcare providers were prosecuted for fraud in the past year.

Response:
The Chairperson confirmed that this question would be answered in writing. Dr Whelan added that a detailed record is maintained regarding investigations, outcomes, and recoveries.

2. NHI Positioning and Litigation

Question by: Elanor Becker
Ms Becker asked how the Scheme is positioning itself for NHI implementation and for an update on the HFA's legal challenge.

Response:
The Chairperson stated that six review applications have been filed and will proceed through the North Gauteng High Court. DHMS awaits the State's response.

Given the uncertainty surrounding the NHI Act's implementation, DHMS is closely monitoring developments to respond appropriately when clearer steps are outlined.

3. Stress Testing under NHI

Question by: Tebogo Malatji
Mr Malatji enquired about stress testing solvency and liquidity under NHI scenarios.

Response:
The Chairperson acknowledged the uncertain policy landscape. DHMS continues to monitor developments but noted that meaningful scenario planning is constrained by current uncertainty.

4. PHP Usage and Associated Fees

Question by: Michael Stow
Mr Stow asked what percentage of members are using the Personal Health Program (PHP) and what DHMS pays to Discovery Vitality (Pty) Ltd.

Response:
The Chairperson clarified that DHMS does not pay Discovery Vitality (Pty) Ltd. Instead, DHMS pays a fee per eligible member to Discovery Health (Pty) Ltd for access to the PHP App. The fee is revised annually based on uptake.

Ms Mbewu added that 12% of members have activated PHP since January. Dr Whelan noted that the program aims to improve long-term health outcomes, ultimately lowering healthcare costs and benefiting the sustainability of the Scheme.

5. Ethical Investments

Question by: Renah King
Ms King queried whether the Scheme uses ethical parameters for investing, particularly in light of global arms trades and ongoing conflicts.

Response:
Ms Mbewu confirmed that the Scheme applies ethical investment parameters, including those guided by ESG frameworks used by its asset managers. She clarified that the Scheme's equity holdings are largely within Southern Africa, and international investments do not include equities.

Conclusion

The Chairperson concluded the session by noting that all outstanding questions would be answered in writing after the AGM.

4 Governance

4.1 The Scheme's Trustee Remuneration Policy and approval of the 2025 Trustee Remuneration

The Chairperson introduced Mr Bongani Hlophe, the Chairperson of the Scheme's Remuneration Committee, and advised that Mr Hlophe would present the DHMS Trustee Remuneration and the approval of the 2025 Trustee Remuneration.

Context to the Above

The aim of the presentation was to:

- Give members critical insight that would enable eligible Scheme members to express their views on the DHMS Trustee Remuneration Policy, which was being put to the meeting for a vote by ballot in terms of the process that Mr Bhowani from Forvis Mazars had already outlined, and which is conducted in accordance with King IV.

- Present the 2025 Trustee Remuneration rate, which was put to the meeting for a majority vote via ballot, in line with the voting process as explained by Mr Bhowani. For 2025, the rate that required approval was a VAT-exclusive rate of R4 732.00. The presentation would provide context and further detail on how the rate actually functions.

Mr Hlophe commented that the structure of the presentation would cover the following:

1. Remuneration Governance Context
2. Trustee Remuneration Policy Framework
    - Remuneration Philosophy and Methodology
    - Proposed Remuneration

3. Proposed 2025 Remuneration

    - Chairperson of the Board of Trustees

- Trustees
- Chairpersons of Board Committees

Remuneration Governance Context

Mr Hlophe explained that remuneration — in this case, the Scheme's policy — is guided by the King IV Code Principles on fair, responsible, and transparent remuneration. It is compliant with the Medical Schemes Act requirements. The remuneration practices are aligned with Circular 41 of 2014 as issued by the CMS. Mr Hlophe further explained that the Board was responsible for the development and implementation of a remuneration policy applicable to Scheme employees, as well as Trustees and Board Committee Members. The Board had delegated the responsibility for oversight of implementation of the policy to the Remuneration Committee ("RemCo"). However, the Board retains final responsibility for both policy development and implementation.

RemCo comprises three Trustees, one of whom is the Chairperson of the Board, and two Independent Committee Members. RemCo is currently chaired by an Independent Committee Member, namely Mr Hlophe.

Adoption and Approval of Remuneration

Trustee remuneration is presented at this AGM for a majority vote by members, after the approval thereof by the Board of Trustees, based on the recommendation of RemCo.

Approval of Trustee Remuneration Policy

The Remuneration Policy applicable to Trustee and Board Committee Member remuneration for the current financial year is reviewed and recommended by RemCo to the Board for approval and is thereafter tabled at the AGM for a non-binding advisory vote by members.

Trustee Remuneration Transparency and Disclosure

Trustee remuneration is disclosed in the following submissions, documents, and meetings:

- At the AGM – the Remuneration Policy is presented to Scheme members for a non-binding advisory vote.
- At the AGM – the proposed remuneration rates are presented to Scheme members for a majority vote.
- To the CMS – the regulator of medical schemes.
- In the Integrated Report – as part of the Scheme's annual financial statements.

Remuneration Philosophy

The Scheme is complex and operates within an ever-evolving contextual landscape, which has impacted the broader industry. Given the stature, complexity, and size of the Scheme, its approach is to attract and retain high-calibre individuals with exceptional skills in areas relevant to the Scheme's strategic context. The Scheme recognises the significant responsibilities and fiduciary risk borne by Trustees. It also acknowledges the substantive time commitment required of Trustees. The Scheme ensures that it maintains appropriate cost management in alignment with its non-profit status, while also promoting transparency and disclosure to members.

Remuneration Methodology

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

In 2014, the CMS published Circular 41, which provides guidelines on Trustee remuneration. DHMS's RemCo engaged PwC to assist in developing a new remuneration methodology and benchmark applicable to the Trustees. This benchmarking system has been approved by the CMS and has been in use since then. It is submitted annually to the CMS for ongoing approval.

Remuneration is calculated based on the following factors:

- Number of meetings planned per year
- Preparation time required for each meeting
- Duration of each meeting
- Estimated time required between meetings
- Number of actual meetings attended

These metrics are also reported in the annual reports, which detail how DHMS has paid its Trustees over time.

Trustee remuneration is based on an hourly rate, determined with reference to market-related professional fees, discounted by 30% to reflect the Scheme's non-profit status. This ensures fiscally responsible compensation while remaining competitive.

For 2025, the proposed hourly rate is R4 732.00 (excl. VAT). This is calculated as follows: R6 750.00 (market-related professional rate) less 30% = R4 732.00. This represents a 4.8% adjustment from the 2024 rate.

Total fees payable to Trustees and Board Committee Members comprise:

- 70% annual base fee
- 30% for meeting attendance
- Additional fees for unplanned meetings

For 2025, the policy has been reviewed by RemCo and remains unchanged. All fees are exclusive of VAT, and VAT-registered Trustees may claim VAT by invoicing the Scheme accordingly.

Market Benchmarking

One of the critical issues associated with the Scheme's remuneration infrastructure is the need for regular benchmarking. Mr Hlophe noted that the Scheme had undertaken a review of the remuneration policy and benchmarking process. Last year, the Scheme commissioned RemChannel to conduct a market benchmark of the Scheme's Trustee fees.

However, a key limitation was the scarcity of remuneration data in the medical schemes sector. As a result, the Scheme also benchmarked against the financial services and insurance sectors, and wherever available, used data from the medical services industry. The 2023 benchmark was considered the first iteration.

In 2024, RemChannel invited DHMS to participate in a sector-specific benchmarking exercise, which the Scheme accepted. This second iteration aims to ensure that the Scheme is compared with similar organisations. Once the benchmarking is complete, RemCo will engage with the results, make recommendations to the Board, and, if any changes are proposed, those will be presented to members at the AGM in an appropriate manner for approval.

Additional Considerations

Certain policy components are not strictly remunerative but do entail costs and compensatory elements. These include:

- Trustees are not remunerated for training. However, the Scheme covers training fees, travel, and accommodation costs for conferences.
- Trustees do not participate in or benefit from incentive programmes, nor do they receive consulting fees.
- Trustees are reimbursed for reasonable travel-related expenses upon approval.
- The Scheme provides professional indemnity cover for all Trustees, whether elected or appointed.

Proposed 2025 Trustee Remuneration – Chairperson of the Board of Trustees

The proposed Trustee remuneration for the Chairperson of the Board for 2025 is a total estimated fee of R1 059 968. The Chairperson is responsible for the efficient conduct of meetings, requiring approximately 20 hours of preparation time per meeting and 8 hours of attendance, totalling 28 hours per meeting.

With an average of 8 meetings per year, the annual time commitment amounts to 224 hours (28 x 8). At the proposed hourly rate of R4 732.00, this results in the estimated total fee. However, this amount is illustrative, as actual fees will depend on the number of meetings attended.

Proposed 2025 Trustee Remuneration – Trustees

The same methodology applies to Trustees, but with reduced preparation time. Each Trustee spends approximately 8 hours preparing for each meeting, and 8 hours attending, totaling 16 hours per meeting. For 8 meetings annually, this results in 128 hours.

Based on the proposed hourly rate of R4 732.00, the estimated total fee is R605 696. This is a projection; actual fees depend on the number of meetings attended.

Mr Hlophe referred members to the Scheme's annual report for actual payments made in the current financial year.

Proposed 2025 Trustee Remuneration – Chairpersons of Board Committees

The methodology remains consistent, with some variation in hours due to the functional nature of committee mandates. The preparation time for a Committee Chairperson is 11 hours, and meeting duration is 4.5 hours, totalling 15.5 hours per meeting.

With an average of 4 committee meetings per year, the total time commitment is 62 hours. At R4 732.00 per hour, the estimated total is R293 384. Again, actual remuneration is based on meetings attended.

Mr Hlophe reiterated that the annual report provides detailed disclosures on actual payments made.

Conclusion

Mr Hlophe moved that members approve the Trustee Remuneration rate for 2025 through the voting process, and that they express their views on the Remuneration Policy through the non-binding advisory vote on the ballot.

Mr Hlophe then handed the meeting back to the Chairperson, who assessed whether there were any questions from members regarding the presentation. There were no questions.

4.2 Appointment of Auditors

The Chairperson advised that the Audit Committee of the Board had assessed the suitability of Deloitte Touche Tohmatsu Limited ("Deloitte") for reappointment as the Scheme's auditors. Following careful consideration, the Audit Committee recommended the reappointment of Deloitte.

The Chairperson accordingly proposed that Deloitte be appointed as the auditors of the Scheme for the 2025 financial year. This proposal formed the basis of Resolution 3, with voting conducted via the polling function on the virtual meeting platform.

5 Motions

5.1. Feedback on 2024 AGM Motion

The Chairperson noted that, at the previous AGM, Members had voted in favour of the following motion:

> *"Trustees to conduct a review of KeyCare Plus plan benefits with particular focus on reinstating unlimited or increasing the number of casualty visits per year, allowing the selection of two primary care physicians, the administration involved in service providers and members, as well as the casualty visit fee available to members."*

Following a thorough review of the identified benefits and having considered the original rationale for the benefit changes, the Trustees concluded that the changes made to the KeyCare Plus benefits were both appropriate and effective. Specifically, the changes addressed the deteriorating losses on the KeyCare Plus plan while preserving members' access to care.

The Chairperson further noted that formal feedback was provided to the Member who raised the motion, and this feedback was also made available on the Scheme's website for access by all Members.

5.2. 2025 AGM Motions

The Chairperson advised that, in terms of Rules 25.1.6 and 25.1.7 of the Scheme Rules, the Principal Officer has received no valid motions for the 2025 AGM.

6 General

The Chairperson enquired whether any Members wished to raise additional matters under "General." The following points were noted:

1. Ethical Investment in Technology and Services

Raised by: Algonda Perez

Ms Perez enquired about the steps taken to ensure that DHMS invests in ethically sound technologies and services.

The Chairperson noted that a similar question had previously been asked by Renah King and addressed earlier in the meeting.

Ms Mbewu added that DHMS takes independent legal advice when the Board or its Committees need to make key decisions. These decisions undergo careful consideration, including ethical dimensions. Furthermore, DHMS benefits from the guidance of Independent Committee Members, who serve on sub-committees and assist in assessing the appropriateness of proposals—ethical considerations being a key part of that process.

2. Discovery's Participation in the Future of Health Summit

Raised by:

- Layla Cassim
- Aboobaker Amooji

Ms Cassim expressed disgust and disappointment at Discovery's hosting of a conference featuring Israeli speakers—the Future of Health Summit held in late 2024. She referenced the ongoing humanitarian crisis in Gaza and questioned how Discovery could associate with such an event. Ms Cassim stated that Discovery must be held accountable for its perceived complicity in what she described as genocide, and she strongly objected to her funds being used in this manner.

Mr Amooji posed a related question, querying why Discovery collaborates with the Zionist regime, which he believes is inflicting genocide on Palestinians. He questioned whether the Scheme is engaged in organ harvesting, given its associations with Israel.

Response by Dr Whelan:

Dr Whelan acknowledged that the situation in the Middle East is deeply unfortunate and painful to witness. He affirmed that DH and DHMS call for a peaceful resolution to the conflict as soon as possible.

Regarding the Future of Health Summit, Dr Whelan clarified:

- The Summit is a global forum comprising 35 leading international healthcare organisations, such as Stanford Medicine and Royal Melbourne Hospital.
- DH is one of many participating members.
- The Summit was hosted in Cape Town in November 2024, and over 80 international healthcare leaders attended, from countries including Switzerland, Canada, Australia, and Brazil, along with approximately 100 healthcare leaders from South Africa, including provider groups, pharmaceutical companies, and industry bodies.
- The purpose of the Summit was to discuss healthcare challenges and opportunities in South Africa and globally, and to share ideas for improving patient care.
- Among the 180 attendees, there were five delegates from the Sheba Medical Centre in Israel, a facility ranked by *Newsweek* among the top 10 medical centres globally.
- All attendees from Sheba Medical Centre were healthcare professionals and hospital administrators, attending in that capacity only.

Dr Whelan emphasized that DH issued an apology at the time for any unintended distress caused by the hosting of the Summit. DH acknowledges the sensitivity of the conflict and the concerns raised by members and apologises unreservedly for any distress caused.

He reiterated that Discovery, as a publicly listed commercial organisation operating across multiple countries, has no political or religious affiliations. DH remains guided by its core purpose: *to make people healthier and to enhance and protect their lives*. That principle underpins all of DH's decisions and actions.

Dr Whelan confirmed that DH had initiated a full ethics committee review, including external independent input, to ensure its participation in the Future of Health Summit aligned with its values and core purpose. DH will continue to review its future participation in such events based on these guiding principles.

3. Trustee Elections and Political Influence

Raised by: Mzwake Dlamini

Mr Dlamini referred to a News24 report alleging that religious groups were attempting to influence trustee elections and asked what the Board was doing to ensure that the Scheme remains apolitical.

Response by the Chairperson:

The Chairperson explained that all trustee nominees are subjected to the same independent and rigorous nomination and election process. These processes are entirely independent from the Scheme and the Board of Trustees. An independent electoral body and an independent nominations committee oversee these processes.

As the 2025 elections had not yet concluded, the Chairperson declined to comment further on the contestation of the elections but reassured Members that the long-standing, independent processes were fully adhered to again this year.

4. Ethical Framework for Future Engagement

Raised by: Omar Parak

Mr Parak enquired, in light of the public criticism and media coverage of the Future of Health Summit, what ethical framework DH would adopt to guide speaker selection and international collaborations going forward.

Response by the Chairperson:

The Chairperson responded that the Board had requested the Scheme Office, in conjunction with the Stakeholder Relations and Ethics Committee, to develop a framework of considerations to guide decision-making in such matters going forward.

5. Funding of Political Parties

Raised by: Zukiwe Mabusela

Ms Mabusela asked whether the Scheme funds any political parties in South Africa and, if so, which ones.

Response by the Chairperson:

The Chairperson confirmed that DHMS does not fund any political parties in South Africa.

6. Auditors of the Scheme

Raised by:

- Alec Davis
- Chrystal Arende

Mr Davis asked how long Deloitte had served as auditors of the Scheme, and Ms Arende enquired about the previous auditors.

Response by Ms Mbewu:
Ms Mbewu confirmed that 2025 is Deloitte's first year as the appointed auditors of the Scheme. For transparency, she noted that the auditors' opinion, as contained in the Integrated Report, includes a statement of the length of their tenure. The previous auditors of the Scheme were PricewaterhouseCoopers (PwC).

Closure of General Matters
The Chairperson noted that no further questions had been raised and proposed that the meeting proceed to the voting phase.

7 Voting and closure of the AGM

The Chairperson reminded Members that voting on all resolutions would remain open until 19:00 on 26 June 2025, after which voting would close and no further votes would be accepted.

The resolutions presented were as follows:

- **Resolution 1:** Approval of 2025 Trustee Remuneration
- **Resolution 2:** Non-binding advisory vote on the Trustee Remuneration Policy
- **Resolution 3:** Appointment of Auditors for 2025
- **Resolution 4:** Motions *(no valid motions were received)*
- **Resolution 5:** Election of three candidates to serve as Trustees of the Scheme

There being no further business, the Chairperson thanked all Members for their attendance and engagement with the Scheme, and declared the AGM closed.

[Note: The use of sign language interpreters was used throughout the proceedings of the AGM]