
Discovery
Health Medical Scheme
FOR OUR
MEMBERS
INTEGRATED
REPORT 2017

OUR VALUES guide our behaviours and interactions with all our stakeholders:

INTEGRITY: If we act with integrity we will be doing the right thing. We will take personal accountability for our actions and, in our actions and decisions, hold true to our promise that we care.

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

ADAPTABILITY AND AGILITY: We will be sensitive to the external environment and to the needs of others in the team, while remaining responsive to changing needs and adapting to the pace of change, particularly with regard to uncertain health policy and markets.

TEAM WORK, SUPPORT AND CARE: We will support and care for each other, sharing the load and working interdependently.

PURSUIT OF EXCELLENCE: We will focus on continuous improvement, development and quality with learning as our core way of working.

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

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

Why do we exist?

OUR PURPOSE is to care for our members' health and wellness by engaging the brightest minds and innovative solutions to provide access to affordable, equitable and quality, value-based healthcare that meets their needs now and sustainably into the future.

OUR VISION is to be the best medical Scheme in the country.

In the interests of our members we will always pursue excellence, leveraging the Vested® outsourcing model to lead healthcare innovation and create value.

We will work closely with our regulator, our Administrator and Managed Care Provider, and the industry to shape an inclusive and complete healthcare system in South Africa.

PAGE REFERENCE

During 2017, the Scheme placed higher emphasis on good corporate citizenship and ethics. Read more about what we are doing on **pages 30 – 31**.

PAGE REFERENCE

Our relationships with our stakeholders are essential to our ability to create value. Read more about how we engage with them on **pages 33 – 43**.

01 ABOUT OUR REPORT

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

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

BOARD OF TRUSTEES RESPONSIBILITIES AND APPROVAL

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

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

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

Signed on behalf of the Trustees

Neil Morrison
Chairperson

Daisy Naidoo
Trustee

Dr Nozipho Sangweni
Principal Officer

PAGE REFERENCE

The resources on **pages 170 – 175** of this Report directs stakeholders to more information on DHMS, important contact details, and how to submit a complaint or compliment, or report fraud or unethical behaviour. It also provides details that stakeholders can use to give feedback on this Report.

The glossary of terms is provided on **pages 173 – 175**.

SCOPE AND BOUNDARY

This Report covers the benefit year from 1 January 2017 to 31 December 2017, also referred to as the 2017 financial year (the year). In addition, this Report touches on some events in early 2018 that occurred prior to the date of approval of this Report by the Trustees, and contains some forward-looking information.

This Report takes guidance from the King IV Report on Corporate Governance for South Africa 2016 (King IV) and, where not superseded by King IV, the King Code of Governance Principles 2009 (King III). The Scheme uses the International Integrated Reporting Framework as the basis for preparing and improving its reporting, and applies it insofar as it is relevant and applicable to medical schemes in South Africa.

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

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

PAGE REFERENCE

Read more about how we operate on **pages 18 – 19**, and more about Discovery Health's initiatives for the Scheme on **pages 86 – 93**.

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

MATERIALITY DETERMINATION

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

The Trustees scan the environment and consider Board and Scheme Office reports, the Scheme's risk register, and product and benefit enhancement opportunities to determine material matters. Stakeholder feedback is also considered, both formal (stakeholder activities and feedback sessions) and informal (emails and calls to the Scheme). The Trustees ensure that the Scheme's strategic priorities are adapted, where appropriate, to ensure that all material matters are considered in implementing the Scheme's strategic objectives.

PAGE REFERENCE

The material matters relevant to the benefit year are set out on **page 11**.

PAGE REFERENCE

Read more about our interaction with our various stakeholders on **pages 33 – 43**.

COMBINED ASSURANCE

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

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

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

AUDITOR INDEPENDENCE

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

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

INTEGRATED REPORT 2017

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

OUR STAKEHOLDERS AND GOOD CORPORATE CITIZENSHIP

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This section discusses the Scheme's approach to responsible corporate citizenship and its ethics and values. It also discusses how each of the Scheme's key stakeholders obtain value from the Scheme, within the context of the Scheme's primary responsibility to create value for its members, who are its primary stakeholders.

GOVERNANCE

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For readers who are interested in the details of the Scheme's governance, this chapter provides an overview from the Chairperson and a description of the legislation governing the Scheme and its governance structures and framework, including the Board of Trustees and Board Committees. It also reviews notable regulatory and industry matters dealt with during 2017.

PERFORMANCE

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For readers who are interested in more about the performance of the Scheme during 2017, this chapter provides management commentary on the Scheme's strategic, operating and financial performance during 2017. It also includes a review of initiatives undertaken by Discovery Health on behalf of the Scheme and its members.

ABOUT OUR REPORT

inside flap

Sets out the assurances provided for this Report and its purpose, scope and boundary, and the Board's statement of responsibilities.

FINANCIALS

94

Full Annual Financial Statements and notes to the Financial Statements.

ABOUT DHMS

02

For current and potential members, this chapter provides an overview of the Scheme and its material matters, key risks and objectives.

It also indicates who leads and governs the Scheme, and provides a snapshot of key performance information.

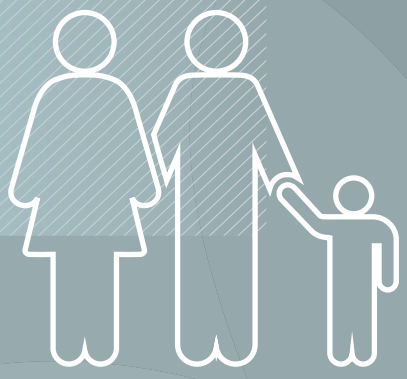
RESOURCES AND GLOSSARY

170

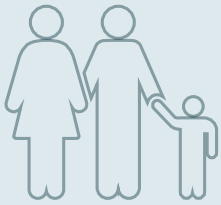
A quick reference guide for contact information, feedback, compliments and complaints processes, and guidance on where to find additional information.

Unfamiliar terms in the Report? Find definitions in our Glossary.

02 ABOUT DHMS



WHO WE ARE



Discovery Health Medical Scheme (DHMS or the Scheme) is a registered open medical scheme which any member of the public can join, subject to its Rules[1].

The Scheme exists to **care for our members' health and wellness** by **engaging the brightest minds and innovative solutions** to provide access to **affordable, equitable and quality, value-based healthcare** that meets their needs now and sustainably into the future.

Covering
2 777 946
BENEFICIARIES
at 31 December 2017

DHMS is the
LARGEST OPEN MEDICAL SCHEME
in South Africa

with an open medical scheme
MARKET SHARE OF 56%[2]

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

The Scheme outsources its administration and managed care functions through a formal contractual arrangement with Discovery Health (Pty) Ltd, with its business model based on Vested® outsourcing.

1 *The Scheme Rules are available to members on www.discovery.co.za/medical-aid/scheme-rules.*
2 *Based on beneficiaries, according to the Council for Medical Schemes Annual Report 2016–2017 (www.medicalschemes.com/Publications.aspx).*
3 *Medical Schemes Act 131 of 1998, as amended.*

WHY JOIN DHMS?

QUALITY OF CARE IS ONE OF OUR KEY MEMBERSHIP PROPOSITIONS

One of the Scheme's major longer-term strategies is to drive value-based healthcare, which is a delivery model in which providers are reimbursed based on health outcomes, and to promote member access to programmes and providers that are committed to continuous improvement in quality healthcare.

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

WE MAKE SURE THAT YOUR INVESTMENT IN MEMBERSHIP TAKES CARE OF YOU

86% of contributions received are used to fund member benefits

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

In pricing member contributions for each year, the Scheme's objective is to ensure sufficient contribution income to pay all claims, and to return a modest surplus to meet regulatory requirements as well as to maintain a cushion against unexpected cost increases. This is in accordance with the fundamental operating principles of a non-profit organisation.

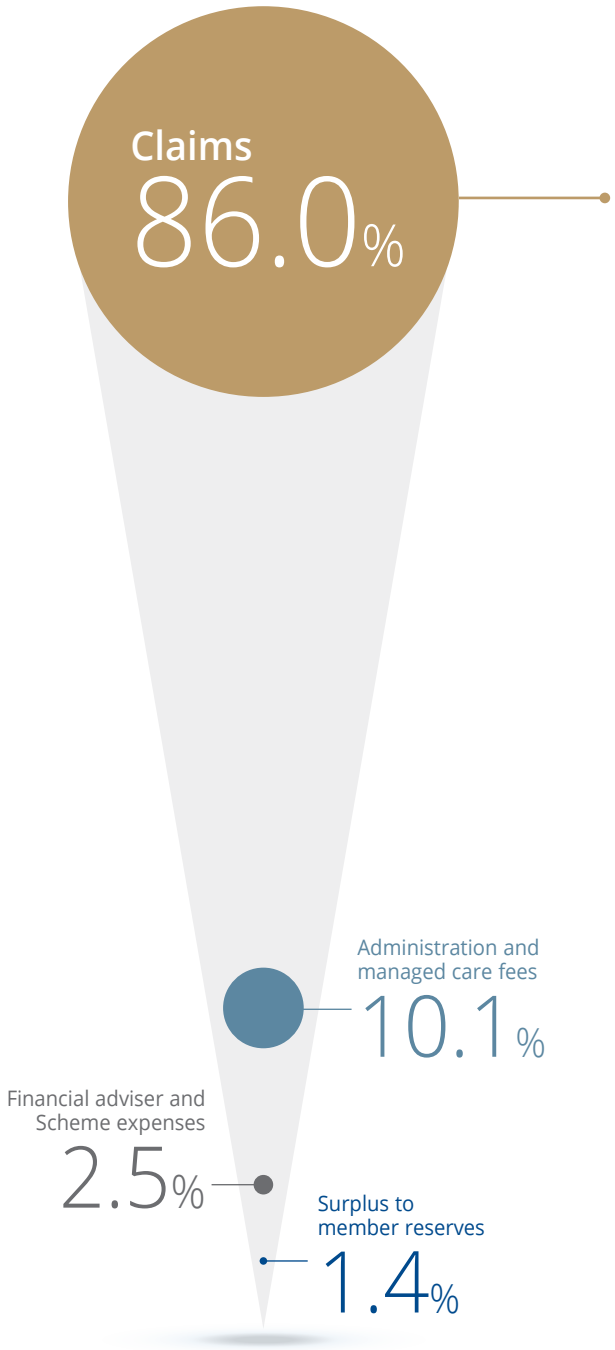
The Scheme's income is used to fund activities to support and benefit its members, as well as ensure the sustainability of DHMS through activities such as innovation, administration, managed care, financial advisers and the daily operations of the Scheme.

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

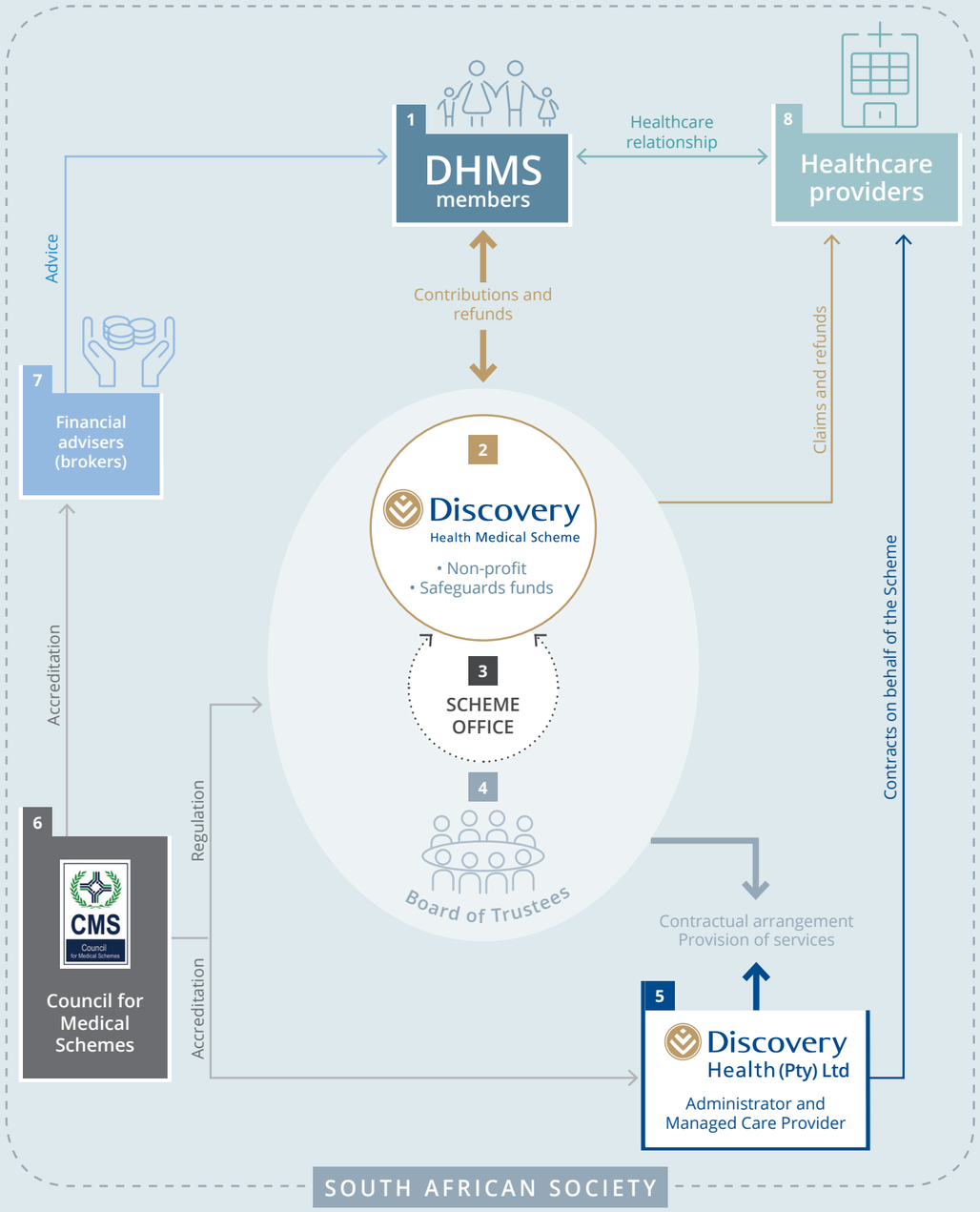
PAGE REFERENCE

Read more about the Scheme's reserves and how we ensure the protection of your funds and the sustainability of DHMS on **pages 8 – 9**.

2017 DHMS EXPENSE BREAKDOWN



OUR WORLD



The Scheme recognises a duty of ethical administration, social responsibility and good corporate citizenship. While it regards its members' access to healthcare as its primary responsibility, it observes its Constitutional and other civic obligations to South African society at large.

1 DHMS MEMBERS

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

Any member of the public can join DHMS[1] and choose from 17 benefit options and six network efficiency discount options designed to cater for a wide range of affordability and healthcare needs[2].

2 DISCOVERY HEALTH MEDICAL SCHEME

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

3 SCHEME OFFICE

(Principal Officer and executive management team)

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

Supported by an executive management team, the Principal Officer plays a critical role in the effective operation of the Scheme. The Principal Officer and the management team collaborate closely with the Scheme's Administrator and Managed Care Provider, Discovery Health, in implementing strategy and daily operations. The diverse management team's skills and expertise include medical, actuarial, risk management, business management, strategic development, financial management, investment, legal, ethics, compliance and research capabilities.

4 BOARD OF TRUSTEES

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

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

PAGE REFERENCE

Read more about our stakeholders on **pages 33 – 43**, about our Trustees on **pages 20 – 23** and about how we are governed on **pages 47 – 65**.

5 DISCOVERY HEALTH (PTY) LTD

(Administrator and Managed Care Provider)

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

Administration services provided include:

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

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

Managed care services provided include:

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

6 COUNCIL FOR MEDICAL SCHEMES

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

7 FINANCIAL ADVISERS

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

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

8 HEALTHCARE PROVIDERS

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

1 *Subject to any applicable Scheme Rules and restrictions of the Medical Schemes Act 131 of 1998, as amended (the Act).*
2 *Members and potential members can discuss their unique needs with a financial adviser to select the most appropriate plan for them.*

KEY PERFORMANCE INFORMATION

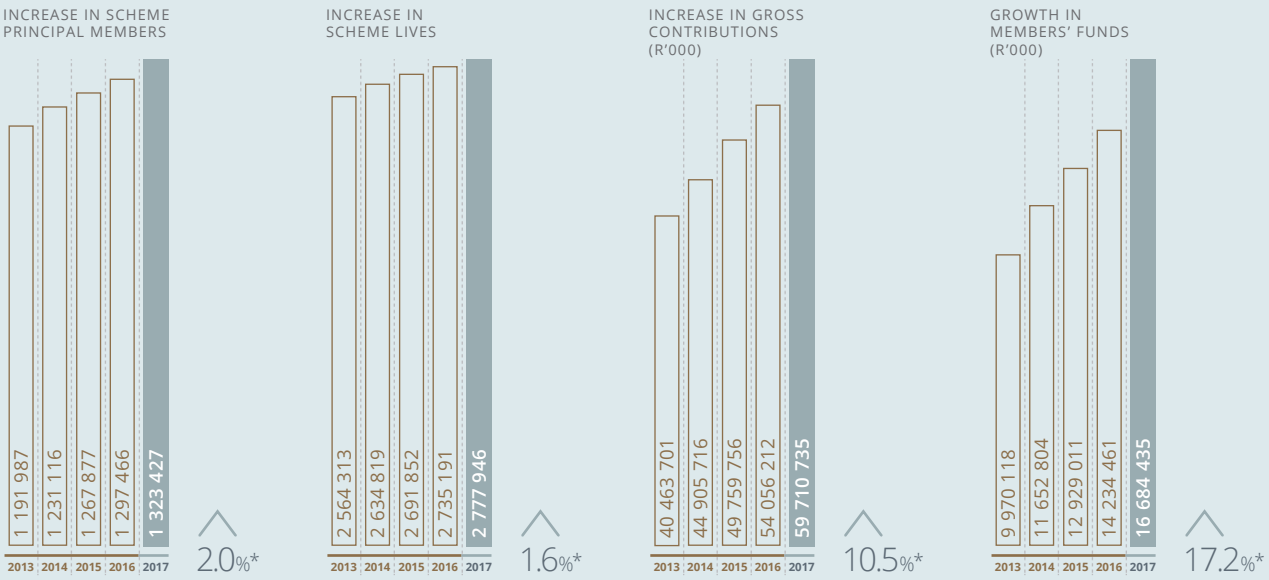
DHMS delivered a positive net healthcare result of R968 million for the year ended 31 December 2017 (2016: R102 million). The year-on-year increase in the operating result (contribution income less claims and all other Scheme expenses) was mainly attributable to the impact of in-hospital and out-of-hospital risk management initiatives implemented from the end of 2016 in response to a trend of increased utilisation of healthcare services in the 2015 and 2016 periods.

Despite volatile investment markets, the Scheme generated healthy investment income of R1 433 million (2016: R1 257 million) contributing to the net surplus for the year of R2 450 million (2016: R1 305 million).

This strong financial performance increased members' funds to R16.7 billion (2016: R14.2 billion) with a solvency level of 27.44% (2016: 26.33%), versus the regulatory requirement of at least 25%. The Scheme's financial strength and ability to pay claims was once again confirmed with a credit rating of AAA from the independent credit rating agency, Global Credit Rating Co (GCR). This is the 17th consecutive year the Scheme has achieved the highest possible rating a medical scheme can attain in the industry in South Africa. In the Trustees' view, DHMS ended 2017 in its strongest financial position in its history, and is very well positioned to continue to meet its members' needs going forward.

KEY HISTORICAL PERFORMANCE INDICATORS

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



** Year-on-year change (2016 – 2017).*

ENSURING THE SCHEME'S SUSTAINABILITY

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

GROWTH AND SUSTAINABILITY

MEMBERSHIP SIZE

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

- **2 777 946** beneficiaries as at 31 December 2017 (2016: 2 735 191)
- **56%** share of open scheme market (2016: 55%)

CONTRIBUTION INCREASES

Reflects value for money for members and effective risk management.

- Average contributions **16.4%** lower[1] than the next eight open schemes by size (for 2017: 14.6%)

MEMBERSHIP GROWTH

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

- Average net membership and beneficiary growth of **2.08%** and **1.59%** respectively (2016: 2.45% and 1.71%)[2]
- Average age at year end of **34.50** (2016: 34.17)[3]
- **9.33%** pensioner ratio (2016: 8.92%)
- **5%** annualised lapse rate (2016: 5%)

PLAN MOVEMENTS

Indicates satisfaction, stability in benefit design and appropriate pricing.

- No change for 2018: **94.24%** (for 2017: 93.86%)
- Upgrades for 2018: **3.24%** (for 2017: 2.91%)
- Downgrades for 2018: **2.52%** (for 2017: 3.23%)

FINANCIAL STRENGTH AND MANAGEMENT

ABSOLUTE RESERVES

Demonstrates ability to meet large, unexpected claims variation.

- Accumulated funds expressed as a percentage of gross annual contributions of **27.44%** (2016: 26.33%), exceeding the statutory solvency requirement of **25%**
- **AAA independent credit rating** for claims paying ability (2016: AA+)

PRICING SUFFICIENCY

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

- Net surplus for the year of **R2 450 million** (2016: R1 305 million)

PRUDENT INVESTMENT MANAGEMENT

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

- **10.00%** average return on investments (2016: 8.80%)

DHMS RECEIVES EXCEPTIONAL VALUE FOR ITS ADMINISTRATION AND MANAGED CARE EXPENSES.

For every **R1.00 spent** by DHMS on administration and managed care fees in 2016, members of DHMS received **R2.00** (2015: R1.85) in value from the activities of Discovery Health.

Administration fees 7.56%
of gross contributions (2016: 7.68%)

Managed care fees 2.57%
of gross contributions (2016: 2.60%)

PAGE REFERENCE
For an explanation of how the Scheme calculates the value provided by Discovery Health see **page 19**.

1 *To ascertain the contribution differential between DHMS and competitors, we calculate an average contribution within each plan category for a family unit comprising one principal member, one adult and one child dependant (a family of three). These average contributions are then weighted (for DHMS and the next eight largest open schemes) according to the distribution of members across DHMS plans. This ensures that plans with similar benefits are being compared on a like-for-like basis, thereby providing a reasonable estimate of the discount that a typical member of DHMS enjoys relative to members of similar options in competitor schemes. DHMS typically compares itself against our next nine largest competitors, but Sizwe's final contribution increases for 2018 were unconfirmed at the time of publishing and so this comparison excludes Sizwe.*

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

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

PAGE REFERENCE
For full information on the Scheme's performance, please see **pages 74 – 85**, and for the Annual Financial Statements see **pages 94 – 169**.

OUR OPERATING CONTEXT AND MATERIAL MATTERS

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

The members of the Council for the CMS are appointed by the Minister of Health for a period of no more than three years per term, and for a maximum of two terms. The Registrar is the Chief Executive and accounting officer of the CMS. The registration of medical schemes is subject to compliance with the provisions of the Act and the promotion of public interest.

In terms of the schemes regulated by the CMS, the Council is responsible for ensuring that:

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

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

The CMS also accredits medical scheme administrators and managed care providers to provide services to medical schemes and their members, and accredits financial advisers to provide advice to the public on private healthcare cover. All fees paid by medical schemes to financial advisers are prescribed by the Minister of Health.

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

At the end of 2016 there were 82 medical schemes registered with the CMS, consisting of 22 open schemes and 60 restricted schemes, covering over 8 878 000 beneficiaries. These schemes paid out approximately R151.2 billion in total healthcare benefits[2] in 2016 (2015: R138. 9 billion)[3]. DHMS facilitates access to private healthcare for over 2 777 000 beneficiaries[4], approximately 56% of the open schemes market.

Through its Administrator and Managed Care Provider, Discovery Health, DHMS strives to ensure a seamless integration of services, quality of care for members, and cost efficiency in the context of a fragmented healthcare system. The Scheme also works closely with regulatory authorities as necessary, which in the last few years has related to Prescribed Minimum Benefit (PMB) reforms by the CMS, developments around National Healthcare Insurance (NHI) and the Competition Commission's Health Market Inquiry (HMI) into private healthcare in South Africa.

1 The CMS undertakes its own process of vetting trustees and principal officers; this is in addition to the process undertaken by DHMS's Nomination Committee.

2 Total healthcare benefits paid refers to the sum of the benefits paid from both the risk pools of medical schemes and the savings accounts of members.

3 Source: CMS Annual Report 2016–2017 (www.medicalschemes.com/Publications.aspx).

4 As at 31 December 2017.

OUR MATERIAL MATTERS

The Scheme's material matters are the most important factors that affect our ability to create value for our members and other stakeholders over time, and ensure sustainability in the current complex operating environment.

Our material matters are interrelated; with careful management, they present opportunities for the Scheme to differentiate itself, enhance its reputation and protect its leading market position in South Africa, as well as achieve its objectives of sustainability and increased member value. The material matters are related to our risks, opportunities, strategic objectives and ongoing Board discussions, and are formally reviewed on an annual basis by the Trustees.

We exist for our members, which puts member health and wellness at the heart of what we do. To succeed, Scheme sustainability and healthcare affordability must be maintained in a challenging economic climate, which is influenced by healthcare systems reform and the impact of ethical business practices. We manage these inter-related matters and deliver services to our members through the Vested model.

MEMBER HEALTH AND WELLNESS

- A fragmented healthcare system that results in variable quality of care and compromises the provision of patient-centric care
- South Africa's high burden of communicable and lifestyle diseases, and its ageing population
- Promoting a patient-centred healthcare model and ensuring knowledgeable and empowered members

HEALTHCARE SYSTEM REFORM

- Incomplete implementation of social solidarity principles contributing to inflation and reducing access to healthcare
- A complex regulatory environment

ETHICAL BUSINESS

- Heightening awareness and increasing environmental scanning
- Focusing on ethical due diligence and King IV
- Ensuring that any lack of governance and controls in the broader business and political environment do not negatively impact the Scheme's operations and its members

SCHEME SUSTAINABILITY AND HEALTHCARE AFFORDABILITY IN A CHALLENGING ECONOMIC CLIMATE

- Slow economic growth and rising unemployment exacerbated by retrenchments by employer groups
- Affordability constraints in an inflationary environment with limited resources that threaten Scheme sustainability, potentially increasing the burden on the public healthcare system
- National budget allocations and amendments increasing pressure on affordability

THE VESTED OUTSOURCING MODEL

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

RISK MITIGATION
AND OUR STRATEGY

Mitigating our residual risks

DHMS constantly scans the internal and external environments to assess risks and opportunities emanating from the triple context of environment, society and economy in which the organisation operates and in relation to the capitals that the organisation uses and affects.

Risks are rated according to impact and likelihood on a five-point scale of low to catastrophic, and assessed according to the Scheme's Board-approved enterprise risk management framework as well as the risk appetite framework and statement.

This process provides an assessment of the potential opportunities presented by risks with potentially negative effects on achieving organisational objectives, as well as an assessment of the organisation's dependence on resources and relationships as represented by the various forms of capital.

Risk responses and mitigation plans are then put into place and monitored by the Scheme Office, with regular reporting to relevant Board Committees and to the Board. High and medium high residual risks and their mitigation strategies are shown alongside. DHMS currently has no catastrophic risks.

AFFORDABILITY OF CONTRIBUTIONS AND MEDICAL INFLATION

The risk that contributions to the Scheme become unaffordable in the long term due to the impact of demand and supply side factors and inflation drivers.

- Risk management interventions are implemented by Discovery Health on behalf of DHMS. These include closer management of networks and hospital admissions, as well as the implementation of innovative value-based contracting and reimbursement mechanisms.

PAGE REFERENCE

Read more about these factors and drivers on **page 78**.

STAKEHOLDER MANAGEMENT

The risk of inadequate stakeholder management, resulting in harm to the Scheme's business and reputation, and its perception in the eyes of members and other key stakeholders.

- Engaging proactively and frequently with all stakeholder groups and ensuring effective oversight of engagement by a dedicated Board Committee. The Trustees embrace the Treating Customers Fairly (TCF) principles and framework, and receive regular reports on the performance of Discovery Health on TCF key fairness indicators.
- In addition, DHMS conducts ongoing environmental scanning to identify possible risks related to its key stakeholders and develops or amends strategies to deal effectively with risks.

REGULATORY CHANGE

The risk of changes in the regulatory environment that may have an adverse impact on the operations, competitive advantage, strategy and sustainability of the Scheme.

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

COMPLIANCE

The risk of not complying with laws, regulations, rules and related self-regulatory Scheme standards and codes of conduct, as well as the failure to uphold the Scheme's core values and codes.

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

INFORMATION AND CYBER

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

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

OUTSOURCING

The risk that outsourced providers fail to service members and providers according to agreements in place, and do not perform in a manner consistent with the values, strategies and objectives of the Scheme.

- Discovery Health reports extensively to the Board and the Board Committees on a regular basis, which enables the Trustees to ensure that the strategic and operational requirements agreed on, and which are set out in extensive service level requirements, are met. Operational matters are reported to the Scheme Office, which oversees mitigation strategies and their implementation.

CLAIMS

Medical schemes set contribution rates before the end of each benefit year for the following year. There is a related risk of healthcare costs rising faster than inflation due to demand side factors (such as age, gender, chronic status and anti-selection) and/or supply side factors (such as technology and provider driven increases in utilisation).

- Scheme experience shows that the risk management initiatives implemented by Discovery Health have resulted in material savings for DHMS that have successfully reduced the impact of this risk. However, the Scheme continues to actively monitor objectives in this regard.

OUR APPROACH TO PERFORMANCE

To ensure the long-term sustainability of the Scheme, it is essential that the internal and external factors and material risks are constantly reviewed and considered. While these considerations require that the strategy evolves over time, its development is always guided by the core purpose of the Scheme: to care for our members' health and wellness by engaging the brightest minds and innovative solutions to provide access to affordable, equitable and quality, value-based healthcare that meets their needs now and sustainably into the future.

In this respect, DHMS formulates its strategy to be responsive to the operating environment and the needs of its members and other stakeholders.

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

As the Scheme is prohibited from directly or indirectly borrowing money by the Act, it only has two sources of financial capital available: member contributions and returns on the investment of member funds. This limitation requires balancing the resources required to meet its objectives and ensuring the long-term financial sustainability and solvency requirements required by the CMS.

DHMS has a fiduciary obligation to maximise investment returns while having due regard to associated risks; thus considering issues that can impact the longer-term sustainability of investment performance is important. In this regard, the Trustees have approved a framework for responsible investment that guides the approach and model adopted when investing.

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

Work streams and related objectives are adjusted in response to changing circumstances, and the policies and planning related to the work streams are reviewed and approved by the Trustees as required. These work streams are cascaded to multiple Board Committees, which have terms of reference that are approved by the Board. The Committees have annual calendars that detail the work plan for the year. The Scheme Office interfaces with these Committees and the Board, reporting regularly on its oversight and monitoring responsibility as well as risk mitigation for emerging risks. The Scheme Office applies a performance management strategy that requires strategic, structural and cultural alignment to attain the overall performance targets of its employees. The incentive and reward structures are designed to reward excellence in performance and foster an environment of continuous learning and development.

The strategic themes discussed in our 2016 Integrated Report have largely been retained for this report and are forward looking to 2018, but their wording and categorisation has been amended in line with management's priorities and current environmental factors.

OUR STRATEGIC THEMES AND PERFORMANCE IN 2017

01 Superior quality of care for members

- Key longer-term strategies for DHMS are to:
  - Drive value-based healthcare, a delivery model in which providers are reimbursed based on health outcomes; and
  - To promote member access to programmes and providers that are committed to continuous improvement in quality healthcare.
- The Scheme and Discovery Health continuously implement and monitor various quality of care projects that strive to ensure effective outcomes measurement and the sharing of quality outcomes data with members and healthcare providers, including:
  - Risk-sharing arrangements; and
  - The integration of the stages of the disease management journey, with several promising pilot projects currently underway that are designed to promote care provision by multi-disciplinary teams, care coordination and outcomes-based reimbursement.
- DHMS participates in the Health Quality Assessment's annual assessment of quality in healthcare by medical schemes and the CMS's PMB review process, which has been reinitiated.
- The Scheme also obtains regular reports on quality indicators, metrics, standards and benchmarks.

PAGE REFERENCE

Read more about these projects on **pages 35 – 36**, **38 – 39** and **89 – 93**.

Related

MATERIAL MATTERS

- Member health and wellness
- The Vested model

RISKS

- Stakeholder management
- Regulatory change
- Outsourcing

STAKEHOLDERS

- Members and employer groups
- Providers
- Council for Medical Schemes
- National Department of Health
- Discovery Health

02 Lowest healthcare costs

- The average contribution of a Scheme member was 16.4% (2016: 14.6%) lower[1] than the next eight[2] largest open schemes on a plan-for-plan comparison basis, and the weighted average contribution increases for those schemes was 8.8% compared to DHMS's 7.9%.
- Monitoring the drivers of claims cost, utilisation and clinical risks is ongoing, and the Scheme leverages its scale and the powerful analytics capability of Discovery Health to identify risks at an early stage and respond quickly.
- In 2017, various risk mitigation strategies were implemented that yielded positive results.

PAGE REFERENCE

Read more about the contribution differential on **page 77**.

Related

MATERIAL MATTERS

- The Vested model
- Scheme sustainability and healthcare affordability[3]

RISKS

- Affordability of contributions and medical inflation
- Claims

STAKEHOLDERS

- Members and employer groups
- Providers
- Discovery Health

1 *Based on the rate for a principal member plus one adult beneficiary and one child beneficiary, and on information sourced by the Scheme to end March 2018.*

2 *Not including Sizwe. DHMS typically compares itself against our next nine largest competitors but Sizwe's final contribution increases for 2018 were unconfirmed at time of publishing.*

3 *Abbreviated from "Scheme sustainability and healthcare affordability in a challenging economic climate".*

03 Personalised, predictive and preventative approach

- We work to ensure that our range of plans offer sufficient member choice, ongoing benefit optimisation and plan design refinement, which is overseen by our Product Committee.
- As the Scheme believes strongly in the value of driving member wellness, we offer extensive preventative and screening benefits.
- Our members have voluntary access to a world-leading science-based wellness programme, Vitality[1], with ongoing monitoring of the impact of our various wellness activities and interventions reported to the Clinical Governance and Non-healthcare Expenses Committees.

PAGE REFERENCE
Read more about the impact of Vitality on **page 91**.

Related

MATERIAL MATTERS
- Member health and wellness
- The Vested model

RISKS
- Stakeholder management
- Outsourcing

STAKEHOLDERS
- Members and employer groups
- Providers
- Discovery Health
- Financial advisers

04 Member-centric servicing

- Discovery Health's strong ongoing focus on service excellence and peace of mind for members is measured through metrics such as member perception, first call resolution and service levels, which supported an average member perception score of 9.14 out of 10 (2016: 9.17).
- Discovery Health's ongoing incorporation of new digital and other technologies to enhance members' experience and engage them in their healthcare drove the introduction of DrConnect in 2017:
  - DrConnect is an information platform for doctors and members that has access to a database of 6.5 billion curated medical questions and allows members to ask questions to a network of over 108 000 doctors internationally.
  - It is available at no charge to Scheme members through their smartphones and the website, and to doctors via HealthID.

PAGE REFERENCE
Read more about DrConnect on **pages 36 – 39**, and how we engage with our members on **pages 34 – 36**.

Related

MATERIAL MATTERS
- Member health and wellness
- The Vested model

RISKS
- Stakeholder management
- Information and cyber
- Outsourcing

STAKEHOLDERS
- Members and employer groups
- Providers
- Discovery Health

1 *Vitality is administered by Discovery Vitality (Pty) Ltd., registration number 1999/007736/07, an authorised financial services provider.*

05 Excellent governance

- In line with best governance practice, the Scheme has been working to integrate King IV requirements into its governance structures, processes and disclosures. To this end, the Scheme has amended all Committee and Board terms of reference and governance documentation. The Scheme plans to obtain an independent external assessment of the results of this work during 2018.
- In accordance with King IV best practice, the Stakeholder Relations Committee updated its mandate to emphasise social and ethics governance, and has been renamed the Stakeholder Relations and Ethics Committee. Among other areas of good corporate citizenship, the Committee will oversee the review of ethics in the Scheme and its environment, and the implementation of actions to achieve its responsibilities. The Scheme has engaged The Ethics Institute, of which it is a member, in this regard.
- During 2017, two Trustees were elected by members at the Scheme's AGM, and two additional Trustees were appointed by the Board to replace outgoing Board-appointed Trustees. The new Trustees were assessed against fit and proper criteria by the Nomination Committee and formally appointed in June and August respectively.

Related

MATERIAL MATTERS

- Ethical business

RISKS

- Compliance
- Regulatory change

STAKEHOLDERS

- Members and employer groups
- Employees
- Council for Medical Schemes

PAGE REFERENCE

Read more about our approach to good corporate citizenship and our culture, ethics and values on **pages 30 – 31**.

06 Best practice outsourcing and a focus on innovation

- The Scheme continues to engage external experts to assess components of the Vested model and its implementation, as well as the outcomes of the relationship.
- DHMS uses pragmatic, replicable methodology for measuring the value added by Discovery Health for the Scheme and its members. The assessment reported to the Trustees in 2017 showed that in 2016, for every R1.00 the Scheme spent on administration and managed care services, R2.00 of value was added by Discovery Health (2015: R1.85).
- A new set of administration and managed care agreements with Discovery Health were finalised and came into effect on 1 January 2018.
- The Scheme Office continues to optimise its outsourced business model, with assessments conducted and structures established to optimise the transactional, relational and innovation aspects of the agreements on an ongoing basis. These activities are reported to the Non-healthcare Expenses Committee and to the Board on a regular basis.

Related

MATERIAL MATTERS

- The Vested model
- Scheme sustainability and healthcare affordability[1]

RISKS

- Affordability of contributions and medical inflation
- Stakeholder management
- Outsourcing

STAKEHOLDERS

- Members and employer groups
- Providers
- Discovery Health

PAGE REFERENCE

Read more about how we ensure our members receive value for money on **page 19**.

1 *Abbreviated from "Scheme sustainability and healthcare affordability in a challenging economic climate".*

07 Stakeholder relations

- DHMS engages with all of its stakeholders on an ongoing basis.
- In 2017, regulatory engagement was a particular focus for the Scheme. Frequent interactions were held, particularly with the CMS, which publishes regular circulars and other guidelines for the industry to which the Scheme submitted comprehensive responses as required.
- The Scheme continued to engage extensively and proactively with the Competition Commission on its Health Market Inquiry (HMI), including participating in industry seminars held on various topics that the HMI is investigating.

PAGE REFERENCE

Read more about how we engage with our stakeholders on **pages 33 – 43**.

Related

MATERIAL MATTERS

- Healthcare system reform
- Ethical business

RISKS

- Stakeholder management
- Regulatory change
- Compliance

STAKEHOLDERS

- All stakeholders

08 Financial performance

- DHMS manages its investment portfolio in a diversified manner to optimise investment returns within its approved risk appetite.
- Despite challenging economic conditions, the Scheme generated healthy investment income of R1 433 million (2016: R1 257 million) contributing to the net surplus for the year of R2 450 million (2016: R1 305 million).

PAGE REFERENCE

Read more about the Scheme's performance on **pages 74 – 85**.

Related

MATERIAL MATTERS

- Scheme sustainability and healthcare affordability[1]
- Ethical business

RISKS

- Affordability of contributions and medical inflation

STAKEHOLDERS

- Members and employer groups
- Employees

1 *Abbreviated from "Scheme sustainability and healthcare affordability in a challenging economic climate".*

HOW WE OPERATE

DELIVERING VALUE THROUGH AN INTEGRATED PROVIDER MODEL

As per the Act and the Scheme Rules, the Trustees appoint an accredited administrator and managed care provider to execute the Scheme's operations.

DHMS purchases its administration and managed care services from a single provider, Discovery Health (Pty) Ltd, as the Trustees believe that an integrated model (as opposed to a fragmented model where multiple service providers are utilised) delivers optimal efficiency and value to Scheme members.

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

WHAT THIS MEANS FOR OUR MEMBERS

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

AN OUTCOMES-DRIVEN APPROACH TO CREATING VALUE

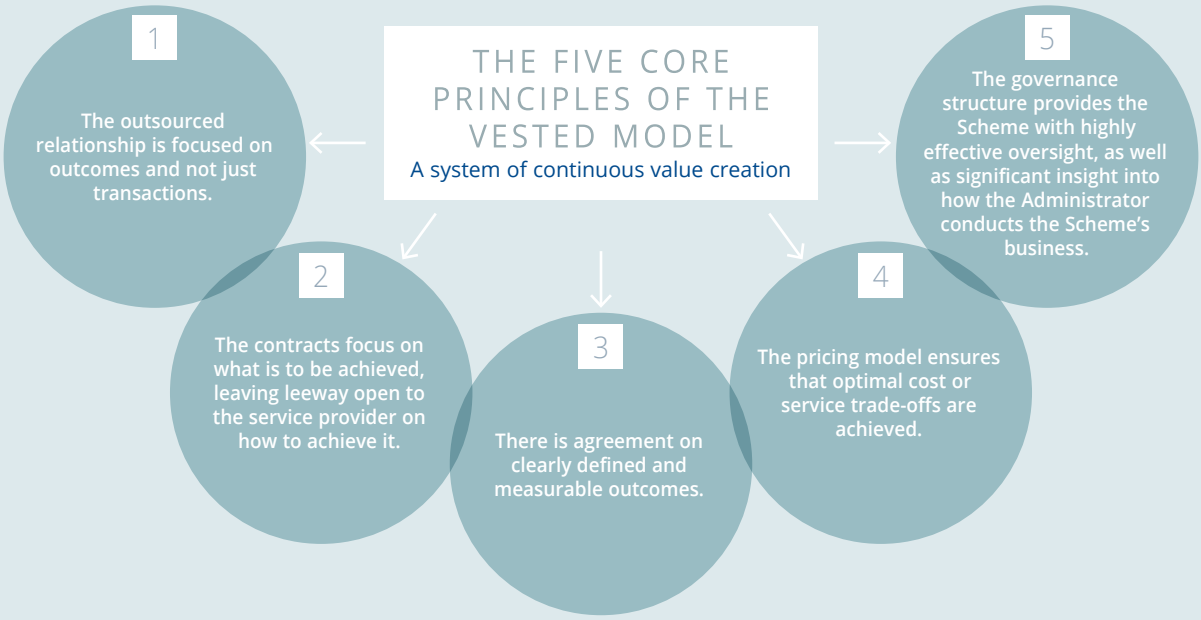
The working relationship between the Scheme and Discovery Health is governed by the Vested® outsourcing model (Vested model). This aligns the transactional and relational governance elements of this relationship with global best outsourcing practice.

A Vested outsourcing agreement is characterised by:

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

This strengthens the strategic alignment between organisations and encourages a value-driven relationship. In effect, it frees both organisations to do what they do best by contracting for results and not activities – which allows for innovation, improved service and continuous value creation.

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



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

THE CONTINUAL IMPROVEMENT JOURNEY

Optimising an outsourcing model is a journey, with changes embedded at all levels to create a sustainable system for continuous value creation. Enhancements to the Vested model continue to be implemented to achieve ongoing improvement.

The Scheme engages regularly with independent international Vested model experts who conduct reviews of its implementation. In 2017, two operational committees were also established to monitor and optimise the relationship and the innovation work that the model promotes.

WHAT THIS MEANS FOR OUR MEMBERS

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

- An unmatched record of innovation.
- High levels of member satisfaction with service levels.
- Focused clinical risk management solutions resulting in significant claims cost reduction, enhancing the sustainability of the Scheme.
- Improved stakeholder relations.
- Continued membership growth from an already high base.
- Improved outsourcing governance ensuring that the Scheme can measure and report on the performance of and value provided by the Administrator and Managed Care Provider.
- Continued excellent Scheme performance across all key metrics, including financial performance and membership growth.

VALUE FOR MONEY PROVIDED BY DISCOVERY HEALTH

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

A pragmatic and replicable methodology for measuring the value added by Discovery Health has been applied for 2014, 2015 and 2016[1], and the latest results were reported to the Trustees in 2017. The assessment takes account of value added from providing basic administration services, managing claims costs, making members healthier, attracting and retaining members, any additional services offered, and innovation.

2016: R2.00	2015: R1.85	2014: R1.73

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

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

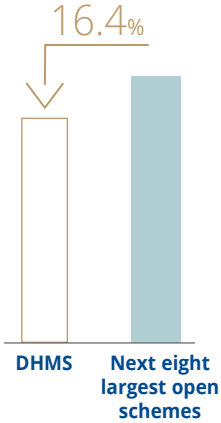
Deloitte are of the opinion that the increase in value added from 2015 to 2016 is reasonable.

1 *In the past, the Scheme used a methodology developed by Deloitte to assess the value added, which relied on publicly available information. Due to differences in the specification of the underlying data across the industry, the method was no longer suitable.*

WHAT THIS MEANS FOR OUR MEMBERS

Our members are better off when the Administrator and Managed Care Provider adds more value than the fees paid to it by the Scheme. The value for money that Discovery Health provides plays out in many ways for members, from access to highly effective managed care programmes such as DiabetesCare, to a significant difference in contribution costs:

DHMS CONTRIBUTION 16.4% LOWER THAN THE NEXT EIGHT LARGEST OPEN SCHEMES



Average contribution differential for a family unit comprising one principal member, one adult and one child dependant (a family of three) for 2018.

PAGE REFERENCE

Read more about the contribution differential and DHMS's performance on **pages 76 – 85**, as well as Discovery Health's initiatives for the Scheme on **pages 86 – 93**.

WHO LEADS US

Our Trustees

In the King IV Report on Corporate Governance for South Africa 2016, corporate governance is defined as the exercise of ethical and effective leadership by boards to achieve the following governance outcomes:

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

The DHMS Trustees embrace the principles of the King IV Report on Corporate Governance for South Africa 2016 (King IV) in achieving its governance outcomes for the Scheme and within the Scheme environment. The Trustees are required to lead ethically and effectively, and each Trustee (individually and collectively as part of the Board) should cultivate the characteristics of integrity, competence, responsibility, accountability, fairness and transparency, and exhibit them in their conduct.

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

In addition, the Trustees have access to professional advice, both inside and outside the Scheme, for them to properly perform their duties. The Trustees may obtain such external or other independent professional advice as they consider necessary to carry out their duties.

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

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

- Overseeing and directing the management of the Scheme's outsourced activities performed by the Administrator and Managed Care Provider;
- Applying sound business principles to ensure the financial soundness of the Scheme;
- Ensuring that proper control systems are employed by and on behalf of the Scheme;
- Appointing, evaluating and delegating functions to the Principal Officer, who is the chief executive officer of the Scheme;
- Ensuring that the Scheme Rules, operation and administration comply with the provisions of the Act, and all other applicable laws;
- Ensuring that adequate and appropriate information is communicated to members regarding their rights, benefits, contributions and responsibilities in terms of the Scheme Rules;
- Taking all reasonable steps to protect the confidentiality of medical records concerning the state of health of the Scheme's members; and
- Overseeing the implementation of strategy.

The Trustees may be elected or appointed. At least 50% of the Trustees are elected by Scheme members, and the Board may appoint additional Board Committee members to fill any knowledge, experience and skills gaps.

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

MR NEIL MORRISON

BSc (Hons) Physics; MA (Economics)

CHAIRPERSON

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

Mr Morrison was elected as a Trustee in 2016 and currently serves on the Stakeholder, Remuneration, Investment and Non-healthcare Expenses Committees. He was elected Chairperson of the Board on 14 August 2017, upon Mr van der Nest SC's retirement.

ELECTED BY MEMBERS AT THE 2017 AGM

MS JOAN ADAMS SC

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

Ms Adams SC has been an advocate for 30 years, 20 years of which have been in private practice (after resigning in 1996 as a Senior State Advocate). She served for five years on two presidentially elected Commissions of Inquiry involving financial irregularities. She was appointed a Senior Counsel in early 2018.

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

Ms Adams SC specialises in medical law, mediation, forensic investigations, serious economic offences, professional ethics and disciplinary enquiries in both the public and private sectors, and has served as chairperson on numerous professional conduct enquiries of the Health Professions Council of South Africa and various other institutions.

Ms Adams SC was elected as a Trustee in 2017 and serves on the Clinical Governance, Audit and Risk Committees.

DR SUSETTE BRYNARD

BSc (Sciences); PhD (Education)

Dr Brynard is a research fellow at the University of the Free State, specialising in people management. She was formerly part of the management team of the Bloemfontein College of Education. She is currently a director of SAMBA, a co-operative buy-aid, a position she has held for the last 24 years. She attained her post graduate degrees cum laude and is doing ground-breaking work on the education and development of Down syndrome learners internationally.

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

MR JOHN BUTLER SC

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

Mr Butler SC is a practising advocate. He was appointed a senior counsel in 2008.

He specialises in commercial practice, including in insolvency, company, insurance, finance and banking, and competition law. He has served as an Acting Judge of the High Court of South Africa, and as an arbitrator in commercial disputes. He is a former chairperson of the Cape Bar Council.

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

MR JOHAN HUMAN

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

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

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

1 *Forensic Practitioner, South Africa.*
2 *Fellow of the Institute of Actuaries UK.*
3 *Fellow of the Actuarial Society of South Africa.*

MR DAVID KING

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

Mr King is a seasoned business executive with over 25 years' multinational experience. He spent 12 years as Human Resources Director of Brandhouse Beverages and was instrumental in that entity becoming a formidable competitor in the South African drinks industry. Previously, he chaired the Board of Trustees of Oxygen Medical Scheme. He is an expert in executive leadership and employee engagement.

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

DR DHESAN MOODLEY

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

Dr Moodley is currently in private practice in Functional and Anti-aging Medicine. He is also the chairman of Pinpoint Solutions, a healthcare organisation that focuses on HIV and chronic conditions in the public sector. In the past, he was president of Alexander Proudfoot, CEO of Bluepeter Consulting, partner of Ethos Private Equity Technology Fund, associate partner at Accenture and principal at Gemini Consulting. He has deep expertise in health insurance and healthcare. His past and present affiliations include the Young Presidents' Organisation, World Presidents' Organisation, American Academy of Anti-aging Medicine, South African Medical Association, Black Management Forum of South Africa, and American Chamber of Commerce.

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

MS DAISY NAIDOO

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

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

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

RETIRED DURING 2017

MR MICHAEL VAN DER NEST SC

BA LLB

CHAIRPERSON

Mr van der Nest SC has been in private practice for over 30 years and was appointed Senior Counsel in 2000. He has been an Acting Judge of the High Court of South Africa on various occasions, and has arbitrated various commercial disputes.

His practice is of a specialised commercial nature in merger and competition cases, accounting and valuation, mining, contractual disputes, insurance, aviation and construction disputes, financial instruments, banking and regulatory matters.

Mr van der Nest SC was appointed as a Trustee in 2011 and 2014, and served as Chairperson of the Board for both periods. He also served on the Remuneration and Stakeholder Relations Committees until his term ended in August 2017.

MR GILES WAUGH

MA; FIA[1]; FASSA[2]

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

Mr Waugh was appointed as a Trustee in 2011 and 2014. He served on the Audit and Risk Committees and Chaired the Product and Non-healthcare Expenses Committees until his term ended in June 2017.

1 Fellow of the Institute of Actuaries UK.

2 Fellow of the Actuarial Society of South Africa.

OUR INDEPENDENT BOARD COMMITTEE MEMBERS

MR IMTIAZ AHMED

CA(SA)

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

Chairperson of the Investment Committee.

MR DON ERIKSSON

CA(SA)

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

Resigned as Chair and as Committee member of the Remuneration Committee on 15 November 2017.

MR PETER GOSS

MA: Criminal Justice; P/G BTech: Forensic Investigation; Certificate Programme: Corporate Governance

Extensive expertise as a managing director in business consulting and advisory services; corporate governance, anti-corruption and medical schemes board elections expert.

Chairperson of the Nomination Committee.

MR STEVEN GREEN

BSc (Hons) Information Systems; BSc Computer Science

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

Member of the Audit and Risk Committees.

MRS SUE LUDOLPH

CA(SA)

Technical expert in IFRS and financial and integrated reporting, including standard-setting for accounting in South Africa; established and implemented the strategy and work plan for South Africa's first top 100 CFO Forum to guide, influence and lead on issues affecting CFOs and business; judge for the PwC Building Public Trust Awards since 2014.

Member of the Audit and Risk Committees.

MRS PHILILE MAPHUMULO

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

More than 11 years' experience in investment banking; has served as a non-executive director on various company boards.

Member of the Audit, Risk and Investment Committees.

PROF MIKE SATHEKGE[1]

MBChB, MMed, FAMS, PhD

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

Member of the Clinical Governance Committee.

MR ROY SHOUGH

CA(SA); HDipBDP; CISA[2] (Lapsed); ISACA CIA[3]; IIA

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

Member of the Nomination Committee.

PROF SELMA SMITH

MBChB; M Prax Med; FCFP(SA)

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

Member of the Clinical Governance Committee.

PROF ZEPHNE VAN DER SPUY

MBChB; MRCOG[4]; PhD; FRCOG[5]; FCOG (SA)[6]

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

Member of the Clinical Governance Committee.

MR BARRY STOTT

CA(SA)

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

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

MR TOM WIXLEY

BCom; CA(SA)

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

Member of the Nomination Committee.

1 *Resigned 15 March 2018.*
2 *Certified Information Systems Auditor.*
3 *Certified Internal Auditor.*
4 *Member of the Royal College of Obstetricians and Gynaecologists.*
5 *Fellow of the Royal College of Obstetricians and Gynaecologists.*
6 *Fellow of the College of Obstetricians and Gynaecologists of South Africa.*

OUR EXECUTIVE

MANAGEMENT TEAM

Part of the fiduciary duties of the Board described in the Scheme Rules is that it appoints a Principal Officer to manage the day-to-day affairs of the Scheme. The Principal Officer must be fit and proper to hold this office and may appoint any staff required for the proper execution of the business of the Scheme.

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

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

REMUNERATION AND HR PLANNING

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

In 2017, the Scheme Office consisted of twelve staff members, with a team of six executives reporting to the Principal Officer and supported by a Scheme Secretariat department and an administration department. This very lean employee complement makes succession planning challenging. As a result, the operational model applied by the Scheme Office requires significant overlap in the capabilities of the executive team. This must be supported by a mature knowledge management and retention strategy to mitigate this risk in various ways, including sufficiency in the notice period for scarce skills that allows for transition.

STAFF MOVEMENTS AND ORGANISATION REDESIGN DURING 2017

Dr Unati Mahlati joined the team as the Chief Medical Officer on 8 June 2017. This position became vacant when Dr Nozipho Sangweni, the previous Chief Medical Officer, was appointed as the Principal Officer by the Trustees. Dr Mahlati is a medical doctor who specialised in public health and has extensive experience in both the public and private healthcare sectors. She has over ten years' experience in private healthcare funding.

Mr Jan van Staden, the Chief Financial Officer (CFO), resigned in December 2017. All potential risks related to the departure of the CFO are being actively managed. The Chief Risk and Operations Officer, who has previously managed the portfolio, has been appointed as the acting CFO. At the time of publishing, the nature and requirements of the CFO role going forward were under review.

The Scheme Office undertook an extensive exercise to optimise the Scheme's operating model. One of the key outcomes has been a redesign that incorporates the expanded King IV governance code and the Board requirement for further bolstering and emphasis on social and ethics oversight, which was considered critical in the context of heightened exposures of ethical and governance failures in the external environment. The Legal and Regulatory Affairs portfolio, headed by Mr Howard Snoyman, has been modified to Legal and Ethics. As an admitted attorney with a specialisation in healthcare law and ethics, Mr Snoyman is ideally suited to take on this portfolio. Regulatory oversight has been incorporated into the compliance function in the portfolio of Governance and Compliance. This is headed by Mrs Yashmita Mistry, an admitted attorney who also heads the Scheme's Secretariat function.

DR NOZIPHO SANGWENI 01

PRINCIPAL OFFICER

MBChB; MBA; PGDip Occupational Health; PGDip Civil Aviation Management

Accounting Officer of the Scheme, Council member of iFHP[1], and a board member of the HFA[2].

MR HOWARD SNOYMAN 02

HEAD: LEGAL AND ETHICS

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

Vice President and Board member of the Corporate Counsel Association of South Africa; Board member of the Marketing Code Authority.

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

MS MICHELLE CULVERWELL 03

HEAD: SPECIAL PROJECTS AND STAKEHOLDER RELATIONS

BA (Hons); MBA in Executive Management

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

MR SELWYN KAHLBERG 04

CHIEF RISK AND OPERATIONS OFFICER

ACTING CFO (FROM 1 JANUARY 2018)

BSc (Hons) Actuarial; CFA; FASSA; FIA

This role advises on and oversees strategic and operational enterprise risk management, administration and managed care contracting and outsourced operations, and ensures optimisation of operational efficiency, non-healthcare expenses and adherence to the defined risk appetite, to support the sustainability of the Scheme.

DR UNATI MAHLATI[3] 05

CHIEF MEDICAL OFFICER

MBChB; FCPHM[4]; MMed

Board member of HQA[5].

This role advises on and oversees strategic and operational clinical governance and risk management, product development and marketing. It ensures that Scheme resources in this respect are fully optimised in the best interest of members and sustainability. All oversight and risk mitigation activity is aligned to the risk appetite of the Scheme.

MRS YASHMITA MISTRY 06

HEAD: GOVERNANCE AND COMPLIANCE

LLB

This role provides a central source of guidance to the Scheme on governance matters, ensures the management, coordination and responsibility for the Scheme Secretariat function, and ensures Scheme compliance to its legislative and regulatory universe.

05 02 01 03 06 04

MR JAN VAN STADEN[6] NOT SHOWN

CHIEF FINANCIAL OFFICER

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

SAICA[7] Medical Schemes Project Group member

This role advises on and oversees strategic and operational investment, finance and audit matters, to ensure Scheme resources are optimised fully in the best interest of members, keeping within the defined risk appetite and ensuring the sustainability of the Scheme.

1 *iFHP: International Federation of Health Plans.*
2 *HFA: Health Funders Association.*
3 *Joined the Scheme on 8 June 2017.*
4 *Fellow of the College of Public Health Medicine of South Africa.*
5 *HQA: Health Quality Assessment.*
6 *Resigned in December 2017.*
7 *SAICA: South African Institute of Chartered Accountants.*

03

OUR STAKEHOLDERS AND GOOD CORPORATE CITIZENSHIP

DRIVING GOOD CORPORATE CITIZENSHIP AND STAKEHOLDER VALUE

As a medical scheme in South Africa, Discovery Health Medical Scheme (DHMS or the Scheme) operates under principles of social solidarity, whereby the Scheme pools member contributions and manages them to fund member healthcare equitably. As such, the Scheme exists for the benefit of all its members. This stands as the primary guiding principle for everything the Scheme does.

The Scheme acknowledges its responsibility and obligation to work with the communities in which it operates, both directly and indirectly, to optimise the healthcare system in South Africa for the benefit of all. As the largest open scheme in South Africa, DHMS plays an important role in making progress on this objective. The Scheme also supports the work of its Administrator and Managed Care Provider, Discovery Health (Pty) Ltd, through its shared value model for engaging stakeholders as partners to work together with them towards this objective. The Scheme could not continue to function without the support of its stakeholders and broader society.

PAGE REFERENCE

In a shared-value health insurance system, all stakeholders benefit when the system improves. Read more about the shared value model at **https://www.discovery.co.za/corporate/discovery-shared-value-insurance-model**. Some examples about how shared value works with healthcare providers can be found on **pages 38 – 39**.

PAGE REFERENCE

Read more about how we engage with our immediate stakeholders on **pages 33 – 43**.

The King IV Report on Corporate Governance for South Africa 2016 (King IV) requires that specific areas of responsible corporate citizenship should be overseen and monitored. In late 2017, the mandate of the Stakeholder Relations and Ethics Committee[1] was expanded to include social and ethics governance. To guide its oversight and reporting requirements, the Committee has adopted a framework that is adapted from its work on corporate social responsibility and from The Ethics Institute[2], and which incorporates the King IV requirements, as below:

Reporting to the Committee in terms of this framework has been initiated and will be further developed. The Committee has placed an initial focus on organisational ethics, Treating Customers Fairly (TCF), fraud and corruption detection and response, and the Scheme's workplace. Presentations and reports on these areas have been received by the Committee, which has requested further detail to support its ability to monitor progress. Future areas of focus will include closer engagement with key stakeholders, and a review of ethical contracting and procurement contracts, and other relevant internal Scheme policies.

PAGE REFERENCE

Read more about the Committee on **pages 64 – 65**.
Read more about TCF on **page 32**.

1 *Previously the Stakeholder Relations Committee.*
2 *Crane, Matten & Spence (2008); The Ethics Institute material from 2017.*

OUR CULTURE, ETHICS AND VALUES

The Scheme strives to operate according to the highest ethical standards, specifically those relevant to a medical scheme, and an employer. The Scheme's policies specify the standards of ethical behaviour expected of its Board of Trustees (the Board or the Trustees) and employees in areas such as compliance with the law, the protection of personal information, human rights, employee rights and sound business practices. Regular assessments are conducted into the effectiveness of the Scheme's governing bodies to identify any areas of concern. These policies are available to all Trustees and to employees on the Scheme's intranet. Reference to the policies is included in all employment contracts.

In accordance with the increased focus by the Board on ethics, and with the expanded mandate of the Stakeholder Relations and Ethics Committee, the Trustees have initiated a full ethics review of its internal and external environments, including ethical contracting. Areas for improvement and implementation plans will be reviewed by the Committee during the course of 2018, and improvements to structures and processes, where required, are expected as an outcome of this work.

To support the focus on ethics, the executive head of the legal and regulatory functions in the Scheme Office has been assigned the ethics portfolio, and the role title was amended in late 2017 to Head: Legal and Ethics.

During 2017, the Scheme's organisational culture was assessed by independent experts and a desired culture was mapped out. Progress in this regard will be assessed during the course of 2018.

PAGE REFERENCE

Read more about Board and Committee evaluations conducted on **pages 48 and 52**.

OUR VALUES guide our behaviours and interactions with all our stakeholders.

INTEGRITY: If we act with integrity we will be doing the right thing. We will take personal accountability for our actions and, in our actions and decisions, hold true to our promise that we care.

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

ADAPTABILITY AND AGILITY: We will be sensitive to the external environment and to the needs of others in the team, while remaining responsive to changing needs and adapting to the pace of change, particularly with regard to uncertain health policy and markets.

TEAM WORK, SUPPORT AND CARE: We will support and care for each other, sharing the load and working interdependently.

PURSUIT OF EXCELLENCE: We will focus on continuous improvement, development and quality with learning as our core way of working.

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

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

MORAL DUTIES AND ETHICAL VALUES

The Scheme's standards of behaviour are aligned with the ethical values and moral duties outlined in the King Report on Governance for South Africa and the King Code of Governance Principles 2009 (King III) as well as the expectations of the Council for Medical Schemes (CMS) that are articulated in its governance framework:

MORAL DUTIES

Conscience, stakeholder inclusivity, competence, commitment and courage.

ETHICAL VALUES FOR GOVERNANCE, MANAGEMENT AND OPERATIONS

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

TREATING CUSTOMERS FAIRLY

The TCF Framework has its foundation in sound business principles and good governance. The Scheme voluntarily embraces the TCF principles and recognises their relevance to the quality of service and interactions that Discovery Health provides to our members.

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

THE DESIRED OUTCOMES OF TCF ARE:

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

The Risk Committee has received and reviewed detailed reports on TCF in the past; these reports will now also be reviewed by the Stakeholder Relations and Ethics Committee.

ENGAGING WITH OUR STAKEHOLDERS

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

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

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

For example, Discovery Health responds to our members' queries via call centres and through e-mail; engages with doctors through multiple communication channels to demonstrate new tools and initiatives; provides training and support to financial advisers on the Scheme's products; and develops healthcare provider networks to control costs for our members and the Scheme, and reports to the Scheme on all such interactions.

The Scheme has adopted the principles of the Vested model. The Vested model places a strong emphasis on trust; trust as the basis for stakeholder relationships will be further developed to include all its stakeholders.

PAGE REFERENCE

For more information on the Vested model see **page 18**.

During 2017, the Scheme Office conducted a detailed perception survey of stakeholder relationship owners throughout its environment, which included assessments of mutual trust and the impact and level of risk posed. The results of the survey were presented to the Stakeholder Relations and Ethics Committee in early 2018. Opportunities for improvement will be considered by the Committee during the course of 2018, and the results of the survey will be used to inform further development of stakeholder engagement plans.

PAGE REFERENCE

The sections on **pages 34 – 43** detail engagement with our key stakeholders, and touch on planned activities or outcomes for 2018 where relevant.

OUR MEMBERS

The Scheme's purpose recognises that we exist for our members, who entrust us with their healthcare funding needs. Thus, the Scheme aims to ensure the long-term affordability of contributions so that members can continue to access private healthcare of the highest standard. Building and maintaining strong relationships with all our other stakeholders supports our ability to achieve these objectives.

One of the Scheme's major longer-term strategies is to drive value-based healthcare, which is a delivery model in which providers are reimbursed based on health outcomes, and to promote member access to programmes and providers that are committed to continuous improvement in quality healthcare.

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

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

PAGE REFERENCE

The Principal Officer's contact details are on **page 170**.

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

Related

MATERIAL MATTERS
(see page 11)

- Member health and wellness
- Scheme sustainability and healthcare affordability in a challenging economic climate

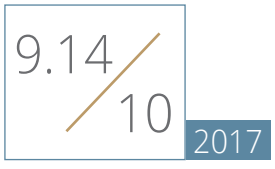
RISKS
(see pages 12 – 13)

- Affordability of contributions and medical inflation
- Stakeholder management
- Information and cyber
- Outsourcing
- Claims

ENSURING OUR MEMBERS STAY SATISFIED

Member satisfaction is at the core of the Scheme and Discovery Health's ethos, and members' perceptions of the service they receive is tracked at multiple points and locations, including walk-in centres, after-claims processes and the call centre.

We are proud to have maintained a high average member perception score in 2017:



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

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

Launched in 2015, the service reduces hospital admissions and the length of hospital stays, and potentially avoids readmissions – thereby adding beneficial value to the member, treating doctor and the Scheme. Highly qualified ICU-trained nurses care for patients in the comfort of their own homes, reducing exposure to hospital-acquired infections and allowing patients to recover faster. This improves appropriate hospital bed allocation and alleviates the burden of families travelling to and from hospital.

The programme currently focuses on four main therapeutic areas:

- INTRAVENOUS INFUSIONS: antibiotics, steroids, enzymes, iron, immunoglobulins and fluid replacement.
- WOUND CARE: moderate to severe wounds not requiring hospitalisation.
- POSTNATAL CARE: three visits by a qualified midwife for both mother and baby if safely discharged one day early, and within a six week period post-birth.
- END-OF-LIFE CARE: facilitating referrals to the Advanced Illness Benefit teams.

PAGE REFERENCE

Read more about the Advanced Illness Benefit on **page 89**.

Discovery HomeCare is available in all large cities and towns throughout South Africa, and in more remote areas on a case-by-case basis. The programme has grown strongly over the last year, with approximately 400 visits per month in 2017 and 650 in December alone. There is also no member co-payment when utilising Discovery HomeCare services; co-payments with some other agencies that provide similar services average R195 per day. In 2016 and 2017, Discovery HomeCare realised savings of R2 million per year for the Scheme.

The service has been well received by our members, with nursing care consistently rated highly at 9.6 out of 10 by patients, with 97% preferring Discovery HomeCare to hospitalisation.

Member feedback on Discovery HomeCare

"Oh absolutely! It's the best service in the world. I get to carry on working and don't have to traumatise my kids by being in hospital. I'll be the Discovery HomeCare brand ambassador!"

"Dr J... would like to thank the nurses that see her patients for wound care. She has received such good feedback from our patients. Thank you again."

"I love Discovery. I have a kidney infection and instead of lying in hospital for 5 days, I get to stay at home! There is no ways I can afford 5-7 days in a hospital bed right now! Seriously a brilliant service, I say it over and over. I am so terrified of hospitals, so this is a huge deal for me."

"I just wanted to send you a mail to say thank you very much for your excellent service and for the quick response. I really do appreciate all your help and efficient work. Your service which you provided was top notch service."

Several new Discovery HomeCare initiatives went live in 2017:

- **An Aged Care pilot** running in four retirement villages in Gauteng. These provide high-quality care for residents in their units or at care centres, which reduces the need for hospital admissions or allows earlier discharge to a safe environment for optimal recovery and care.
- **HealthID integration** allows doctors to refer their patients to Discovery HomeCare via the HealthID application and review progress and discharge reports (including photographs) via the app.
- **An OrthoHomeCare pilot** with orthopaedic surgeons who provide pre-surgery home assessments and visits on the day of discharge to ensure patient's environments and care is optimised, which reduces hospital readmissions due to potentially avoidable complications.

1 *Discovery HomeCare is operated by Grove Nursing Services (Pty) Ltd, registration number 2015/191080/07. Grove Nursing Services is a wholly-owned subsidiary of Discovery Healthcare Services (Pty) Ltd.*

EMPOWERING OUR MEMBERS TO MAKE BETTER CHOICES

Since 2015, Discovery Health has been reporting on Scheme members' ratings on the quality of care and patient experience provided by private hospitals. Since its publication on the Discovery website to the end of 2017, the Patient Satisfaction Score (PaSS) has been viewed more than 61 000 times and the overall average PaSS score has increased from 56% in 2013 to 59.3 % in 2016[1] in response to the sharing of results with members on the website.

Drawing on global best practice, Discovery Health has partnered with a selection of public, private and NGO partners to run the Smart Health Decisions programme, working with family practitioners. It encourages patients to have conversations with their doctors about specific focus areas. As an example, to help combat the growing challenge of antibiotic resistance one focus area is promoting discussions on the over-utilisation and misuse of antibiotics.

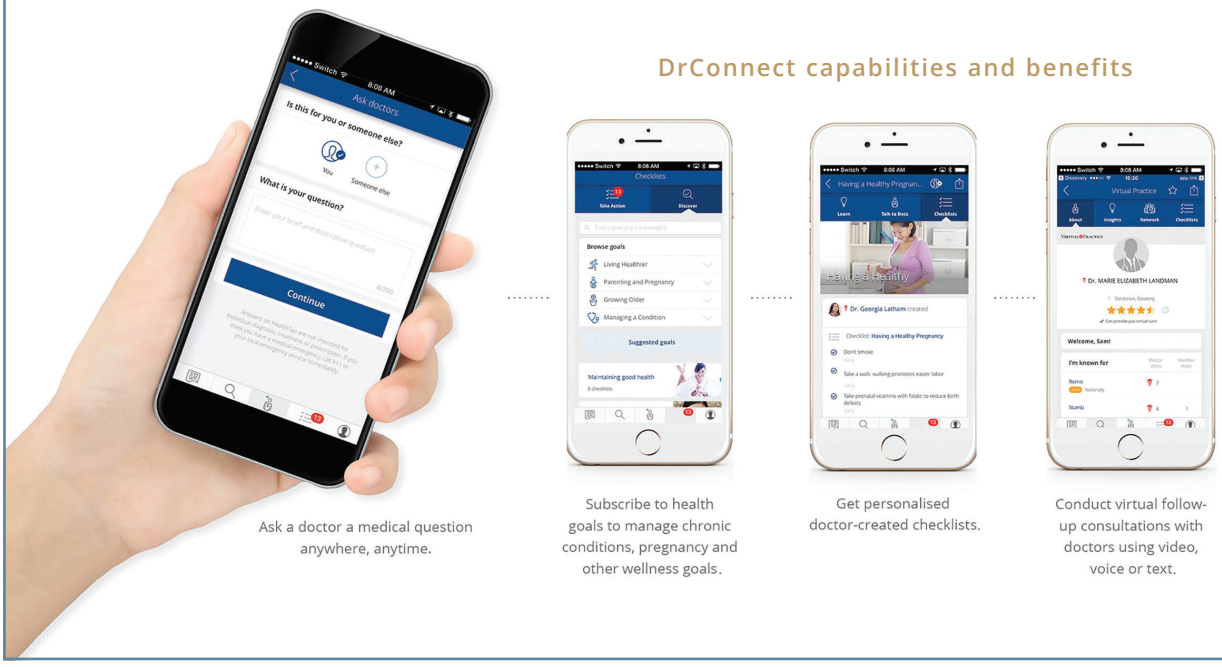
A new addition for 2017 was the General Practitioner (GP) survey that allows members to rate and/or recommend their GP based on service satisfaction by analysing five key measures: continuity of care, discussion of medication, professionalism of office staff, patient communication, and doctor availability. As the survey matures, results will be shared with providers and members.

1 2017 score not available at time of publishing.

Empowering our members with digital solutions

DrConnect was launched in 2017. It provides access to a database of 6.5 billion curated medical questions and allows members to ask questions of a network of over 108 000 doctors internationally for an immediate response and guidance. In addition, members benefit from personalised tips and checklists created by doctors to help them meet their health goals. Integrated with Discovery HealthID, DrConnect also enables virtual follow-up consultations using video, voice or text with selected doctors that members have seen in the last 12 months in a completely secure, private environment. As of February 2018, 69 742 DHMS members were registered on DrConnect and 1 509 South African doctors were participating on the platform.

DrConnect capabilities and benefits



Ask a doctor a medical question anywhere, anytime.

Subscribe to health goals to manage chronic conditions, pregnancy and other wellness goals.

Get personalised doctor-created checklists.

Conduct virtual follow-up consultations with doctors using video, voice or text.

HEALTHCARE PROVIDERS AND PROFESSIONAL SOCIETIES

The Scheme continues to develop and maintain mutually supportive partnerships with healthcare providers from all disciplines in the pursuit of quality, cost-effective healthcare for their patients – our members.

We remain certain that the Scheme's and Discovery Health's strategy to progressively implement value-based care initiatives in collaboration with healthcare providers plays a significant role in mitigating some of the challenges experienced by healthcare professionals. These include prevailing regulatory and impending health system policy changes, and socio-economic and other healthcare market pressures, including increasing medical litigation. To this end, we are increasingly contracting with and reimbursing doctors on the basis of the value derived from their services, including member satisfaction and health outcomes, among other measures. In this regard, we distinguish the performance measurements based on whether the doctor manages patients with unexpected sudden onset, short-duration (acute) illnesses or illnesses of prolonged duration (chronic conditions).

We started 2017 with the successful launch of the Premier Plus GP network for chronic disease management, specifically Premier Plus for Diabetes. Although it is still too early to measure the sustained impact of the initiative, initial results are positive as seen in improvements in process of care measures across screening, testing and medicine compliance rates. Building on the DiabetesCare initiative, we will be extending the concept to a Premier Plus GP network for HIV management (HIVCare), with plans to extend Premier Plus to cardiac and mental healthcare in 2019.

For GPs managing patients presenting with acute conditions, we will be launching a new value-based multiplier in 2018 that rewards healthcare providers with improved measures in the access, efficiency, quality, patient experience and wellness domains. In line with this development, we initiated a GP Patient Experience Survey in 2017 and will share the results with stakeholders in due course.

We have also invested significant effort and resources in engaging specialists and their respective professional societies to develop value-based care projects. Two examples of this are developing an acceptable model for an arthroplasty centre of excellence network in 2018, and developing solutions to support the South African Society for Obstetricians and Gynaecologists clinical governance project. These initiatives also support quality measurement through electronic Patient Health Records development (supported by the Discovery Health digital platforms, including HealthID and DrConnect) and disease registries.

The Scheme continues to lead the sector in implementing innovative alternative reimbursement models with the major hospital groups. The Scheme also has contracts with all major pathology groups and radiology practices, as well as most other healthcare professionals. These arrangements provide members with certainty of cover and a wide range of options to avoid co-payments, and ensure the Scheme complies with Prescribed Minimum Benefit legislation in terms of the Medical Schemes Act 131 of 1998, as amended (the Act).

Regular meetings, workshops and thought leadership summits are held to examine pertinent issues affecting healthcare delivery in South Africa and other sector issues. Continuous engagement with the pharmaceutical industry aims to secure the best possible prices of medicines for members, thereby protecting the pool of funds from which members' claims are paid.

We continue to participate in workgroups with various healthcare providers and professional societies to address topics including provider challenges, new technology and claims coding, with good progress made in all areas. The focus remains on enhancing affordable quality care and sustainability.

Over the past year collaboration has continued on initiatives that are aligned to the principles of a shared value healthcare system. In 2018 we will continue to partner with the profession to accelerate the shift towards value-based healthcare and shared value payment.

OTHER ENGAGEMENTS INCLUDED THE FOLLOWING:

- Extensive communication sent to doctors to update them regarding any Scheme and Discovery Health changes they need to be aware of.
- Ongoing engagement with societies and representative bodies in the sector.
- Articles published in medical journals and the press to showcase quality-of-care improvement initiatives and collaboration with doctors.

Related

MATERIAL MATTERS
(see page 11)

- Member health and wellness
- Healthcare system reform
- Ethical business

RISKS
(see pages 12 – 13)

- Affordability of contributions and medical inflation
- Stakeholder management
- Compliance
- Outsourcing
- Claims
- Regulatory change

SHARED VALUE HEALTHCARE INITIATIVES IMPROVE QUALITY AND REMUNERATION

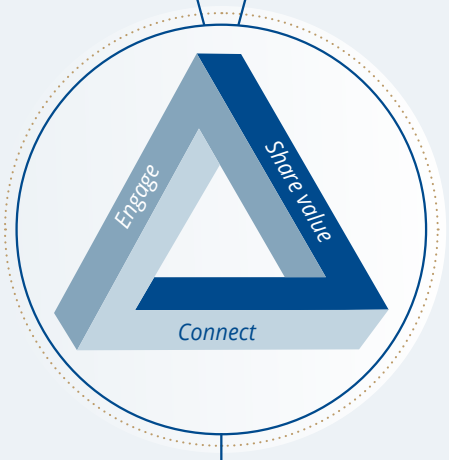
The World Economic Forum's insight report (April 2017) on Value in Healthcare, describes value-based healthcare as "a genuinely patient-centric way to design and manage health systems. Compared to what health systems currently provide, it has the potential to deliver substantially improved heath outcomes at significantly lower cost."

1 Shared value initiatives

Quality networks, governance projects and the measurement of quality metrics have the common aim to improve quality and the efficiency of health care.

2 Enhanced remuneration

Practices that participate and perform through these value-based partnerships benefit from enhanced remuneration through value-based multipliers.



3 Digital health technology

Discovery HealthID

DrConnect by HealthTap

HealthID and DrConnect seamlessly connects doctors with patients and peers both locally and all over the world, in a completely secure, confidential environment. Fully integrated with HealthID, you have access to your patients' health information anytime.

Key predictions of quality of care innovations 2020

At a Discovery Quality Summit held in early 2018, panellists predicted key quality-of-care innovations likely to materialise in South Africa in the next two years:

- Publication of quality metrics across organisations in an interpretable format.
- Inclusion of the voice of the patient in standardised quality reporting through patient experience surveys.
- Regulatory shift to team-based care with aligned reimbursement structures such as bundled fees.
- Delivery and management of healthcare via virtual experiences and digital tool utilisation.
- Adoption of blockchain technology in healthcare systems to enable secure access to clinical data.
- Growth of public private partnerships to develop an affordable open source electronic medical record.

DHMS looks forward to working with Discovery Health to drive these innovations forward to achieve better quality care for our members, and to further our aims as a good corporate citizen.

1 Shared value initiatives

PARTNERING WITH THE PREMIER PLUS NETWORK TO IMPROVE DIABETES OUTCOMES

Diabetes is one of the most significant contributors to disease burden in South Africa and a significant cost driver for the Scheme. In response, Discovery Health established the DiabetesCare programme to ensure more effective treatment of members diagnosed with diabetes.

The DiabetesCare programme is delivered through the GP Premier Plus network and is an integral component of disease management at a primary care level. At the end of 2017, the programme had 11 561 registered members (12% of total registered diabetic members, suggesting rapid growth from the programme's inception in 2016).

Process measures at the end of 2017 indicate that the percentage of diabetic members who have had at least one HBA1c test is 78% for DiabetesCare enrolled members, compared to 57% for non-DiabetesCare enrolled members. Similarly, DiabetesCare enrolled members have a higher percentage of cholesterol testing (58% versus 35%) and a higher dietician consulting rate (8.2% to 2.4%).

78%
HBA1c testing of enrolled members

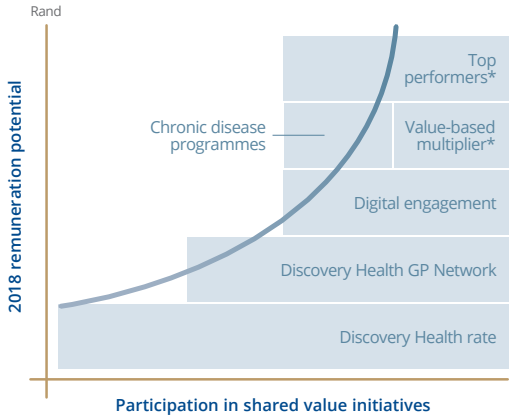
58%
lipogram testing of enrolled members

2 Enhanced remuneration

In the Surgicom Governance Project[1], participating surgeons collaborate to improve adherence to clinical guidelines and tracking clinical outcomes through electronic discharge summaries. The shared value principles that framed the project are being realised, with participating surgeons having received over R5 million in additional income. One material benefit of this programme is the publishing of discharge summaries by treating surgeons. So far, over 15 000 discharge summaries have been published on the HealthID electronic platform.

1 Read more about the Surgicom Governance Project at http://www.surgicom.co.za/members.

ILLUSTRATIVE REMUNERATION POTENTIAL DEPENDING ON YOUR PRACTICE



* *Performance criteria detailed in your practice specific communication*

3 Digital health technology

SUPPORTING DOCTORS IN QUALITY OF CARE WITH DIGITAL SOLUTIONS

HealthID remains the flagship Discovery Health digital offering for health professionals. By the end of 2017, approximately 4 400 doctors were using HealthID on a monthly basis and more than 1.53 million members[1] have provided consent to their doctors to access their health records. HealthID is a key strategy to improve the quality of care and is the backbone of Discovery Health's vision to build a better shared value healthcare system. Further functionality upgrades that will further empower health professionals are planned for 2018.

1 Of schemes administered by Discovery Health.
2 As at end February 2018.

1.53 million ***members***[1] have given consent to doctors to view their health records

1 509 ***doctors*** participating in DrConnect[2]

4 400 ***doctors*** using HealthID monthly

69 742 ***members***[1] using DrConnect

FINANCIAL ADVISERS (BROKERS)

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

Financial advisers introduce individual consumers and employers to the full spectrum of medical schemes in the industry and assist them to compare the benefits, pricing, strengths and weaknesses, and service levels of competing medical schemes.

Consumers are then able to match their needs with the most appropriate medical scheme and plan offering. Once consumers have joined a scheme, financial advisers provide ongoing information through annual reviews, and update members and employers on product and service changes.

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

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

Engagements in 2017 included:

- The annual product update on the Scheme's product and benefit enhancements for the new benefit year was provided in a national rollout to over 200 broker consultants and agents, and presented and broadcast to more than 8 200 financial advisers from the annual product launch event.
- National presentations at two different times in the year to corporate brokerages provided information on the Scheme's strategies, industry position, financial results and risk management initiatives.
- Broker consultants were trained and assessment done on their knowledge of the Scheme's products, the private healthcare sector, and sales and presentation skills.
- Major corporate brokerages were provided with a comprehensive analysis of the South African medical schemes industry and a comparative analysis of 2016 open medical scheme financials.
- Perception surveys were conducted to establish how satisfied financial advisers are with the service they receive. The overall perception score by brokers of Discovery Health for the year was 8.97 out of 10, slightly up from 8.7 in 2016.

Related

MATERIAL MATTERS
(see page 11)

- Scheme sustainability and healthcare affordability in a challenging economic climate
- Healthcare system reform

RISKS
(see pages 12 – 13)

- Affordability of contributions and medical inflation
- Stakeholder management
- Regulatory change

DISCOVERY HEALTH (PTY) LTD

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

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

PAGE REFERENCE

Read more about the Vested model and how we operate on **pages 18 – 19**.

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

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

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

During 2017, DHMS renewed its Administration and Managed Care Contracts with Discovery Health. The Scheme also established the operational Relationship Management and Innovation Committees to actively monitor and optimise the working relationship between the organisations and ensure continuing focus on innovation respectively. These Committees will come into full operation during the course of 2018.

Related

MATERIAL MATTERS
(see page 11)

- Member health and wellness
- The Vested model
- Scheme sustainability and healthcare affordability in a challenging economic climate
- Ethical business

RISKS
(see pages 12 – 13)

- Affordability of contributions and medical inflation
- Stakeholder management
- Information and cyber
- Outsourcing

EMPLOYER GROUPS

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

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

In 2017, the following engagement activities were conducted:

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

1 *Based on 2016 Global Credit Ratings reports for open medical schemes.*

Related

MATERIAL MATTERS
(see page 11)

- Member health and wellness
- Scheme sustainability and healthcare affordability in a challenging economic climate

RISKS
(see pages 12 – 13)

- Affordability of contributions and medical inflation
- Stakeholder management
- Outsourcing
- Claims

OUR EMPLOYEES

The Scheme is committed to protecting the dignity, safety and health of our employees, providing decent work, fair remuneration, training and development opportunities, and treating them equitably and ethically.

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

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

During 2017, the Scheme Office engaged in a review of its operating model which, among other outcomes, served to clarify the work of the Scheme Office and the role profiles of employees. Small amendments have been made to the organisation structure as a result. The Scheme also conducted culture assessments and mapped out its desired culture.

In 2018, changes identified from the operating model review will be further embedded. The Scheme plans to review and optimise its performance management framework as well as review progress in moving towards its desired culture. In addition, an ethics review has been initiated by the Trustees that may result in amendments to the ethics policy.

Related

MATERIAL MATTERS
(see page 11)

- Scheme sustainability and healthcare affordability in a challenging economic climate
- Healthcare system reform
- Ethical business

RISKS
(see pages 12 – 13)

- Stakeholder management
- Regulatory change
- Compliance
- Information and cyber

REGULATORY BODIES

The Scheme and Discovery Health are required to adhere to strict legislation, primarily the Act.

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

COUNCIL FOR MEDICAL SCHEMES

The CMS[1] regulates all medical schemes in South Africa. Its role includes:

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

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

In 2017, the CMS published 81 circulars and the Scheme submitted responses to those where required, as well as to other ad hoc and formal enquiries from the CMS. The CMS also publishes an annual report covering activity across the private healthcare industry.

THE NATIONAL DEPARTMENT OF HEALTH

The Scheme interacts with the National Department of Health whenever required. In particular, the Scheme has submitted comments on the National Health Insurance (NHI) White Paper and participated wherever possible in work streams relating to the NHI.

DHMS supports the objectives of universal health coverage and looks forward to opportunities to collaborate with the Department of Health and all other stakeholders in determining how best the sector can achieve the objectives of quality and equitable healthcare.

THE COMPETITION COMMISSION

The Competition Commission's Health Market Inquiry (HMI) into the private healthcare sector[2] continues. The inquiry is a general investigation into the state and types of competition in the market, and does not relate to any specific organisation. One of the aims of the Inquiry is to promote competition to benefit consumers. The Scheme looks forward to its final report, expected in August 2018, as opportunities exist for the HMI to make recommendations that will support innovation and competition in the industry, reduce the fragmentation of healthcare, and fully implement the social solidarity framework within which medical schemes in South Africa operate.

During 2017, the Scheme engaged regularly with the HMI Panel, made submissions and attended industry seminars as needed, and cooperated fully and openly in the process. We will continue to do so in 2018.

Related

MATERIAL MATTERS
(see page 11)

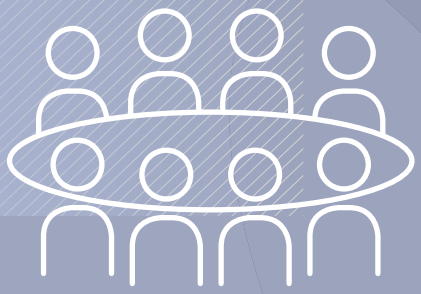
- Member health and wellness
- Scheme sustainability and healthcare affordability in a challenging economic climate
- Healthcare system reform
- Ethical business

RISKS
(see pages 12 – 13)

- Affordability of contributions and medical inflation
- Stakeholder management
- Regulatory change
- Compliance

1 *Find out more about the CMS at www.medicalschemes.com.*
2 *Find out more about the Healthcare Market Inquiry at www.compcom.co.za/healthcare-inquiry/.*

04 GOVERNANCE



OUR CHAIRPERSON'S STATEMENT

The King IV Report on Corporate Governance for South Africa 2016 reinforces the view that organisations are required to adopt a holistic approach to governance and be transparent to their stakeholders.

Accordingly, the Discovery Health Medical Scheme Board of Trustees adopted this latest governance code, which became applicable in the Scheme in January 2018.

It seeks to ensure an ethical culture, good performance and effective control to support the creation of value for, and service to, our members.

The governance ecosystem of the Board of Trustees (the Board or the Trustees) is informed by the Medical Schemes Act 131 of 1998, as amended (the Act), its Regulations, the Scheme Rules and the King IV Report on Corporate Governance for South Africa 2016 (King IV). Conducted in 2017, an external review of the operational model of the Scheme Office confirmed that its primary focus and expertise is governance best practice in supporting excellent and affordable healthcare for all our members.

The Discovery Health Medical Scheme (DHMS or the Scheme) supports the objectives of universal health coverage and we will support the government's National Health Insurance (NHI) policy to ensure DHMS activities complement the objectives of government policy.

We look forward to the conclusion of the Competition Commission's Health Market Inquiry (HMI), for which the final report is expected in August 2018. The Scheme has participated fully and diligently in the HMI, and our expectation is that it will result in the attainment of a more integrated and cost-effective private healthcare sector that is focused on quality.

The Trustees note the appointment of the new Council of the Council for Medical Schemes (CMS) and wish them a successful tenure. The Scheme engages extensively and transparently with the CMS on various governance and regulatory matters, and we remain committed to continue developing trust and building on our constructive relationship.

During 2017, the Board finalised a new set of administration and managed care agreements with our Administrator and Managed Care Provider, Discovery Health (Pty) Ltd (Discovery Health), for implementation in January 2018. The new contracts support our objective of achieving maximum value for our members while improving their healthcare outcomes and easing their administration burden. In addition, the agreement focuses on the continued investment in incremental innovation by Discovery Health for the benefit of the Scheme and its members. The Board believes this will strengthen DHMS's position as the leading medical scheme in South Africa.

PAGE REFERENCE

Read more about Discovery Health's innovations for the Scheme on **pages 89 – 93** and in the Stakeholders section on **pages 35 – 36** and **pages 38 – 39**.

The Trustees sought independent expert opinion from Deloitte to confirm quantitatively that the Scheme does achieve significant value for money from its contracts with Discovery Health. In 2017, Deloitte verified that Discovery Health added R2.00 of value for every R1.00 paid to them in 2016, up from R1.85 in 2015.

The terms of two Trustees ended during 2017, being Mr Giles Waugh and Mr Michael van der Nest SC. Both were long-standing members of the Board and its various Committees, and Mr van der Nest SC served as Chairperson of the Board for two terms. They always exercised their fiduciary responsibility in an exemplary manner.

At our AGM in June 2017, members elected two new Trustees; we welcome Dr Susette Brynard and Ms Joan Adams SC to the Board. Ms Adams SC is an advocate with a particular interest in medical law and Dr Brynard has a PhD in education and a strong personal involvement in healthcare advocacy.

The Board comprises individuals with a broad array of skills and experience, including legal, actuarial, accounting, economics, governance, clinical, financial, investment and human resources. This provides me with confidence in our ability to interrogate and debate the wide range of issues we are confronted with, and further determine outcomes that serve the best interests of our members and society.

I wish to thank our retiring Chairperson, Mike van der Nest, and retiring Trustee, Giles Waugh, for their outstanding service and dedication to the Scheme. My thanks are also due to my current colleagues on the Board of Trustees, the Scheme Office and Discovery Health. I am honoured by the faith shown by my fellow Trustees in electing me as the new Chairperson of the Scheme in 2017. I would also like to acknowledge the excellent leadership of Dr Nozipho Sangweni, who completed her first year as Principal Officer of the Scheme in January 2018.

NEIL MORRISON

CHAIRPERSON

How we are governed

All medical schemes in South Africa are governed by the Act. The Scheme Rules[1] are developed in accordance with the Act and approved annually by the CMS.

Additional governance guidance is taken from King IV and, where not superseded by King IV, by the King Report on Governance for South Africa and the King Code of Governance Principles 2009 (King III). These governance codes set the standard for good corporate governance in South Africa and are recognised as best practice internationally.

GOVERNANCE FRAMEWORK AND BOARD RESPONSIBILITY

DHMS is governed by an independent Board of Trustees, which is responsible for the oversight of the business of the Scheme. The Trustees hold the decision-making power of the Scheme and are ultimately responsible for overseeing the development and implementation of the Scheme's strategy and the sound management of its business, including Scheme policies. The Board's overriding objective is to ensure that the best interests of Scheme members are served equitably and in the context of the sustainability of DHMS.

The Board is satisfied that it has fulfilled its mandate in accordance with its charter and carried out its duties in an ethical, responsible and equitable manner during the year.

According to the Scheme Rules, the affairs of the Scheme must be managed according to these Rules by a Board of fit and proper members (i.e. with the requisite character, integrity, skill, competence, financial soundness and ability to exercise a fiduciary duty) of at least five and a maximum of eight Trustees.

At least 50% of Trustees on the Board are elected by members at any given time, which means that the Board has no influence over the re-election of these Trustees. In terms of its limited succession planning ability, the Board may also appoint additional Trustees to fill skills gaps if required or re-appoint a Trustee taking into account their performance and the skills and knowledge that are required on the Board. Trustees serve a term of three years and are eligible for subsequent re-election or re-appointment, but may not serve more than two consecutive terms.

The Board comprises independent, highly skilled professionals with expertise in legal, actuarial, accounting, economics, governance, clinical, financial, investment and human resources. The Board is satisfied that the diversity of skills and experience of the Trustees enables it to carry out its duties in a competent way that fulfils its responsibility to the Scheme's members.

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

The role of the Trustees is to:

- Evaluate, direct and monitor the Scheme's strategy, ensuring that it is aligned with the purpose and value drivers of the Scheme, and the legitimate interests and expectations of stakeholders;
- Review the sustainability of the Scheme and evaluate whether the services offered by the Administrator and Managed Care Provider meet the needs of the Scheme and its members, and offer value for money;
- Monitor innovation and oversee the improvement of all levels of the Scheme's operations;
- Monitor adherence to the Scheme Rules and the provisions of the Act in the day-to-day running of the Scheme's affairs; and
- Consider stakeholder perceptions and their impact on the Scheme's reputation.

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

The duties of the Trustees, set out in the Act and Scheme Rules, are to:

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

Trustees are remunerated for their services in terms of the Scheme's Remuneration Policy, which is included on **pages 66 to 69** of this Integrated Report. The benchmarked professional fees of Trustee and Board Committee members are discounted to recognise the non-profit status of medical schemes.

BOARD EVALUATIONS

The Board conducts annual self-assessments which include an evaluation of the Chairperson, a Trustee peer and self-rating, and an overall Board performance evaluation. These evaluations assess the following:

- Whether the Chairperson fulfils his role, leads the Board effectively in determining the Scheme's strategy and in assessing major risks impacting the Scheme's ability to deliver on its strategy, among other matters.
- The Trustee peer and self-rating assesses the following:
  - The role, responsibilities and duties of a Trustee, and their fitness and propriety in terms of skill and knowledge.
  - Whether a Trustee understands their role, responsibilities and duties in terms of the Act, the Scheme Rules and other legislation (such as the Companies Act 71 of 2008).
  - Whether the Trustee understands the interest and expectations of the Scheme's members and other stakeholders, and the Scheme's strategic objectives.
- The Board evaluation assesses the effectiveness of the Board in terms of the following matters, among others:
  - Whether it acts with due care, diligence, skill and good faith in ensuring the best interests of the Scheme and its members.
  - Whether it assesses the implementation of all strategic deliverables by the Scheme Office.
  - If it ensures that the outsourced activities performed by the Administrator and Managed Care Provider meets the needs of the Scheme and its members.
  - If it ensures that the Scheme Rules and all applicable legislation is adhered to in the day-to-day running of the Scheme Office, and ensures that proper control systems are employed by and on behalf of the Scheme.
  - If it considers stakeholder perceptions and their impact on the Scheme's reputation.

Based on the reviews conducted, the Trustees are satisfied with the effectiveness of the Chairperson and the Board as a whole. The outcome from the Trustee peer and self-rating evaluation did not identify any material weaknesses; however, this process aims to continually improve Board performance and effectiveness, and any concerns raised are discussed and addressed by the Trustees.

During 2018, the Scheme will be engaging the Institute of Directors in Southern Africa (IoDSA) to conduct an independent effectiveness review of the Board and Board Committees.

BOARD COMPOSITION, ATTENDANCE, RULES AND INDEPENDENCE

Where members of the Board or its Committees have served for longer than nine years, the Trustees must consider whether or not they remain independent.

The Trustees have considered the tenures of Mr Barry Stott, Chair of the Audit and Risk Committees, and Mr Steven Green, independent member of the Audit and Risk Committees, and believe that they remain sufficiently independent of the Scheme to continue serving on these Committees.

In addition, the Trustees have considered the independence of the Chairperson of the Board and believe him to be independent.

CURRENT TRUSTEE[1]

	Name of Trustee or Board Committee member	Designation	Appointed/elected	Start of term	End of term
1	**Michael van der Nest SC**	Trustee – Chair	**Appointed** 1st term	16 Aug 2011	15 Aug 2014
		Trustee – Chair	**Appointed** 2nd term	15 Aug 2014	14 Aug 2017
2	**Giles Waugh**	Trustee	**Appointed** 1st term	14 Apr 2011	13 Apr 2014
		Trustee	**Appointed** 2nd term	02 Jun 2014	02 Jun 2017
3	**Daisy Naidoo**	Trustee	**Elected** 1st term	20 Jun 2013	19 Jun 2016
		Trustee	**Elected** 2nd term	23 Jun 2016	22 Jun 2019
4	**Neil Morrison**	Trustee – Chair	**Elected**	23 Jun 2016	22 Jun 2019
5	**David King**	Trustee	**Elected**	23 Jun 2016	22 Jun 2019
6	**Dhesan Moodley**	Trustee	**Elected**	23 Jun 2016	22 Jun 2019
7	**John Butler SC**	Independent Co-opted member	**Appointed**	05 Sep 2016	
		Trustee	**Appointed**	14 Jun 2017	13 Jun 2020
8	**Johan Human**	Independent Co-opted member	**Appointed**	05 Sep 2016	
		Trustee	**Appointed**	14 Aug 2017	13 Aug 2020
9	**Joan Adams SC**	Trustee	**Elected**	22 Jun 2017	21 Jun 2020
10	**Susette Brynard**	Trustee	**Elected**	22 Jun 2017	21 Jun 2020
11	**Barry Stott**	Chair of the Audit and Risk Committees, independent Investment Committee member	**Appointed**	01 Jul 2013	
12	**Don Eriksson**	Chair of the Remuneration Committee	**Appointed**	08 Apr 2013	15 Nov 2017
13	**Imtiaz Ahmed**	Chair of the Investment Committee	**Appointed**	20 Jan 2016	
14	**Zephne van der Spuy**	Independent Clinical Governance Committee member	**Appointed**	04 Jul 2016	
15	**Mike Sathekge**	Independent Clinical Governance Committee member	**Appointed**	01 Jan 2016	
16	**Selma Smith**	Independent Clinical Governance Committee member	**Appointed**	01 Jan 2016	
17	**Philile Maphumulo**	Independent Audit, Risk and Investment Committees member	**Appointed**	20 Jan 2016	
18	**Sue Ludolph**	Independent Audit and Risk Committees member	**Appointed**	20 Jan 2016	
19	**Steven Green**	Independent Audit and Risk Committees member	**Appointed**	11 Dec 2001	
20	**Peter Goss**	Chair of the Nomination Committee	**Appointed**	22 Oct 2015	
21	**Tom Wixley**	Nomination Committee member	**Appointed**	22 Oct 2015	
22	**Roy Shough**	Nomination Committee member	**Appointed**	22 Oct 2015	

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

1 *Current Trustees at the time of publishing this Integrated Report.*

Board meetings attendance in 2017		21 Feb	22 Feb	28 Feb	24 Mar	06 Apr	09 Jun	14 Jun	12 Jul	07 Aug	29 Aug	16 Nov
Trustees	Mr Michael van der Nest SC#	✓	✓	✓	✓	✓	✓	✓	✓	✓	–	–
	Mr Neil Morrison▫	✓	✓	✓	✓	✓	✓	✓	✓	x	✓	✓
	Mr Giles Waugh*	x	✓	✓	✓	✓	–	–	–	–	–	–
	Ms Daisy Naidoo	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
	Mr David King	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
	Mr Dhesan Moodley	✓	✓	✓	✓	✓	✓	✓	✓	x	✓	✓
	Ms Joan Adams SC∞	–	–	–	–	–	–	–	✓	✓	✓	✓
	Mr Johan Human◊	✓	✓	✓	–	✓	✓	✓	✓	x	✓	✓
	Mr John Butler SC◊◆	✓	✓	–	–	✓	✓	✓	x	x	✓	✓
	Dr Susette Brynard∞	–	–	–	–	–	–	–	✓	✓	✓	✓
Chairperson: Audit and Risk Committee	Mr Barry Stott	✓	✓	✓	✓	✓	✓	✓	✓	x	✓	✓

 # Term as a Trustee/Chair ended on 14 August 2017 and Mr Neil Morrison was appointed by the Board as Chair on 6 April 2017, which appointment took effect on 14 August 2017 when Michael van der Nest SC's term as a Trustee/Chair ended.

▫ Elected as Chair on 14 August 2017.

** Term as a Trustee ended on 2 June 2017.*

∞ Elected as a Trustee on 22 June 2017.

◊ Independent Co-opted member until 14 August 2017, whereafter appointed as a Trustee.

◆ An administrative error in the Scheme Office resulted in Mr John Butler SC not receiving full remuneration as an Independent Co-opted member. In 2018, the remuneration was adjusted to correct this omission.

The meetings on 28 February, 14 June and 7 August were teleconferences.
The meeting on 24 March was with the Nomination Committee.

GOVERNANCE AND MANAGEMENT STRUCTURES

BOARD COMMITTEES

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

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

SCHEME MANAGEMENT

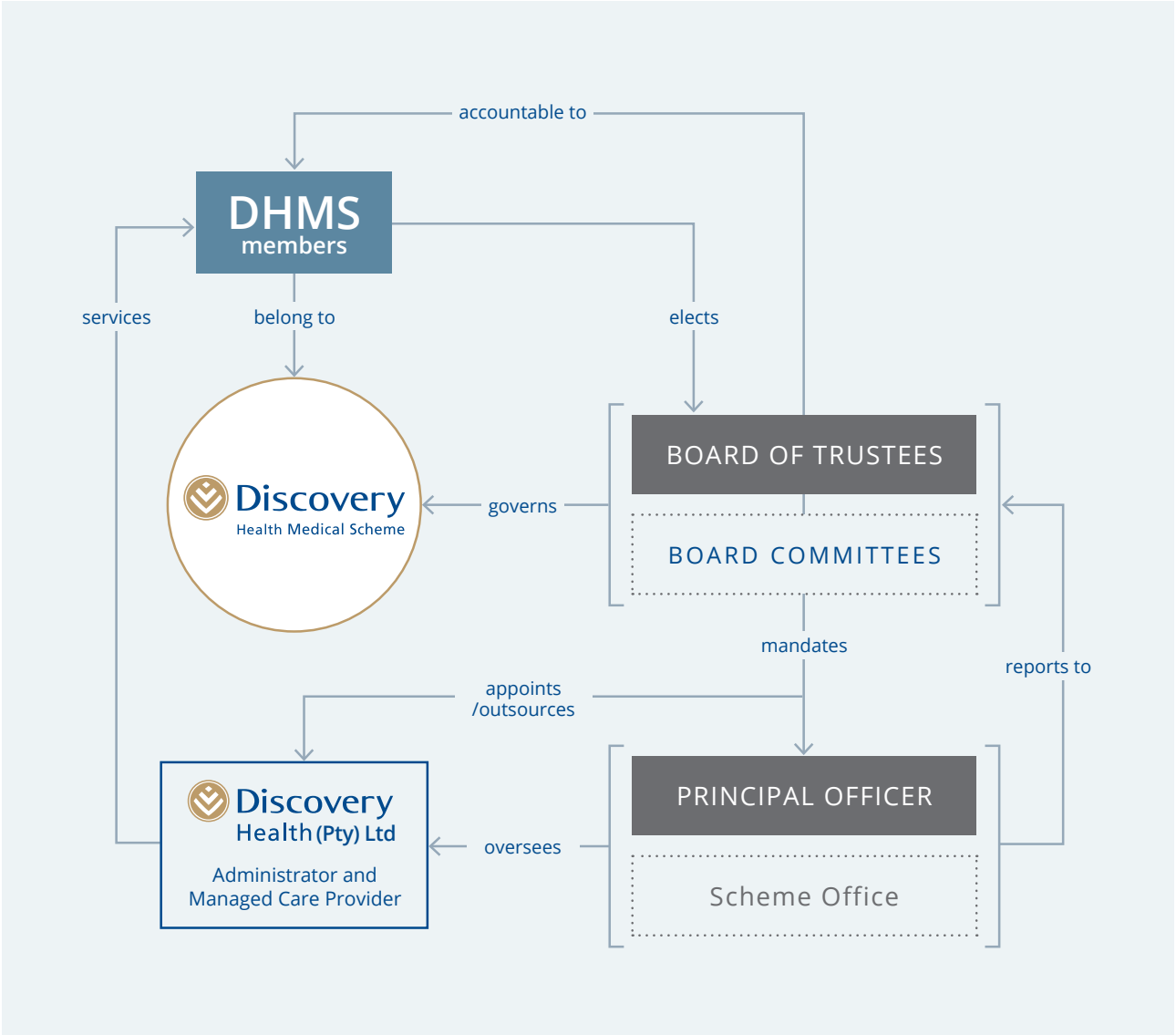
The Trustees appoint and delegate accountability for the day-to-day management of the Scheme to a Principal Officer, who is the chief executive of the Scheme. The Principal Officer executes the Trustees' decisions and implements strategy, and is supported by an executive management team.

SCHEME SECRETARIAT

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

DELEGATION OF AUTHORITY

The Board has implemented a formal delegation of authority that defines the authority, roles and responsibilities required for the optimal operation of the Scheme. During 2017, the Scheme commenced a process to review its operating model. This was completed towards the end of 2017 and resulted in recommendations relating to detailed accountabilities and authorities for each role in the Scheme Office. Once finalised, the recommendations will be incorporated into the existing delegation of authority.



OUR BOARD COMMITTEES

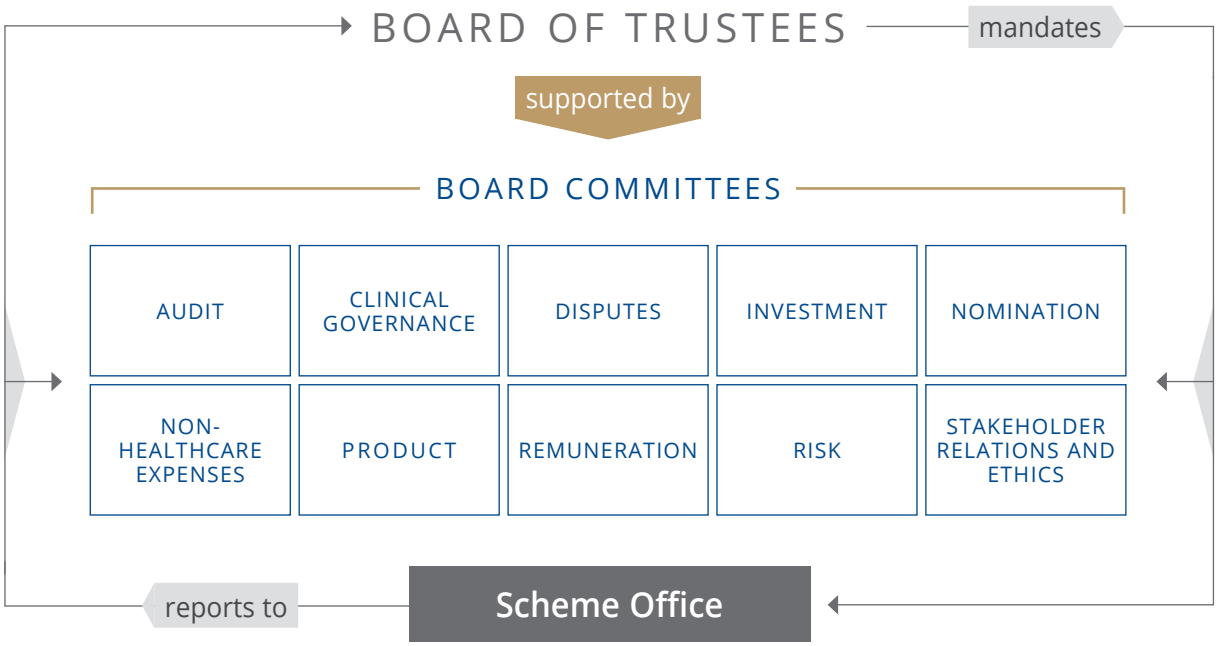
To fulfil its fiduciary and oversight duties effectively, the Board is assisted by ten Committees that are established according to governance best practice and the requirements of legislation.

Committee members are remunerated for their services in terms of the Scheme's Remuneration Policy, which is included on **page 66 to 69** of this Report. The benchmarked professional fees of Trustee and Board Committee members are discounted to recognise the non-profit status of medical schemes.

Each Committee conducted the annual self-assessments to evaluate their effectiveness and procedures, which covers areas such as:

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

Each Committee was satisfied with the results of the assessments, and no material weaknesses were identified.



AUDIT COMMITTEE

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

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

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

OUR AUDIT COMMITTEE CHAIRPERSON

MR BARRY STOTT

CA(SA)

Mr Stott commenced articles with PwC in February 1968 in the audit division. He was appointed partner in 1982, responsible for audits in the insurance and asset management industry. Mr Stott also led the financial services industry practice and financial services knowledge management division, and ensured that PwC staff were up to date on all issues in the industry, trained in industry specialisation and on all IFRS issues relating to the financial services industry.

Since retiring from PwC in June 2009, Mr Stott has been a member of audit panels for Momentum Asset Management, Momentum Wealth, Rand Merchant Bank Asset Management and Advantage Asset Management. Since January 2010, Mr Stott has been an independent non-executive director of Clientèle Holdings Ltd, Clientèle Life Limited and Clientèle General Limited. He is the chairman of the Audit, Risk, and Remuneration Committees of the Clientele Group, as well as a member of the Clientèle Group Investment Committee and attends Actuarial Committee meetings.

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

HOW THE COMMITTEE DISCHARGED ITS FIDUCIARY DUTIES DURING 2017

PAGE REFERENCE

Read the Audit Committee's report on **pages 97 – 98**, and more about non-compliance matters on **pages 81 – 82**.

The Committee is satisfied that the activities it has conducted and the manner in which it has reported and recommended to the Board during 2017 have fulfilled its responsibilities in accordance with its terms of reference.

COMPOSITION AND MEETINGS IN 2017

The Audit Committee comprises highly skilled and experienced members with extensive actuarial, financial and IT skills. At the end of 2017, the Committee comprised four Trustees and four independent members, one of whom Chaired the Committee.

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

Committee members may consult any expert or specialist to assist the Committee in performing its duties. The external auditors and the Principal Officer, as well as the internal auditors attend all Committee meetings by invitation and have unrestricted access to the Chairperson of the Audit Committee. The heads of the outsourced administration functions, which includes the finance and actuarial functions, also attend the meeting to allow the Committee to obtain insight and comfort regarding the outsourced functions.

Audit Committee attendance in 2017		10 Mar	17 Mar	15 Aug	23 Aug	03 Oct
Chairperson	Mr Barry Stott (Independent member)	✓	✓	✓	✓	✓
Committee members	Ms Daisy Naidoo (Trustee)	✓	✓	✓	✓	✓
	Mr Giles Waugh (Trustee)#	✓	x	–	–	–
	Mr Neil Morrison (Trustee)◆	✓	✓	–	–	–
	Ms Joan Adams SC (Trustee)*	–	–	✓	✓	✓
	Mr Johan Human (Trustee)∞	–	–	x	✓	✓
	Mrs Sue Ludolph (Independent member)	✓	✓	✓	✓	✓
	Mr Steven Green (Independent member)	✓	✓	✓	✓	✓
	Mrs Philile Maphumulo (Independent member)	✓	✓	✓	✓	✓

 # Term as a Trustee ended on 2 June 2017.

** Elected as a Trustee on 22 June 2017 and appointed to the Committee on 12 July 2017.*

◆ Appointed by the Board as Chair on 6 April 2017 which appointment took effect on 14 August 2017 and at that time resigned as a member of the Committee.

∞ Independent member until 14 August 2017, whereafter appointed as a Trustee and appointed to the Committee on 12 July 2017.

FUTURE FOCUS AREAS

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

With effect from 2018, the Audit Committee has been assigned the mandate for monitoring the effectiveness and appropriateness of the combined assurance model.

CLINICAL GOVERNANCE COMMITTEE

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

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

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

The Committee's responsibilities are to:

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

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

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

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

HOW THE COMMITTEE DISCHARGED ITS FIDUCIARY DUTIES DURING 2017

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

The Committee met four times during 2017 and considered strategic risk management plans and reports. The Committee approved and monitored the development of new quality of care initiatives, including patient reported experience and outcomes measurement surveys in the primary healthcare setting (the GP PREMS survey) and specialist settings (the joint arthroplasty PROMS), and initial clinical outcomes measurement in the hospital setting (mortality and readmissions). The Committee also considered the 2016 HQA results for the Scheme, which are benchmarked against industry performance and approved related plans for continuous improvement.

In line with the adoption of the value-based care model, the Committee endorsed and monitored the development and implementation of new models of healthcare delivery and alternative reimbursement models. These included the DiabetesCare and HIVCare programmes delivered through the new Premier Plus GP network for chronic disease management in the primary healthcare setting, centres of excellence (e.g. the Joint Arthroplasty network) and various governance projects in collaboration with selected specialist professional societies.

The Committee also considered the value of Discovery Health's digital platforms to enable value-based care. This included the integration of HealthID in both the chronic disease management and acute primary care setting, and DrConnect in enabling convenient access to healthcare advice any time to members, digital consultations and professional development support to the healthcare provider fraternity.

The Committee continued to provide oversight in relation to the approval and monitoring of new pilot projects designed to evaluate the development of funding policies for new health technology, routine health technology assessment reports and medicine/ pharmaceutical benefit risk management.

The Committee also continues to monitor developments in the private healthcare market, including the on-going Health Market Inquiry and health systems policy reform (in particular, the NHI policy and Prescribed Minimum Benefit Review projects). With respect to CMS activities, the Committee monitors the impact of CMS publications including draft and final Benefit Definitions, CMS Scripts, and any clinical governance related CMS circulars and guides, and evaluates the contributions and submissions made by the Scheme and Discovery Health in relation to these publications.

In addition, the Committee monitors other public health related topics that may impact the Scheme population's health and claims utilisation, including outbreaks and epidemics, through passive surveillance and reporting of claims data.

The Committee is satisfied that the activities it has conducted and the manner in which it has reported and recommended to the Board during 2017 have fulfilled its responsibilities in accordance with its terms of reference.

COMPOSITION AND MEETINGS IN 2017

At the end of 2017 the members included two Trustees, one of whom Chaired the Committee, and three independent members and the Chief Medical Officer of the Scheme.

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

Clinical Governance attendance in 2017		30 Mar	01 Jun	30 Oct	31 Oct
Chairperson	Dr Dhesan Moodley (Trustee)	✓	✓	✓	✓
Committee members	Ms Joan Adams SC (Trustee)#	–	–	✓	✓
	Prof Zephne van der Spuy (Independent member)	✓	✓	✓	✓
	Prof Mike Sathekge (Independent member)	✓	x	x	x
	Prof Selma Smith (Independent member)	✓	✓	✓	✓
	Dr Nozipho Sangweni (Principal Officer)* %	✓	✓	✓	✓
	Dr Unati Mahlati (Chief Medical Officer)∞ %	–	–	✓	✓

 # Elected as a Trustee on 22 June 2017 and appointed to the Committee on 12 July 2017.

** Appointed as Principal Officer on 1 January 2017 and acted as Chief Medical Officer until 7 June 2017.*

∞ Appointed as Chief Medical Officer on 7 June 2017.

% Scheme Executives. All remaining Committee members are non-executive.

FUTURE FOCUS AREAS

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

DISPUTES COMMITTEE

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

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

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

The Committee's responsibilities are to:

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

HOW THE COMMITTEE DISCHARGED ITS FIDUCIARY DUTIES DURING 2017

The Committee heard a total of 52 disputes. Although 740 disputes were lodged in 2017, 688 of these were resolved prior to a hearing, indicating the efficacy of the dispute resolution process.

The Committee is satisfied that the activities it has conducted during 2017 have fulfilled its responsibilities in accordance with its operating framework.

COMPOSITION AND MEETINGS IN 2017

Each Disputes Panel consists of three members drawn from the greater Disputes Committee, each of whom have either legal or medical expertise. Each Panel presiding over all Dispute Hearings requires at least one legal expert and at least one medical expert. The Chairperson of all Dispute Hearings is always a practising attorney. While not employed by the Scheme, Committee members are remunerated for their time and input in objectively hearing and adjudicating cases, regardless of the outcome of the hearings.

Dispute Hearings are scheduled as and when required, and draw from the legal and medical panellists available at the time. The Committee can be constituted several times a week if required to attend to increased caseloads. Due to the frequency of hearings and variation of panellists, an attendance register is not shown. During 2017, every hearing was properly constituted.

FUTURE FOCUS AREAS

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

INVESTMENT COMMITTEE

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

The Committee's responsibilities are to:

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

HOW THE COMMITTEE DISCHARGED ITS FIDUCIARY DUTIES DURING 2017

- Conducted a procurement process for the appointment of its asset consultant, which resulted in the reappointment of the incumbent asset consultant.
- Considered the Scheme's strategic investment strategy as well as the tactical asset allocations that take account of current market conditions.
- Appointed a new boutique equity asset manager and made an allocation of investments into an equity index tracking fund and a listed property fund.
- Adopted a Tactical Asset Allocation Framework.
- Reviewed the results of the Scheme's annual due diligence exercise conducted across all its asset managers, which included on-site visits. No specific concerns were identified.
- Reviewed quarterly credit risk reports in terms of the Scheme Credit Risk Policy to ensure credit risk was being appropriately managed.
- Reviewed the performance of asset managers.

The Committee is satisfied that the activities it has conducted and the manner in which it has reported and recommended to the Board during 2017 have fulfilled its responsibilities in accordance with its terms of reference.

COMPOSITION AND MEETINGS IN 2017

At the end of 2017, the Committee consisted of four Trustees and three independent members, one of whom Chaired the Committee. The Committee receives investment advice and quarterly reports from the asset consultants, Riscura, who attend all Committee meetings. Asset managers are invited to attend meetings on a rotational basis to report on their strategy and performance.

Investment Committee attendance in 2017		13 Feb	04 Apr	07 Jun	12 Sep	07 Nov
Chairperson	Mr Imtiaz Ahmed (Independent member)	✓	✓	✓	✓	✓
Committee members	Ms Daisy Naidoo (Trustee)	✓	✓	✓	✓	✓
	Dr Dhesan Moodley (Trustee)	✓	✓	✓	✓	✓
	Mr Johan Human (Trustee)#	–	–	–	✓	✓
	Mr Neil Morrison (Trustee)	✓	✓	✓	✓	✓
	Mr Barry Stott (Independent member)	✓	✓	✓	✓	✓
	Ms Philile Maphumulo (Independent member)*	–	–	–	✓	✓

 # Independent member until 14 August 2017, whereafter appointed as a Trustee. Appointed to the Committee on 12 July 2017.

** Appointed as an Independent member on 12 July 2017.*

FUTURE FOCUS AREAS

During 2018, the Committee will review its strategic and tactical asset allocation to account for changes in the market conditions and the Scheme's risk appetite. This will include a review of the Scheme's hedging strategies.

NON-HEALTHCARE EXPENSES COMMITTEE

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

PAGE REFERENCE
Read more about the Vested model on **page 18**.

The Committee's responsibilities are to:

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

HOW THE COMMITTEE DISCHARGED ITS FIDUCIARY DUTIES DURING 2017

- Agreed revised contractual terms and fees with Discovery Health for providing administration and managed care services for the period starting January 2018.
- Reviewed reports on the service levels achieved by Discovery Health and approved changes to them in line with the operating environment.
- Assessed innovations by Discovery Health.
- Reviewed reports on the Scheme's non-healthcare expenses against budget and recommended the 2018 budget to the Trustees for approval.

The Committee is satisfied that the activities it has conducted and the manner in which it has reported and recommended to the Board during 2017 have fulfilled its responsibilities in accordance with its terms of reference.

COMPOSITION AND MEETINGS IN 2017

At the end of 2017, the Committee comprised five Trustees, one of whom Chaired the Committee, and the Principal Officer. Committee meetings are attended by the DHMS Chief Risk and Operations Officer, who is responsible for oversight of the outsourced administration and managed healthcare services, as well as the Chief Financial Officer. Executive management of Discovery Health attend when required by the Committee.

Non-healthcare Expenses Committee attendance in 2017

		06 Mar	22 Mar	04 May	05 Jun	10 Oct
Chairperson	Mr Giles Waugh (Trustee)#	✓	✓	✓	–	–
	Ms Daisy Naidoo (Trustee)◆	✓	✓	✓	✓	✓
Committee members	Mr David King (Trustee)	✓	✓	✓	✓	✓
	Mr John Butler SC (Trustee)*	–	–	–	–	✓
	Mr Neil Morrison (Trustee)	✓	✓	✓	✓	✓
	Mr Johan Human (Trustee)∞	✓	✓	✓	✓	–
	Dr Nozipho Sangweni (Principal Officer)%	✓	✓	✓	✓	✓

 # Term as a Trustee and Chair ended on 2 June 2017.

◆ Appointed as the Chair on 5 June 2017.

** Appointed as a Trustee on 14 June 2017 and appointed to the Committee on 12 July 2017.*

∞ Independent member until 14 August 2017, whereafter appointed as a Trustee.

% Scheme Executive. All remaining Committee members are non-executive.

The meetings on 6 March and 4 May were workshops. A workshop was also held after the Committee meeting on 22 March 2017.

FUTURE FOCUS AREAS

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

NOMINATION COMMITTEE

The Committee oversees the nomination process to elect and appoint suitably fit and proper persons as Trustees. In terms of the Scheme Rules, the Trustees may appoint an independent third-party service provider to assist the Nomination Committee in carrying out its functions. For the 2017 election, the Trustees approved the appointment of PwC's Forensic Services division to act as the Independent Electoral Body (IEB) for the Scheme.

In 2017, an election was conducted at the Scheme's AGM. The Nomination Committee oversaw this process from a governance perspective in terms of its mandate.

HOW THE COMMITTEE DISCHARGED ITS FIDUCIARY DUTIES DURING 2017

The Committee performed the following functions:

- Oversaw the procedural aspects of the nominations process in terms of approving communications to members.
- Ensured that the IEB applied a vetting process so that the candidates who stood for election were fit and proper. During the vetting process, each nominee was subject to strict vetting criteria.
- Reviewed and discussed the draft candidate list compiled by the IEB, and thereafter presented the final list to the Trustees in terms of the candidates that would stand for election.
- Assessed the eligibility, fitness and propriety of the Trustees that were appointed by the Board.

The Committee is satisfied that the activities it has conducted and the manner in which it has reported and recommended to the Board during 2017 have fulfilled its responsibilities in accordance with its terms of reference.

COMPOSITION AND MEETINGS IN 2017

The Committee comprises three independent members who are independent of the Board and Board Committees. Committee meetings are attended by the IEB and its representatives.

Nomination Committee attendance in 2017		24 Mar	27 Mar	06 Apr	11 Apr
Chairperson	Mr Peter Goss (Independent member)	✓	✓	✓	✓
Committee members	Mr Roy Shough (Independent member)	✓	✓	✓	✓
	Mr Tom Wixley (Independent member)	✓	✓	✓	✓

FUTURE FOCUS AREAS

In 2018, no Trustee elections will be held by the Scheme. A Trustee election will be held in 2019 and the Nomination Committee will oversee this process from a governance perspective in terms of its mandate.

PRODUCT COMMITTEE

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

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

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

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

HOW THE COMMITTEE DISCHARGED ITS FIDUCIARY DUTIES DURING 2017

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

The Committee collaborated with the Audit Committee and Clinical Governance Committee in considering the financial impact and actuarial valuation, and clinical appropriateness of the 2018 product design and benefit amendments, prior to making the final recommendations to the Board for approval.

The Committee is satisfied that the activities it has conducted and the manner in which it has reported and recommended to the Board during 2017 have fulfilled its responsibilities in accordance with its terms of reference.

COMPOSITION AND MEETINGS IN 2017

At the end of 2017, the Committee comprised four Trustees, one of whom Chaired the Committee, and the Principal Officer. The Committee obtains regular reports and presentations from Discovery Health, and the relevant individuals are regularly invited to Committee meetings for this purpose.

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

Product Committee attendance in 2017		29 Mar	26 Jul	23 Aug
Chairperson	Mr Giles Waugh (Trustee)#	✓	–	–
	Mr Johan Human (Trustee)*	✓	✓	✓
Committee members	Dr Dhesan Moodley (Trustee)	✓	✓	✓
	Ms Daisy Naidoo (Trustee)	✓	✓	✓
	Dr Susette Brynard (Trustee)∞	–	✓	✓
	Dr Nozipho Sangweni (Principal Officer)%	✓	✓	✓

 # Term as a Trustee and Chair ended on 2 June 2017.

** Independent member until 14 August 2017, whereafter appointed as a Trustee and appointed as Chair on 2 June 2017.*

∞ Elected as a Trustee on 22 June 2017 and appointed to the Committee on 12 July 2017.

% Scheme Executive. All remaining Committee members are non-executive.

FUTURE FOCUS AREAS

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

REMUNERATION COMMITTEE

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

The Committee's responsibilities are to:

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

HOW THE COMMITTEE DISCHARGED ITS FIDUCIARY DUTIES DURING 2017

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

With the support of the Committee, the Scheme presented its Trustee Remuneration Policy to members at its 2017 AGM for a non-binding advisory vote, which received 96% approval. The Scheme also presented its Trustee remuneration, which received a 98%[2] approval. The formal approval of Trustee remuneration by members is a standing agenda item at each AGM.

The Committee is satisfied that the activities it has conducted and the manner in which it has reported and recommended to the Board during 2017 have fulfilled its responsibilities in accordance with its terms of reference.

COMPOSITION AND MEETINGS IN 2017

At the end of 2017, the Committee comprised four Trustees, three of whom were appointed to the Committee during 2017, and an independent member who Chaired the Committee. The Principal Officer attends Committee meetings by invitation.

The Committee makes regular use of independent remuneration experts from PwC, and engaged Spencer Stuart to recruit for the Scheme Office and the LRMG Performance Agency to conduct the Scheme's operating model review during 2017. Individuals from these organisations are occasionally invited to Committee meetings.

Remuneration Committee attendance in 2017		25 May	15 Nov
Chairperson	Mr Don Eriksson (Independent member)∞	✓	✓
Committee members	Mr David King (Trustee)	✓	✓
	Mr Michael van der Nest SC (Trustee)#	✓	–
	Mr John Butler SC (Trustee)*	–	✓
	Mr Neil Morrison (Trustee)◊	–	✓
	Dr Susette Brynard (Trustee)◆	–	✓

∞ Mr Eriksson served as the Chair of the Committee from 8 April 2013 to 15 November 2017 and resigned for personal reasons from the Committee on 15 November 2017, after which Mr David King was appointed Chair by the Committee.

 # Term as a Trustee ended on 14 August 2017.

** Appointed as a Trustee on 14 June 2017 and appointed to the Committee on 12 July 2017.*

◊ Appointed to the Committee on 12 July 2017.

◆ Elected as a Trustee on 22 June 2017 and appointed to the Committee on 12 July 2017.

1 At least 50% of Trustees must be elected by members at any time, which means that succession planning is not possible for these positions.

2 The AGM elections and voting results are available at https://www.discovery.co.za/medical-aid/notices.

FUTURE FOCUS AREAS

For 2018, the Committee's mandate was amended to explicitly include supporting the Trustees in ensuring that remuneration in the Scheme is fair, responsible and transparent to promote positive outcomes and the achievement of objectives. In this regard, the Committee will ensure that the remuneration policy is designed to attract, retain, motivate and reward high-calibre individuals, promote the achievement of strategic objectives, and promote an ethical culture and responsible corporate citizenship.

In effect, the Committee has already been fulfilling this mandate by ensuring that independent professional benchmarking of remuneration was practised and by reviewing the Scheme's employee value proposition. The Committee will continue to engage in these activities. Specifically, during the course of 2018, the Committee will review the Scheme's performance management framework.

King IV requires that the governing body should set targets for race and gender, and the Scheme will give due consideration to these provisions regarding the appointment of candidates, and apply those in the context of the medical scheme environment. This provision may only be exercised by the Board in terms of appointments being made by the Board, as members standing for election are elected by Scheme members at an election held at the AGM. Therefore the voting process does not allow the Board control with regard to diversity targets. The Scheme is committed to maintaining a fair and non-discriminatory working environment.

The Remuneration Committee will assist the Board in discharging the provisions regarding the appointment of candidates.

RISK COMMITTEE

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

The Committee's responsibilities are to:

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

COMPLIANCE MANAGEMENT

The Trustees recognise their responsibility to internal and external stakeholders in terms of the regulatory requirements applicable to the Scheme.

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

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

COMBINED ASSURANCE

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

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

The combined assurance assessment showed that overall, adequate assurance was provided and received in respect of all significant risks for the 2017 benefit year. The Trustees are comfortable with the level and type of assurance the Scheme obtains.

RISK MANAGEMENT

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

The Scheme outsources certain risk management activities to the Discovery Group Risk Management function.

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

HOW THE COMMITTEE DISCHARGED ITS FIDUCIARY DUTIES DURING 2017

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

The Committee is satisfied that the activities it has conducted and the manner in which it has reported and recommended to the Board during 2017 have fulfilled its responsibilities in accordance with its terms of reference.

COMPOSITION AND MEETINGS IN 2017

At the end of 2017, the Committee comprised three Trustees and four independent members, one of whom Chaired the Committee. Members of the Scheme Office management are also members of the Committee.

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

Risk Committee attendance in 2017

		10 Mar	04 Aug	15 Aug	03 Oct
Chairperson	Mr Barry Stott (Independent member)	✓	✓	✓	✓
Committee members	Mr Giles Waugh (Trustee)#	✓	–	–	–
	Ms Daisy Naidoo (Trustee)	✓	✓	✓	✓
	Ms Joan Adams SC (Trustee)*	–	✓	✓	✓
	Mr Neil Morrison (Trustee)◊	✓	–	–	–
	Mr Johan Human (Trustee)∞	–	✓	x	✓
	Mrs Sue Ludolph (Independent member)	✓	✓	✓	✓
	Mr Steven Green (Independent member)	✓	✓	✓	✓
	Mrs Philile Maphumulo (Independent member)	✓	✓	✓	✓
Scheme Management	Dr Nozipho Sangweni (Principal Officer)%	✓	x	✓	✓
	Dr Unati Mahlati◆%	–	✓	✓	✓
	Mr Selwyn Kahlberg%	✓	✓	✓	✓
	Mr Jan van Staden□%	✓	x	✓	✓
	Mrs Yashmita Mistry%	✓	x	✓	✓
	Ms Michelle Culverwell%	✓	✓	✓	x
	Mr Howard Snoyman%	✓	x	x	✓

 # Term as a Trustee ended on 2 June 2017.

** Elected as a Trustee on 22 June 2017 and appointed to the Committee on 12 July 2017.*

◊ Appointed by the Board as Chair of the Board on 6 April 2017 which appointment took effect on 14 August and at that time resigned as a member of the Committee.

∞ Independent member until 14 August 2017, whereafter appointed as a Trustee.

% Scheme Executives. All remaining Committee members are non-executive.

◆ Appointed as Chief Medical Officer on 7 June 2017.

□ Resigned in December 2017.

The meeting on 4 August was a workshop.

FUTURE FOCUS AREAS

In late 2017, the Committee approved enhancements to the Scheme's enterprise risk management framework to align with King IV best practice. The 'triple context' and 'six capitals' concepts prescribed by King IV are catered for in the Scheme's risk taxonomy. Risk is defined as:

- The possibility of an event materialising that could have a negative impact on the Scheme achieving its strategic objectives, together with the opportunity that may present itself as a consequence of the event occurring; or
- The failure to capitalise on opportunities that would advance the Scheme in achieving its strategic objectives.

In addition, the Committee's terms of reference have also been amended to align with King IV. In this regard, the Committee will continue to exercise due care and responsibility in fulfilling its mandate.

With effect from 2018, the Audit Committee has been assigned the mandate for monitoring the effectiveness and appropriateness of the combined assurance model.

STAKEHOLDER RELATIONS AND ETHICS COMMITTEE[1]

The Committee assists the Trustees in identifying important stakeholder groups and their legitimate interests and expectations. The Committee also oversees the development and implementation of adequate processes and procedures for stakeholder engagement, ensuring that the legitimate interests of stakeholders are balanced against the best interests of the Scheme as a whole. The Committee may rely on other Board Committees in its oversight responsibilities.

The Committee's responsibilities are to:

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

HOW THE COMMITTEE DISCHARGED ITS FIDUCIARY DUTIES DURING 2017

- Reviewed reports relating to overall stakeholder engagement, social media engagement, disputes and complaints, and high-risk cases.
- Reviewed plans for engagement with stakeholders with regards to the Scheme's AGM and Trustee nominations and elections.
- Reviewed member engagement, communication approaches and activities undertaken by the Scheme and Discovery Health in relation to the Competition Commission's HMI into the private healthcare sector, general Competition Commission matters, the Department of Health, the CMS and other regulatory activity.
- Reviewed health professional engagement strategies to encourage participation in quality of care, alternative reimbursement mechanisms and centres of excellence initiatives in development by Discovery Health.
- Reviewed innovative proposals for member engagement by Discovery Health.
- Considered the possible expansion of its mandate to incorporate social and ethics governance in accordance with King IV best practice requirements.
- Recommended to the Board that its mandate be extended to incorporate ethics and responsible corporate citizenship and, subsequent to Board approval, adopted a revised terms of reference in this regard.
- Received presentations from The Ethics Institute on its ethical obligations.

The Committee is satisfied that the activities it has conducted and the manner in which it has reported and recommended to the Board during 2017 have fulfilled its responsibilities in accordance with its terms of reference.

1 *At the end of 2017, the Committee adopted an expanded social and ethics governance mandate and new name of Stakeholder Relations and Ethics Committee (previously Stakeholder Relations Committee).*

COMPOSITION AND MEETINGS IN 2017

At the end of 2017, the Committee comprised five Trustees[1], one of whom Chaired the Committee, and the Principal Officer. The Committee requires that one of its members is a member of the medical profession.

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

Stakeholder Relations and Ethics Committee attendance in 2017

		23 Feb	25 Jul	26 Oct
Chairperson	Mr John Butler SC (Trustee)*	✓	✓	✓
Committee members	Dr Dhesan Moodley (Trustee)	✓	✓	✓
	Mr Michael van der Nest SC (Trustee)#	✓	x	–
	Mr David King (Trustee)	✓	✓	✓
	Dr Susette Brynard (Trustee)∞	–	✓	✓
	Mr Neil Morrison (Trustee)◆	–	✓	✓
	Dr Nozipho Sangweni (Principal Officer)%	✓	✓	x

* *Independent member until 14 June 2017, whereafter appointed as a Trustee.*

\# *Term as a Trustee ended on 14 August 2017.*

∞ *Elected as Trustee on 22 June 2017 and appointed to the Committee on 12 July 2017.*

◆ *Appointed to the Committee on 12 July 2017.*

% *Scheme Executive. All remaining Committee members are non-executive.*

FUTURE FOCUS AREAS

In late 2017, the Committee changed its name and amended its mandate to include social and ethics governance in accordance with King IV best practice. The terms of reference now include requirements to ensure that DHMS has an ethical culture and operates as a good corporate citizen.

In this regard, the Committee will actively monitor and provide oversight of the Scheme's responsible corporate citizenship activities, and is incorporating extended reporting into its agenda; for example, reporting on Treating Customers Fairly and on fraud and forensics. Specifically, the Committee will be overseeing an extensive review of ethics in the Scheme's internal and external environments on behalf of the Trustees, and will provide regular reports to the Board.

PAGE REFERENCE

Read more about the Stakeholder Relations and Ethics Committee on **pages 30 – 33**.

1 *One of whom was an independent member of the Committee until his appointment as a Trustee in June 2017.*

DISCOVERY HEALTH MEDICAL SCHEME
BOARD AND BOARD COMMITTEE MEMBER

REMUNERATION POLICY

Background and context

The Discovery Health Medical Scheme (DHMS or the Scheme) strives, through its remuneration policies, to provide an ethical business framework for the establishment of protocols to equitably and responsibly remunerate, in accordance with the recommended remuneration practices stipulated in the King IV Report on Corporate Governance for South Africa 2016 (King IV), high calibre people with above average industry ability and leadership potential, to effectively govern the Scheme's operations and safeguard members' interests.

The provision of the Scheme's remuneration policies that are respectively applicable to the Trustees and Board Committee members and employees of the Medical Scheme relates to and upholds the obligations of the following legislation and regulations:

- King IV.
- Medical Schemes Act 131 of 1998, as amended (the Act) and the Scheme Rules.
- Council for Medical Schemes Guidelines for Trustee Remuneration.
- The Companies Act 71 of 2008.
- The Promotion of Equality and Unfair Discrimination Act 4 of 2000.
- The Labour Relations Act 66 of 1995.
- The Basic Conditions of Employment Act 75 of 1997.
- The Employment Equity Act 55 of 1998.

The Scheme shall refer to the applicable provisions of King IV for matters that are not covered in the scope of, or are addressed in, the Act and the Scheme Rules.

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

REMUNERATION GOVERNANCE

The primary objective of King IV is to provide best practice recommendations to enable entities in South Africa to improve their corporate governance practices, and includes and has bearing on the remuneration practices of corporations.

Principle 14 of King IV states that the governing body should ensure that the organisation remunerates fairly, responsibly and transparently so as to promote the achievement of strategic objectives and positive outcomes in the short, medium and long term.

THE SCHEME'S REMUNERATION GOVERNANCE MODEL

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

DELEGATION OF RESPONSIBILITY OF OVERSIGHT OF SCHEME REMUNERATION

The Principal Officer and executive management of the Scheme are responsible for the day-to-day running of the Scheme, with the aim of maximising value for members and other stakeholders.

The Board of Trustees (Board) is responsible for strategic oversight and to review the implementation of strategy by executive management of the Scheme, and to ensure that effective mechanisms and controls are in place to protect the interests of the members of the Scheme.

The Board of the Scheme is responsible for the development and implementation of a:

- Remuneration Policy for the employees of the Scheme; and
- Remuneration Policy for the Trustees and Board Committee members.

The Board, in turn, delegates responsibility for oversight of the Scheme's remuneration practices to the Remuneration Committee.

The role of the Remuneration Committee is to make recommendations to the Board regarding the remuneration strategy, policies and practices of the Scheme. The Remuneration Committee:

- Is constituted of Trustees and independent members, which ensures that the work of this committee is free from conflict, which in turn provides a substantial degree of security for members;
- Acts under the delegated authority of the Board of the Scheme;
- Has a role to provide an independent influence on remuneration decisions made in respect of the Board and Board Committee members and employees of the Scheme; and
- Is also assisted by independent remuneration advisors and experts.

REMUNERATION POLICIES

The Scheme has established remuneration policies for the employees, the Board and Board Committee members.

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

ADOPTION AND APPROVAL OF THE SCHEME'S REMUNERATION POLICIES

TRUSTEES AND BOARD COMMITTEE MEMBERS' REMUNERATION POLICY

To enable Scheme members to express their views on the Scheme's remuneration policy for Trustees and Board Committee members, the policy will be tabled at the Scheme's Annual General Meeting (AGM) for a non-binding advisory vote.

EMPLOYEE REMUNERATION POLICY

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

MITIGATION OF CONFLICT OF INTERESTS

Trustees and Board Committee members hold non-executive status within the Scheme and are therefore, in terms of the Scheme's remuneration policy and in accordance with best corporate remuneration governance practices, not permitted to be paid consulting fees for consulting services rendered or to participate in any incentive programmes of the Scheme. This ensures that Trustees and Board Committee members are able to act independently of any personal interest when making a fiduciary decision for or on behalf of the Scheme.

MARKET BENCHMARKING

The remuneration of the Trustees, Board Committee members and employees of the Scheme are benchmarked periodically through independent review. The Scheme's Remuneration Committee uses:

- Market trends in professional fees/rates for professionals in the field of law, actuarial science, medicine and commerce for determining Trustee and Board Committee member fees; and
- Market trends and independent benchmarking of remuneration of positions in an applicable industry for employees.

This provides the Scheme with information relating to market trends in remuneration practices and ensures that the Scheme compensates Board and Board Committee members and employees in accordance with appropriate market norms.

The benchmarked professional fees of Trustee and Board Committee members are discounted to recognise the non-profit status of medical schemes.

DISCLOSURE OF INFORMATION REGARDING REMUNERATION

In accordance with recommended practice in King IV:

- The remuneration policies for Trustees and Board Committee members shall be tabled at the AGM of the Scheme for a non-binding advisory vote; and
- The remuneration of the Trustees and Board Committee members shall be approved by members at the AGM of the Scheme and shall be reported on in the Scheme's Integrated Report.

This information shall be disclosed at least 21 days prior to the AGM.

Members at the AGM are provided with indicative examples of how the Board and Board Committee members' remuneration is calculated.

The Council for Medical Schemes are provided with details of how the proposed Trustees and Board Committee member fees for each year have been determined, as well as the details of the independent external advisors who provided advice to the Remuneration Committee on the structuring of Trustees and Board Committee member fees.

The above practices have been implemented to increase the Board's transparency and accountability to members of the Scheme in respect of the decisions that they make on the remuneration policies and practices of the Scheme.

Policy details

PURPOSE OF POLICY

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

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

SCOPE OF POLICY

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

POLICY STATEMENT

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

REMUNERATION OF THE BOARD OF TRUSTEES AND BOARD COMMITTEE MEMBERS OF THE SCHEME

The DHMS fee structure is designed to recognise the important strategic oversight role of the Trustees and Board Committee members, and their fiduciary duties to ensure the long-term sustainability of the Scheme. It is therefore critical for DHMS to attract and retain Trustees and Board Committee members with the appropriate skills and expertise to oversee the business of the Scheme in the best interest of members.

The fee structure recognises the contribution of Trustees and Board Committee members in terms of their knowledge, skills, expertise and time commitments, and includes the following elements:

- Trustees and Board Committee members are entitled to remuneration in respect of services rendered in their capacity as members of the Board and Committees as determined and recommended by the Scheme's Remuneration Committee, which is reviewed on an annual basis.
- Trustees and Board Committee members are compensated a market-related, but discounted, professional fee commensurate with the level of skill and expertise required in relation to the nature of the duties and concomitant responsibility attributed to the specific role and function of Trustees.
- The fees take into account the fact that the Scheme is a non-profit entity. Trustees and Board Committee members hold non-executive status within the Scheme and are, therefore, in terms of the Scheme's remuneration policy, not permitted to be paid consulting fees for consulting services rendered.
- The remuneration of Trustees and Board Committee members is limited to a fee and does not include any additional benefits such as participation in the Scheme's incentive programme. This ensures that Trustees are able to act independently of any personal interest in terms of their fiduciary duties.
- The total annual fees payable to Trustees and Board Committee members is split into an annual base fee (70%) and a fee per meeting (30%). The annual base fees and fees per meeting payable to Board Committee members are not the same as those payable to Trustees, and are based on a lower meeting duration and fewer meetings. The number of hours required will be different for Board Committee meetings, taking into consideration the relative strategic importance and time requirements.
- This recognises the ongoing responsibility of Trustees for the efficient control of the Scheme.
- The annual base fee is paid quarterly in arrears.
- The Scheme does not pay Trustees and Board Committee members any remuneration or fees for attending conferences or training events over and above the training provider's fees and travel, accommodation and subsistence costs. It is the view of the Scheme that attending a conference or training event is sufficient reward.

CALCULATION OF THE REMUNERATION OF BOARD AND BOARD COMMITTEE MEMBERS

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

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

The number of hours required will be different for Board and Board Committee meetings, taking into consideration the relative strategic importance and time requirements for the Board and various Board Committee meetings.

The Chairperson of the Board and Chairpersons of Board Committees will have an increased requirement based on time commitments to prepare and/or to attend ad hoc meetings commensurate with the inherent additional requirements held by the position, and will be remunerated for this additional time requirement.

The professional fee (hourly rate) is the same for all Board and Board Committee members as it represents the economic value of the Board and Board Committee member.

PARTICIPATION IN INCENTIVE PROGRAMMES

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

REIMBURSEMENTS

Trustees or Board Committee members may be reimbursed for all reasonable expenses incurred by them in the performance of their duties as Trustees.

In order to be reimbursed for travel expenses, the Trustees or Board Committee members must submit all supporting documentation (e.g. tax invoices etc.) of the travel expenses he/she is claiming. Reimbursement payments are reviewed and approved by Chief Financial Officer and Principal Officer.

APPROVAL OF BOARD AND BOARD COMMITTEE MEMBERS' REMUNERATION

The Scheme's Trustee and Board Committee member remuneration for each financial year going forward is reviewed and recommended by the Remuneration Committee to the Board for provisional approval, and thereafter approved through a vote by members at the AGM of the Scheme.

The Scheme's members and the Council for Medical Schemes shall be provided with the required information pertaining to the proposed remuneration of the Board of Trustees and Board Committee members at least 21 days prior to the AGM.

DISCLOSURE OF BOARD AND BOARD COMMITTEE MEMBERS' REMUNERATION

The principles of maximum transparency and disclosure regarding remuneration are endorsed by the Scheme:

- The Trustees shall disclose annually in writing to the Registrar any payment or considerations made to them in that particular year by the Scheme.
- The remuneration of the Trustees and Board Committee members shall also be disclosed to members of the Scheme and shall be reported in the Scheme's Integrated Report.
- The Council for Medical Schemes and members shall also be provided with details of how the proposed Trustees' and Board Committee members' fees were determined, as well as the details of the independent advisers who provided advice to the Remuneration Committee on the structuring of Trustees' and Board Committee members' fees.

REMUNERATION PAYMENT PROCEDURES

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

APPLICATION OF TRUSTEE LIABILITY INSURANCE

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

REGULATORY AND INDUSTRY MATTERS
DEALT WITH IN 2017

CIRCULARS 20 OF 2015 AND 59 OF 2016

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

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

CIRCULARS 29 AND 36 OF 2015 AND CIRCULAR 37 OF 2016

Final Undesirable Business Practice Declaration in terms of Section 61 (2) of the Act.

Issued by the CMS on 17 April 2015, Circular 29 of 2015 indicated that the CMS had published Notice 333 of 2015 in the Government Gazette setting out draft undesirable business practices for the medical schemes industry, specifically pertaining to electoral practices. The Scheme's final representations on this notice were submitted to the CMS on 29 May 2015.

Subsequent to this Circular, the CMS published Notice 305 of 2016 on 27 May 2016 in the Government Gazette that differed to the one published on 17 April 2015. The Scheme responded to the notice on 8 July 2016 and no further feedback was received from the Registrar.

On 6 December 2017, the CMS published Press Release 15 of 2017 advising the industry that it has published final declarations as set out in Notice 943 of 2017 in the Government Gazette.

CMS MATTERS

Rule 11 and Rule 14.7 of the Scheme Rules remain unregistered with the CMS. Rule 11 deals with preventing members from re-joining the Scheme immediately after committing fraud or deliberate non-disclosure against it; to protect its greater membership, the Scheme believes that such members should be prohibited from re-joining the Scheme for a certain time period. During 2016, the Scheme appealed the non-registration of Rule 11 in terms of Section 49 and subsequently Section 50 of the Act. The Scheme was unsuccessful in both appeals.

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

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

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

A revision of the 2010 PMB Code of Conduct was initiated by the CMS in March 2017. Following stakeholder workshops and submissions, the CMS presented a draft revised PMB Code of Conduct for public comments through Circular 74 of 2017, published in November 2017. The Scheme and Discovery Health contributed to the Health Funders Association submission in this regard.

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

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

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

The HMI seeks to determine whether there are aspects of the South African private healthcare market which distort, restrict or prevent competition. The Scheme supports the inquiry and has cooperated fully and extensively with the HMI Panel. The Competition Commission's final HMI report is expected to be published by 31 August 2018.

DEPARTMENT OF LABOUR REVIEW

In August 2017, the Scheme was included in a Department of Labour review in terms of Section 43 of the Employment Equity Act. In this regard, the Department of Labour found that the Scheme was not compliant in terms of section 20 (1). The Scheme has rectified this non-compliance and has reached a settlement agreement with the Department of Labour in this regard.

NATIONAL HEALTH INSURANCE

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

The NHI policy approved by Cabinet in June 2017 proposes a single funder, single payer model implemented in three phases over 14 years. Currently, uncertainty remains on some aspects of the proposed model, including the role of the private healthcare funders within an NHI environment and the exact funding mechanisms for the NHI Fund.

The Scheme and Discovery Health continue to participate and make relevant contributions to the process through various opportunities and forums open to stakeholders.

PERSONAL MEDICAL SAVINGS ACCOUNTS

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

WITSMED AMALGAMATION

On 7 August 2017, the Trustees considered and approved a proposed amalgamation with the University of the Witwatersrand, Johannesburg Staff Medical Aid Fund (WitsMed). A Special General Meeting was held on 7 September 2017 to allow members to vote on the proposed amalgamation with WitsMed where the majority of members present voted in its favour. On 23 November 2017, the CMS published Circular 72 of 2017 that confirmed the amalgamation with an effective date of 1 January 2018. The full reserves of R140 million (i.e. assets minus liabilities including any unrealised gains) were transferred to the Scheme on amalgamation.

05 PERFORMANCE

OUR PRINCIPAL OFFICER'S REVIEW OF THE YEAR

Discovery Health Medical Scheme continues to grow despite challenging economic conditions, and I am proud to report that the Scheme is financially stronger than it has ever been, with a record level of reserves.

We have been able to share that strength with our members through benefit amendments for 2018, in particular our increased maternity benefits, and through the lowest contribution increases in several years.

The Scheme (or DHMS) only has two sources of income: member contributions and the return on members' funds invested. With a limited source of funds, we are constantly focused on ensuring the sustainability of DHMS. This requires that members receive value from our benefit offering, and that we mitigate any adverse impact that the prevailing economic and other macroeconomic factors may have on members in terms of private healthcare funding.

The Board of Trustees (the Board or the Trustees) and the Scheme Office closely monitor metrics and other information to assess the financial wellbeing of our members. We continue to note with concern the rising cost of private healthcare, which continues to be above inflation and has been extensively discussed in interactions with the Competition Commission's Healthcare Market Inquiry (HMI). Also, with South Africa's low economic growth, stagnant employment growth and high household debt, and, as shown in DHMS's own data, increasing retrenchments at large corporates, it is evident that more members are finding private healthcare difficult to afford.

Also impacting financial wellbeing and the affordability of private healthcare is the low increase in rebates for medical aid tax credits, as detailed by the Minister of Finance in the Medium-term Budget Policy Statement 2017 and subsequent announcements in February 2018. Furthermore, the value-added tax (VAT) increase by 1 percentage point to 15%, effective 1 April 2018, further adds pressure on consumers.

In leveraging the Scheme's unmatched ability in the industry to absorb environmental shocks, DHMS will not be passing the VAT increase onto members during the remainder of 2018 and will absorb the increase from our operating surplus. As noted above, the Scheme's reserves are at record levels, and shielding members from unexpected additional contribution increases was deemed appropriate by the Trustees.

The Scheme supports the objectives of universal health coverage and participates in all forums regarding the National Health Insurance (NHI). As the private healthcare sector is undoubtedly a national asset, these discussions are an opportunity for the Scheme to collaborate with the Department of Health and all other stakeholders in determining how best the sector can achieve the objectives of quality and equitable healthcare.

The Scheme works hard with its Administrator and Managed Care Provider, Discovery Health (Pty) Ltd (Discovery Health), to contain the impact of healthcare inflation on our members. This is achieved through a number of initiatives that prioritise quality and cost efficiency measures. For instance, when contracting with service providers, we strive to shift reimbursement agreements towards value-based contracting, thus moving away from the traditional fee-for-service model. This clinical integration improves outcomes and fosters collaboration and innovation in multidisciplinary teams by ensuring the entire cycle of care is contracted for and monitored. We initiated some exciting pilots in this regard in 2017.

PAGE REFERENCE

Read more on **pages 37 – 39**.

Also, to support the ongoing success of the Vested® outsourcing model (Vested model) that emphasises the role of innovation in providing value to our members, the Trustees have established two new operational committees in 2017: an Innovation Committee and a Relationship Management Committee. Respectively, these committees will monitor the work on innovation that Discovery Health engages in on behalf of the Scheme and work to optimise the relationship between the Scheme and Discovery Health.

On the Scheme's second source of income, the return on members' funds invested, we achieved excellent results for 2017, with investment income of R1 433 million (2016: R1 257 million). This contributed to the net surplus for the year of R2 450 million (2016: R1 305 million), thereby safeguarding member funds and Scheme sustainability. Investment income was supported by, among other strategies, the Scheme's offshore hedging strategy that provided effective protection from the strong appreciation of the Rand over the year.

During 2017, the Scheme introduced the Essential Smart plan. With this addition, DHMS has created the Smart Plan Series and changed the name of the Smart Plan, which has been available from the start of 2016, to Classic Smart. The Smart Plan Series shows ongoing excellent performance and growth, with both plans attracting young and healthy members to the Scheme.

The healthcare sector in South Africa continues to be a dynamic environment. DHMS is an active member of the Health Funders Association (HFA), an industry body that represents stakeholders in the private healthcare funding environment. The HFA represents 20 medical schemes, which combined, account for 76% of the open medical scheme environment and 53% of the total market[1]. It considers issues affecting all members and engages with various bodies, institutions and structures to ensure a robust and viable private healthcare industry.

As of 1 January 2018, DHMS amalgamated with the University of the Witwatersrand, Johannesburg Staff Medical Aid Fund (Witsmed). Initiated in August 2017, the amalgamation process was conducted in accordance with the requirements of the Medical Schemes Act 131 of 1998, as amended (the Act), its Regulations and the Scheme Rules. The Council for Medical Schemes (CMS) approved the amalgamation after receiving confirmation that the majority of voting members from both schemes were in favour of the amalgamation and any objection received was considered and addressed. The Competition Commission considered and approved the amalgamation as required by the Competition Act 89 of 1998.

All amalgamation proposals are carefully and thoroughly assessed by the Scheme to ensure that the amalgamation would not result in an adverse impact on the member profile, the claims experience and reserves.

As reflected in our material matters detailed in this Integrated Report on **page 11**, the Scheme Office and Trustees are troubled by the recent governance and ethics failures in organisations across the public and private sectors. While the Scheme's financial exposure to Steinhoff was limited, as part of ongoing adherence to governance and ethical codes, in particular the King IV Report on Corporate Governance for South Africa 2016 (King IV), the Scheme is conducting an extensive review of its internal and external stakeholder environment and is optimising the structure that continually monitors and evaluates related risks.

The governance of the CMS vests in a board appointed by the Minister of Health, referred to as the Council. Dr Clarence Mini has been appointed as the new Chairperson of the Council and we congratulate him and wish him well in this position. The Scheme continues to interact constructively with the CMS and will continue to contribute through the various forums and structures where sector participation is required.

During 2017, the Scheme Office welcomed a new Chief Medical Officer, Dr Unati Mahlati, and bade farewell to its Chief Financial Officer (CFO), Jan van Staden. Mr van Staden departed to pursue his own interests and we wish him well in this. In the interim, the CFO portfolio is managed by our Chief Risk and Operations Officer, Mr Selwyn Kahlberg, who has previously managed the portfolio.

At the end of my first year as the Principal Officer of the Scheme, I extend my thanks to the Trustees, independent Committee members and to the Scheme Office team for their unwavering support during this time, which has been a period of great learning and personal development for me. I also welcome the Trustees appointed and elected to the Board during the course of 2017, and express my appreciation for the way in which they have integrated into the Scheme's governing bodies with great concern for their fiduciary duties and the wellbeing of the Scheme and its members.

DR NOZIPHO SANGWENI

PRINCIPAL OFFICER

1 *Based on principal members of member schemes.*

DISCOVERY HEALTH MEDICAL SCHEME

PERFORMANCE

Overview

Discovery Health Medical Scheme delivered a positive net healthcare result of R968 million for the year ended 31 December 2017 (2016: R102 million). The year-on-year increase in the operating result (contribution income less claims and all other Scheme expenses) was mainly attributable to the impact of in-hospital and out-of-hospital risk management initiatives implemented from the end of 2016 in response to a trend of increased utilisation of healthcare services in the 2015 and 2016 periods. Despite volatile investment markets, the Scheme generated healthy investment income of R1 433 million (2016: R1 257 million) contributing to the net surplus for the year of R2 450 million (2016: R1 305 million).

This strong financial performance increased members' funds to R16.7 billion (2016: R14.2 billion) with a solvency level of 27.44% (2016: 26.33%), versus the regulatory requirement of at least 25%. The Scheme's financial strength and ability to pay claims was once again confirmed with a credit rating of AAA from the independent credit rating agency, Global Credit Rating Co (GCR). This is the 17th consecutive year the Scheme has achieved the highest possible rating a medical scheme can attain in the industry in South Africa. In the Trustees' view, DHMS ended 2017 in its strongest financial position in its history, and is very well positioned to continue to meet its members' needs going forward.

17 Benefit options (2016: 16)

6 Network efficiency discount options* (2016: 6)

EXECUTIVE SERIES
- Executive

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

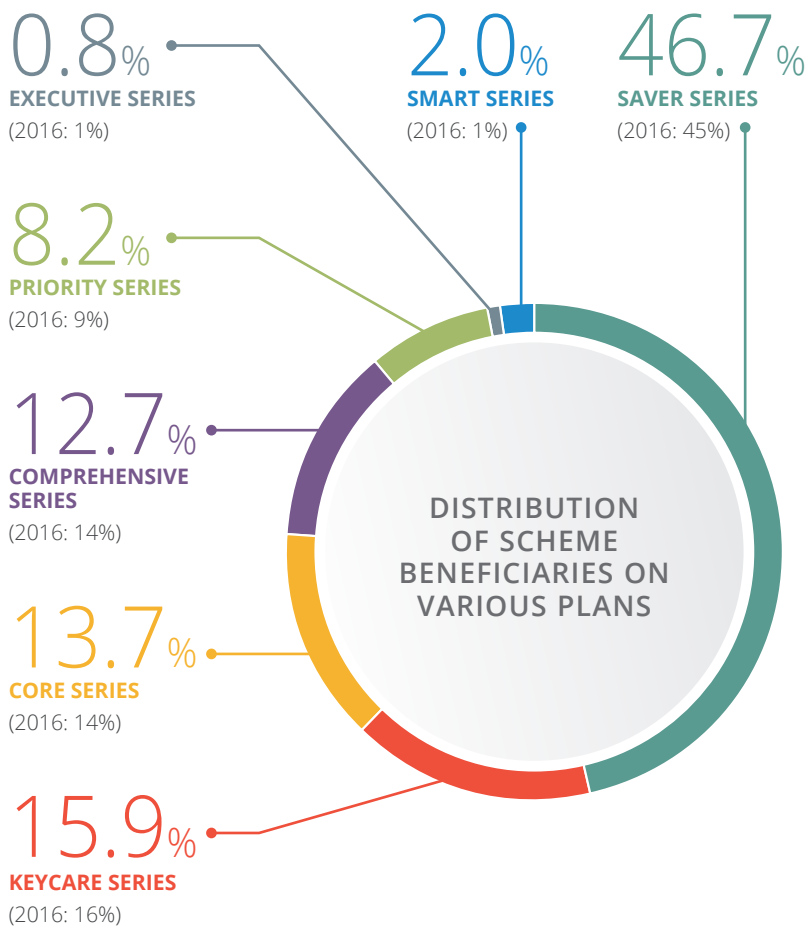
CORE SERIES
- Classic Core
- Essential Core
- Coastal Core
- Classic Delta* Core
- Essential Delta* Core

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

PRIORITY SERIES
- Classic Priority
- Essential Priority

KEYCARE SERIES
- KeyCare Plus
- KeyCare Core
- KeyCare Access

SMART SERIES
- Classic Smart
- Essential Smart



GROSS CONTRIBUTION INCOME

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

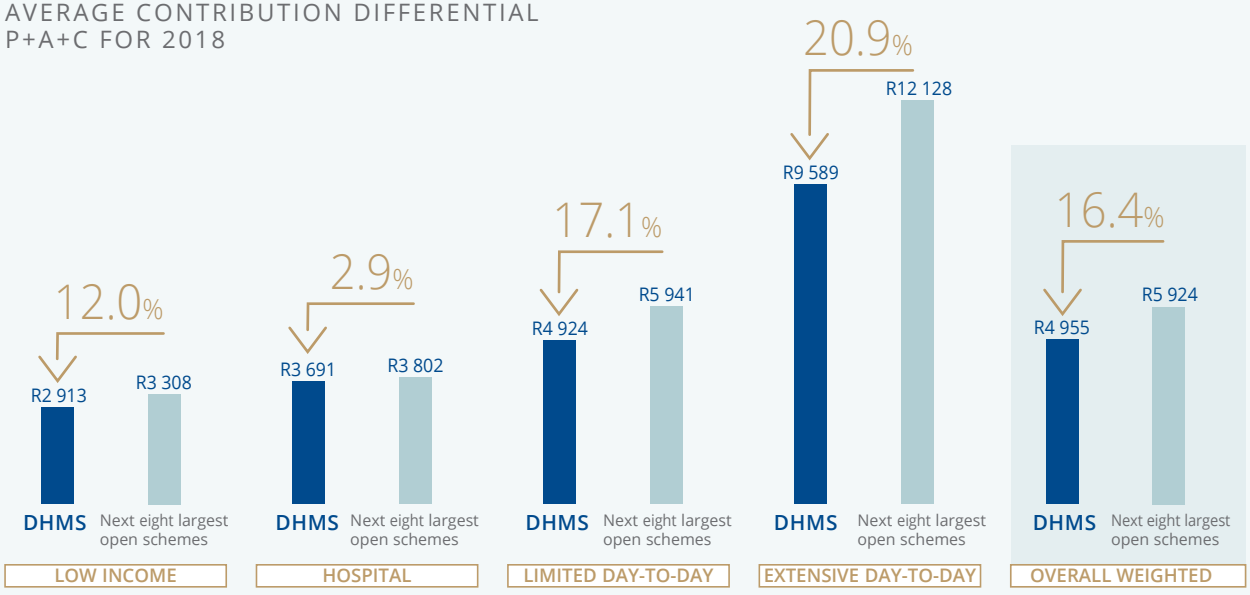
The Scheme remained highly competitive with average contributions for 2018 being 16.4% lower on a plan for plan basis (for 2017: 14.6%[1]) (based on the rate for a principal member plus one adult beneficiary and one child beneficiary) than the next eight open schemes by size, largely due to our ability to contain the impact of medical inflation. The Scheme's competitiveness was reflected in the lowest contribution increases in several years for 2018, which were the lowest of all but one open scheme competitor and well below the average for open schemes. Net membership and beneficiary growth of 2.08% and 1.59% respectively further demonstrates the Scheme's attractiveness and competitiveness.

The Scheme's commitment to its members and its high levels of efficiency is demonstrated by 86% of contributions received being used for members' direct benefit by funding claims and reserves (to meet regulatory solvency requirements). The remainder is utilised to fund activities to support and benefit members in areas such as innovation, administration, managed care, financial advisers and the daily operations of the Scheme.

Gross contribution income rose 10.46% to R59.7 billion (2016: R54.1 billion), driven by contribution increases and net membership growth of 2.08%. The most significant net membership growth was recorded in the mid to low tier options, where the Saver series and Smart series recorded net membership growth of 26 034 and 21 726 respectively. The Comprehensive series experienced the largest decline in principal membership of 12 905.

DHMS AVERAGE CONTRIBUTIONS ARE LOWER[2]

AVERAGE CONTRIBUTION DIFFERENTIAL
P+A+C FOR 2018



1 *The 2017 comparison is against all nine largest open schemes.*

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

DHMS typically compares itself against our next nine largest competitors, but Sizwe's final contribution increases for 2018 were unconfirmed at the time of publishing and so the 2018 comparison excludes Sizwe.

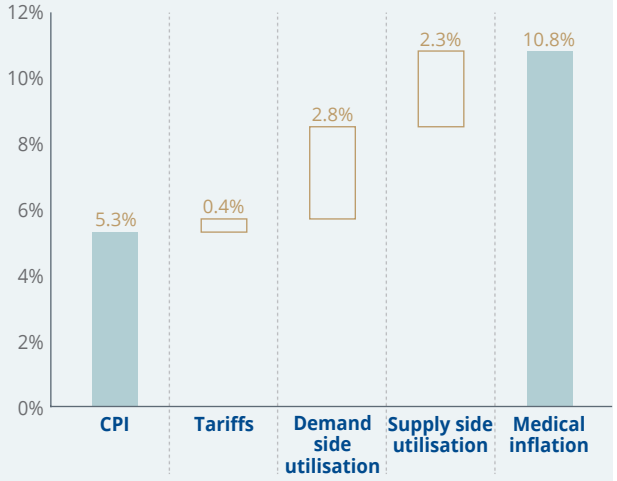
NET CLAIMS INCURRED

Net claims incurred increased by 9.9% to R40.2 billion (2016: R36.6 billion), which is a lower rate of increase than observed in the prior year.

Escalating healthcare costs remain a concern to medical schemes, with healthcare inflation consistently above the consumer price index (CPI). The main driver of healthcare inflation is higher utilisation of healthcare services due to demand side and supply side effects, with a limited contribution from tariff increases. Supply side utilisation is driven by an increase in available services, such as new hospitals, and technological developments in healthcare; demand side utilisation pertains to the deterioration in the demographic profile of beneficiaries, specifically a higher ratio of older and ailing members who need more, higher priced healthcare services. A summary of the composition of medical inflation (annualised over the period 2010 to 2017) is illustrated in the diagram below.

Despite these cost pressures, the Scheme was able to contain the gross claims ratio[1] to 86% (2016: 87%) due to robust risk management interventions implemented by the Scheme's Administrator and Managed Care Provider, Discovery Health.

AVERAGE ANNUALISED INFLATION RATE (2008 – 2016)



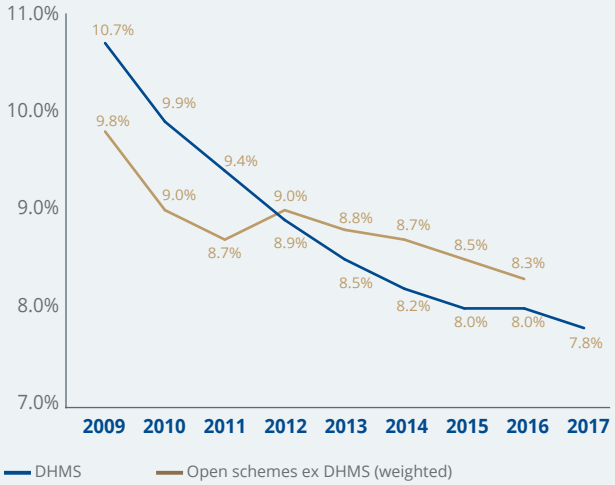
GROSS ADMINISTRATION EXPENDITURE

Gross administration expenditure consists of administration fees and other operational Scheme expenditure, of which the most significant component is administration fees paid to the Scheme's Administrator and Managed Care Provider, Discovery Health. The gross increase in administration fees of 8.7% to R4.5 billion (2016: R4.2 billion) was attributable to the administration fee per member rate increase and growth in average Scheme membership of 2.08%. The administration fee per average member per month increased by 6.5% from R270.49 to R288.05, as significant scale-related administration fee discounts continued to contain administration fee increases to below CPI.

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

The Scheme's analysis of the CMS Annual Report 2016–2017 shows that at 8.0% for 2016, DHMS continued to rank below the weighted average gross administration expenditure for open schemes when considered as a proportion of gross contribution income, which was 8.3% excluding the Scheme. This ranks the Scheme 17th out of 22 open medical schemes, meaning that DHMS fees are the sixth lowest in the open medical schemes market.

GROSS ADMINISTRATION EXPENDITURE AS % OF GROSS CONTRIBUTION INCOME



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

ACCREDITED MANAGED CARE SERVICES COSTS

The increase in accredited managed care services costs of 9.0% to R1.5 billion (2016: R1.4 billion) was attributable to both the accredited managed care costs per member per month rate increase, and growth in average Scheme membership of 2.08%.

Managed care costs per average member per month increased by 6.8%, from R91.72 to R97.96. Managed care costs as a percentage of gross contribution income continued to decline with the 2017 ratio at 2.57% (2016: 2.60%).

An analysis of the CMS Annual Report 2016–2017 shows that the Scheme's managed care cost as a proportion of gross contribution income was 2.60%, compared to the weighted average of 2.23% excluding the Scheme. Although the managed care costs may appear more expensive relative to other open schemes, it does not consider the complexity of the Scheme's benefits, the breadth of managed care services offered, or the claims cost savings generated by the managed care services. In 2016[1], claims cost savings of R153.29 (2015: R136.29) per average beneficiary per month were realised through claims review processes, implemented protocols, price negotiations and drug utilisation reviews. This equates to a saving of R2.53 (2015: R2.33) for every Rand paid in managed care costs – an exceptional return on investment of 253%.

INVESTMENT RESULTS

The Scheme's investment portfolio is suitably diversified and managed to optimise returns within its approved risk appetite. Asset allocation is managed and monitored from an asset and liability perspective, while ensuring sufficient liquid funds are available to meet claims and other liabilities as they fall due. Given the short-term nature of Scheme liabilities, a significant portion of its assets are invested in money market and cash investments, with smaller allocations to bonds (local and foreign) and equities. During 2017, the Scheme added two additional equity managers and a listed property asset manager.

The Scheme earned an overall investment return of 10% for 2017 (2016: 8.8%). The Scheme's diversified investment strategy resulted in outperformance of its strategic benchmark.

MEMBER DISPUTES AND CMS COMPLAINTS

DHMS undertakes a thorough investigation and review of formal disputes lodged by members with the Scheme to resolve as many as possible internally, prior to a member needing to resort to laying a complaint with the CMS. As the Scheme is able to readily access all the relevant information to assist members and work together to assess the merits of a dispute, the internal disputes mechanism is succeeding in reaching an amicable solution in the majority of cases, with a high rate of withdrawals and settlements being achieved.

In 2017, 740 disputes were lodged in terms of Rule 27[2], with 688 or 93% of disputes being settled or withdrawn prior to a hearing. Only 52 cases (7%) proceeded to a hearing before the Disputes Committee.

The number of CMS complaints dropped marginally to 763 in 2017 (2016: 773). This means that only 0.001% of 53 621 046 claims made in 2017 (2016: 52 439 955) resulted in a complaint to the CMS. The ratio of internal disputes to CMS complaints has risen from 39% in 2015 to 51.7% in 2016, and ultimately to 97% in 2017.

1 *Source: The Value Added Assessment report; figures are only available for the preceding year.*
2 *Rule 27 of the DHMS Rules deals with complaints and disputes. The Rules are available to members on www.discovery.co.za/medical-aid/scheme-rules.*

SOLVENCY

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

At 31 December 2017, the Scheme's solvency level of 27.44% (2016: 26.33%) of gross annual contributions was R1.5 billion (2016: R719 million) more than the statutory solvency requirement.

R'000	2017	2016
Total members' funds per Statement of Financial Position	**16 684 435**	14 234 461
Less: cumulative unrealised net gain on remeasurement of investments to fair value	**(298 722)**	–
Accumulated funds per Regulation 29	**16 385 712**	14 234 461
Gross annual contribution income	**59 710 735**	54 056 212
Solvency margin = Accumulated funds/gross annual contribution income x 100	**27.44%**	**26.33%**

PRUDENT FINANCIAL MANAGEMENT

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

R'000	Dec 2017	Dec 2016
Gross annual contributions	**59 710 735**	54 056 212
Total outstanding contributions, excluding December[1]	**23 120**	24 258
% outstanding	**0.04%**	0.04%

DUE APPLICATION OF THE SCHEME RULES

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

ENSURING STATUTORY AND REGULATORY COMPLIANCE

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

1 *Outstanding contributions for December are excluded as the majority of outstanding contributions are collected within one month. The purpose of this table is to provide a view on the efficient collection of contributions older than 30 days.*

MATTERS OF NON-COMPLIANCE FOR THE YEAR ENDED 31 DECEMBER 2017

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

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

STATUTORY SCHEME SOLVENCY

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

During 2017, the Scheme's solvency level dropped below 25% during January. In January, the drop was attributable to the impact of annual contribution increases (schemes are required to hold reserves equal to annualised inflation-adjusted contributions from the first day of the financial year).

At 31 December 2017, the Scheme's accumulated funds expressed as a percentage of gross annual contributions was 27.44% (2016: 26.33%), exceeding the statutory solvency requirement of 25%.

SUSTAINABILITY OF BENEFIT PLANS

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

For the year ended 31 December 2017 the following plans did not comply with Section 33 (2):

Benefit plan (R'000)	Net healthcare result	Net deficit
Executive	(334 418)	(324 005)
Classic Comprehensive	(963 232)	(819 810)
Classic Comprehensive Zero MSA	(2 763)	(1 514)
KeyCare Plus	(535 785)	(212 254)

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

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

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

INVESTMENT IN EMPLOYER GROUPS AND MEDICAL SCHEME ADMINISTRATORS

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

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

INVESTMENTS IN OTHER ASSETS IN TERRITORIES OUTSIDE SOUTH AFRICA

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

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

MINIMUM AMOUNT INVESTED IN CASH [CATEGORY 1 (A) (I) AND 1 (A) (II)]

Explanatory note 2 to Annexure B to the Regulations of the Act requires a medical scheme to have a minimum of 20% of its Regulation 30 assets invested in cash [Category 1 (a) (i) and 1 (a) (ii)]. As at 31 March 2017, the Scheme did not meet this requirement as it held 19.79% in cash [Category 1 (a) (i) and 1 (a) (ii)]. The non-compliance was due to a difference in interpretation between the CMS and DHMS of the relevant clauses of Regulation 30 of the Act. The Scheme has amended its calculation methodology to be aligned with the CMS interpretation.

Prior to Circular 2 of 2018: Personal Medical Savings Accounts and scheme rules, Personal Medical Savings Account (PMSA) assets were included as part of the Scheme's assets during the period July to December 2017. The PMSA assets were included in assessing compliance with the requirement for a minimum of 20% of Regulation 30 assets being invested in cash [Category 1 (a) (i) and 1 (a) (ii)]. After excluding PMSA assets from Scheme assets, there were certain months where this requirement was not met.

As at 31 December 2017, 32.51% of Scheme assets were invested in cash [Category 1 (a) (i) and 1 (a) (ii)] and therefore met the minimum 20% requirement. This requirement has been met using the amended calculation methodology and excluding PMSA assets.

CONTRIBUTIONS RECEIVED AFTER DUE DATE

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

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

BROKER FEES PAID

In terms of Regulation 28 (5) of the Act, broker fees shall be paid on a monthly basis on receipt by a medical scheme of the relevant monthly contribution in accordance with the maximum amount payable per Regulation 28 (2), limited to one broker as required by Regulation 28 (8).

In some instances brokers were compensated prior to receipt of the relevant monthly contribution, the amount paid was more than the prescribed amount and more than one broker per member was paid. In the instances where brokers were paid above the prescribed amount or more than one broker was paid, the value is negligible and represents less than 0.01% of the total broker fees paid for the year. The exceptions relate to transactions that do not occur frequently and the Administrator has developed exception reporting to identify and correct these transactions, and has a well-established claw-back system to rectify commission overpayments.

WAITING PERIODS

Section 29A of the Act states the instances when medical schemes may impose waiting periods upon a person in respect of whom an application is made for membership or admission as a dependent. The waiting periods range from a three month general waiting period to a twelve month condition-specific waiting period. During the year under review, there were isolated instances where waiting periods were not applied in accordance with the Act. For the instances identified, the incorrect application of waiting periods has been rectified and a review conducted, which confirmed that no claims were rejected as a result of the waiting periods being incorrectly applied.

PRESCRIBED MINIMUM BENEFITS

Section 29 (1) (o) and Regulation 8 provides the scope and level of minimum benefits that the Scheme must provide to members and dependants. During the year under review there were isolated instances where the Scheme did not pay claims in accordance with the scope and level of minimum benefits. The claims were reprocessed and correctly paid prior to the end of the benefit year.

RESERVE ACCOUNTS

PAGE REFERENCE

Movements in reserve accounts are set out in the Statement of Changes in Funds and Reserves on **page 104**.

OUTSTANDING CLAIMS

PAGE REFERENCE

Movements in the outstanding claims provision are set out in Note 6 to the Annual Financial Statements on **page 116**.

PERSONAL MEDICAL SAVINGS ACCOUNTS

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

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

The Scheme's liability to members in respect of PMSAs is reflected as a current liability in the Annual Financial Statements (Note 8) and is repayable in terms of Regulation 10 of the Act. During 2017, the funds backing this liability were invested separately from the Scheme's assets and were managed by two independent asset managers, Taquanta and Aluwani. The average interest earned on these funds was 8.33% in 2017 (2016: 7.64%).

PAGE REFERENCE

See also Personal Medical Savings Accounts on **page 71** and **page 118** for Note 8 in the Annual Financial Statements.

GOING CONCERN

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

AUDITOR INDEPENDENCE

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

OPERATIONAL STATISTICS

2017

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

2016

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

* *The Smart Plan was introduced in 2016, and expanded into a series (Classic Smart and Essential Smart) in 2017.*

DISCOVERY HEALTH'S

INITIATIVES FOR THE SCHEME

Discovery Health's business model

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

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

Ongoing investments in digital innovation and a significant focus on improving value in healthcare through efficiency and quality care helps ensure better health outcomes, while maintaining extensive care, support and the latest medical technologies for where and when members need it most. DHMS's full spectrum of plan options enables Discovery Health and the Scheme to offer DHMS members excellent value for money, and the comprehensive and integrated wellness offering helps members to understand and improve their health. The downstream impact of these initiatives is manifested in lower costs for the Scheme and improved quality of care for its members.

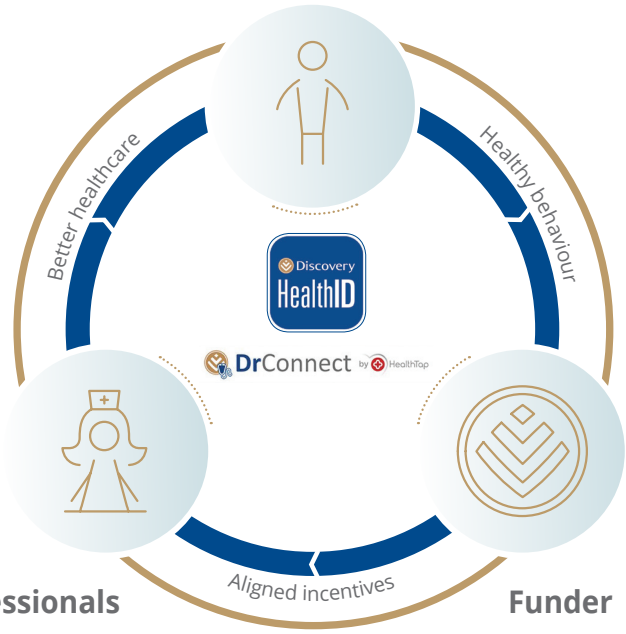
BUILDING A SHARED VALUE HEALTHCARE SYSTEM

Globally, governments and private healthcare funders are grappling with the complex problem of maintaining a fragile balance between access to healthcare, cost and quality. Most healthcare systems face a common set of challenges that contribute to healthcare costs escalating faster than general inflation, making it increasingly difficult to provide access to the high-quality healthcare our society increasingly expects.

Private healthcare financing provided by medical schemes inherently benefits society by protecting individuals and organisations from adverse events. Discovery Health's vision is to amplify the benefits by delivering an integrated value-driven healthcare system, which is centred on meeting the needs of its members and delivering access to the best quality care at outstanding value for all key stakeholders. This vision is realised through a pioneering shared value healthcare model that incentivises people to be healthier, which generates lower claims and higher surpluses for client schemes, and incentivises healthcare professionals through value-based contracting, leading to a healthier society and more members and clients selecting Discovery Health.

Patients

Better health, more value through lower contributions and richer benefits



Healthcare professionals

Increased revenues/better remuneration
Reduced administrative burden
Improved productivity and satisfaction

Funder

Lower claims
Healthier members
Increased surplus and sustainability

The patient

The patient is at the centre of any healthcare system built on shared value principles. This approach empowers patients, places them at the centre of decision making and delivers the best value to them in terms of financial and health outcomes.

Healthcare funders

Governments and private healthcare funders such as insurers and medical schemes who pay for healthcare are critical to governance and financial liquidity of the shared value system. Discovery Health is a pioneer and champion of this model in South Africa and intends to further improve on gains made to benefit members and the Scheme.

Providers of healthcare services

This includes doctors, specialists, hospitals, pharmaceutical companies, pharmacies and manufacturers of medical equipment. Discovery Health has made major strides in moving away from a traditional fee-for-service model to value-based payment models that focus on the quality of care and patient outcomes. We have developed and implemented several value-based contracts with health professionals, and are continually engaging with relevant parties to set up favourable value-based remuneration incentives, drive a cost-effective medicine strategy and use technology effectively to improve patient experience and reduce cost of care.

DISCOVERY HEALTH'S OPERATIONS IN ACTION

R31.6 million
CLAIMS PAID
per hour

264 500
CLAIMS RECEIVED
per day

36 200 calls
PER DAY

A Discovery baby is born
EVERY 6 MINUTES

2 940
HOSPITAL ADMISSIONS
approved per day

WELLNESS

13 900
WELLNESS SCREENINGS
per month

47 100
VITALITY CHECKS
per month

DIGITAL SUPPORT

4 400
DOCTORS USING
HealthID per month

3.7 million
SMART PHONE
logins per month

2 million
WEB USERS
as at 31 December 2017

205 800
SOCIAL MEDIA FOLLOWERS
as at 31 December 2017

ENSURING HIGHER QUALITY HEALTHCARE

Discovery Health continuously strives to improve the quality of healthcare available to DHMS members by maintaining a cohesive system in which healthcare professionals work in integrated teams and are paid using innovative alternative reimbursement models based on shared value principles.

Over the years, Discovery Health has also developed comprehensive, best-in-class disease management and care coordination programmes to improve member's access and quality of care, while also lowering the overall cost of healthcare. These include chronic disease programmes for diabetes, renal failure, HIV, mental health, and care coordination programmes aimed at complex patients with multiple conditions. Some examples of these programmes include:

THE CO-ORDINATED CARE PROGRAMME

The Co-ordinated Care Programme is a voluntary programme designed to coordinate long-term care for very ill members. It resulted in the following outcomes improvements for active enrolled members from 2008 to 2017 inclusive:

- ↓40% reduction in hospital per life per month healthcare costs
- ↓17% reduction in admission rate
- ↓48% reduction in 30-day all cause re-admission rate

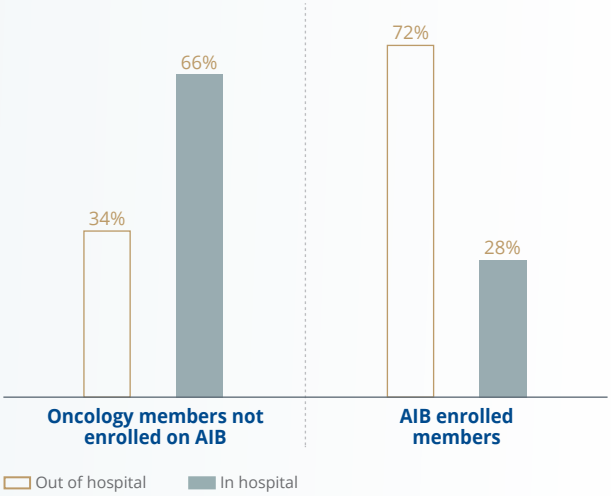
THE ADVANCED ILLNESS BENEFIT

Discovery Health's internal data shows that the hospital costs of members during the last 12 months of life are four times higher and increase from four to 10 times in their last month of life, typically due to intensive hospital care in the final weeks. Over 60% of our members pass away in hospital, but research shows that more than 80% of people worldwide wish to pass away at home.

To address members' wishes and reduce the Scheme's costs, Discovery Health and DHMS developed and launched the Advanced Illness Benefit (AIB) within the Scheme. This benefit gives members with advanced stages of cancer access to a comprehensive palliative care programme. This includes Discovery HomeCare – where professionally trained Discovery nurses provide high-quality care at home. With unlimited benefits, access to home-based care and a care coordinator, the service has had a significant impact on patients and their families, with over 70% of our members in this programme electing to spend their last weeks at home with their families.

PAGE REFERENCE

Read more about Discovery HomeCare on **page 35**.



CADCare PROGRAMME

The CADCare programme aims to increase value for money for DHMS and its members in cardiac care. It involves an episode fee for invasive and non-invasive cardiac catheterisation tests, aiming to increase the use of non-invasive methods (instead of the invasive method that carries a higher risk for patients). The programme is gaining traction with positive early results.

NOTABLE **HIGHLIGHTS** INCLUDE:

33%
of cardiologists enrolled

Invasive angiogram rate showed a
3.9% reduction
for the SASCI[1] network against a 1.1% increase for the non-network doctors.

CTCA eligible invasive angiogram rate showed a
7.3% reduction
for SASCI network against a 3.4% reduction for non-network doctors

22.3%
CTCAs for the SASCI network compared to 20.7% for non-network doctors

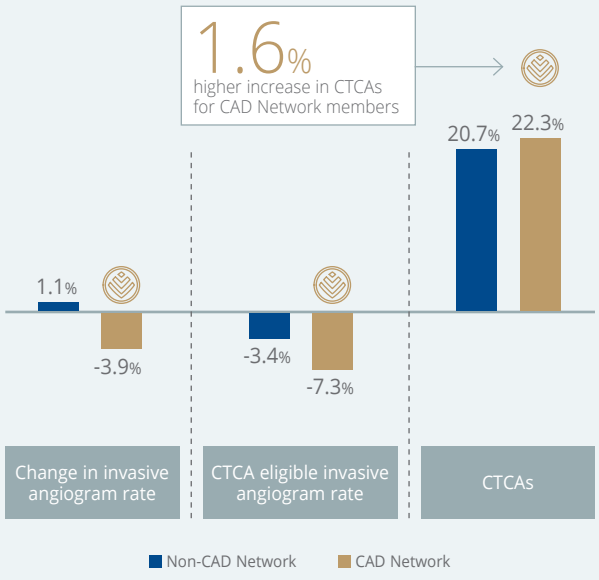
CADCare PROGRAMME IS REDUCING DOWNSTREAM RISK AND COST

CADCare PROGRAMME OUTCOMES

- Defined pathway for CAD
- Single global fee that aligns risk incentives
- 33% of practices enrolled

CADCare outcomes (YTD September 2017)

DRIVING A REDUCTION IN ANGIOGRAMS AND AN INCREASE IN THE CTCA RATE



PAGE REFERENCE

Read more about Discovery Health's initiatives for the Scheme, such as DiabetesCare, HealthID and DrConnect on **pages 86 – 93**.

1 *South African Society of Cardiovascular Intervention.*

IMPROVING WELLNESS

Vitality[1] is Discovery's world leading, internationally recognised science-based wellness programme that incentivises and rewards a healthy lifestyle.

Substantial, peer-reviewed evidence has been published in leading international and local journals that shows the significant impact on health status, health claims and health outcomes of engagement in the Vitality programme. In short, members' health, hospital admissions, and mortality rates improve as they engage more with Vitality. As a result, DHMS benefits significantly from long-term healthcare cost savings and improvements in the Scheme's risk profiles, and associated employers also benefit from improved health status, wellbeing and higher productivity of their employees who engage with Vitality.

VITALITY HAS HAD A SIGNIFICANT IMPACT ON DHMS

Vitality has achieved savings for DHMS of R11.5 billion between 2008 and 2016. The total Vitality savings are quantified in four components:

POSITIVE MEMBER DEMOGRAPHICS

Vitality enables DHMS to attract and retain younger, healthier members.

INITIAL ENGAGEMENT SELECTION AND BEHAVIOUR MAINTENANCE

Vitality also enables DHMS to attract and retain people that exercise more when compared to non-Vitality members. It is estimated that this initial and ongoing engagement selection resulted in savings of R3.8 billion for DHMS between 2008 and 2016.

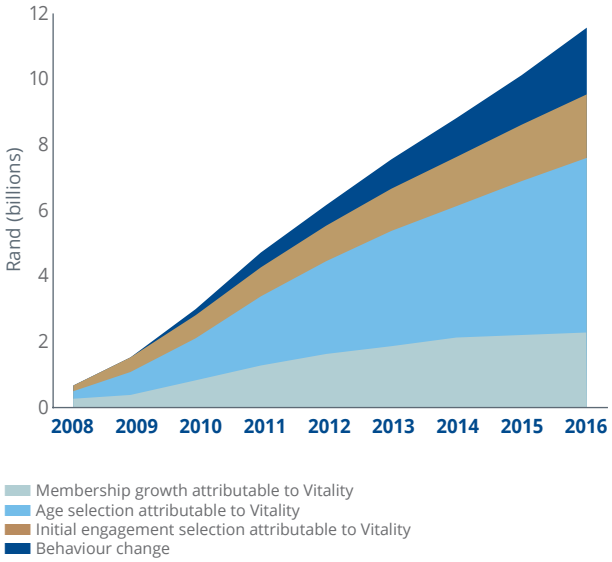
BEHAVIOUR CHANGE

Vitality encourages members to increase engagement in healthy behaviour, which results in further savings for DHMS as claims are lower for members who increase their level of engagement with wellness activities.

ATTRACTING NEW MEMBERS

Vitality provides a substantial competitive advantage to DHMS and contributes to attracting a strong flow of new members. As new members tend to claim significantly less than existing members, any net new membership growth improves the Scheme's financial position.

CUMULATIVE VITALITY SAVINGS



LOWERING THE COST OF HEALTHCARE

To provide access to quality, cost-effective healthcare, Discovery Health works closely with healthcare providers and their professional societies. Discovery Health is shifting away from a traditional fee-for-service model in favour of value-based payment models that are focused on quality of care and patient outcomes. Several value-based contracts with doctors have been developed and implemented, and there is continued engagement with the industry to identify additional methods of reducing healthcare costs.

In addition, Discovery Health continues to grow and maintain provider networks that are efficient, drive adoption of evidence-based and cost-effective generic medicines, and incorporate technology into the healthcare system; together, these measures help to counteract medical inflation without compromising access to and quality of healthcare.

Discovery Health's managed care processes and interventions have resulted in significant savings for DHMS and have had a clear impact on the Scheme's loss ratio and operating surplus.

MEDICINE SAVINGS

Discovery Health's medicines strategy spans the entire medicines value chain, from price negotiations with manufacturers and agents, to dispensing and claims reimbursement. Key components of this strategy include risk management, provider contracting, claims processing, pharmacy reporting, supply chain integration, clinical database optimisation and legal and regulatory compliance.

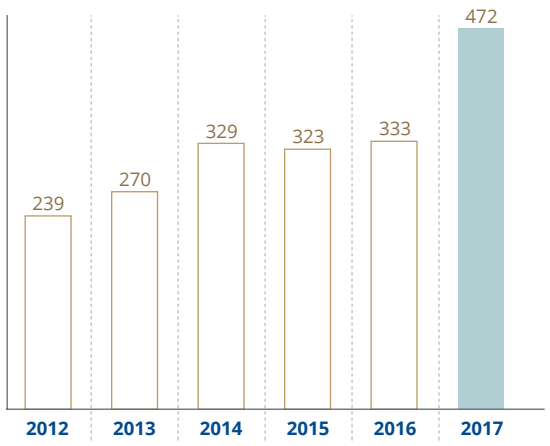
1 *DHMS members have voluntary access to Vitality membership. Vitality is administered by Discovery Vitality (Pty) Ltd, registration number 1999/007736/07, an authorised financial services provider.*

2017 figures not available at the time of publication.

FORENSICS

Discovery Health applies advanced data science techniques to proactively detect healthcare fraud and abuse. In addition, the forensics and analytics units have developed various tools and reports for the ongoing detection of potential fraud and abuse against the Scheme, which has led to the recovery of millions of Rands a year.

DHMS SAVINGS AND RECOVERIES (R'millions)



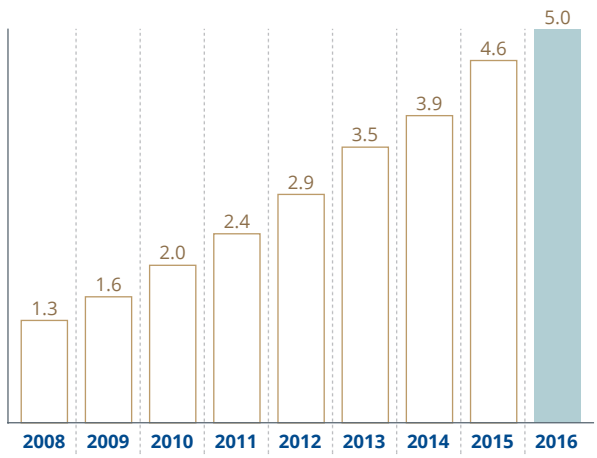
Includes total savings and recoveries, hospital group settlements and deferred amounts.

ALTERNATIVE REIMBURSEMENT MODELS

Discovery Health has negotiated a number of alternative reimbursement models with hospital groups and suppliers of surgical items, generating further savings.

Risk management savings are generated through tariff and medicine savings, funding policies, forensics, alternative reimbursement models and surgical item management. The total managed care savings per year, from these interventions, after allowing for inflation, are:

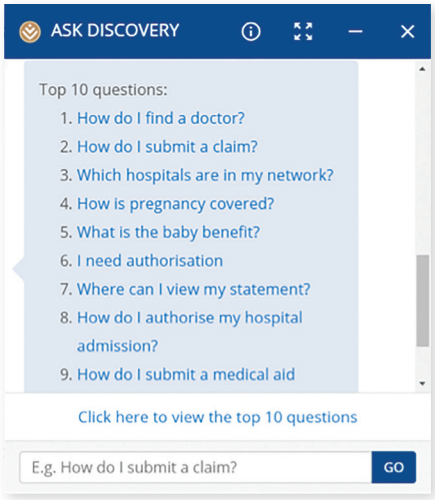
MANAGED CARE SAVINGS PER YEAR Rand (billions)



The cumulative managed care savings for DHMS are estimated to be approximately R27.2 billion between 2008 and 2016, after allowing for inflation.

ENABLING PERSONALISED HEALTHCARE AND SERVICE BENEFITS THROUGH TECHNOLOGY

Discovery Health is leveraging artificial intelligence (AI) principles to provide automated, personalised service, product information and support. By harnessing the power of big data and using sophisticated analytics, Discovery Health can better understand customer behaviour and provide automated customer service, personalised product information and support. In June 2017, Discovery Health launched and AI-based search tool, 'Ask Discovery', on the DHMS website. This allows Scheme members to ask questions in any format, and the AI tool directs them to the precise section of the website to answer their question.



SINCE LAUNCHING **ASK DISCOVERY** ON 13 JUNE 2017:

Users have asked

305 000

QUESTIONS

averaging **4 800** questions a day

106 000

PEOPLE HAVE USED THE SERVICE,

with 1 500 new users every day

The most common questions received to date are **"HOW DO I GET MY TAX CERTIFICATE?"** and **"HOW DO I FIND A DOCTOR?"**

HealthID

HealthID provides doctors with a more complete view of their patient's health history and test results. This improves patient care and reduces the likelihood of serious medical errors and duplicate or unnecessary pathology tests. In addition, HealthID also reduces a doctor's administrative burden by making it quick and easy to fill in Chronic Illness Benefit applications and providing them with the relevant scheme formulary list.

DrConnect

The new Discovery DrConnect functionality provides seamless access to high-quality medical information from a worldwide network of over 108 000 doctors. It also facilitates personalised interactions between patients and their doctors.

PAGE REFERENCE

Read more about DrConnect on **page 36**.

DISCOVERY MEMBER APP

The Discovery Member App allows a user to access and experience all their Discovery products wherever they are.

SMART SERIES

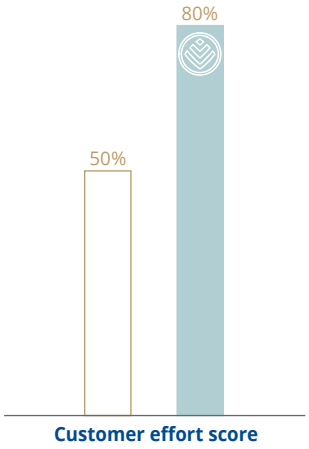
Launched in 2016, the Smart Series incorporates the best of Discovery Health's analytical tools and digital assets to form a seamless integrated digital healthcare plan with smart network providers and medical services for DHMS members. The series offers the best value for money in the South African open medical scheme market, due to its use of digital technology and smart networks to significantly reduce healthcare costs.

The series attracts a tech-savvy and younger generation of members who are empowered to manage their own health plans and spending. Initially launched as the Smart Plan in 2016, it was highly successful and was expanded in 2017 to include both Classic and Essential options. By the end of 2017, Classic Smart had over 40 000 members and Essential Smart over 14 000.

MAINTAINING WORLD-CLASS SERVICE LEVELS

In 2017, Discovery Health continued to push service excellence in the delivery of quality healthcare in an environment of high medical inflation. In comparison with international benchmarks, Discovery Health's service metrics exceed international best practice benchmarks.

DISCOVERY HEALTH SCORE (80%) VERSUS 2017 INTERNATIONAL BEST PRACTICE BENCHMARK (50%)



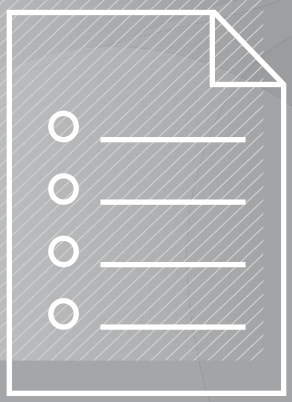
Source: Dimension Data 2017 Global Customer Experience Benchmarking Report

FUTURE FOCUS AREAS

Collaboration with the South African Society of Obstetricians and Gynaecologists to better manage safe deliveries, early elective C-sections and the high rates of admissions to neonatal intensive care units.

Enhance public reporting of the hospital experience of patients. The Discovery Health Patient Survey Score will be updated to include reporting on mortality rates and re-admission rates.

06 FINANCIALS



STATEMENT OF RESPONSIBILITY BY THE BOARD OF TRUSTEES

for the year ended 31 December 2017

The Board of Trustees is responsible for ensuring that adequate accounting records are maintained and for the preparation, integrity and fair presentation of the Annual Financial Statements of Discovery Health Medical Scheme (the Scheme). The Annual Financial Statements comprise the Statement of Financial Position at 31 December 2017, and the Statements of Comprehensive Income, Changes in Funds and Reserves and Cash Flows for the year then ended, and the Notes, comprising a summary of significant accounting policies and other explanatory information. The Annual Financial Statements have been prepared in accordance with International Financial Reporting Standards and the Medical Schemes Act 131 of 1998, as amended, (the Act) and include amounts based on judgements and reasonable estimates.

The Trustees consider that in preparing the Annual Financial Statements they have used the most appropriate accounting policies, consistently applied and that all applicable International Financial Reporting Standards have been followed. The Trustees are satisfied that the information contained in the Annual Financial Statements fairly presents the results of operations for the year and the financial position of the Scheme at year end. The Trustees also reviewed the other information included in the Integrated Report and are responsible for both its accuracy and its consistency with the Annual Financial Statements.

The Trustees are responsible for the Scheme's systems of internal control and incorporate risk management and internal control procedures, which are designed to provide reasonable, but not absolute assurance that assets are safeguarded and the risks facing the business are being controlled. Reliance is placed on Discovery Health (Pty) Ltd's system of internal controls.

Even an effective system of internal control, no matter how well designed, has inherent limitations, including the possibility of circumvention and the overriding of controls. An effective system of internal control therefore aims to provide reasonable assurance with respect to the reliability of financial information and, in particular, the presentation of Annual Financial Statements. To the best of their knowledge and belief, based on the above, the Trustees are satisfied that no material breakdown in the operation of the systems of internal control and procedures have occurred during the year under review.

The Board of Trustees has reviewed the Scheme's budget for the year ending 31 December 2018. On the basis of this review and in light of the current financial position and available cash resources, the Trustees have no reason to believe that the Scheme will not be a going concern for the foreseeable future. The going concern basis has therefore been adopted in preparing the Annual Financial Statements and these financial statements support the viability of the Scheme.

The Scheme's external auditors, PricewaterhouseCoopers Incorporated, have audited the Annual Financial Statements and their unqualified report is presented on pages 99 to 101. The Annual Financial Statements, which are presented on pages 95 to 169 were approved by the Board of Trustees on 12 April 2018 and are signed on its behalf by:

N MORRISON
CHAIRPERSON

D NAIDOO
TRUSTEE

DR N SANGWENI
PRINCIPAL OFFICER

REPORT OF THE AUDIT COMMITTEE

for the year ended 31 December 2017

We are pleased to present our report for the financial year ended 31 December 2017. The Audit Committee (the Committee) is an independent statutory committee. Duties are delegated to the Committee by the Board of Trustees.

Audit Committee terms of reference and assessment

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

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

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

Audit Committee members, meeting attendance and assessment

The membership and attendance of the members of the Committee has been set out on page 55.

Role and responsibilities

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

External Auditor appointment and independence

The Committee considered the matters set out in Section 36 of the Act and nominated PricewaterhouseCoopers Inc. for appointment as external auditor of the Scheme. Corlia Volschenk was approved by the Council for Medical Schemes as the statutory auditor of the Scheme for the financial period 1 January 2017 to 31 December 2017 in accordance with section 36 (2) of the Act on 3 October 2017.

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

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

The Committee, following consultation with the Scheme's Executive Officers, approved the engagement letter, audit plan, budgeted audit fees and representation letter for the year ended 31 December 2017. The Committee approved the actual audit fees for the year ended 31 December 2016.

There is a formal policy in respect of the provision of non-audit services by the External Auditors of the Scheme and a formal procedure governs the process whereby the Auditor is appointed to provide any non-audit services. The Chairperson of the Committee approves the nature and extent of any non-audit services that the External Auditor provides in terms of the agreed pre-approval policy and a schedule of approved non-audit services is reviewed annually by the Committee. Fees in respect of audit and non-audit services are reflected in Note 15 to the Annual Financial Statements.

During the year, the Committee met with the External Auditors without management being present.

Internal Auditors (IA)

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

The Committee considered and approved the IA Charter.

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

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

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

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

During the year, the Committee met with the CAE without management being present.

Financial statements and accounting practices

The Committee has reviewed the accounting policies and the Scheme's Annual Financial Statements and is satisfied that they are appropriate and comply with International Financial Reporting

REPORT OF THE AUDIT COMMITTEE CONTINUED

for the year ended 31 December 2017

Standards, the Act and circulars issued by the Council for Medical Schemes.

Internal financial controls

The Committee is responsible for assessing the Scheme's system of internal financial and accounting control. In this regard the Committee has, among other things, evaluated the adequacy and effectiveness of the Scheme's systems of internal control and made appropriate recommendations to the Board of Trustees. This included a formal documented review by the Internal Audit function of the design, implementation and effectiveness of the Administrator's system of internal financial controls pertaining to the Scheme. Based on the results of this review, it is the view of the Committee that Reasonable Assurance* can be placed on the internal controls and risk management and High Assurance** can be placed on the adequacy and effectiveness of the Scheme's internal financial controls, relative to the fair presentation of the Annual Financial Statements.

* *Reasonable Assurance – The existing control framework provides reasonable assurance that material risks are identified and managed effectively.*

** *High Assurance – The existing control framework provides a high level of assurance that the Annual Financial Statements are fairly presented.*

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

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

Whistle blowing

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

Ethics and compliance

The Committee is responsible for reviewing any major breach of relevant legal and regulatory obligations. The Committee is satisfied that there has been no material non-compliance with laws and regulations, except for the matters of non-compliance with the Act as detailed in Note 33 to the Annual Financial Statements.

Risk management

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

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

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

Going concern

The Committee has reviewed the Scheme's financial position as at 31 December 2017, as well as the budget for the year ending 31 December 2018. Total members' funds exceeded R16.6 billion with a solvency level of 27.44% as at 31 December 2017. Further, the Scheme had sufficient financial resources (cash and cash equivalents and financial assets at fair value through profit or loss) investments as at 31 December 2017 to cover monthly claims expenditure 5.78 times.

On the basis of this review and taking note of the current net surplus of R2.5 billion, the Committee considers that:

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

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

MR B STOTT
CHAIRPERSON: AUDIT COMMITTEE

12 April 2018

INDEPENDENT AUDITOR'S REPORT

To the members of Discovery Health Medical Scheme

Report on the financial statements

Opinion

We have audited the financial statements of Discovery Health Medical Scheme (the Scheme), set out on pages 102 to 169, which comprise the statement of financial position as at 31 December 2017, and the statement of comprehensive income, the statement of changes in funds and reserves, and the statement of cash flows for the year then ended, and notes to the financial statements, including a summary of significant accounting policies.

In our opinion, these financial statements present fairly, in all material respects, the financial position of the Scheme as at 31 December 2017, and its financial performance and cash flows for the year then ended in accordance with International Financial Reporting Standards and the requirements of the Medical Schemes Act of South Africa.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (ISAs). Our responsibilities under those standards are further described in the Auditor's responsibilities for the audit of the financial statements section of our report. We are independent of the Scheme in accordance with the Independent Regulatory Board for Auditors Code of Professional Conduct for Registered Auditors (IRBA Code) and other independence requirements applicable to performing audits of financial statements in South Africa. We have fulfilled our other ethical responsibilities in accordance with the IRBA Code and in accordance with other ethical requirements applicable to performing audits in South Africa. The IRBA Code is consistent with the International Ethics Standards Board for Accountants Code of Ethics for Professional Accountants (Parts A and B). We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Key audit matters

Key audit matters are those matters that, in our professional judgement, were of most significance in our audit of the financial statements of the current period. These matters were addressed in the context of our audit of the financial statements as a whole, and in forming our opinion thereon, and we do not provide a separate opinion on these matters.

Key audit matter	How our audit addressed the key audit matter
Outstanding claims provision The outstanding claims provision (IBNR) of R1 240 billion at year-end as described in Note 6 to the financial statements, is a provision recognised for the estimated cost of healthcare benefits that have been incurred prior to year-end but that were only reported to the Scheme after year-end. The outstanding claims provision is calculated by the Scheme's actuaries, is reviewed by management and the Audit Committee, and recommended to the Board of Trustees for approval. The Scheme's actuaries use an actuarial model based on the Scheme's actual claim development patterns throughout the year to project the year-end provision. This model applies a combination of the Basic Chain Ladder (BCL) and Cost Per Event (CPE) methods. The claim treatment date, processing date and amount are used to derive claim development patterns. These historical patterns are then used to estimate the outstanding claims provision. We identified this as a matter of most significance to the audit because of the uncertainty in the projected claims pattern. A change in the projected claims pattern can cause a material change to the amount of the provision.	For a sample of actual claims received in the 2017 financial year, we tested the accuracy of the service and process dates and we identified no inconsistencies. We made use of various data analytics to substantively test the relevant claim rules against which the actual claims received by the Scheme are assessed for completeness and validity of actual claims data. The claims data that was included in the Scheme's actuarial model was agreed to the actual claims data that was tested above in the member administration system with no material differences noted. We obtained an understanding from the Scheme's actuaries regarding the process to calculate the outstanding claims provision. The actuarial model applied by the Scheme is generally applied within the medical scheme industry. To test the reasonableness of the Scheme's estimation process we compared actual claim results in the current year to the prior year provision and no material differences were noted. Our actuarial specialist independently calculated the Scheme's outstanding claims provision, taking into account the method applied by the Scheme and the claim data tested above. We compared our results with those of the Scheme and found the amounts to approximate each other.

INDEPENDENT AUDITOR'S REPORT CONTINUED

Other information

The Scheme's Trustees are responsible for the other information. The other information comprises the information included in the Discovery Health Medical Scheme Integrated Report as at 31 December 2017. This does not include the financial statements and our auditor's report thereon.

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

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

Responsibilities of the Scheme's Trustees for the financial statements

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

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

Auditor's responsibilities for the audit of the financial statements

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

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

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

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

From the matters communicated with the Scheme's Trustees, we determine those matters that were of most significance in the audit of the financial statements of the current period and are therefore the key audit matters. We describe these matters in our auditor's report unless law or regulation precludes public disclosure about the matter or when, in extremely rare circumstances, we determine that a matter should not be communicated in our report because the adverse consequences of doing so would reasonably be expected to outweigh the public interest benefits of such communication.

Report on other legal and regulatory requirements

Non-compliance with the Medical Schemes Act of South Africa

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

- **Section 33 (2) (b) of the Medical Schemes Act of South Africa:** Certain benefit options were not self-supporting in terms of financial performance, as disclosed in Note 33 of the financial statements; and
- **Regulation 29 (2) of the Medical Schemes Act of South Africa:** The Scheme's accumulated funds expressed as a percentage of gross annual contributions was below the statutory solvency requirement of 25% at the end of January 2017. However, at 31 December 2017, the Scheme's accumulated funds expressed as a percentage of gross annual contributions was 27.44% which exceeded the statutory solvency requirement of 25%, as disclosed in Note 33 of the financial statements.

PricewaterhouseCoopers Inc.
Director: C Volschenk
Registered Auditor
Johannesburg
12 April 2018

STATEMENT OF FINANCIAL POSITION

as at 31 December 2017

R'000	Notes	2017	2016
ASSETS			
Non-current assets		**4 417**	5 614
Long term employee benefit plan asset	25	**4 417**	5 614
Current assets		**25 728 677**	20 864 905
Financial assets at fair value through profit or loss	2	**14 005 644**	12 211 677
Derivative financial instruments	7	**85 857**	54 760
Trade and other receivables	3	**1 147 665**	2 058 008
Cash and cash equivalents			
– Personal Medical Savings Account trust assets	4	**4 609 149**	4 142 672
– Medical Scheme assets	5	**5 880 362**	2 397 788
Total assets		**25 733 094**	20 870 519
FUNDS AND LIABILITIES			
Members' funds		**16 684 435**	14 234 461
Accumulated funds		**16 684 435**	14 234 461
Current liabilities		**9 048 659**	6 636 058
Outstanding claims provision	6	**1 240 063**	1 121 394
Derivative financial instruments	7	**86 445**	4 376
Personal Medical Savings Account trust liabilities	8	**4 656 633**	4 204 043
Trade and other payables	9	**3 065 518**	1 306 245
Total funds and liabilities		**25 733 094**	20 870 519

STATEMENT OF COMPREHENSIVE INCOME

for the year ended 31 December 2017

R'000	Notes	2017	2016
Risk contribution income	10	**48 702 024**	43 626 398
Relevant healthcare expenditure		**(41 747 808)**	(38 035 898)
Net claims incurred	11	**(40 228 057)**	(36 613 210)
Claims incurred	11	**(40 371 417)**	(36 772 332)
Third party claim recoveries	11	**143 360**	159 122
Accredited managed healthcare services (no risk transfer)	12	**(1 534 311)**	(1 407 267)
Net profit/(loss) on risk transfer arrangements	13	**14 560**	(15 421)
Risk transfer arrangement fees		**(392 023)**	(366 344)
Recoveries from risk transfer arrangements		**406 583**	350 923
Gross healthcare result		**6 954 216**	5 590 500
Broker service fees	14	**(1 214 205)**	(1 101 648)
Expenses for administration	25	**(4 511 596)**	(4 150 194)
Other operating expenses	15	**(260 461)**	(236 206)
Net healthcare result		**967 954**	102 452
Other income		**1 893 686**	1 524 116
Investment income	21	**1 433 187**	1 257 479
Net gains on financial assets at fair value through profit or loss	22	**458 753**	264 278
Sundry income	23	**1 746**	2 359
Other expenditure		**(411 666)**	(321 118)
Expenses for asset management services rendered		**(44 428)**	(31 076)
Interest paid	24	**(367 238)**	(290 042)
Net surplus for the year		**2 449 974**	1 305 450
Other comprehensive income		**–**	–
Total comprehensive income for the year		**2 449 974**	1 305 450

STATEMENT OF CHANGES IN FUNDS AND RESERVES

for the year ended 31 December 2017

R'000	2017 Accumulated funds	2016 Accumulated funds
Balance at beginning of the year	**14 234 461**	12 929 011
Total comprehensive income for the year	**2 449 974**	1 305 450
Total member funds at end of the year	**16 684 435**	14 234 461

STATEMENT OF CASH FLOWS

for the year ended 31 December 2017

R'000	Notes	2017	2016
CASH FLOWS FROM OPERATING ACTIVITIES			
Cash flows generated from operations before working capital changes	27	**1 017 921**	151 902
Working capital changes:			
Decrease/(Increase) in trade and other receivables	27.1	**822 739**	(500 589)
Increase in outstanding claims provision		**118 669**	136 307
Increase in Personal Medical Savings Account trust liabilities		**452 590**	467 384
Increase in trade and other payables	27.2	**1 759 273**	123 640
Cash generated by operations		**4 171 192**	378 644
Purchases of financial instruments	27.3	**(2 953 775)**	(1 922 170)
Proceeds from sale of financial instruments	27.4	**1 669 533**	1 258 510
Increase in Long Term Employee Plan Asset		**(3 848)**	(7 544)
Interest received	21	**1 349 125**	1 206 486
Dividend income	21	**84 062**	50 993
Interest paid	24	**(367 238)**	(290 042)
Net cash flows from operating activities		**3 949 051**	674 877
NET INCREASE IN CASH AND CASH EQUIVALENTS		**3 949 051**	674 877
Cash and cash equivalents at beginning of year		**6 540 460**	5 865 583
CASH AND CASH EQUIVALENTS AT END OF YEAR		**10 489 511**	6 540 460
Cash and cash equivalents comprise			
Personal Medical Savings Account trust assets	4	**4 609 149**	4 142 672
Medical Scheme assets	5	**5 880 362**	2 397 788
		10 489 511	6 540 460

ACCOUNTING POLICIES

for the year ended 31 December 2017

General information

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

The Scheme is an open medical scheme registered in terms of the Medical Schemes Act 131 of 1998, as amended (the Act) and is domiciled in South Africa.

These Annual Financial Statements were authorised for issue by the Board of Trustees on 12 April 2018.

1 Basis of preparation

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

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

The preparation of financial statements in conformity with IFRS requires the use of certain critical accounting estimates. It also requires management to exercise its judgement in the process of applying the Scheme's accounting policies. The areas involving a higher degree of judgement, or areas where estimates are significant to the Annual Financial Statements, are disclosed in Note 32.

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

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

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

ACCOUNTING POLICIES CONTINUED

for the year ended 31 December 2017

1 Basis of preparation *continued*

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

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

Standard	Scope	Effective date
IFRS 4 (Amendment): Insurance contracts	These two amendments address the interaction between IFRS 9: Financial Instruments and IFRS 4. A temporary exemption from IFRS 9 has been granted to insurers that meet the specified criteria and an optional accounting policy choice has been introduced to allow an insurer to apply the overlay approach to designated financial assets when it first applied IFRS 9. The Scheme will not apply the temporary exemption or the overlay approach.	01 January 2018.
IFRS 9 (Amendment): Financial instruments	The final version of IFRS 9 replaces IAS 39 Financial Instruments: Recognition and Measurement and comprises guidance on Classification, Measurement, Impairment Hedge Accounting and Derecognition. IFRS 9 introduces a new approach to the classification of financial assets, which is driven by the business model in which the asset is held and its cash flow characteristics. A new business model was introduced which allows certain financial assets to be categorised as "fair value through other comprehensive income" in certain circumstances. The requirements for financial liabilities are mostly carried forward from IAS 39. Some changes were made to the fair value option for financial liabilities to address the issue of own credit risk allowing the recognition of these changes in other comprehensive income for liabilities designated as fair value through profit or loss. The standard changes the impairment model from an incurred loss model and introduces a single "expected credit loss" impairment model for the measurement of financial assets. The standard contains a new model for hedge accounting that aligns the accounting treatment with the entity's risk management activities. Enhanced disclosures will provide better information about risk management and the effect of hedge accounting on the financial statements. Potential impact: The Scheme classifies financial assets at "fair value through profit or loss" or "amortised cost". The changes introduced by this standard will have no material impact on the Scheme. The introduction of the expected credit loss model and the requirement for the loss allowance to be measured at an amount equal to the lifetime expected credit losses has been assessed and not expected to have a material impact on the Scheme's results. The Scheme does not have any financial liabilities at fair value.	01 January 2018.

1 Basis of preparation *continued*

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

Standard	Scope	Effective date
IFRS 16: Leases	The standard introduces a single lessee accounting model and requires a lessee to recognise assets and liabilities for all leases with a term of more than 12 months, unless the underlying asset is of low value. A lessee is required to recognise a right-of-use asset representing its right to use the underlying asset and a lease liability representing its obligation to make lease payments. A lessee measures right-of-use assets similarly to other non-financial assets (such as property, plant and equipment) and lease liabilities similarly to other financial liabilities. As a consequence, a lessee recognises depreciation on the right-of-use asset and interest on the lease liability, and also classifies cash repayments of the lease liability into a principal and interest portion and presents them in the statement of cash flows. The Scheme does not have any agreements with a term of more than 12 months.	01 January 2019.
IFRS 17: Insurance contracts	The standard was issued in May 2017 and supersedes IFRS 4 Insurance Contracts. The standard creates one accounting model for all insurance contracts and establishes principles for the recognition, measurement, presentation and disclosure of insurance contracts issued. The standard requires insurance contracts to be measured using updated estimates and assumptions that reflect the timing of cash flows and take into account any uncertainty relating to insurance contracts. The standard provides for a simplified approach (premium allocation approach) for the measurement of a group of insurance contracts only if at the inception of the group, the entity reasonably expects that the simplification will produce measurement of the liability for remaining coverage that would not differ materially from that produced using the general measurement model and if the coverage period is one year or less. Potential impact: The coverage period for the Scheme's contracts is one year or less allowing for the premium allocation approach to be applied, resulting in similar treatment to the current accounting treatment with the most notable exception being the treatment of onerous contracts.	01 January 2021.

ACCOUNTING POLICIES CONTINUED

for the year ended 31 December 2017

2 Classification, recognition, presentation and derecognition of financial instruments

The Scheme recognises a financial instrument when, and only when, it becomes a party to the contractual provisions of the instrument. The Scheme classifies its financial instruments into the following categories: financial assets or financial liabilities at fair value through profit or loss, and loans and receivables. Loans and receivables are receivables other than those arising from insurance contracts and include balances due by related parties, sundry accounts receivable and interest receivable. Loans and receivables are disclosed under Trade and other receivables.

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

Offsetting financial instruments

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

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

Derecognition of financial assets and liabilities

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

- The contractual right to the cash flows from the asset expires.
- The Scheme retains the contractual right to receive cash flows of the asset, but assumes the obligation to pay one or more third parties the cash flow without material delay.
- The Scheme transfers the asset, while transferring substantially all the risks and rewards of ownership.
- The Scheme neither transfers the financial asset nor retains significant risk and reward of ownership, but has transferred control of the financial asset.

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

3 Financial assets

Financial assets at fair value through profit or loss

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

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

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

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

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

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

Trade and other receivables

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

Receivables are initially recognised at fair value plus transaction costs and subsequently measured at amortised cost using the effective interest rate method, less provision for impairment.

4 Foreign currency translation

Functional and presentation currency

Items included in the Annual Financial Statements are measured using the currency of the primary economic environment in which the entity operates (functional currency).

The functional and presentation currency of the Scheme is the South African Rand (R).

Transactions and balances

Foreign currency transactions are translated into the functional currency using the exchange rates prevailing at the dates of the transactions. Foreign exchange gains and losses resulting from the settlement of such transactions and from the translation at year-end exchange rates of monetary assets denominated in foreign currencies are recognised in the Statement of Comprehensive Income.

5 Scheme amalgamations

Scheme amalgamations are accounted for by applying the acquisition method.

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

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

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

Section 63 (14) of the Act prescribes that relevant assets and liabilities of the party effecting the transfer shall vest in and become binding upon the party to which transfer is effected.

No goodwill is recognised on the amalgamation of schemes.

6 Cash and cash equivalents

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

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

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

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

7 Impairment of financial assets

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

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

- Significant financial difficulty of service provider or member debtors.
- Breach of contract, such as non-payment of member contributions when due and if these remain unpaid for extended periods.
- Default or delinquency in payments due by service providers and other debtors.
- Observable data indicating that there is a measurable decrease in the estimated future cash flows from other Scheme assets since the initial recognition of those assets, although the decrease cannot yet be attributed to the individual financial assets in the Scheme.
- Adverse changes in the payment status of members of the Scheme.
- National or local economic conditions that correlate with non-payment of debtor contributions.

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

If there is objective evidence that an impairment loss on a financial asset has been incurred, the amount of the loss is measured as the difference between the assets' carrying amount and the present value of estimated future cash flows discounted at the financial asset's original effective interest rate. The carrying amount of the asset is reduced and the amount of the loss is recognised in the Statement of Comprehensive Income.

When a receivable is uncollectable, it is written off against the related provision for impairment. Such receivables are written off after all the necessary collection procedures have been completed and the amount of the loss has been determined. Subsequent recoveries of amounts previously written off decrease the amount of the provision for impairment in the Statement of Comprehensive Income.

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

ACCOUNTING POLICIES CONTINUED

for the year ended 31 December 2017

8 Members' funds

The funds represent the accumulated funds of the Scheme. The funds are mainly held as statutory reserves in lieu of the solvency requirement as required by the Act.

9 Financial liabilities

Financial liabilities are initially recognised at fair value net of transaction costs incurred. After initial recognition the financial liabilities are measured at amortised cost, using the effective interest rate method. In addition, the Scheme is not permitted to borrow, in terms of Section 35 (6) (c) of the Act. The Scheme therefore has no long-term financial liabilities.

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

Trade payables

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

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

Personal Medical Savings Account trust liabilities

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

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

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

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

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

10 Provisions

The Scheme recognises a provision once the following conditions are met:

- It has a present legal or constructive obligation as a result of past events.
- It is probable that an outflow of resources embodying economic benefits will be required to settle the obligation.
- A reliable estimate of the amount of the obligation can be made.

Provisions are measured as the present value of management's best estimate of the expenditure required to settle the obligation at the reporting date. Where the effect of discounting to present value is material, provisions are adjusted to reflect the time value of money.

Outstanding claims provision

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

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

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

11 Contingent liability

The Scheme will disclose a contingent liability if one of the following conditions are met:

- A possible obligation arising from past events, the existence of which will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the Scheme.
- A present obligation that arises from past events but not recognised because:
  - It is not probable that an outflow of resources will be required to settle an obligation.
  - The amount of the obligation cannot be measured with sufficient reliability.

12 Member insurance contracts

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

The contracts issued compensate the Scheme's members for healthcare expenses incurred and are detailed in Note 30.

13 Contribution income

Gross contributions comprise risk contributions and Personal Medical Savings Account contributions.

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

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

14 Relevant healthcare expenditure

Relevant healthcare expenditure consists of net claims incurred, accredited managed healthcare services (no risk transfer) and net income or expense from risk transfer arrangements.

14.1 Claims incurred

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

Risk claims incurred comprise:

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

Net of:

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

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

14.2 Risk transfer arrangements

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

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

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

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

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

ACCOUNTING POLICIES CONTINUED

for the year ended 31 December 2017

14 Relevant healthcare expenditure *continued*

14.3 Accredited managed healthcare services (no risk transfer)

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

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

15 Liability adequacy test

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

16 Broker service fees

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

17 Expenses for administration and other operating expenses

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

18 Investment income

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

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

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

19 Reimbursements from the road accident fund

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

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

20 Unallocated funds

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

Unallocated funds that have legally prescribed, that is funds older than three years, are written back and are included under Sundry income on the face of the Statement of Comprehensive Income.

A liability for unallocated funds that have not legally prescribed is recognised and disclosed under Trade and other payables. The liability is measured at amortised cost using the effective interest rate method.

21 Employee benefits

Pension obligations

All employees of the Scheme are members of defined contribution plans. Defined contribution plans are plans under which the Scheme pays fixed contributions to separate legal entities.

The Scheme has no legal or constructive obligation to pay further contributions if the funds do not hold sufficient assets to pay all employees the benefits relating to employee service in the current and prior periods. The Scheme has no further payment obligations once the contributions have been paid. Contributions to the defined contribution funds are recognised in the net surplus or deficit for the year in which they are incurred.

Other post-employment obligations

The Scheme has no liability for the post-retirement medical benefits of employees.

Other long term employee benefits

The long term employee benefit plan refers to awards made to qualifying employees.

The amount recognised in the Statement of Financial Position in respect of the defined benefit plan is the present value of the defined benefit obligation at the end of the reporting period less the fair value of plan assets out of which the obligations are to be settled directly. The defined benefit obligation is calculated using the Projected Unit Credit Method.

Leave pay accrual

The Scheme recognises in full employees' rights to annual leave entitlement in respect of past service.

Bonuses

Management and staff bonuses are recognised as an expense in staff costs as incurred.

22 Income tax

In terms of Section 10 (1) (d) of the Income Tax Act 58 of 1962, as amended, receipts and accruals of a benefit fund are exempt from normal tax. A medical scheme is included in the definition of a benefit fund and consequently the Scheme is exempt from income tax.

23 Allocation of income and expenditure to benefit plans

The following items are directly allocated to benefit plans:

- Contribution income.
- Claims incurred.
- Risk transfer arrangement fees.
- Accredited managed healthcare service fees.
- Expenses for administration.
- Broker service fees.
- Interest paid on Personal Medical Savings Accounts.

The remaining items are allocated as detailed below:

- For contributions that are not directly allocated to benefit plans, these amounts are apportioned based on a percentage of net contribution income per plan.
- For claims that are not directly allocated to benefit plans, these amounts are apportioned based on a percentage of net claims incurred per plan.
- The following items are apportioned based on the number of members per benefit plan:
  - Other operating expenditure;
  - Investment income, excluding interest income on Personal Medical Savings Accounts;
  - Net fair value gains/(losses) on financial assets at fair value through profit or loss;
  - Other income;
  - Expenses for asset management services rendered; and
  - Interest paid, excluding Personal Medical Savings Accounts.

24 Structured entities

A structured entity is an entity that has been designed so that voting or similar rights are not the dominant factor in deciding who controls the entity, such as when any voting rights relate to administrative tasks only, and the relevant activities are directed by means of contractual agreements. A structured entity often has some or all of the following features or attributes:

- Restricted activities.
- A narrow and well-defined objective, such as to provide investment opportunities for investors by passing on risks and rewards associated with the assets of the structured entity to investors.
- Insufficient equity to permit the structured entity to finance its activities without subordinated financial support.
- Financing in the form of multiple contractually linked instruments to investors that create concentrations of credit or other risks (tranches).

The Scheme has determined that some of its investments in pooled funds and in collective investments (funds) are investments in unconsolidated structured entities. Disclosure of these investments has been made in Note 31 to the Annual Financial Statements. The objectives include achieving medium to long-term capital growth and the investment strategy does not include the use of leverage.

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

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

NOTES TO THE ANNUAL FINANCIAL STATEMENTS

for the year ended 31 December 2017

R'000	2017	2016
1 Accounting policies		
The accounting policies of the Scheme are set out on pages 105 to 113.		
2 Financial assets at fair value through profit or loss		
The Scheme's financial assets at fair value through profit or loss are summarised by measurement classes as follows:		
Current assets	**14 005 644**	12 211 677
– Offshore bonds	**1 463 064**	1 245 709
– Equities	**3 378 331**	2 049 834
– Yield-enhanced bonds	**3 721 190**	3 413 740
– Inflation-linked bonds	**792 666**	610 476
– Money market instruments	**4 268 369**	4 891 918
– Listed property investments	**382 024**	–
	14 005 644	12 211 677
Reconciliation of the balance at the beginning of the year to the balance at the end of the year:		
At the beginning of the year	**12 211 677**	11 399 332
Acquisitions	**2 953 775**	1 922 170
Disposals	**(1 571 646)**	(1 127 159)
Net gains on revaluation of financial assets at fair value through profit or loss (Note 22)	**411 838**	17 334
At the end of the year	**14 005 644**	12 211 677
A register of investments is available for inspection at the registered office of the Scheme.		
3 Trade and other receivables		
Insurance receivables		
Contribution receivables	**751 192**	1 629 627
Contributions outstanding	**762 685**	1 639 386
Less: Provision for impairment	**(11 493)**	(9 759)
Member and service provider claims receivables	**94 025**	84 190
Amount due	**361 566**	341 473
Less: Provision for impairment	**(267 541)**	(257 283)
Other risk transfer arrangements	**11 796**	24 426
Recoveries due from other risk transfer arrangements	**3 660**	6 718
Share of outstanding claims provision (Note 6)	**8 136**	17 708
Broker fee receivables	**743**	1 084
Amounts due from brokers	**1 690**	1 948
Less: Provision for impairment	**(947)**	(864)
Other insurance receivables	**52 045**	138 781
Total receivables arising from insurance contracts	**909 801**	1 878 108

R'000	2017	2016
3 Trade and other receivables *continued*		
Loans and receivables		
Balance due by related party	**18 616**	20 540
Discovery Third Party Recovery Services (Pty) Ltd (Note 25)	**18 616**	20 540
Sundry accounts receivable	**215 234**	157 670
Interest receivable	**4 014**	1 690
Total receivables arising from loans and receivables	**237 864**	179 900
	1 147 665	2 058 008

At 31 December 2017 the carrying amounts of Trade and other receivables approximate their fair values due to the short term maturities of these assets. Interest is not charged on overdue balances. The estimated future cash flow receipts have not been discounted as the effect would be immaterial.

4 Cash and cash equivalents – Personal Medical Savings Account trust assets

(Monies managed by the Scheme on behalf of members)

PERSONAL MEDICAL SAVINGS ACCOUNT TRUST PORTFOLIO (Managed by Aluwani Capital Partners (Pty) Ltd)		
Balance at beginning of the year	**2 071 391**	1 832 987
Net additional Investments	**55 608**	84 040
Interest Income	**177 819**	154 364
Balance at the end of the year	**2 304 818**	2 071 391
PERSONAL MEDICAL SAVINGS ACCOUNT TRUST PORTFOLIO (Managed by Taquanta Asset Managers (Pty) Ltd)		
Balance at beginning of the year	**2 071 281**	1 834 469
Net additional Investments	**61 143**	86 660
Interest Income	**171 907**	150 152
Balance at the end of the year	**2 304 331**	2 071 281
Total Personal Medical Savings Account trust assets	**4 609 149**	4 142 672

These funds represent members' Personal Medical Savings Account assets managed by the Scheme on behalf of its members. As required by Circular 38 of 2011 and Circular 5 of 2012 issued by the Council for Medical Schemes, these assets have been invested separately from the Scheme's assets. The difference between total Personal Medical Savings Account assets and Personal Medical Savings Account liabilities (Note 8) is reconciled monthly and arises from timing of cash flows to and from the portfolios. For the year under review the average rate earned on the Personal Medical Savings Account Trust assets was 8.33% (2016: 7.64%).

NOTES TO THE ANNUAL FINANCIAL STATEMENTS CONTINUED

for the year ended 31 December 2017

R'000	2017	2016
5 Cash and cash equivalents – medical scheme assets		
Current accounts	**3 891 038**	940 981
Money market instruments	**1 989 324**	1 456 807
	5 880 362	2 397 788
At 31 December 2017 cash and cash equivalents are carried at amortised cost, which approximates fair value.		
6 Outstanding claims provision		
Outstanding claims provision – not covered by risk transfer arrangements	**1 231 927**	1 103 686
Outstanding claims provision – covered by risk transfer arrangements (Note 3)	**8 136**	17 708
	1 240 063	1 121 394
Analysis of movement in outstanding claims		
Balance at beginning of the year	**1 121 394**	985 087
Payments in respect of prior year	**(1 117 213)**	(951 858)
Over provision in prior year (Note 11)	**4 181**	33 229
Outstanding claims provision raised in current year	**1 235 882**	1 088 165
Not covered by risk transfer arrangements	**1 227 746**	1 070 457
Covered by risk transfer arrangements (Note 3)	**8 136**	17 708
Balance at end of the year	**1 240 063**	1 121 394
Analysis of outstanding claims provision		
Estimated gross claims	**1 323 263**	1 192 494
Less:		
Estimated recoveries from savings plan accounts (Note 8)	**(83 200)**	(71 100)
Balance at end of the year	**1 240 063**	1 121 394

R'000	2017	2016
7 Derivative financial instruments		
Financial assets held at fair value through profit or loss		
Current assets		
– Derivative financial instruments	**85 857**	54 760
Financial liabilities held at fair value through profit or loss		
Current liabilities		
– Derivative financial instruments	**(86 445)**	(4 376)
Derivative financial (liability)/asset at the end of the year	**(588)**	50 384
Reconciliation of the balance at beginning of the year to the balance at the end of the year:		
Derivative financial asset/(liability) at the beginning of the year	**50 384**	(65 210)
Net realised gain on derivative financial instruments (Note 27.4)	**(89 802)**	(131 351)
Realised gains on derivative financial instruments	**(91 869)**	(136 710)
– Equity portfolio derivatives	**–**	(693)
– Zero-cost currency collars	**(91 869)**	(136 017)
Realised losses on derivative financial instruments	**2 067**	5 359
– Bond portfolio derivatives	**2 067**	3 719
– Zero-cost currency collars	**–**	1 640
Net fair value gain on derivative financial instruments (Note 22)	**38 830**	246 944
Gains on revaluation of derivative financial instruments to fair value	**179 148**	255 039
– Equity portfolio derivatives	**–**	9 138
– Zero-cost equity collars	**–**	91 072
– Zero-cost currency collars	**174 851**	154 829
– Bond portfolio derivatives	**4 297**	–
Losses on revaluation of derivative financial instruments to fair value	**(140 318)**	(8 095)
– Zero-cost equity collars	**(138 330)**	–
– Bond portfolio derivatives	**(1 988)**	(8 095)
Derivative financial (liability)/asset at the end of the year	**(588)**	50 384

Derivative Instruments

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

The Scheme's equity managers entered into All Shareholder Index (ALSI) and SWIX 40 futures contracts to generate an equity-related return on cash held in the equity portfolios.

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

Details of the Scheme's derivatives and the impact of these instruments on investment return are set out in the Financial Risk Management Report (Note 31).

NOTES TO THE ANNUAL FINANCIAL STATEMENTS CONTINUED

for the year ended 31 December 2017

R'000	2017	2016
8 Personal Medical Savings Account trust liabilities		
(Personal Medical Savings Account trust monies managed by the Scheme on behalf of its members)		
Balance on Personal Medical Savings Accounts at the beginning of the year	**4 204 043**	3 736 659
Add:		
Personal Medical Savings Accounts contributions received or receivable	**11 008 711**	10 429 814
For the current year (Note 10)	**11 008 711**	10 429 814
Interest on Personal Medical Savings Accounts (Note 24)	**367 238**	287 923
Transfers received from other medical schemes	**31 784**	13 691
Less:		
Claims paid to or on behalf of members (Note 11)	**(10 602 298)**	(9 942 225)
Refunds on death or resignation	**(352 845)**	(321 819)
Balance due to members on Personal Medical Savings Accounts held in trust at the end of the year	**4 656 633**	4 204 043
It is estimated that claims to be paid out of members' Personal Medical Savings Accounts in respect of claims incurred in 2017 but not reported will amount to approximately R83 200 000 (2016: R71 100 056) (Note 6).		
As at 31 December 2017 the carrying amount of the members' Personal Medical Savings Accounts were deemed to be equal to their fair values, which is the amount payable on demand. The amounts were not discounted, due to the demand feature.		
Interest is allocated on these Personal Medical Savings Account balances monthly in accordance with Circular 38 of 2011 and Circular 5 of 2012 issued by the Council for Medical Schemes. The Scheme does not charge interest on negative (overdrawn) Personal Medical Savings Account balances.		
9 Trade and other payables		
Insurance payables		
Contributions received in advance	**1 851 573**	137 260
Contribution refunds due to employers	**1 110**	1 804
Reported claims not yet paid	**562 086**	548 257
Balance at the beginning of the year	**548 257**	506 752
Net movement for the year	**13 829**	41 505
Broker fee creditors	**111 819**	97 234
Accredited brokers	**111 819**	97 234
Total liabilities arising from insurance contracts	**2 526 588**	784 555
Financial liabilities		
Balance due to related parties	**513 571**	469 924
Discovery Health (Pty) Ltd (Note 25)	**513 571**	469 924
Unallocated funds	**8 943**	2 438
Total accruals	**16 416**	49 328
General accruals	**16 317**	49 268
Leave pay provision	**99**	60
Total arising from financial liabilities	**538 930**	521 690
	3 065 518	1 306 245
At 31 December 2017 the carrying amounts of insurance and other payables approximate their fair values due to the short term maturities of these liabilities.		

R'000	2017	2016
10 Risk contribution income		
Gross contributions per registered Scheme rules	**59 710 735**	54 056 212
Less:		
Personal Medical Savings Account contributions (Note 8)	**(11 008 711)**	(10 429 814)
	48 702 024	43 626 398
11 Net claims incurred		
Current year claims per registered Scheme rules	**50 855 045**	46 578 250
Claims not covered by risk transfer arrangements	**50 448 462**	46 227 327
Claims covered by risk transfer arrangements (Note 13)	**406 583**	350 923
Movement in outstanding claims provision	**118 670**	136 307
Over provision in prior year (Note 6)	**(4 181)**	(33 229)
Adjustment for current year	**122 851**	169 536
	50 973 715	46 714 557
Less:		
Claims charged to members' Personal Medical Savings Accounts (Note 8)	**(10 602 298)**	(9 942 225)
Claims incurred	**40 371 417**	36 772 332
Third party claim recoveries	**(143 360)**	(159 122)
	40 228 057	36 613 210

Risk transfer arrangements

During 2017 the Scheme had six (2016: six) risk transfer arrangements in place. The methodologies used to determine the claims covered by these arrangements are set out below.

- **Risk transfer arrangement covering in-hospital and out-of-hospital benefits for certain members on the KeyCare Plus and KeyCare Access plans.**

  The claims experience for members on the KeyCare Plus and KeyCare Access plans for the 2017 benefit year that were not part of this risk transfer agreement was used as the basis for determining the claims under this arrangement. These claim amounts are adjusted to include a provision for outstanding claims and then converted to a per life per month (PLPM) rate using the membership on the KeyCare Plus and KeyCare Access plans.

  In order to determine the value of claims under this arrangement, the average 2017 PLPM rate is multiplied by the lives exposure for this arrangement's membership.

- **Risk transfer arrangement providing optometry services to members on the KeyCare Plus and KeyCare Access plans.**

  An analysis as to the expected costs of optometry benefits using the experience from other Scheme plans was conducted. These claim amounts are adjusted to include a provision for outstanding claims and converted to a PLPM rate. Generally the claims experience on KeyCare Plus and KeyCare Access is different to that of other Scheme plans as KeyCare Plus and KeyCare Access is aimed at a specific target market and the benefits are restricted. To allow for this, the overall PLPM is adjusted by the ratio of KeyCare Plus and KeyCare Access claims experience to the other plans offered by the Scheme. The value of claims under this arrangement is determined by multiplying the PLPM rate by the lives exposure for KeyCare Plus and KeyCare Access.

- **Risk transfer arrangement providing dentistry services to members on the KeyCare Plus and KeyCare Access plans.**

  The cost of the group of dental procedure codes was isolated. Using claims data linked to this group, the overall PLPM cost of dental services on all plans excluding KeyCare Plus and KeyCare Access was estimated. These claim amounts are adjusted to include a provision for outstanding claims. Generally, the claims experience on KeyCare Plus and KeyCare Access is different to that of other Scheme plans as KeyCare Plus and KeyCare Access is aimed at a specific target market and the benefits are restricted. To allow for this, the overall PLPM is adjusted by the ratio of KeyCare Plus and KeyCare Access claims experience to the other benefit plans offered by the Scheme. The value of claims under this arrangement is determined by multiplying the PLPM rate by the lives exposure for KeyCare Plus and KeyCare Access.

NOTES TO THE ANNUAL FINANCIAL STATEMENTS CONTINUED

for the year ended 31 December 2017

11 Net claims incurred *continued*

- **Risk transfer arrangement covering treatment for Executive and Comprehensive Plan members diagnosed with diabetes (type I and II).**

  For their diabetes-related treatment, members have a choice of using the managed care organisation under this risk transfer arrangement or not. As the risk profile of the two groups of members are similar, the claims experience of the Executive and Comprehensive Plan members who have not elected to use this provider was used to estimate the members' fee-for-service cost for those who have elected to use this provider.

  As no underlying fee-for-service data is available, the cost of providing the capitated services was estimated as follows:

  - PLPM estimates were calculated for consultations, procedures, medication and hospital admissions to the extent that these services were covered under this risk transfer arrangement for the Executive and Comprehensive Plan members who have not elected this provider.
  - The expected fee-for-service cost was calculated by multiplying the calculated PLPM costs by the number of members exposed for the period on this programme.

- **Risk transfer arrangement providing acute medication dispensing services to members on the Smart plan.**

  The Scheme contracted with two providers as Designated Service Providers (DSPs) to provide acute medication dispensing services for Smart plan members. The Scheme remunerates the DSPs at the contracted monthly capitation fee.

  The estimated claims incurred under this arrangement is determined using the acute medicine claims experience for members not on the Smart plan and calculating a PLPM rate. The value of claims under this arrangement is determined by multiplying the PLPM rate by the lives exposure for Smart Plan members.

R'000	2017	2016
12 Accredited managed healthcare services (no risk transfer)		
The accredited managed healthcare services (no risk transfer) have been grouped into the following categories of services.		
Discovery Health (Pty) Ltd		
Active Disease Risk Management Services and Disease Risk Management Support Services	**494 155**	453 235
Hospital Benefit Management Services	**458 289**	420 400
Managed Care Network Management Services and Risk Management Services	**426 180**	390 788
Pharmacy Benefit Management Services	**155 687**	142 844
	1 534 311	1 407 267
13 Net profit/(loss) on risk transfer arrangements		
The Scheme operated the following risk transfer arrangements during the year:		
Risk transfer arrangement fees	**(392 023)**	(366 344)
Recoveries under risk transfer arrangements (Note 11)	**406 583**	350 923
	14 560	(15 421)

R'000	2017	2016
14 Broker service fees		
Brokers' fees	**1 214 205**	1 101 648
	1 214 205	1 101 648
15 Other operating expenses		
Association fees	**1 359**	1 616
Audit fees	**9 066**	11 594
Audit services for the year ended 2017	**1 759**	–
Audit services for the year ended 2016	**3 084**	1 661
Audit services for the year ended 2015	**–**	2 462
Other services	**4 223**	7 471
Audit Committee and Risk Committee fees (Note 16)	**2 001**	1 755
Audit Committee	**1 458**	1 167
Risk Committee	**543**	588
Bank charges	**9 817**	10 681
Clinical Governance Committee fees	**662**	375
Council for Medical Schemes	**44 103**	40 631
Debt collecting fees	**2 789**	3 850
Dispute Committee fees	**636**	871
Fidelity Guarantee Insurance	**285**	226
General meeting costs	**9 989**	8 986
Investment Committee fees	**701**	323
Investment reporting fees	**3 669**	3 416
Legal fees	**476**	816
Net impairment losses (Note 17)	**87 604**	75 167
Non-Healthcare Expenses Committee Fees	**131**	–
Nomination Committee fees (Note 18)	**285**	571
Other expenses	**25 951**	25 499
Principal Officer fees – Remuneration	**5 128**	5 706
Principal Officer fees – Unvested long term employee benefit	**1 803**	1 438
Printing, postage and stationery	**839**	735
Product Committee fees	**73**	–
Professional fees	**10 517**	9 548
Remuneration Committee fees	**106**	109
Scheme Office costs	**5 658**	6 314
Staff costs (Note 19)	**28 723**	20 127
Sundry amounts written off	**100**	293
Stakeholder Relations and Ethics Committee* fees	**156**	129
Trustees' remuneration and consideration expenses (Note 20)	**7 834**	5 430
	260 461	236 206

* *Previously Stakeholder Relations Committee.*

NOTES TO THE ANNUAL FINANCIAL STATEMENTS CONTINUED

for the year ended 31 December 2017

R'000	2017	2016
16 Audit Committee and Risk Committee fees		
Audit Committee fees	**1 458**	1 167
B Stott – Independent member (Chairperson)	**818**	603
S Green – Independent member	**213**	158
D King – Independent member	**–**	64
S Ludolph – Independent member	**225**	163
P Maphumulo – Independent member	**202**	179
Risk Committee fees	**543**	588
B Stott – Independent member (Chairperson)	**156**	161
S Green – Independent member	**125**	128
D King – Independent member	**–**	57
S Ludolph – Independent member	**137**	113
P Maphumulo – Independent member	**125**	129
	2 001	1 755

These are payments to independent members of the Audit and Risk Committees. These members are not Trustees of the Scheme. Amounts paid to Trustee members of these Committees are disclosed in Note 20.

R'000	2017	2016
17 Net impairment losses		
Insurance and other receivables		
Contributions that are not collectable	**1 734**	126
Movement in provision	**1 734**	126
Members' and service providers' portions that are not recoverable	**85 688**	76 422
Movement in provision	**85 688**	76 422
Amounts due by brokers that are not recoverable	**82**	81
Movement in provision	**82**	81
Payables/receivables written off	**111**	(1 462)
Less:		
Previously written off receivables recovered	**(11)**	–
	87 604	75 167
18 Other Committee fees		
Nomination Committee fees		
P Goss – Independent member (Chairperson)	**89**	201
T Wixley – Independent member	**89**	184
R Shough – Independent member	**107**	186
	285	571
19 Staff costs		
Salaries and bonuses	**23 099**	16 466
Pension costs – defined contribution plans	**1 497**	1 160
Medical and other benefits	**846**	699
Long term employee benefits service cost	**3 242**	1 563
Increase in leave pay accrual	**39**	239
	28 723	20 127
Number of employees at 31 December	**12**	11

NOTES TO THE ANNUAL FINANCIAL STATEMENTS CONTINUED

for the year ended 31 December 2017

20 Trustees' remuneration and consideration expenses

The following table records the remuneration and consideration paid to Trustees during the year:

31 December 2017	Services as Trustee R'000	Committee fees: Audit Committee R'000	Risk Committee R'000	Investment Committee R'000	Clinical Governance Committee R'000	Product Committee R'000	Committee fees: Non-healthcare Expenditure Committee R'000	Remuneration Committee R'000	Stakeholder Relations and Ethics[1] Committee R'000	Trustee travel R'000	Total R'000
N Morrison (Chairperson)	**625**	**90**	**51**	**222**	**–**	**11**	**136**	**38**	**51**	**–**	**1 224**
M van der Nest SC	**573**	**–**	**–**	**–**	**–**	**–**	**–**	**49**	**66**	**1**	**689**
G Waugh	**180**	**67**	**45**	**–**	**–**	**56**	**92**	**–**	**–**	**7**	**447**
D Moodley	**486**	**–**	**–**	**222**	**241**	**114**	**–**	**–**	**114**	**18**	**1 195**
D King	**488**	**–**	**–**	**–**	**–**	**–**	**136**	**76**	**114**	**90**	**904**
D Naidoo	**521**	**210**	**139**	**247**	**–**	**113**	**155**	**–**	**–**	**–**	**1 385**
J Adams SC	**231**	**115**	**84**	**–**	**115**	**–**	**–**	**–**	**–**	**–**	**545**
J Butler SC	**248**	**–**	**–**	**–**	**–**	**–**	**54**	**43**	**85**	**36**	**466**
J Human	**202**	**78**	**63**	**104**	**–**	**69**	**–**	**–**	**–**	**53**	**569**
S Brynard	**202**	**–**	**–**	**–**	**–**	**63**	**–**	**38**	**63**	**44**	**410**
Total	**3 756**	**560**	**382**	**795**	**356**	**426**	**573**	**244**	**493**	**249**	**7 834**

31 December 2016	Services as Trustee R'000	Committee fees: Audit Committee R'000	Risk Committee R'000	Investment Committee R'000	Clinical Governance Committee R'000	Product Committee R'000	Committee fees: Non-healthcare Expenditure Committee R'000	Remuneration Committee R'000	Stakeholder Relations Committee R'000	Trustee travel R'000	Total R'000
M van der Nest SC (Chairperson)	813	–	–	–	–	–	–	66	104	22	1 005
P Maserumule	206	–	–	95	–	–	–	–	35	–	336
N Graves SC	247	–	–	46	–	35	64	33	–	13	438
Z van der Spuy	260	–	–	–	71	45	–	–	–	69	445
G Waugh	441	129	132	–	–	121	102	–	–	–	925
D Moodley	207	5	–	56	86	52	–	–	–	24	430
N Morrison	220	66	71	56	–	5	32	–	–	2	452
D King	206	–	–	–	–	–	41	33	45	59	384
D Naidoo	469	127	133	132	–	52	91	–	–	11	1 015
Total	**3 069**	**327**	**336**	**385**	**157**	**310**	**330**	**132**	**184**	**200**	**5 430**

1 At the end of 2017, the Committee adopted an expanded social and ethics governance mandate and new name of Stakeholder Relations and Ethics Committee (previously Stakeholder Relations Committee).

NOTES TO THE ANNUAL FINANCIAL STATEMENTS CONTINUED

for the year ended 31 December 2017

R'000	2017	2016
21 Investment income		
Financial assets at fair value through profit or loss:	**1 383 773**	1 200 503
Dividend income	**84 062**	50 993
Interest income	**1 299 711**	1 149 510
Cash and cash equivalents interest income	**49 414**	56 976
Investment income per Statement of Comprehensive Income	**1 433 187**	1 257 479
The Scheme's total interest income is summarised below.		
Financial assets not at fair value through profit or loss:		
Cash and cash equivalents interest income	**49 414**	56 976
Financial assets at fair value through profit or loss:		
Interest income	**1 299 711**	1 149 510
Total interest income	**1 349 125**	1 206 486
22 Net gains on financial assets at fair value through profit or loss		
Net fair value gains on financial assets at fair value through profit or loss (Note 2):	**411 838**	17 334
Fair value gains on financial assets at fair value through profit or loss:	**529 340**	180 725
– Equities	**435 490**	126 213
– Money market instruments	**27 814**	598
– Inflation-linked bonds	**–**	5 574
– Listed property investments	**29 476**	–
– Yield-enhanced bonds	**36 560**	48 340
Fair value losses on financial assets at fair value through profit or loss:	**(117 502)**	(163 391)
– Equities	**–**	(64 229)
– Money market instruments	**–**	(2 759)
– Offshore bonds	**(96 851)**	(88 161)
– Inflation-linked bonds	**(14 592)**	(7 845)
– Yield-enhanced bonds	**(6 059)**	(397)
Net fair value gains on derivative financial instruments (Note 7):	**38 830**	246 944
Fair value gains on derivative financial instruments:	**179 148**	255 039
Fair value losses on derivative financial instruments:	**(140 318)**	(8 095)
Net fair value gains on cash and cash equivalents	**8 085**	–
	458 753	264 278

R'000	2017	2016
23 Sundry income		
Prescribed amounts written back	**24 951**	2 433
(Reversal of stale cheques written back)/Stale cheques written back	**(23 205)**	(74)
	1 746	2 359
24 Interest paid		
Financial assets not at fair value through profit or loss:		
Interest on Personal Medical Savings Accounts (Note 8)	**367 238**	287 923
Interest paid to Administrator (Note 25)	**–**	2 119
	367 238	290 042

25 Related party transactions

The Scheme is governed by the Board of Trustees who are elected by the members of the Scheme.

Key management personnel and their close family members

Key management personnel are those persons having authority and responsibility for planning, directing and controlling the activities of the Scheme. Key management personnel include the non-executive Board of Trustees and the Executive Officers of the Scheme. The disclosure deals with full-time Executive Officers who are compensated on a salary basis, and non-executive Board of Trustees who are compensated on a fee basis.

Close family members include close family members of the Board of Trustees and Executive Officers of the Scheme.

Parties with significant influence over the Scheme

Administrator

Discovery Health (Pty) Ltd has significant influence over the Scheme, as Discovery Health (Pty) Ltd participates in the Scheme's financial and operating policy decisions, but does not control the Scheme. Discovery Health (Pty) Ltd provides administration, managed care services, broker services and wellness programmes.

Third party collection services are provided through Discovery Third Party Recovery Services (Pty) Ltd, specialist pharmaceutical services through Southern RX Distributors (Pty) Ltd and home-based care through Grove Nursing Services (Pty) Ltd, all wholly-owned subsidiaries of Discovery Health (Pty) Ltd.

NOTES TO THE ANNUAL FINANCIAL STATEMENTS CONTINUED

for the year ended 31 December 2017

25 Related party transactions *continued*

Transactions with related parties

The following provides the total amount in respect of transactions, which have been entered into with related parties for the relevant financial year.

Transactions with key management personnel and their close family members which includes Trustees and Executive Officers:

R'000	2017	2016
Statement of Comprehensive Income transactions		
Compensation		
Short term employee benefits	**(35 683)**	(26 381)
Unvested long term employee benefit	**(5 045)**	(3 000)
Contributions and claims		
Gross contributions received	**761**	724
Claims paid from the Scheme	**(454)**	(281)
Claims paid from the Personal Medical Savings Account	**(182)**	(163)
Interest paid on Personal Medical Savings Accounts	**(1)**	(1)
Statement of Financial Position transactions		
Long term employee benefit plan asset	**4 417**	5 614
Plan asset	**8 981**	9 738
Plan liability	**(4 564)**	(4 124)
Contribution debtors	**57**	35
Personal Medical Savings Account balances	**(12)**	(28)

The terms and conditions of the related party transactions were as follows:

Transactions	Nature of transactions and their terms and conditions
Compensation	This constitutes remuneration and consideration paid to Trustees and Executive Officers, short term employee benefits and unvested long term employee benefits.
Contributions received	This constitutes the contributions paid by the related party as a member of the Scheme, in their individual capacity. All contributions were on the same terms as applicable to other members.
Claims incurred	This constitutes amounts claimed by the related parties, in their individual capacity as members of the Scheme. All claims were paid out in terms of the rules of the Scheme, as applicable to other members.
Contribution debtors	This constitutes outstanding contributions receivable. The amounts are due immediately. No impairment provisions have been raised on these amounts.
Personal Medical Savings Account balances	The amounts owing to the related parties relate to Personal Medical Savings Account balances to which the parties have a right. In line with the terms applied to other members, the balances earn monthly interest on an accrual basis, at interest rates aligned to the rates earned within the Personal Medical Savings Account Trust Portfolios. The amounts are all current and would need to be payable on demand as applicable to other members.

25 Related party transactions *continued*

Transactions with entities that have significant influence over the Scheme

R'000	2017	2016
Discovery Health (Pty) Ltd – Administrator		
Statement of Comprehensive Income transactions		
Administration fees paid	**(4 511 596)**	(4 150 194)
Interest paid on monthly balances (Note 24)	**–**	(2 119)
Statement of Financial Position transactions		
Balance due to Discovery Health (Pty) Ltd (Note 9)*	**(384 681)**	(351 510)
Discovery Health (Pty) Ltd – Managed care organisation		
Statement of Comprehensive Income transactions		
Accredited managed healthcare services (no risk transfer) (Note 12)	**(1 534 311)**	(1 407 267)
Statement of Financial Position transactions		
Balance due to Discovery Health (Pty) Ltd at year end (Note 9)*	**(128 890)**	(118 414)
Discovery Health (Pty) Ltd – Brokers		
Statement of Comprehensive Income transactions		
Broker fees paid	**–**	(14 135)
Discovery Third Party Recovery Services (Pty) Ltd		
Statement of Comprehensive Income transactions		
Third party collection fees	**(21 827)**	(22 030)
Statement of Financial Position transactions		
Balance due to the Scheme at year end (Note 3)	**18 616**	20 540
Southern RX Distributors (Pty) Ltd		
Statement of Comprehensive Income transactions		
Claims paid from the Scheme	**(205 254)**	(145 325)
Statement of Financial Position transactions		
Claims due to provider	**(1 916)**	(1 837)
Discovery Health (Pty) Ltd – Wellness experiences		
Statement of Comprehensive Income transactions		
Claims paid from the Scheme	**(16 489)**	(9 541)
Statement of Financial Position transactions		
Claims due to provider	**(2)**	(93)
Grove Nursing Services (Pty) Ltd		
Statement of Comprehensive Income transactions		
Claims paid from the Scheme	**(7 862)**	(9 677)
Statement of Financial Position transactions		
Claims (due to)/ from provider	**(153)**	(35)

** Total amount due to Discovery Health (Pty) Ltd for the current financial year is R514 million (2016: R 470 million), disclosed in Note 9.*

NOTES TO THE ANNUAL FINANCIAL STATEMENTS CONTINUED

for the year ended 31 December 2017

25 Related party transactions *continued*

Transactions with entities that have significant influence over the Scheme *continued*

The terms and conditions of the transactions with entities with significant influence over the Scheme were as follows:

Administration agreement

The administration agreement is in terms of the Rules of the Scheme and in accordance with instructions given by the Board of Trustees. The agreement was effective from January 2015 for a three year period which ended on 31 December 2017. A new agreement for a five year period has been entered into effective from 1 January 2018. The Scheme and the Administrator shall be entitled to terminate the agreement by giving the other party at least 12 calendar months' written notice. Effective from January 2017, the parties agreed that no interest would be levied on amounts owing.

The administration fees are an all-inclusive fee, calculated on a per member per month basis. The total expense for administration cost changes in line with membership growth and inflation.

The main categories of service provided can be broken down as follows:

- Member and provider servicing;
- Marketing and advertising;
- Financial and actuarial services; and
- Governance, risk, compliance and internal audit.

Managed healthcare agreement

Managed healthcare means clinical and financial risk assessment and management of healthcare, with a view to facilitating appropriateness and cost-effectiveness of relevant health services within the constraints of what is affordable, through the use of rules-based and clinical management-based programmes.

The Scheme has contracted with the Administrator to provide accredited managed healthcare services (no risk transfer). These services include bill review, specialist and hospital referrals, case management, disease management (where healthcare benefits are not included in the contract), peer review, claims audits and statistical analysis.

This agreement is in accordance with instructions given by the Board of Trustees. The agreement was effective from January 2015 for a three year period which ended on 31 December 2017. A new agreement for a five year period has been entered into effective from 1 January 2018. The Scheme and Discovery Health (Pty) Ltd shall be entitled to terminate the agreement by giving the other party at least 12 calendar months' written notice. Effective from January 2017, the parties agreed that no interest would be levied on amounts owing.

The accredited services provided by the managed care organisation include:

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

25 Related party transactions *continued*

Third party collection services

The Scheme has contracted with Discovery Third Party Recovery Services (Pty) Ltd, a wholly owned subsidiary of Discovery Health (Pty) Ltd, to manage the identification and collection of third party recoveries from the Road Accident Fund and the Compensation for Occupational Injuries and Diseases. The Scheme has sold all Road Accident Fund claims incurred by the Scheme during the period 1 January 2017 to 31 December 2017 to Discovery Third Party Recovery Services (Pty) Ltd for the amount of R15 million (2016: R14 million).

Specialist Pharmaceutical Services

The Scheme is contracted with Southern RX Pharmacy, a wholly owned subsidiary of Discovery Health (Pty) Ltd to provide specialist pharmaceutical services to members of the Scheme.

Wellness experiences

Discovery Health (Pty) Ltd provides wellness experiences through lifestyle and health assessments to Scheme members with the use of information technology and on-site medical evaluations of key health indicators.

Home-based nursing services

The Scheme is contracted with Grove Nursing services also known as Discovery HomeCare services, a wholly owned subsidiary of Discovery Health (Pty) Ltd, to provide home-based care to members of the Scheme in the comfort of their home.

Broker service fees

The Scheme contracted with Discovery Health (Pty) Ltd to provide broker services directly to the consumer. The amounts were determined and paid based on the terms and conditions applicable to other brokers. This agreement was terminated during 2016 and no amounts were paid to Discovery Health (Pty) Ltd during the year under review.

NOTES TO THE ANNUAL FINANCIAL STATEMENTS CONTINUED

for the year ended 31 December 2017

26 Surplus/(deficit) from operations per benefit plan

2017	Executive R'000	Classic Comp. R'000	Classic Comp. Zero MSA R'000	Classic Core R'000	Classic Saver R'000	Classic Priority R'000	Essential Comp. R'000	Essential Saver R'000	Essential Core R'000
Risk contribution income	**925 588**	**10 127 603**	**60 524**	**1 999 904**	**10 690 234**	**4 470 174**	**1 008 291**	**3 495 369**	**1 193 011**
Net claims incurred	(1 193 107)	(10 161 581)	(57 558)	(1 457 631)	(7 977 065)	(3 565 076)	(861 544)	(2 156 717)	(784 339)
Claims incurred	(1 194 229)	(10 177 005)	(57 652)	(1 463 164)	(8 008 290)	(3 575 217)	(863 324)	(2 169 553)	(788 666)
Third party claim recoveries	1 122	15 424	94	5 533	31 225	10 141	1 780	12 836	4 327
Net income/(expense) on risk transfer arrangements	(572)	(12 956)	(199)	–	–	–	(1 995)	–	–
Risk transfer arrangement fees	(10 080)	(138 895)	(1 169)	–	–	–	(14 420)	–	–
Recoveries from risk transfer arrangements	9 508	125 939	970	–	–	–	12 425	–	–
Accredited managed healthcare services (no risk transfer)	(12 446)	(171 435)	(1 038)	(59 452)	(335 991)	(111 187)	(19 830)	(133 479)	(44 975)
Relevant healthcare expenditure	**(1 206 125)**	**(10 345 972)**	**(58 795)**	**(1 517 083)**	**(8 313 056)**	**(3 676 263)**	**(883 369)**	**(2 290 196)**	**(829 314)**
Gross healthcare result	**(280 537)**	**(218 369)**	**1 729**	**482 821**	**2 377 178**	**793 911**	**124 922**	**1 205 173**	**363 697**
Broker service fees	(11 547)	(161 712)	(960)	(46 371)	(299 770)	(105 070)	(18 837)	(105 091)	(32 258)
Expenses for administration	(40 220)	(554 028)	(3 356)	(192 226)	(1 085 766)	(359 412)	(64 086)	(431 333)	(145 337)
Other operating expenses	(2 114)	(29 123)	(176)	(10 092)	(57 056)	(18 884)	(3 369)	(22 649)	(7 631)
Net healthcare result	**(334 418)**	**(963 232)**	**(2 763)**	**234 132**	**934 586**	**310 545**	**38 630**	**646 100**	**178 471**
Investment income	11 628	160 198	971	55 540	313 841	103 886	18 534	124 636	41 999
Net fair value gains on financial assets at fair value through profit or loss	3 669	50 511	309	17 733	100 334	32 929	5 840	40 376	13 594
Sundry income	11	153	–	66	375	108	20	180	61
Other income	**15 308**	**210 862**	**1 280**	**73 339**	**414 550**	**136 923**	**24 394**	**165 192**	**55 654**
Expenses for asset management services rendered	(359)	(4 961)	(31)	(1 723)	(9 729)	(3 219)	(572)	(3 864)	(1 303)
Interest paid	(4 536)	(62 479)	–	–	(122 291)	(40 501)	(7 228)	(48 529)	–
Other expenditure	**(4 895)**	**(67 440)**	**(31)**	**(1 723)**	**(132 020)**	**(43 720)**	**(7 800)**	**(52 393)**	**(1 303)**
Net surplus/(deficit) for the year	**(324 005)**	**(819 810)**	**(1 514)**	**305 748**	**1 217 116**	**403 748**	**55 224**	**758 899**	**232 822**

26 Surplus/(deficit) from operations per benefit plan *continued*

2017	Essential Priority R'000	Coastal Saver R'000	Coastal Core R'000	KeyCare Plus R'000	KeyCare Core R'000	KeyCare Access R'000	Classic Smart R'000	Essential Smart R'000	Total R'000
Risk contribution income	**296 693**	**6 144 961**	**2 711 384**	**4 620 954**	**239 426**	**61 615**	**528 258**	**128 035**	**48 702 024**
Net claims incurred	(187 054)	(4 849 658)	(2 191 449)	(4 267 578)	(150 219)	(25 603)	(297 584)	(44 294)	(40 228 057)
Claims incurred	(187 801)	(4 869 552)	(2 200 521)	(4 293 000)	(151 800)	(26 132)	(299 905)	(45 606)	(40 371 417)
Third party claim recoveries	747	19 894	9 072	25 422	1 581	529	2 321	1 312	143 360
Net income/(expense) on risk transfer arrangements	–	–	–	32 924	–	(267)	(2 375)	–	14 560
Risk transfer arrangement fees	–	–	–	(215 369)	–	(2 954)	(9 136)	–	(392 023)
Recoveries from risk transfer arrangements	–	–	–	248 293	–	2 687	6 761	–	406 583
Accredited managed healthcare services (no risk transfer)	(8 146)	(216 145)	(98 103)	(268 094)	(16 434)	(5 511)	(22 359)	(9 686)	(1 534 311)
Relevant healthcare expenditure	**(195 200)**	**(5 065 803)**	**(2 289 552)**	**(4 502 748)**	**(166 653)**	**(31 381)**	**(322 318)**	**(53 980)**	**(41 747 808)**
Gross healthcare result	**101 493**	**1 079 158**	**421 832**	**118 206**	**72 773**	**30 234**	**205 940**	**74 055**	**6 954 216**
Broker service fees	(7 252)	(184 488)	(72 897)	(139 717)	(7 303)	(1 937)	(14 980)	(4 015)	(1 214 205)
Expenses for administration	(26 325)	(698 495)	(317 029)	(468 790)	(15 445)	(6 213)	(72 250)	(31 285)	(4 511 596)
Other operating expenses	(1 384)	(36 705)	(16 655)	(45 484)	(2 784)	(933)	(3 789)	(1 633)	(260 461)
Net healthcare result	**66 532**	**159 470**	**15 251**	**(535 785)**	**47 241**	**21 151**	**114 921**	**37 122**	**967 954**
Investment income	7 612	201 923	91 649	250 408	15 350	5 147	20 864	9 001	1 433 187
Net fair value gains on financial assets at fair value through profit or loss	2 418	64 268	29 191	80 559	4 957	1 669	6 969	3 427	458 753
Sundry income	8	225	103	324	22	7	42	41	1 746
Other income	**10 038**	**266 416**	**120 943**	**331 291**	**20 329**	**6 823**	**27 875**	**12 469**	**1 893 686**
Expenses for asset management services rendered	(237)	(6 260)	(2 842)	(7 760)	(476)	(159)	(650)	(283)	(44 428)
Interest paid	(2 967)	(78 707)	–	–	–	–	–	–	(367 238)
Other expenditure	**(3 204)**	**(84 967)**	**(2 842)**	**(7 760)**	**(476)**	**(159)**	**(650)**	**(283)**	**(411 666)**
Net surplus/(deficit) for the year	**73 366**	**340 919**	**133 352**	**(212 254)**	**67 094**	**27 815**	**142 146**	**49 308**	**2 449 974**

NOTES TO THE ANNUAL FINANCIAL STATEMENTS CONTINUED

for the year ended 31 December 2017

26 Surplus/(deficit) from operations per benefit plan *continued*

2016	Executive R'000	Classic Comp. R'000	Classic Comp. Zero MSA R'000	Classic Core R'000	Classic Saver R'000	Classic Priority R'000	Essential Comp. R'000	Essential Saver R'000	Essential Core R'000
Risk contribution income	**875 516**	**9 802 065**	**51 050**	**1 857 849**	**9 115 477**	**4 202 272**	**1 014 102**	**2 885 453**	**1 013 633**
Net claims incurred	(1 157 978)	(9 709 842)	(47 899)	(1 340 447)	(6 784 281)	(3 384 976)	(833 849)	(1 805 622)	(660 685)
Claims incurred	(1 159 318)	(9 728 653)	(48 001)	(1 346 843)	(6 817 367)	(3 396 783)	(836 103)	(1 818 786)	(665 369)
Third party claim recoveries	1 340	18 811	102	6 396	33 086	11 807	2 254	13 164	4 684
Net income/(expense) on risk transfer arrangements	(2 425)	(35 647)	(320)	–	–	–	(4 161)	–	–
Risk transfer arrangement fees	(9 914)	(131 482)	(938)	–	–	–	(13 673)	–	–
Recoveries from risk transfer arrangements	7 489	95 835	618	–	–	–	9 512	–	–
Accredited managed healthcare services (no risk transfer)	(12 280)	(172 806)	(915)	(57 064)	(294 412)	(107 268)	(20 650)	(112 847)	(39 701)
Relevant healthcare expenditure	**(1 172 683)**	**(9 918 295)**	**(49 134)**	**(1 397 511)**	**(7 078 693)**	**(3 492 244)**	**(858 660)**	**(1 918 469)**	**(700 386)**
Gross healthcare result	**(297 167)**	**(116 230)**	**1 916**	**460 338**	**2 036 784**	**710 028**	**155 442**	**966 984**	**313 247**
Broker service fees	(11 360)	(165 057)	(828)	(42 828)	(259 350)	(102 255)	(20 642)	(86 194)	(26 669)
Expenses for administration	(39 938)	(562 224)	(2 975)	(185 567)	(957 550)	(348 811)	(67 157)	(366 937)	(129 091)
Other operating expenses	(2 063)	(28 989)	(153)	(9 580)	(49 421)	(18 009)	(3 469)	(18 938)	(6 662)
Net healthcare result	**(350 528)**	**(872 500)**	**(2 040)**	**222 363**	**770 463**	**240 953**	**64 174**	**494 915**	**150 825**
Investment income	10 968	154 294	818	50 982	263 050	95 799	18 438	100 903	35 499
Net fair value gains on financial assets at fair value through profit or loss	2 370	33 385	174	10 798	55 540	20 560	3 986	20 697	7 236
Sundry income	20	308	(1)	95	498	184	33	184	65
Other income	**13 358**	**187 987**	**991**	**61 875**	**319 088**	**116 543**	**22 457**	**121 784**	**42 800**
Expenses for asset management services rendered	(272)	(3 820)	(23)	(1 259)	(6 505)	(2 369)	(453)	(2 490)	(874)
Interest paid	(3 806)	(53 555)	–	(83)	(91 299)	(33 251)	(6 402)	(35 016)	(57)
Other expenditure	(4 078)	(57 375)	(23)	(1 342)	(97 804)	(35 620)	(6 855)	(37 506)	(931)
Net surplus/(deficit) for the year	**(341 248)**	**(741 888)**	**(1 072)**	**282 896**	**991 747**	**321 876**	**79 776**	**579 193**	**192 694**

26 Surplus/(deficit) from operations per benefit plan *continued*

2016	Essential Priority R'000	Coastal Saver R'000	Coastal Core R'000	KeyCare Plus R'000	KeyCare Core R'000	KeyCare Access R'000	KeyCare Smart R'000	Total R'000
Risk contribution income	**297 133**	**5 385 228**	**2 413 696**	**4 207 970**	**220 866**	**57 055**	**227 033**	**43 626 398**
Net claims incurred	(205 856)	(4 491 692)	(1 962 720)	(3 964 639)	(127 085)	(22 924)	(112 715)	(36 613 210)
Claims incurred	(206 777)	(4 514 656)	(1 973 413)	(3 993 633)	(128 916)	(23 551)	(114 163)	(36 772 332)
Third party claim recoveries	921	22 964	10 693	28 994	1 831	627	1 448	159 122
Net income/(expense) on risk transfer arrangements	–	–	–	31 190	–	(2 923)	(1 135)	(15 421)
Risk transfer arrangement fees	–	–	–	(204 582)	–	(2 923)	(2 832)	(366 344)
Recoveries from risk transfer arrangements	–	–	–	235 772	–	–	1 697	350 923
Accredited managed healthcare services (no risk transfer)	(8 360)	(204 472)	(94 660)	(250 933)	(15 471)	(5 423)	(10 005)	(1 407 267)
Relevant healthcare expenditure	**(214 216)**	**(4 696 164)**	**(2 057 380)**	**(4 184 382)**	**(142 556)**	**(31 270)**	**(123 855)**	**(38 035 898)**
Gross healthcare result	**82 917**	**689 064**	**356 316**	**23 588**	**78 310**	**25 785**	**103 178**	**5 590 500**
Broker service fees	(7 510)	(174 400)	(65 440)	(124 596)	(6 517)	(1 794)	(6 208)	(1 101 648)
Expenses for administration	(27 182)	(664 984)	(307 902)	(436 502)	(14 540)	(6 115)	(32 719)	(4 150 194)
Other operating expenses	(1 404)	(34 320)	(15 889)	(42 119)	(2 598)	(908)	(1 684)	(236 206)
Net healthcare result	**46 821**	**(184 640)**	**(32 915)**	**(579 629)**	**54 655**	**16 968**	**62 567**	**102 452**
Investment income	7 465	182 695	84 590	224 314	13 832	4 846	8 986	1 257 479
Net fair value losses on financial assets at fair value through profit or loss	1 604	38 516	17 766	46 306	2 820	1 013	1 507	264 278
Sundry income	13	343	158	411	25	10	13	2 359
Other income	**9 082**	**221 554**	**102 514**	**271 031**	**16 677**	**5 869**	**10 506**	**1 524 116**
Expenses for asset management services rendered	(184)	(4 516)	(2 090)	(5 540)	(342)	(119)	(220)	(31 076)
Interest paid	(2 591)	(63 409)	(143)	(380)	(23)	(11)	(16)	(290 042)
Other expenditure	**(2 775)**	**(67 925)**	**(2 233)**	**(5 920)**	**(365)**	**(130)**	**(236)**	**(321 118)**
Net surplus/(deficit) for the year	**53 128**	**(31 011)**	**67 366**	**(314 518)**	**70 967**	**22 707**	**72 837**	**1 305 450**

NOTES TO THE ANNUAL FINANCIAL STATEMENTS CONTINUED

for the year ended 31 December 2017

R'000	2017	2016
27 Cash flows from operations before working capital changes		
Net surplus for the year	**2 449 974**	1 305 450
Adjustments for:		
Impairment losses (Note 17)	**87 604**	75 167
Interest received (Note 21)	**(1 349 125)**	(1 206 486)
Dividend income (Note 21)	**(84 062)**	(50 993)
Interest paid (Note 24)	**367 238**	290 042
Unvested long term employee benefit	**5 045**	3 000
Net gains on financial assets at fair value through profit or loss (Note 22)	**(458 753)**	(264 278)
	1 017 921	151 902
Reconciliation of movements in the cash flow statement		
27.1 Increase/(decrease) in trade and other receivables	**822 739**	(500 589)
Opening balance	**2 058 008**	1 632 586
Closing balance (Note 3)	**(1 147 665)**	(2 058 008)
Impairment losses	**(87 604)**	(75 167)
27.2 Increase in trade and other payables	**1 759 273**	123 640
Opening balance	**(1 306 245)**	(1 182 605)
Closing balance (Note 9)	**3 065 518**	1 306 245
27.3 Purchases of financial instruments	**(2 953 775)**	(1 922 170)
Financial assets at Fair value (Note 2)	**(2 953 775)**	(1 922 170)
27.4 Proceeds from sale of financial instruments	**1 669 533**	1 258 510
Financial assets at Fair value (Note 2)	**1 571 646**	1 127 159
Money market instruments (Note 22)	**8 085**	–
Derivative financial instruments (Note 7)	**89 802**	131 351

28 Events after the reporting period

No significant events occurred between the reporting date and the date the financial statements were authorised for issue. During the year under review an amalgamation was confirmed with the University of the Witwatersrand, Johannesburg Staff Medical Aid Fund with an effective date of 1 January 2018. The detail of the amalgamation is set out in Note 29.

29 Amalgamations

University of the Witwatersrand, Johannesburg Staff Medical Aid Fund

An amalgamation between the Scheme and University of the Witwatersrand, Johannesburg Staff Medical Aid Fund (WitsMed) was confirmed and effective from 1 January 2018. The disclosures provided below have no effect on the current reporting period but have been provided to enable users to evaluate the nature and financial effect of the amalgamation that occurs after the end of the current reporting period.

WitsMed is a not-for-profit restricted medical scheme registered in terms of the Act. Membership of the Scheme is open to all current and retired employees of the University of the Witwatersrand, its subsidiaries and associates. Retired employees of subsidiaries and associates, which have been disposed of, may continue their membership if they so elect.

In terms of the Act, medical schemes do not have equity therefore the Scheme did not acquire any voting equity interest.

The members of the Scheme and WitsMed voted that the amalgamation of WitsMed with the Scheme would be in the best interest of the WitsMed members.

The Scheme obtained control of WitsMed by means of the exposition requirements as set out in Section 63 of the Act.

On the date of the amalgamation 2 604 principal members and 4 920 beneficiaries joined the Scheme.

No goodwill will be recognised as a result of this transaction.

NOTES TO THE ANNUAL FINANCIAL STATEMENTS CONTINUED

for the year ended 31 December 2017

29 Amalgamations *continued*

The acquisition date fair value of the total consideration to be transferred and the acquisition date fair value of each major class of assets and liabilities is:

R'000	2017	2016
University of the Witwatersrand, Johannesburg Staff Medical Aid Fund		
Reserves effectively transferred:		
(Acquisition date fair value of WitsMed members' interest)	**149 210**	–
Net recognised values of WitsMed identifiable assets and liabilities:	**149 210**	–
Non-current assets	**1 762**	–
Available for sale investments	**1 762**	–
Current assets	**155 227**	–
Cash and cash equivalents	**151 584**	–
Member and service provider claims receivables	**1 370**	–
Provision for impairment	**(1 158)**	
Interest receivable	**767**	–
Other accounts receivable	**2 664**	–
Current liabilities	**(7 779)**	–
Outstanding claims provision	**(4 600)**	–
Reported claims not yet paid	**(2 188)**	–
Contribution in advance	**(159)**	–
Unallocated funds	**(40)**	–
Discovery Health (Pty) Ltd	**(468)**	–
General accruals	**(324)**	–
Closing balance	**149 210**	–
Movements subsequent to the amalgamation date generally relate to contributions, claims and operating expenses adjustments.		
As a result of the amalgamation, the Scheme acquired the following receivables information of which is set out below.		
Fair value of receivables acquired:	**3 463**	–
Insurance receivables	**2 876**	–
Members claim debtors	**211**	–
Service provider claim debtors	**1 159**	–
Other accounts receivable	**2 664**	–
Provision for impairment	**(1 158)**	–
Loans and receivables	**767**	–
Interest receivable	**767**	–
Gross contractual amounts receivable:	**4 801**	
Insurance receivables	**4 034**	–
Member claim debtors	**211**	–
Service provider claim debtors	**1 159**	–
Other accounts receivable	**2 664**	–
Loans and receivables	**767**	–
Interest receivable	**767**	–

29 Amalgamations *continued*

R'000	2017	2016
Best estimate at the acquisition date of the contractual cash flows not expected to be collected are:		
Insurance receivables	**(1 158)**	–
Member claim debtors	**(178)**	–
Service provider claim debtors	**(980)**	–
The amounts recognised as of the acquisition date for each major class of assets acquired and liabilities assumed.		
Non-current assets	**1 762**	–
Available for sale investments	**1 762**	–
Current assets	**155 227**	–
Cash and cash equivalents	**151 584**	–
Member claim debtors	**33**	–
Service provider claim debtors	**179**	–
Interest receivable	**767**	–
Other accounts receivable	**2 664**	–
Current liabilities	**(7 779)**	–
Outstanding claims provision	**(4 600)**	–
Reported claims not yet paid	**(2 188)**	–
Contribution in advance	**(159)**	
Unallocated funds	**(40)**	–
Discovery Health (Pty) Ltd	**(468)**	–
General accruals	**(324)**	–
	149 210	–

NOTES TO THE ANNUAL FINANCIAL STATEMENTS CONTINUED

for the year ended 31 December 2017

30 Insurance risk management report

Nature and extent of risks arising from insurance contracts

The Scheme issues contracts that transfer insurance risk. The primary insurance activity carried out by the Scheme indemnifies covered members and their dependants against the risk of loss arising as a result of the occurrence of a health event, in accordance with the Scheme Rules and the requirements of legislation.

This section summarises these risks and the way in which they are managed.

Insurance risk

The risk under any insurance contract can be expressed as the probability that an insured event occurs multiplied by the expected amount of the resulting claim. Insurance events are random and therefore the actual number and size of events during any year are unknown and vary from those estimated. The principal risk that the Scheme faces under its insurance contracts is that the actual claim payments exceed the projected amount of the insurance liabilities. This could occur because the frequency and severity of claims are greater than estimated.

A larger number of members will result in smaller variability of the actual claims experience relative to expected levels. This is because an adverse experience is diluted by a larger group of members whose claims are stable and thus predictable.

Factors that aggravate insurance risk include unanticipated demographic movements, adverse experience due to an unexpected epidemic, changes in members' disease profiles, unexpected price increases, prevalence of fraud, supplier induced demand and the cost of new technologies or drugs.

The risks that the Scheme faces can be discussed for the different benefits offered. The three main types of benefits offered by the Scheme in return for monthly contributions are indicated below:

Hospital benefits

The hospital benefit covers medical expenses incurred arising from admission to hospital. This includes accommodation, theatre, professional, medication, equipment and consumables.

Day-to-day benefits

Day-to-day benefits cover the cost of out-of-hospital healthcare services, such as visits to general practitioners and dentists as well as prescribed non-chronic medicines. The day-to-day benefits include both the Personal Medical Savings Account (PMSA) and an insurance risk element. This includes the Insured Network Benefit and Above Threshold Benefit (ATB). The Scheme does not carry risk for PMSA benefits.

Chronic benefits

The Chronic Illness Benefit (CIB) covers approved medication and treatment for up to 61 listed conditions, including the 27 Prescribed Minimum Benefit chronic conditions. These include conditions such as HIV/AIDS, high blood pressure, cholesterol and asthma.

The risks associated to the Scheme with the types of benefits offered to members are addressed below:

30 Insurance risk management report *continued*

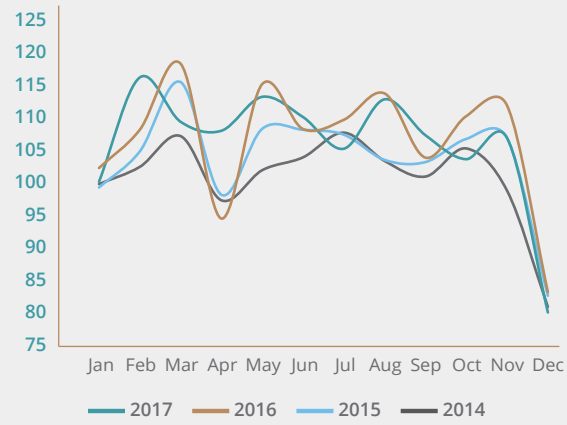
Hospital benefit risk

The main factors impacting the frequency and severity of hospital claims are the number of admissions and the cost per event. An increase in the frequency and severity of claims result in an increase in the cost of claims.

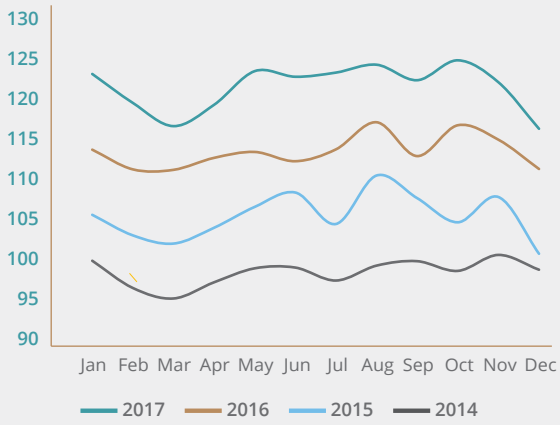
An increase in the admission rate is often linked to increases in the number of beneficiaries at older ages or with chronic conditions. The increase in cost per event is driven by annual tariff and other cost increases. An increased cost per event can also be caused by an increased case-mix, severity of admissions and the introduction of new hospital-based technologies.

The following graphs indicate the change in the admission rate over the past four years as well as the impact on the cost per event. These graphs are indexed to a value of 100 as at January 2014.

Hospital admission rate
(Indexed to Jan 2014 = 100)



Total cost per event
(Indexed to Jan 2014 = 100)

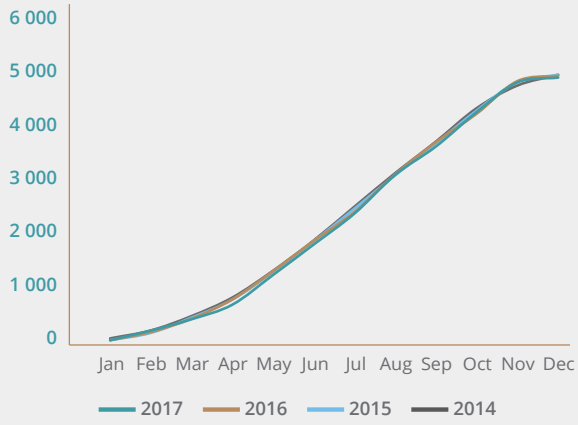


Day-to-day benefits risk

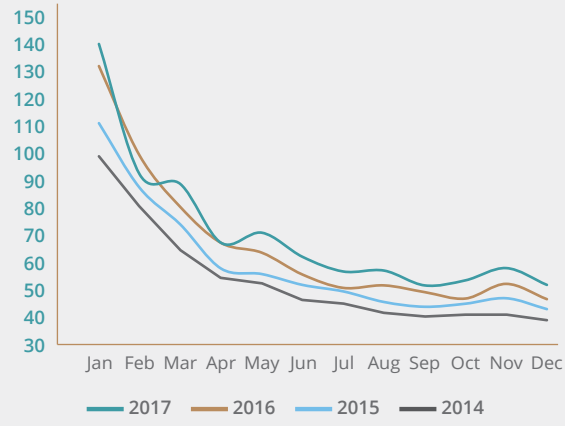
For the Above Threshold Benefit component, the frequency and severity of claims are driven by the number and disease burden of claimants. The mix of members between the different benefit options will also have an impact on the claims.

The frequency of these claims increases throughout the year as an increased number of members run out of their medical savings.

Claimants per 1000 beneficiaries from Above Threshold Benefits
(Indexed to Jan 2014 = 100)



Cost per ATB claimant
(Indexed to Jan 2014 = 100)



NOTES TO THE ANNUAL FINANCIAL STATEMENTS CONTINUED

for the year ended 31 December 2017

30 Insurance risk management report *continued*

Chronic benefits risk

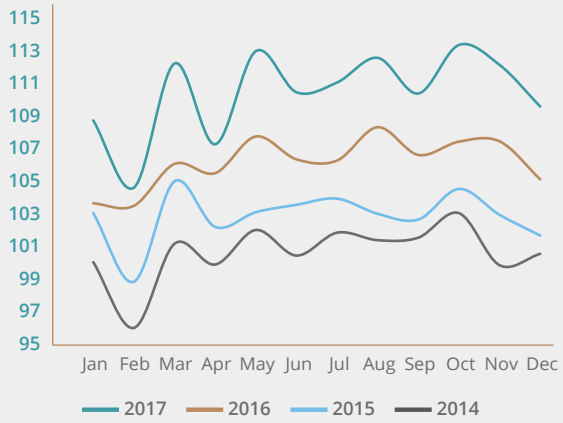
The main factors impacting the frequency and severity of chronic claims are the number of claimants and the cost per claimant respectively.

The cost per claimant increases during the year because Single Exit Price increases usually occur during the first quarter (as opposed to other price increases which happen on 1 January). Each manufacturer also has discretion as to exactly when they will implement this increase following the publication of the increase by the Department of Health.

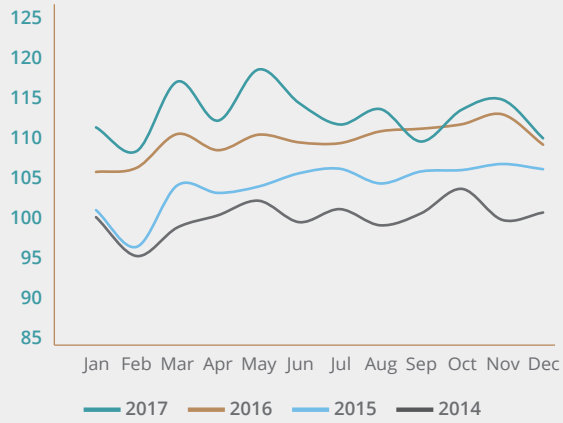
Higher increases in chronic claimants are linked to increases in the number of beneficiaries at older ages. In addition, changes relating to the eligibility for chronic benefits will also impact costs. An increase in the number of items per claimant will drive up the costs of chronic claims per claimant. Increases in the regulated prices for chronic medication, the Single Exit Price, and increases in dispensing fees will also result in an increase in costs per claim. The mix between the various chronic conditions will also have an impact on the frequency and severity of claims.

The following graphs indicate the change in the number of claimants over the past four years as well as the impact on the cost per claimant. These graphs are indexed to a value of 100 as at January 2014.

Chronic claimants per 1000 beneficiaries
(Indexed to Jan 2014 = 100)



Chronic cost per claimant
(Indexed to Jan 2014 = 100)



Risk management

The Scheme has various initiatives that are used to manage the risk associated with claims experience. These include:

- Members have to be referred by a doctor prior to an elective admission.
- All hospital admissions have to be pre-authorised.
- Case managers monitor members with hospital stays that are longer than expected to ensure that members are discharged at appropriate times.
- On-site case managers deployed at high risk establishments.
- The work of the Clinical Policy Unit, which evaluates the effectiveness of new technologies and recommends whether and to what extent the Scheme should cover these.
- The development of protocols around various high cost conditions, such as lower back surgery.
- The Drug Risk Management Unit is responsible for the development and maintenance of risk management strategies, including formulary development and maintenance.
- Designated Service Provider (DSP) Networks, including hospitals, GPs, specialists, retail pharmacies, etc.
- The management and mitigation of the risks associated with chronic illness benefits through an extensive managed care programme, involving detailed drug policy interventions, medicine protocols and benefit rules, all of which comply with the Regulations on Prescribed Minimum Benefits. In addition, the Clinical Policy Unit is involved in evaluating the effectiveness of new drugs and recommends whether the Scheme should cover these drugs or not.
- The establishment of a unit to focus on reducing surgical consumables and devices spend.
- The profiling of statistically significant outlier doctors on admission rate and generated costs as well as peer reviewing them.
- The establishment of the Coordinated Care Programme (CCP). This is a dedicated unit to ensure direct coordination of care from medical providers to high risk beneficiaries that are exposed to conditions that would generate multiple admissions if not managed.
- The establishment of an Advanced Illness Benefit Programme dedicated to managing care during the end of life stage for patients that are terminally ill.
- The establishment of a disease management unit dedicated to managing high risk beneficiaries with complex diseases.
- Alternative reimbursement contracts exist with hospitals to mitigate the risk of additional utilisation above that which is expected for the demographics of the Scheme and severity of admissions.
- Value-based contracting with selected healthcare provides, including establishment of centres of excellence.

30 Insurance risk management report *continued*

Concentration of insurance risk

As the largest open medical scheme by membership in South Africa, the Scheme is not subject to a significant degree of concentration risk. The Scheme also offers a wide range of benefit plans which meet a variety of members' needs. This results in the Scheme being representative of the medical scheme market and, as such, it experiences limited variability of the outcome.

An annual actuarial valuation is performed, which specifies the contribution to be charged in return for the benefits to be provided given the expected demographic profile of each benefit option.

Risk transfer arrangements

The Scheme has six (2016: six) risk transfer agreements in which suppliers are paid to provide certain minimum benefits to Scheme members, as and when required by the members. These arrangements fix the cost to the Scheme of providing these benefits.

The first risk transfer arrangement covers in-hospital and out-of-hospital benefits for certain members on the KeyCare Plus and KeyCare Access plans. There are two arrangements providing optometry and dentistry services to members on the KeyCare Plus and KeyCare Access plans. The fourth arrangement covers the treatment for Executive and Comprehensive plan members diagnosed with diabetes (type I and II). The fifth and sixth arrangements cover Smart plan members for acute medication prescribed by their network doctors.

Risk in terms of risk transfer arrangements

The Scheme does, however, remain liable to its members to provide the benefits. If any supplier fails to meet the obligations of the risk transfer arrangement, the Scheme will cover the cost of the benefit.

When selecting a supplier, the Scheme assesses their ability to provide the relevant service. This is to mitigate the reputational and operational risks that the Scheme faces should a supplier not meet its obligations. The Scheme also monitors the performance of the suppliers, checks the quality of care provided and has access to data on the underlying fee-for-service claims which are included in the arrangement.

Claims development

Detailed claims development tables are not presented as the uncertainty regarding the amount and timing of claim payments are typically resolved within one year and in the majority of cases within three months. At year end, a provision is made for those claims outstanding that are not yet reported at that date.

The methodology followed in setting the outstanding claims provision is the generally accepted actuarial methodology of chain ladder estimation. This methodology is the most objective, but the accuracy of the estimate is sensitive to changes in the average time from treatment to payment of claims. For hospital claims in the latest service month, a blend of the chainladder method and another method using the estimated cost per event and pre-authorised admissions is also followed.

The estimation of the December 2017 outstanding claims provision was made in accordance with Advisory Practice Note 304 of the Actuarial Society. In accordance with this guidance note, the following factors are considered to determine whether they would have any impact on the outstanding claims provision estimate:

- The homogeneity of claims data.
- The credibility of claims data.
- Changes in emergence and settlement patterns.
- The impact of seasonality.
- The impact of re-opened or adjusted claims.
- The impact of benefit limits and changes.
- External influences.
- The demographic profile of the Scheme.

Based on the processing patterns and claims development up to the end of December 2017 in respect of treatment dates during 2017, the recommended provision for outstanding claims as at December 2017 is R1 240 million (2016: R1 121 million).

R'000	2017	2016
The total claims incurred (including the provision for outstanding claims) for the most significant claims categories are as follows:		
Total estimate of incurred claims		
In-hospital claims incurred	**29 475 556**	26 807 352
Chronic claims incurred	**2 474 427**	2 271 897
Out-of-hospital risk claims incurred	**8 240 285**	7 745 832

NOTES TO THE ANNUAL FINANCIAL STATEMENTS CONTINUED

for the year ended 31 December 2017

30 Insurance risk management report *continued*

Concentration of insurance risk *continued*

The table below outlines the sensitivity of insured liability estimates to slower claims processing. If processing is slower than expected, a larger claims provision for unprocessed claims will be required. It should be noted that this is a deterministic approach with no correlations between the key variables

	Change in variable %	Impact on outstanding claims provision 2017 R'000	Impact on outstanding claims provision 2016 R'000
In-hospital claims incurred	1% slower claims processing	**326 614**	318 755
Chronic claims incurred	1% slower claims processing	**10 364**	7 682
Out-of-hospital risk claims incurred	1% slower claims processing	**89 670**	78 728

Liquidity risk

The main component of the Scheme's insurance liabilities is the outstanding claims provision. These are generally settled in a short period of time. Approximately 98% of this provision is settled within three months after the claim was incurred and the balance is settled within six months. The remaining insurance liabilities are generally settled within 30 days.

Liquidity risk can also arise when the Scheme's investment mix does not match the nature of the liabilities. However, investments are managed by professional asset managers and finance professionals whose mandates ensure that investments are always sufficiently liquid to meet current liabilities while excess reserves are invested to maximise investment return within the scope of Regulations to the Medical Schemes Act.

Assumption risk

The Scheme's reserves and therefore solvency are most sensitive to changes in claims development patterns. Another relevant assumption is medical inflation. Other assumptions that are considered include utilisation trends, the impact of new technology and the expected demographic profile of the Scheme membership.

31 Financial risk management report

Overview

The Scheme is exposed to financial risk through its financial assets, insurance assets, financial liabilities and insurance liabilities. In particular, the financial risk is that the proceeds, for any reason, from its financial assets are not sufficient to fund the obligations arising from its insurance contracts. The most important components of financial risk include market risk, interest rate risk, credit risk and liquidity risk.

The Scheme's overall risk management programme focuses on the unpredictability of financial markets and seeks to minimise potential adverse effects on the Scheme's statutory solvency requirement.

The Board of Trustees has overall responsibility for the establishment and oversight of the Scheme's risk management framework.

The Scheme manages these risks through various risk management processes. These processes have been developed to ensure that the long-term investment return on assets supporting the insurance liabilities is sufficient to contribute towards funding members' reasonable benefit expectations.

The Scheme manages the financial risks as follows:

- The Investment Committee, a Committee of the Board of Trustees, recommends the Scheme's investment policy to the Board of Trustees for approval. The Investment Committee meets at least quarterly and reports back to the Board of Trustees on the matters included in its terms of reference.
- The Scheme has appointed reputable external asset managers to manage its investments and their performance is monitored regularly.
- An external asset consulting company has been appointed to assist in formulating the investment strategy and to provide ongoing reporting and monitoring of the asset managers. During the year under review, the Scheme conducted a formal tender process for the asset consultant. The incumbent consultant was reappointed following this process.
- Asset management agreements and mandates are concluded and reviewed by the Scheme's in-house legal counsel.
- An independent valuation of the Scheme's investments is performed by a third party.

31 Financial risk management report *continued*

Personal Medical Savings Account trust assets

These portfolios have been established to manage members' Personal Medical Savings Account balances in portfolios which are distinct and separate from the Scheme.

The Scheme appointed two asset managers, Aluwani Capital Partners (Pty) Ltd and Taquanta Asset Managers, to manage the assets underlying the members' Personal Medical Savings Account balances. These portfolios are managed in accordance with Circular 38 of 2011 and Circular 5 of 2012 issued by the Council for Medical Schemes.

Changes in the interest rates have no bearing on the Scheme's surplus or deficit as the investment income earned, net of fees, is allocated to the members' Personal Medical Savings Account balance. Consequently, no further analysis is presented.

Market risk

Market risk is the risk that changes in market variables, such as foreign exchange rates, interest rates and equity prices will affect the Scheme's income or the value of its holdings in financial instruments. The objective of market risk management is to manage and control market risk exposures within acceptable parameters, while optimising the return on risk.

The table below summarises the primary risks affecting the Scheme's financial assets at fair value through profit or loss exposure to market risk.

R'000	Total	Currency risk	Price risk	Interest rate risk
31 December 2017				
Investments	**14 005 644**			
Offshore bonds	**1 463 064**	✓		✓
Equities	**3 378 331**		✓	
Yield enhanced bonds	**3 721 190**			✓
Inflation linked bonds	**792 666**			✓
Money market instruments	**4 268 369**			✓
Listed property investments	**382 024**		✓	
31 December 2016				
Investments	12 211 677			
Offshore bonds	1 245 709	✓		✓
Equities	2 049 834		✓	
Yield enhanced bonds	3 413 740			✓
Inflation linked bonds	610 476			✓
Money market instruments	4 891 918			✓

The Scheme's insurance liabilities are settled within one year and the Scheme does not discount insurance liabilities. Consequently changes in market interest rates would not affect the Scheme's surplus or deficit arising from changes in the insurance liability.

Currency risk

The majority of the Scheme's benefits are Rand-denominated and therefore the Scheme does not have significant net currency risk relating to benefits.

For the purpose of seeking investment diversification, the Scheme continued to invest in offshore bond portfolios (reference currency is the US dollar). Derivative financial instruments are utilised by bond managers within these portfolios for risk mitigation and efficient portfolio construction. At 31 December 2017 R1.46 billion (2016: R1.25 billion) (Note 2) was invested in these portfolios.

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for the year ended 31 December 2017

31 Financial risk management report *continued*

Currency risk *continued*

- ***Currency derivatives financial instrument (zero-cost currency collars)***

The Scheme enters into zero-cost currency collar arrangements with South African banks to hedge exposure to changes in the Rand/US dollar exchange rate with respect to its offshore bond portfolios. The following table provides detail of the three (2016: one) open contracts at year end expiring during 2018.

		2017		
Contract	Nominal USD value $'000	USD put ("floor")	USD call ("cap")	% above floor
1	$11 250	**R12.70**	**R14.83**	**16.73%**
2	$11 250	**R12.85**	**R14.91**	**16.01%**
3	$98 000	**R13.27**	**R15.30**	**15.30%**

The zero-cost currency collars are not designated as hedge instruments and hedge accounting is thus not applicable. The zero-cost currency collars are categorised as at fair value through profit or loss.

At the time of expiry the following transactions could occur depending on the spot rate at which the Rand is trading against the US Dollar:

- If the spot rate is higher than the cap, the Scheme would be required to pay the difference between the cap and the spot rate to the counterparty.
- If the spot rate is trading lower than the cap but higher than the floor, no action would take place.
- If the spot rate is trading lower than the floor, the counterparty would be required to pay the difference between the floor and the spot rate to the Scheme.

The fair value of these contracts have been included in financial assets. Gains and losses on these arrangements are included in the Net surplus (Note 7).

- ***Currency risk sensitivity analysis***

The sensitivity of the Rand appreciating and depreciating against the US Dollar is presented below. This impact would be recognised in the Net Surplus. The potential outcomes of the sensitivity is based on the assumption that the Rand has strengthened or weakened against the US Dollar by 5% (increase or decrease of R0.62) or 15% (increase or decrease of R1.85) from a spot level of R12.32 to the US Dollar, with all other variables held constant. The analysis is presented including and excluding the impact of the zero-cost currency collars, valued at year-end, based on the underlying valuation variables. The actual outcome of the impact of the zero-cost currency collars would be based on the spot rate at the date of expiry of the respective contracts.

R'000	15% Rand appreciation	5% Rand appreciation	5% Rand depreciation	15% Rand depreciation
(Loss)/gain arising from Rand appreciation/depreciation before zero cost currency collars	(219 460)	(73 153)	73 153	219 460
(Loss)/gain arising from Rand appreciation/depreciation after zero cost currency collars	50 041	69 502	108 303	171 938

Price risk

The Scheme is exposed to equity securities price risk due to equity investments held by the Scheme that are classified as at fair value through profit or loss. The value of the Scheme's equity investments amounted to R3.4 billion (2016: R2 billion) (Note 2).

The Scheme manages the price risk arising from investments in equity securities, through the diversification of its investment portfolios. Diversification of the portfolios is performed by asset managers in accordance with the mandate set by the Scheme. During the year, an additional strategy was implemented to manage price risk, with the decision taken to limit exposure to any constituent of the benchmark to a maximum weight of 15%.

The Scheme purchased derivative financial instruments to protect the solvency of the Scheme as a result of fluctuations in the equity market. The derivative strategy was also adjusted to take into consideration the decision to limit the maximum exposure to 15% of any constituent of the benchmark.

31 Financial risk management report *continued*

Price risk *continued*

- ***Equity derivative financial instrument (zero-cost equity collars)***

The Scheme entered into zero-cost equity collar arrangements to hedge approximately 100% of the exposure to changes in market prices for investments in the equity portfolios. The contracts provide downside protection of up to 15% after a reduction in equity prices of 5% (Scheme is at risk for the first 5% drop in equity prices but protected for the next 15%). To achieve this, the Scheme agreed to forego upside benefit from an increase in equity prices above the pre-determined level (the cap). The cap for these contracts range between 13% and 15% above the pre-determined level. These contracts expire during 2018.

	2017				
Contract	Nominal value R'000	Reference level at trade date	Short put level	Put level	Call level ("cap')
1	**R830 000**	**47 313**[1]	**80.00%**	**95.00%**	**114.00%**
2	**R720 000**	**48 176**[1]	**80.00%**	**95.00%**	**113.07%**
3	**R185 000**	**49 618**[1]	**80.00%**	**95.00%**	**112.88%**
4	**R734 000**	**49 730**[1]	**80.00%**	**95.00%**	**113.16%**
5	**R600 000**	**11 500**[2]	**80.00%**	**95.00%**	**115.63%**
6	**R90 000**	**3 525**[3]	**N/A**	**100.80%**	**115.60%**

1 Reference level: FTSE/JSE TOP40.

2 Reference level: FTSE/JSE SWIX TOP40.

3 Reference level: Naspers (Bloomberg: NPN SJ Equity).

The zero-cost equity collars are not designated as hedge instruments and hedge accounting is thus not applicable. The zero-cost equity collars are categorised as at fair value through profit or loss.

At the time of expiry the following transactions could occur depending on the level at which the equity index trades:

- If the index level is higher than the cap, the Scheme would be required to pay the difference between the cap and the index level to the counterparty.
- If the index level is trading lower than the cap but higher than the floor, no action would take place.
- If the index level is trading lower than the floor but above the short put level, the counterparty would be required to pay the difference between the floor and the index level to the Scheme.
- If the index level is trading lower than the short put level, the counterparty would be required to pay the difference between floor and the short put level to the Scheme.

The fair value of these contracts have been included in financial assets and financial liabilities. Gains and losses on these arrangements are included in the Net surplus (Note 7).

NOTES TO THE ANNUAL FINANCIAL STATEMENTS CONTINUED

for the year ended 31 December 2017

31 Financial risk management report *continued*

Price risk *continued*

- ***Equity price risk sensitivity analysis***

The analysis reflecting the impact of increases or decreases in equity prices has been presented below. This impact would be recognised in the Net Surplus. The potential outcomes of the sensitivity is based on the assumption that equity prices had increased or decreased by 5% or 15%, spot reference levels of 52,533; 11,973 or 3,525 respectively, with all other variables held constant. The analysis is presented excluding and including the impact of the zero-cost equity collars, valued at year-end, based on the underlying valuation variables. The actual outcome of the impact of the zero-cost equity collars would be based on the reference level at the date of expiry of the respective contracts.

The following table indicates the 5% or 15% change in the respective index.

Index	5% increase or decrease	15% increase or decrease
FTSE/JSE TOP40	**2 627**	**7 880**
FTSE/JSE SWIX TOP40	**599**	**1 796**
Naspers (Bloomberg: NPN SJ Equity)	**176**	**529**

R'000	15% price decrease	5% price decrease	5% price increase	15% price increase
(Loss)/gain arising from price decrease/increase before zero-cost equity collars	**(518 695)**	**(172 898)**	**172 898**	**518 695**
(Loss)/gain arising from price decrease/increase after zero-cost equity collars	**(420 860)**	**(168 558)**	**49 726**	**212 665**

The analysis reflecting the impact of increases or decreases in prices of the listed property portfolio has been presented below. This impact would be recognised in the Net Surplus. The potential outcomes of the sensitivity is based on the assumption that prices had increased or decreased by 5% or 15%, with all other variables held constant. This portfolio was only implemented during the course of the year under review and therefore no comparatives are presented. The Scheme has not hedged this portfolio.

R'000	15% price decrease	5% price decrease	5% price increase	15% price increase
(Loss)/gain arising from price decrease/increase	**(60 041)**	**(20 014)**	**20 014**	**60 041**

31 Financial risk management report *continued*

Interest rate risk

The Scheme is exposed to interest rate risk as it places funds in short dated investments, money market accounts and bonds. The risk is managed by maintaining an appropriate mix between fixed and floating rate investments within the Scheme's money market investment portfolio as well as additional fixed and call deposit investments. The bond managers have made use of bond futures and other derivative instruments within these portfolios to manage duration risk.

The table summarises the Scheme's exposure to interest rate risks. Included in the table are the Scheme's investments at carrying amounts, categorised by the earlier of contractual repricing or maturity dates.

As at 31 December 2017 R'000	**0 – 3 Months**	**3 – 12 Months**	**> 12 Months**	**Total**
Cash and cash equivalents	**5 880 362**	**–**	**–**	**5 880 362**
Money market instruments carried at fair value through profit or loss	**–**	**4 268 369**	**–**	**4 268 369**
Yield enhanced bonds carried at fair value through profit or loss	**–**	**3 721 190**	**–**	**3 721 190**
Inflation linked bonds carried at fair value through profit or loss	**–**	**792 666**	**–**	**792 666**
Offshore bonds carried at fair value through profit or loss	**–**	**1 463 064**	**–**	**1 463 064**

As at 31 December 2016 R'000	0 – 3 Months	3 – 12 Months	> 12 Months	Total
Cash and cash equivalents	2 397 788	–	–	2 397 788
Money market instruments carried at fair value through profit or loss	–	4 891 918	–	4 891 918
Yield enhanced bonds carried at fair value through profit or loss	–	3 413 740	–	3 413 740
Inflation linked bonds carried at fair value through profit or loss	–	610 476	–	610 476
Offshore bonds carried at fair value through profit or loss	–	1 245 709	–	1 245 709

- ***Interest rate risk sensitivity analysis***

A sensitivity analysis indicating results of increases in interest rates has been presented below. This impact would be recognised in the Net Surplus. The sensitivity is based on the assumption that local or foreign interest rates had increased or decreased by 1% or 2%, with all other variables held constant.

Gains/(losses) arising from changes in: R'000	**2% interest rate decrease**	**1% interest rate decrease**	**1% interest rate increase**	**2% interest rate increase**
Local portfolios	**73 934**	**38 996**	**(40 491)**	**(75 576)**
Foreign portfolios	**105 103**	**52 552**	**(52 552)**	**(105 103)**

The majority of the Scheme's assets are invested in variable interest rate instruments with a significant portion of the fixed rate instruments maturing in the short term. As a result, interest rate changes are not expected to have a material impact on the valuation of Scheme assets due to the short duration thereof.

NOTES TO THE ANNUAL FINANCIAL STATEMENTS CONTINUED

for the year ended 31 December 2017

31 Financial risk management report *continued*

Legal risk

Legal risk is the risk that the Scheme will be exposed to contractual obligations which have not been provided for. At 31 December 2017 the Scheme did not consider there to be any significant concentration of legal risk that had not been provided for.

Investment risk

Investment risk is the risk that the investment returns on accumulated assets will not be sufficient to cover future liabilities.

The Scheme's Investment Committee oversees that the funds are invested in line with the Act.

The investment philosophy is to hold a diversified pool of assets. The assets are selected as being most appropriate given the liquidity and solvency requirements of the Scheme. In contemplating solvency, the return goals of the Scheme, as well as the risk associated with all assets and asset classes are considered. Diversification is across asset classes, geographic regions as well as managers within asset classes where practical. The Scheme diversifies its investment portfolio by investing in short-term deposits, money market, bond, listed property and equity portfolios managed by reputable asset managers.

The Scheme's investment objective statement is:

- Maximise targeted investment returns, which is dependent on contribution increases implemented over the next year and the evaluation of the solvency level above the statutory minimum requirement from time to time.
- The return target will be reviewed at the end of every year taking into account the actual returns achieved, projected operating surplus and finalised contribution increases.
- To track medical inflation.

The Investment Committee monitors the performance of the Scheme's asset managers to ensure performance in accordance with the agreed mandates.

Breakdown of investments

The investments are split between the following in the Annual Financial Statements:

- Investments carried at fair value through profit and loss; and
- Cash and cash equivalents.

R'000	Segregated Funds	Collective Investment Schemes	Policy of Insurance	Total
31 December 2017				
Investments	**12 542 580**	**901 589**	**561 475**	**14 005 644**
Offshore bonds	**–**	**901 589**	**561 475**	**1 463 064**
Equities	**3 378 331**	**–**	**–**	**3 378 331**
Yield enhanced bonds	**3 721 190**	**–**	**–**	**3 721 190**
Inflation linked bonds	**792 666**	**–**	**–**	**792 666**
Listed property investments	**382 024**	**–**	**–**	**382 024**
Money market instruments	**4 268 369**	**–**	**–**	**4 268 369**
Cash and cash equivalents:	**3 891 038**	**1 989 324**	**–**	**5 880 362**
	16 433 618	**2 890 913**	**561 475**	**19 886 006**
31 December 2016				
Investments	10 965 968	672 885	572 824	12 211 677
Offshore bonds	–	672 885	572 824	1 245 709
Equities	2 049 834	–	–	2 049 834
Yield enhanced bonds	3 413 740	–	–	3 413 740
Inflation linked bonds	610 476	–	–	610 476
Money market instruments	4 891 918	–	–	4 891 918
Cash and cash equivalents:	940 981	1 456 807	–	2 397 788
	11 906 949	2 129 692	572 824	14 609 465

31 Financial risk management report *continued*

Breakdown of investments *continued*

Money market portfolios:

Local portfolios:

The two local money market portfolios are each managed by an independent asset manager. The investment mandate is for an actively managed portfolio of financial instruments aimed at maximising return on the investments, on a long-term basis, with due regard to the relevant risks and the constraints imposed by the mandates.

For the first portfolio, the mandate stipulates liquidity requirements that 5% of the assets must be available within 24 hours and 15% within five working days. The weighted modified duration of the portfolio may not exceed 180 days. The weighted term to maturity of the portfolio shall not exceed two years. The term of each individual instrument is also limited. The average weighted credit rating of this portfolio will not be less than A+.

The liquidity requirements of the second portfolio also stipulate that 5% of the assets must be available on 24 hours notice and an additional 15% within five working days. The average portfolio duration is limited to 180 days. There are a number of additional liquidity requirements included in the mandate such as requiring that all investments with a maturity longer than 18 months must be of a negotiable nature. The key feature of being of a negotiable nature is that the instrument can be sold by the holder of that instrument to another party without requiring explicit consent from the issuer of the instrument.

The performance benchmark for these portfolios has been changed during the year from measuring against the Short Term Fixed Income (STeFI) Composite Index to being measured against the STeFI + 130 basis points per annum over rolling one year periods.

The local money market portfolios comprise approximately 30% (2016: 40%) of the Scheme's financial assets at fair value through profit or loss.

Bond portfolios:

Local portfolios:

The Scheme has two bond portfolios, each managed by an independent asset manager.

One of the portfolios uses a specialist fixed income strategy with South African exposure and invests in a broad spectrum of listed and unlisted fixed income instruments. The instruments are typically investment grade and include but are not limited to asset types such as, listed bonds, credit-linked notes, floating rate notes, interest rate swaps and bond futures. During the year, the benchmark for this portfolio was changed from the 3-month Johannesburg Interbank Agreed Rate (JIBAR) to STeFI 3 month index + 150 basis points per annum.

The other portfolio is a specialist low interest rate yield-enhanced bond portfolio with moderate risk limits that seeks diversity, reasonable yield enhancement, moderate liquidity and relatively low volatility due to constrained interest rate positions. This is achieved by investing in a broad spectrum of fixed interest and yield-enhanced debt instruments. The benchmark for this portfolio is STeFI.

The mandates set specific exposure limits depending on the credit rating of the individual counterparty and set exposure limits to unrated investments. These portfolios comprise approximately 27% (2016: 28%) of the Scheme's financial assets at fair value through profit or loss.

Offshore portfolios:

The Scheme has two offshore portfolios each managed by independent asset managers.

The primary objective of the first portfolio is to provide income and to protect and maximise the real asset value of its investments in terms of their international purchasing power by means of the management and diversification of currency exposure and investment in fixed interest bearing securities of varying maturities. The majority of these assets are denominated in major currencies and exposure to minor currencies is managed on a cautious basis. The fund is benchmarked against 3 month USD LIBOR.

The primary objective of the second portfolio is the long-term growth of capital and income and is a policy of insurance referencing participatory interests in a foreign collective investment scheme portfolio investing in fixed income instruments. The benchmark for this portfolio is the Barclays Capital Global Aggregate.

These portfolios comprise approximately 10% (2016: 10%) of the Scheme's financial assets at fair value through profit or loss.

NOTES TO THE ANNUAL FINANCIAL STATEMENTS CONTINUED

for the year ended 31 December 2017

31 Financial risk management report *continued*

Breakdown of investments *continued*

Inflation linked bonds:

The Scheme has two inflation-linked bond portfolios, each managed by an independent asset manager.

The primary mandate of the first portfolio is aimed at generating inflation-linked bond returns on initial capital invested. The benchmark is the JSE Composite Inflation-Linked Index (CILI).

The second portfolio is a fully discretionary, actively managed portfolio of inflation-linked and fixed income instruments. The portfolio only invests funds in domestic instruments. The benchmark for this portfolio is the JSE Bond Exchange and Actuarial Society of South Africa (JSE BEASSA IGOV Index).

These portfolios comprise approximately 6% (2016: 5%) of the Scheme's financial assets at fair value through profit or loss.

Equity portfolios:

The primary goal is to maximise long-term investment performance with due regard to the relevant risks, including volatility of returns, risk of capital loss and liquidity. These risks are mitigated by blending investment mandates across different manager styles and sectors.

The Scheme has further diversified its equity exposure by adding a long only general equity portfolio, managed by a boutique manager and a passive equity portfolio. The number of portfolios has increased from three to five. Each portfolio is managed by an independent asset manager.

The portfolios may only be invested in South African equities and are to be as fully invested as can practically be achieved at all times. One portfolio has a maximum cash allocation of 2% and the remaining portfolios a maximum allocation of 5%. The portfolios must comply with the Act and are prohibited from investing in Discovery Limited. The Scheme has mitigated exposure to any single benchmark constituent by limiting investment in any single benchmark constituent to a maximum of 15%.

The Scheme considers responsible investing in all its investments. Managers are required to exclude tobacco manufacturers and related exposures by utilising negative screening. This includes all direct investments and indirect investments greater than 5%.

The performance of the actively managed portfolios is measured against the benchmark, which is the FTSE/JSE Shareholder weighted index (SWIX) adjusted to exclude tobacco (as per the Scheme's responsible investment policy) and capping the exposure of any benchmark constituent to 15%. The performance of the passive portfolio is measured against the FTSE/JSE SWIX 40 (J400) adjusted to exclude tobacco (as per the Scheme's responsible investment policy) and capping the exposure of any benchmark constituent to 15%.

These portfolios comprise approximately 24% (2016: 17%) of the Scheme's financial assets at fair value through profit or loss.

Listed property:

During the year, the Scheme allocated a portion of its investments to listed property and appointed an independent asset manager to manage the portfolio.

The primary objective of this mandate is to deliver consistent and incremental out-performance of the benchmark over a long-term period. The benchmark is the SA Listed Property Index (J253).

The mandate does not permit investment in foreign listed shares or direct property investments and requires that there will always be more than six holdings in the portfolio.

This portfolio comprises approximately 3% of the Scheme's financial assets at fair value through profit or loss.

The following table compares the fair value and carrying amounts of assets and liabilities per class of assets and liabilities.

31 Financial risk management report *continued*

Breakdown of investments *continued*

R'000	Financial assets and liabilities at fair value through profit and loss: Designated upon initial recognition	Financial assets and liabilities at fair value through profit and loss: Classified as held for trading	Loans and receivables	Insurance receivables and (payables)	Financial liabilities at amortised cost	Total carrying amount	Fair value amount
31 December 2017							
Investments							
– Offshore bond portfolio	**1 463 064**	**–**	**–**	**–**	**–**	**1 463 064**	**1 463 064**
– Listed equities	**3 378 331**	**–**	**–**	**–**	**–**	**3 378 331**	**3 378 331**
– Yield-enhanced bond portfolio	**3 721 190**	**–**	**–**	**–**	**–**	**3 721 190**	**3 721 190**
– Inflation-linked bond portfolio	**792 666**	**–**	**–**	**–**	**–**	**792 666**	**792 666**
– Listed property investments	**382 024**	**–**	**–**	**–**	**–**	**382 024**	**382 024**
– Money market portfolios	**4 268 369**	**–**	**–**	**–**	**–**	**4 268 369**	**4 268 369**
Cash and cash equivalents:							
Medical Scheme assets	**–**	**–**	**5 880 362**	**–**	**–**	**5 880 362**	**5 880 362**
Personal Medical Savings Account trust assets			**4 609 149**	**–**	**–**	**4 609 149**	**4 609 149**
Trade and other receivables	**–**	**–**	**237 864**	**909 801**	**–**	**1 147 665**	**1 147 665**
Personal Medical Savings Accounts	**–**	**–**	**–**	**–**	**(4 656 633)**	**(4 656 633)**	**(4 656 633)**
Trade and other payables	**–**	**–**	**–**	**(2 526 588)**	**(538 930)**	**(3 065 518)**	**(3 065 518)**
Derivatives held for trading							
– Zero-cost collars	**–**	**(588)**	**–**	**–**	**–**	**(588)**	**(588)**
	14 005 644	**(588)**	**10 727 375**	**(1 616 787)**	**(5 195 563)**	**17 920 081**	**17 920 081**

R'000	Financial assets and liabilities at fair value through profit and loss: Designated upon initial recognition	Financial assets and liabilities at fair value through profit and loss: Classified as held for trading	Loans and receivables	Insurance receivables and (payables)	Financial liabilities at amortised cost	Total carrying amount	Fair value amount
31 December 2016							
Investments							
– Offshore bond portfolio	1 245 709	–	–	–	–	1 245 709	1 245 709
– Listed equities	2 049 834	–	–	–	–	2 049 834	2 049 834
– Yield-enhanced bond portfolio	3 413 740	–	–	–	–	3 413 740	3 413 740
– Inflation-linked bond portfolio	610 476	–	–	–	–	610 476	610 476
– Money market portfolios	4 891 918	–	–	–	–	4 891 918	4 891 918
Cash and cash equivalents:							
Medical Scheme assets	–	–	2 397 788	–	–	2 397 788	2 397 788
Personal Medical Savings Account trust assets			4 142 672			4 142 672	4 142 672
Trade and other receivables	–	–	179 900	1 878 108	–	2 058 008	2 058 008
Personal Medical Savings Accounts	–	–	–	–	(4 204 043)	(4 204 043)	(4 204 043)
Trade and other payables	–	–	–	(784 555)	(521 690)	(1 306 245)	(1 306 245)
Derivatives held for trading							
– Zero-cost collars	–	50 384	–	–	–	50 384	50 384
	12 211 677	50 384	6 720 360	1 093 553	(4 725 733)	15 350 241	15 350 241

NOTES TO THE ANNUAL FINANCIAL STATEMENTS CONTINUED

for the year ended 31 December 2017

31 Financial risk management report *continued*

Credit risk

Credit risk is the risk of financial loss to the Scheme, if a counterparty to a financial instrument fails to meet its contractual obligations.

Key areas where the Scheme is exposed to credit risk are through its trade and other receivables, investments and cash.

Trade and other receivables

Trade and other receivables comprise of insurance receivables and loans and receivables. The main components of insurance receivables are in respect of contributions due from members and amounts recoverable from members in respect of claims debt.

Exposure to credit risk

The carrying amount of trade and other receivables represents the maximum credit exposure.

The Scheme ages and pursues unpaid accounts on a monthly basis. The tables below highlights Trade and other receivables which are due and past due (by number of days).

	Total member and service provider claims receivables									
R'000	Active member claims receivables	Withdrawn member claims receivables	Service provider claims receivables	Total	Contribution receivables	Other risk transfer arrangements	Broker fee receivables	Other insurance receivables	Loans and receivables	Total
31 December 2017										
Not past due	**4 011**	**7 822**	**5 149**	**16 982**	**739 565**	**11 796**	**80**	**52 045**	**237 864**	**1 058 332**
Past due 30 – 60 days	**3 650**	**8 037**	**2 419**	**14 106**	**9 875**	**–**	**587**	**–**	**–**	**24 568**
Past due 61 – 90 days	**3 425**	**8 118**	**2 214**	**13 757**	**2 927**	**–**	**58**	**–**	**–**	**16 742**
Past due 91 – 120 days	**3 369**	**9 458**	**675**	**13 502**	**4 457**	**–**	**5**	**–**	**–**	**17 964**
Past due 121 – 150 days	**4 342**	**12 302**	**2 291**	**18 935**	**5 861**	**–**	**9**	**–**	**–**	**24 805**
Past due 151 – 180 days	**3 370**	**9 896**	**3 461**	**16 727**	**–**	**–**	**4**	**–**	**–**	**16 731**
181 days to more than one year	**36 628**	**207 642**	**23 287**	**267 557**	**–**	**–**	**947**	**–**	**–**	**268 504**
Gross receivables	**58 795**	**263 275**	**39 496**	**361 566**	**762 685**	**11 796**	**1 690**	**52 045**	**237 864**	**1 427 646**
Provision for impairments	**(36 628)**	**(207 642)**	**(23 271)**	**(267 541)**	**(11 493)**	**–**	**(947)**	**–**	**–**	**(279 981)**
Trade and other receivables neither past due nor impaired	**22 167**	**55 633**	**16 225**	**94 025**	**751 192**	**11 796**	**743**	**52 045**	**237 864**	**1 147 665**
31 December 2016										
Not past due	2 395	5 150	10 249	17 794	**1 615 128**	24 426	(90)	138 781	179 900	1 975 939
Past due 30 – 60 days	1 677	6 474	8 720	16 871	**8 712**	–	(78)	–	–	25 505
Past due 61 – 90 days	1 751	8 539	(2 511)	7 779	**6 972**	–	(13 524)	–	–	1 227
Past due 91 – 120 days	2 757	8 250	1 295	12 302	**(7 135)**	–	15 370	–	–	20 537
Past due 121 – 150 days	2 918	8 809	11 616	23 343	**15 709**	–	95	–	–	39 147
Past due 151 – 180 days	2 305	10 447	(4 980)	7 772	**–**	–	55	–	–	7 827
181 days to more than one year	29 308	227 748	(1 444)	255 612	**–**	–	120	–	–	255 732
Gross receivables	**43 111**	**275 417**	**22 945**	**341 473**	**1 639 386**	**24 426**	**1 948**	**138 781**	**179 900**	**2 325 914**
Provision for impairments	(26 707)	(220 454)	(10 122)	(257 283)	**(9 759)**	–	(864)	–	–	(267 906)
Trade and other receivables neither past due nor impaired	16 404	54 963	12 823	84 190	**1 629 627**	24 426	1 084	138 781	179 900	2 058 008

Based on past experience, the Scheme believes that no provision for impairment is required in respect of Contribution debtors that are past due and outstanding for less than 90 days. For member and service provider claims debtors and broker fee debtors that are past due and outstanding for less than 180 days, past experience has indicated that no provision is required. The Scheme has not renegotiated the terms of receivables and does not hold any collateral or guarantees as security.

NOTES TO THE ANNUAL FINANCIAL STATEMENTS CONTINUED

for the year ended 31 December 2017

31 Financial risk management report *continued*

Credit risk *continued*

Provision for impairment

The Scheme establishes an allowance for impairment that represents its estimate of incurred losses in respect of trade and other receivables. The provision is based on the expected difference between the current carrying amount and the amount recoverable from the counter party.

The main components of this provision are:

- A specific loss component that relates to individually significant exposures; and
- A collective loss component established for groups of similar assets in respect of losses that have been incurred but not yet identified.

The collective loss allowance is determined based on historical data of payment statistics for similar financial assets.

The movement in the provision for impairment, for each component of trade and other receivables, during the year ended 31 December:

	Trade and other receivables				
	Insurance receivables				
R'000	Contribution receivables	Member and service provider claims receivables	Other risk transfer arrangements	Broker fee receivables	Total
Balance as at 1 January 2016	9 633	208 529	–	784	218 946
Increase in provision for impairment	126	76 422	–	81	76 629
Amounts utilised during the year	–	(27 668)	–	(1)	(27 669)
Balance as at 31 December 2016	9 759	257 283	–	864	267 906
Balance as at 1 January 2017	**9 759**	**257 283**	**–**	**864**	**267 906**
Increase in provision for impairment	**1 734**	**85 688**	**–**	**82**	**87 504**
Amounts utilised during the year	**–**	**(75 430)**	**–**	**1**	**(75 429)**
Balance as at 31 December 2017	**11 493**	**267 541**	**–**	**947**	**279 981**

31 Financial risk management report *continued*

Credit quality

The credit quality of Trade and other receivables that are neither past due nor impaired as presented on page 154 to 155 can be assessed by reference to historical information about counterparty default.

Contribution debtors

The Scheme collected over 96% (2016: 97%) of outstanding debt in January 2018. Therefore we can establish that the credit quality of contribution debtors is high. Consequently, no additional disclosure of the credit quality is provided.

Active member claims debtors

A provision for impairment covering 62% (2016: 62%) of the debtors has been raised and the Trustees are satisfied that this is adequate.

Withdrawn member claims debtors

These amounts are due from members that have withdrawn from the Scheme. A provision for impairment covering 79% (2016: 80%) of the total amount due has been raised and the Trustees are satisfied that this is adequate.

Other insurance receivables and loans and receivables

These debtors mainly comprises of amounts due by hospitals, which are inherently of high quality. As agreed with the providers the majority of these receivables are recovered by reducing future provider payments providing a high certainty of recoverability and thus no further analysis has been performed on these receivables.

Financial assets held at fair value through profit or loss, cash and cash equivalents and derivative financial instruments

The Scheme's credit risk exposures as at 31 December were as follows:

R'000	**2017**	2016
– Offshore bonds	**1 463 064**	1 245 709
– Yield enhanced bonds	**3 721 190**	3 413 740
– Inflation linked bonds	**792 666**	610 476
– Listed property investments	**382 024**	–
– Money market instruments	**4 268 369**	4 891 918
– Cash and cash equivalents	**5 880 362**	2 397 788
– Derivative financial instruments	**–**	50 384
	16 507 675	12 610 015

NOTES TO THE ANNUAL FINANCIAL STATEMENTS CONTINUED

for the year ended 31 December 2017

31 Financial risk management report *continued*

Exposure to credit risk

The Scheme manages credit risk on its investment portfolios through the appointment of reputable and appropriate asset managers, extensive diversification and ongoing monitoring and management of credit risk exposures and portfolio holdings.

Cash and cash equivalents comprise cash deposits with financial institutions. The risks associated with these deposits are managed by monitoring the Scheme's exposure to external financial institutions against approved deposit limits per institution. Information regarding the credit quality of cash and cash equivalents is provided on pages 160 to 161.

Derivative counterparties are limited to high credit quality financial institutions.

The Scheme's credit risk policy guides the Scheme with respect to credit risk identification, measurement, monitoring and management in its oversight capacity. The policy provides for limits based on parameters such as:

- Instrument and counterparty exposure;
- Credit ratings;
- Geographical exposure;
- Industry exposure; and
- Expected loss.

Compliance with the limits are regularly monitored with a quarterly report back presented to the Scheme's Investment Committee.

The Scheme has assessed whether the above financial assets are impaired. Based on the risk management measures undertaken by the Scheme, there is no objective evidence that any financial assets are impaired below the fair market value stated above.

Credit ratings provide an opinion on the relative ability of an entity to meet its financial commitments, such as interest, dividends or the repayment of capital invested. They are used as indicators of the likelihood of receiving the amounts owed in accordance with the terms on which they were invested.

Definitions of the symbols are presented below.

Long-term rating scales

AAA: Highest credit quality

AAA ratings denote the lowest expectation of default risk and are assigned only in cases of exceptionally strong capacity for payment of financial commitments. This capacity is highly unlikely to be adversely affected by foreseeable events.

AA: Very high credit quality

AA ratings denote expectations of very low default risk and indicate very strong capacity for payment of financial commitments. This capacity is not significantly vulnerable to foreseeable events.

A: High credit quality

A ratings denote expectations of low default risk. The capacity for payment of financial commitments is considered strong. This capacity may, nevertheless, be more vulnerable to adverse business or economic conditions than is the case for higher ratings.

BBB: Good credit quality

BBB ratings indicate that expectations of default risk are currently low. The capacity for payment of financial commitments is considered adequate but adverse business or economic conditions are more likely to impair this capacity.

At 31 December 2017, 2.1% (2017: 1.8%) of the Scheme's financial assets at fair value through profit or loss are invested in instruments with this credit rating.

BB: Speculative

BB ratings indicate an elevated vulnerability to default risk, particularly in the event of adverse changes in business or economic conditions over time, however business or financial flexibility exists which supports the servicing of financial commitments.

At 31 December 2017, 0.7% (2016: 1%) of the Scheme's financial assets at fair value through profit or loss are invested in instruments with this credit rating.

31 Financial risk management report *continued*

Exposure to credit risk *continued*

B: Highly speculative

B ratings indicate that material default risk is present, but a limited margin of safety remains. Financial commitments are currently being met, however capacity for continued payment is vulnerable to deterioration in the business and economic environment.

At 31 December 2017, 0.5% (2016: 0.5%) of the Scheme's financial assets at fair value through profit or loss are invested in instruments with this credit rating.

CCC: Possibility of default

Obligations for which there is a current perceived possibility of default. Timely repayment of principal and interest is dependent on favourable business economic or financial conditions.

At 31 December 2017, 0% (2016: 1.6%) of the Scheme's financial assets at fair value through profit or loss are invested in instruments with this credit rating.

CC: Very high levels of credit risk

Default of some kind appears probable.

At 31 December 2017, 0% (2016: 0%) of the Scheme's financial assets at fair value through profit or loss are invested in instruments with this credit rating.

NOTES TO THE ANNUAL FINANCIAL STATEMENTS CONTINUED

for the year ended 31 December 2017

31 Financial risk management report *continued*

The following table discloses the Scheme's asset credit ratings using official credit ratings. The credit risk policy limits investments in non-investment grade instruments to a maximum of 10% after considering official credit ratings and asset manager assigned internal credit ratings where official ratings are not available. Less than 2% (2016: 4%) of the instruments are invested in non-investment grade instruments after consideration of internally assigned credit ratings.

	Long-term rating					Long-term rating					
R'000	Total	Govt	AAA	AA+ to AA–	A+ to A–	BBB– to BBB+	BB– to BB+	B– to B+	CCC+ to CCC–	CC+	Not rated
2017											
At fair value through profit or loss:	**10 627 313**	**401 511**	**1 296 569**	**6 269 204**	**508 718**	**246 993**	**102 274**	**84 548**	**3 251**	**–**	**1 714 245**
– Offshore bond portfolio	**1 463 064**	**–**	**231 344**	**284 611**	**79 924**	**122 725**	**102 274**	**60 967**	**3 251**	**–**	**577 968**
– Yield enhanced bond portfolio	**3 721 190**	**–**	**698 624**	**2 036 167**	**185 757**	**84 617**	**–**	**23 581**	**–**	**–**	**692 444**
– Inflation linked bond portfolio	**792 666**	**373 927**	**–**	**410 154**	**8 585**	**–**	**–**	**–**	**–**	**–**	**–**
– Money market portfolios	**4 268 369**	**27 584**	**366 601**	**3 538 272**	**234 452**	**39 651**	**–**	**–**	**–**	**–**	**61 809**
– Listed property investments	**382 024**	**–**	**–**	**–**	**–**	**–**	**–**	**–**	**–**	**–**	**382 024**
Cash and cash equivalents	**5 880 362**	**–**	**4 037 907**	**1 655 954**	**29 089**	**101 169**	**15 141**	**–**	**–**	**–**	**41 102**
Total*	**16 507 675**	**401 511**	**5 334 476**	**7 924 158**	**537 807**	**348 162**	**117 415**	**84 548**	**3 251**	**–**	**1 755 347**
2016											
At fair value through profit or loss:	10 161 843	565 317	1 380 392	3 200 030	3 718 408	223 471	128 709	57 319	189 501	–	698 696
– Offshore bond portfolio	1 245 709	–	242 723	451 776	221 380	113 316	128 709	57 319	4 460	–	26 026
– Yield enhanced bond portfolio	3 413 740	60 997	565 333	1 035 608	1 066 578	110 155	–	–	29 068	–	546 001
– Inflation linked bond portfolio	610 476	445 255	16 688	10 204	138 329	–	–	–	–	–	–
– Money market portfolios	4 891 918	59 065	555 648	1 702 442	2 292 121	–	–	–	155 973	–	126 669
Cash and cash equivalents	2 397 788	6 608	201	1 953 693	370 752	–	–	–	15 409	–	51 125
Total*	12 559 631	571 925	1 380 593	5 153 723	4 089 160	223 471	128 709	57 319	204 910	–	749 821

* *Excludes derivative financial assets.*

At the reporting date the credit ratings shown are the most conservative of Moody's, Fitch and S&P and have been provided in a Fitch format.

The Scheme's investments in pooled funds and collective investment schemes (funds) are subject to the terms and conditions of the respective funds' offering documentation and are susceptible to market price risk arising from uncertainties about future values of those funds. The investment manager makes investment decisions after extensive due diligence of the underlying fund, its strategy and the overall quality of the underlying funds' managers. All of the funds in the investment portfolio are managed by portfolio managers who are compensated by the respective funds for their services. Such compensation generally consists of an asset-based fee and a performance-based incentive fee and is reflected in the valuation of the investment in each of the funds.

These investments are included in financial assets at fair value through profit or loss in the statement of financial position and no other risks relating to these investments have been identified other than those already disclosed in previous sections of this report.

NOTES TO THE ANNUAL FINANCIAL STATEMENTS CONTINUED

for the year ended 31 December 2017

31 Financial risk management report *continued*

Credit risk *continued*

The exposure to investments in unconsolidated structured entities is disclosed in the following table:

Name and description	2017 R'000	Authorised programme/ market size	% of authorised programme size/market size	Fair value hierarchy	Debt ranking	Credit ranking	Underlying assets
Asset backed commercial paper	1	R25 billion	0.00%	Level 2 – 100%	Senior secured	A+	Instalment sales agreements Corporate loans Credit card receivables Bonds Equipment leases
Residential mortgage-backed securitisations	478 065	R6.39 billion	0.75%	Level 1 – 67.09% Level 2 – 32.91%	Senior secured	AAA: 81.55% Not rated: 18.45%	Prime home loans
Asset backed securitisations	319 613	R39.5 billion	3.51%	Level 1 – 48.51% Level 2 – 51.49%	Senior secured: 99.14% Junior debt: 0.86%	AA- to AAA: 78.92% Not rated: 21.08%	Vehicle loans Corporate loans Unsecured loans Equipment leases
Commercial mortgage-backed securitisations	19 624	R5.5 billion	0.36%	Level 2 – 100%	Senior secured	AAA	Commercial property
Collateralised loan obligations	41 450	R5 billion	0.83%	Level 1 – 68.63% Level 2 – 31.37%	Senior secured	AAA	Vehicle loans
Collective investment schemes	2 664	R52.8 billion	0.01%	Level 2		AA+	ABSA Money Market Fund
	10 661	R12.6 billion	0.08%	Level 2		AA-	Nedgroup Investments Core Income Fund Class C2
	44 048	R24.4 billion	0.18%	Level 2		AA+	Investec Money Market Fund
	2 627	R26.4 billion	0.01%	Level 2		AA+	Standard Bank Corporate Money Market Fund
	5 023	R13.7 billion	0.04%	Level 2		AA+	Investec Corporate Money Market Fund
	901 589	R4.5 billion	0.02%	Level 2		A	Investec Global Strategic Income Fund

31 Financial risk management report *continued*

Credit risk *continued*

Name and description	2016 R'000	Authorised programme/ market size	% of authorised programme size/market size	Fair value hierarchy	Debt ranking	Credit ranking	Underlying assets
Asset backed commercial paper	–	R25.3 billion	0.00%	Level 1 – 100%	Senior secured – 0.01% Secured – 99.99%	F1+: 100%	Instalment sales agreements Corporate loans Credit card receivables Bonds Equipment leases
Residential mortgage-backed securitisations	354 568	R43.6 billion	0.81%	Level 1 – 93.52% Level 2 – 6.48%	Senior secured – 78.65% Secured – 18.39% Senior Unsecured – 2.96%	A to AAA: 91.50% BBB: 2.16% Not Rated: 6.34%	Prime home loans
Asset backed securitisations	249 368	R27.7 billion	0.90%	Level 1 – 71.11% Level 2 – 28.89%	Senior secured – 89.89% Secured – 5.64% Senior Unsecured – 4.47%	A to AAA: 71.11% BBB: 0.34% Not Rated: 28.55%	Vehicle loans Corporate loans Unsecured loans Equipment leases
	24 401	R2.5 billion	0.98%	Level 1 – 100%	Senior secured	AA to AAA: 100%	Commercial property
Collateralised loan obligations	54 337	R17 billion	0.32%	Level 1 – 100%	Senior secured – 0.01% Secured – 59.41% Unsecured – 40.58%	AA to AAA: 100%	Vehicle loans
Collective investment schemes	3 692	R52.8 billion	0.01%	Level 2		AA+	ABSA Money Market Fund
	917	R14.0 billion	0.01%	Level 2		AA+	Nedgroup Investments Money Market Class C2
	1 468	R26.4 billion	0.01%	Level 2		AA+	Standard Bank Corporate Money Market Fund
	848	R13.7 billion	0.01%	Level 2		AA+	Investec Corporate Money Market Fund
	672 885	R4.5 billion	0.02%	Level 2		A	Investec Target Return Fund

NOTES TO THE ANNUAL FINANCIAL STATEMENTS CONTINUED

for the year ended 31 December 2017

31 Financial risk management report *continued*

Liquidity risk

Liquidity risk is the risk that the Scheme will not have sufficient liquid funds available to settle financial obligations as they fall due.

The Scheme's approach to managing liquidity is to ensure, with significant conservative margin, that it will always have sufficient liquidity to meet its liabilities when due, under both normal and stressed conditions, without incurring unacceptable losses or risking damage to the Scheme's reputation. In order to meet the conflicting objective of enhancing returns while also providing high liquidity, the combined Scheme portfolios have explicit constraints that guarantee liquidity of at least 20% of the Scheme assets within a period of one week.

The Scheme has complied with the requirements regarding the nature and categories of assets as prescribed by Section 35 and Regulation 30 of the Act.

Approximately 98% (R1.8 billion) (2016: 94% – R1.6 billion) of the Scheme's insurance claim liabilities are settled within three months after the claim was incurred and the balance of the claims liability is settled within six months. The Scheme's remaining insurance liabilities are generally settled within 30 days.

A maturity analysis for financial liabilities carried at amortised cost, excluding liabilities arising from insurance contracts is provided below:

	Less than 1 year	Between 1 and 2 years	Between 2 and 5 years
As at 31 December 2017			
Personal Medical Savings Accounts (Note 8)	**4 656 633**	**–**	**–**
Trade and other payables (Note 9)	**538 930**	**–**	**–**
	5 195 563	**–**	**–**
As at 31 December 2016			
Personal Medical Savings Accounts (Note 8)	**4 204 043**	**–**	**–**
Trade and other payables (Note 9)	**521 690**	**–**	**–**
	4 725 733	**–**	**–**

Fair value estimation

Financial instruments

The fair value of financial instruments traded in active markets is based on quoted market prices at the reporting date. The quoted market price used for financial assets held by the Scheme is the current closing price.

The fair value of financial instruments that are not traded in an active market (for example, investments in pooled funds and collective investment schemes) is determined by using valuation techniques. These valuation techniques maximise the use of observable market data where it is available and rely as little as possible on entity-specific estimates. Specific valuation techniques used to value financial instruments include quoted market prices or dealer quotes for similar instruments.

The carrying value less impairment provision of trade receivables and payables are assumed to approximate their fair values due to their short term nature.

Personal Medical Savings Accounts

The members' Personal Medical Savings Accounts contain a demand feature. In terms of Regulation 10 of the Act, any credit balance on a member's Personal Medical Savings Account must be taken as a cash benefit when the member terminates his or her membership of the Scheme or benefit plan, and enrols in another benefit plan or medical scheme without a savings account or does not enrol in another medical scheme. Therefore the carrying values of the members' Personal Medical Savings Accounts are deemed to be equal to their fair values, which is the amount payable on demand.

31 Financial risk management report *continued*

Fair value hierarchy for financial assets measured at fair value

Assets measured at fair value

	Fair value measurement at end of the year using:			
R'000	**R'000**	**Level 1**	**Level 2**	**Level 3**
2017				
Financial assets at fair value through profit or loss:				
Offshore bonds	**1 463 064**	**601 503**	**861 561**	**–**
Equities	**3 378 331**	**3 313 762**	**64 569**	**–**
Yield-enhanced bonds	**3 721 190**	**2 291 984**	**1 429 206**	**–**
Inflation-linked bonds	**792 666**	**790 243**	**2 423**	**–**
Listed property investments	**382 024**	**382 024**	**–**	**–**
Money market instruments	**4 268 369**	**2 227 191**	**2 041 178**	**–**
	14 005 644	**9 606 707**	**4 398 937**	**–**
2016				
Financial assets at fair value through profit or loss:				
Offshore bonds	1 245 709	–	1 245 709	–
Equities	2 049 834	2 049 608	226	–
Yield-enhanced bonds	3 413 740	1 872 474	1 541 266	–
Inflation-linked bonds	610 476	587 154	23 322	–
Money market instruments	4 891 918	2 408 873	2 483 045	–
	12 211 677	6 918 109	5 293 568	–

The fair value assets are classified using a fair value hierarchy that reflects the significance of the inputs used in determining the measurements.

The fair value hierarchy has the following levels:

Level 1 – These are assets measured using quoted prices in an active market.

Level 2 – These are assets measured using inputs other than quoted prices included within Level 1 that are either directly or indirectly observable.

Level 3 – These are assets measured using inputs that are not based on observable market data.

NOTES TO THE ANNUAL FINANCIAL STATEMENTS CONTINUED

for the year ended 31 December 2017

31 Financial risk management report *continued*

Fair value hierarchy for financial assets measured at fair value *continued*

The table below details the valuation techniques and observable inputs for assets falling under Level 2:

Description	Fair value as at 31 December 2017 R'000	Fair value as at 31 December 2016 R'000	Valuation techniques	Observable input
Financial assets at fair value through profit or loss:				
Unlisted:				
Debt securities	**2 293 190**	2 810 297	Reference to listed benchmark bond	Risk free yield to maturity curve, risk free zero curve
Money market securities	**2 041 178**	2 483 271	Discounted cash flow valuation, Black – Scholes model	Published exchange swap curve, published interest rate curve, published credit spread curve/implied credit spread curve, risk free yield to maturity curve, risk free zero curve, swap yield to maturity curve, swap zero curve
Unlisted equity	**64 569**	–	Discounted cash flow valuation	Risk free yield to maturity curve, risk free zero curve
	4 398 937	5 293 568		

Capital management

The Scheme is subject to the capital requirement imposed by Regulation 29 (2) of the Act, which requires a minimum solvency ratio of accumulated funds expressed as a percentage of gross annual contributions of 25%.

The Scheme's objectives when managing capital are to maintain the capital requirements of the Act, and to safeguard the Scheme's ability to continue as a going concern in order to provide benefits for its stakeholders.

The calculation of the regulatory capital requirement is set out below.

R'000	2017	2016
Total members' funds per Statement of Financial Position	**16 684 435**	14 234 461
Less: cumulative unrealised net gain on remeasurement of investments to fair value	**(298 722)**	–
Accumulated funds per Regulation 29	**16 385 712**	14 234 461
Gross annual contribution income	**59 710 735**	54 056 212
Solvency margin = Accumulated funds / gross annual contribution income x 100	**27.44%**	26.33%

At 31 December 2017, the Scheme's regulatory capital level of 27.44% (2016: 26.33%) was R1.46 billion (2016: R719 million) more than the statutory capital requirement of 25%.

32 Critical accounting estimates and judgements

Critical accounting estimates and assumptions

The Scheme makes estimates and assumptions that affect the reported amounts of assets and liabilities within the next financial year. Estimates and judgements are continually evaluated and are based on historical experience and other factors, including expectations of future events that are believed to be reasonable under the circumstances.

Outstanding claims provision

The critical estimates and judgements relating to the outstanding claims provision are set out under Note 30.

Other risk transfer arrangements

The critical estimates and judgements relating to other risk transfer arrangements are set out under Note 11.

Impairment of assets

The critical estimates made by the Scheme are set out under Note 31 and judgements relating to the impairment of assets are set out under Note 7 of the Accounting policies.

33 Non-compliance matters

The Council for Medical Schemes issued Circular 11 of 2006 (the Circular) dealing with issues to be addressed in the audited financial statements of medical schemes. The Circular requires that all non-compliance matters noted should be disclosed in the audited financial statements, irrespective of whether the auditor considers it to be material or immaterial.

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

- **Statutory Scheme Solvency**

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

  During 2017, the Scheme's solvency level dropped below 25% during January. The reason for the drop below 25% was attributable to the impact of annual contribution increases (schemes are required to hold reserves equal to annualised inflation-adjusted contributions from the first day of the financial year). Negative claims experience during November, in line with historic trends, also caused the solvency ratio to drop below 25%.

  At 31 December 2017, the Scheme's accumulated funds expressed as a percentage of gross annual contributions was 27.44% (2016: 26.33%), which exceeds the statutory solvency requirement of 25%.

NOTES TO THE ANNUAL FINANCIAL STATEMENTS CONTINUED

for the year ended 31 December 2017

33 Non-compliance matters *continued*

- **Sustainability of Benefit Plans**

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

  For the year ended 31 December 2017 the following plans did not comply with Section 33 (2):

	Net healthcare result (R'000)	Net surplus/ (deficit) (R'000)
Benefit plan		
Executive	**(334 418)**	**(324 005)**
Classic Comprehensive	**(963 232)**	**(819 810)**
Classic Comprehensive Zero MSA	**(2 763)**	**(1 514)**
KeyCare Plus	**(535 785)**	**(212 254)**

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

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

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

- **Investments in Employer Groups and Medical Scheme Administrators**

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

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

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

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

33 Non-compliance matters *continued*

- **Contributions received after due date**

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

  However, DHMS employs robust credit control processes dealing with the collection of outstanding contributions, including the suspension of membership for non-payment.

- **Broker fees paid**

  In terms of Regulation 28 (5) of the Act, broker fees shall be paid on a monthly basis on receipt by a medical scheme of the relevant monthly contribution in accordance with the maximum amount payable per Regulation 28 (2), limited to one broker as required by Regulation 28 (8).

  In some instances brokers were compensated prior to receipt of the relevant monthly contribution, the amount paid was more than the prescribed amount and more than one broker per member was paid. In the instances where brokers were paid above the prescribed amount or more than one broker was paid, the value is negligible and represents less than 0.01% of the total broker fees paid for the year. The exceptions relate to transactions that do not occur frequently and the Administrator has developed exception reporting to identify and correct these transactions, and has a well-established claw-back system to rectify commission overpayments.

- **Minimum amount invested in cash [Category 1 (a) (i) and 1 (a) (ii)]**

  Explanatory note 2 to Annexure B to the Regulations of the Act requires a medical scheme to have a minimum of 20% of its Regulation 30 assets invested in cash [Category 1 (a) (i) and 1 (a) (ii)]. As at 31 March 2017, the Scheme did not meet this requirement as it held 19.79% in cash [Category 1 (a) (i) and 1 (a) (ii)]. The non-compliance was due to a difference in interpretation between the CMS and DHMS of the relevant clauses of Regulation 30 of the Act. The Scheme has amended its calculation methodology to be aligned with the CMS interpretation.

  Prior to Circular 2 of 2018: Personal Medical Savings Accounts and scheme rules, Personal Medical Savings Account (PMSA) assets were included as part of the Scheme's assets during the period July to December 2017. The PMSA assets were included in assessing compliance with the requirement for a minimum of 20% of Regulation 30 assets being invested in cash [Category 1 (a) (i) and 1 (a) (ii)]. After excluding PMSA assets from Scheme assets, there were certain months where this requirement was not met.

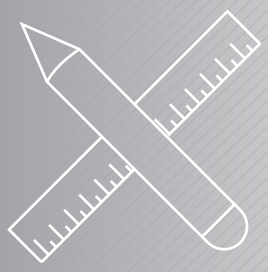
  As at 31 December 2017, 32.51% of Scheme assets were invested in cash [Category 1 (a) (i) and 1 (a) (ii)] and therefore met the minimum 20% requirement. This requirement has been met using the amended calculation methodology and excluding PMSA assets.

- **Waiting periods**

  Section 29A of the Act states the instances when medical schemes may impose waiting periods upon a person in respect of whom an application is made for membership or admission as a dependent. The waiting periods range from a three month general waiting period to a twelve month condition-specific waiting period. During the year under review there were isolated instances where waiting periods were not applied in accordance with the Act. For the instances identified, the incorrect application of waiting periods has been rectified and a review conducted which confirmed that no claims were rejected as a result of the waiting periods being incorrectly applied.

- **Prescribed minimum benefits**

  Section 29 (1) (o) and Regulation 8 provides the scope and level of minimum benefits that the Scheme must provide to members and dependants. During the year under review there were isolated instances where the Scheme did not pay claims in accordance with the scope and level of minimum benefits. The claims were reprocessed and correctly paid prior to the end of the benefit year.



RESOURCES AND GLOSSARY

Contact details

PRINCIPAL OFFICER

Email **principalofficer@discovery.co.za** or call **+27 11 529 2888** and ask for the Principal Officer of Discovery Health Medical Scheme (DHMS or the Scheme).

COUNCIL FOR MEDICAL SCHEMES

DHMS is regulated by the Council for Medical Schemes (CMS).

The CMS can be contacted by telephone on **0861 123 267** or via email on information@medicalschemes.com.

The CMS is located at Block A, Eco Glades 2 Office Park, 420 Witch-Hazel Avenue, Eco Park, Centurion, 0157.

IMPORTANT SOURCES OF INFORMATION

More information about DHMS is available at **www.discovery.co.za/medical-aid/about-discovery-health-medical-scheme**.

A full version of the Scheme Rules is available to registered members at **www.discovery.co.za/medical-aid/scheme-rules**.

More information about the various health plans offered by the Scheme are available at **https://www.discovery.co.za/medical-aid/our-medical-aid-plans**.

The Medical Schemes Act 131 of 1998, as amended, which regulates medical schemes, is available on the CMS website at **www.medicalschemes.com/Content.aspx?130**.

The International Integrated Reporting Framework and related resources can be found at **http://integratedreporting.org/.**

The King Report on Governance for South Africa and King Code of Governance Principles 2009 (King III) and the King IV Report on Corporate Governance for South Africa 2016 (King IV) can be found at **www.iodsa.co.za/?page=kingIII** and **www.iodsa.co.za/page/DownloadKingIVapp** respectively.

WHO TO CONTACT WHEN YOU:

Have a medical emergency or need medically-equipped transport

Call **0860 999 911** (**+27 11 541 1222** when outside of South Africa). Remember to have your membership number ready.

Have any queries about your health plan, benefits, hospital authorisations and claims

Email **healthinfo@discovery.co.za** or call our customer care on **0860 99 88 77** (**+27 11 541 1222** when outside of South Africa). Remember to put your membership number in the subject line of the email.

Want to submit a claim

Email **claims@discovery.co.za**. Remember to put your membership number in the subject line of the email.

Want to see your claims and how they were paid

www.discovery.co.za/medical-aid/your-medical-claims. You will need to be logged into the website to find the information you need.

Want to find information about how we cover certain procedures

www.discovery.co.za/portal/individual/what-we-cover. You will need to be logged into the website to find the information you need.

Want to find a doctor where you won't have to pay a co-payment

www.discovery.co.za/medical-aid/maps. You will need to be logged into the website to find the information you need.

Want to get pre-authorisation for hospital stays or find out about going to hospital

www.discovery.co.za/portal/individual/going-to-hospital. You will need to be logged into the website to apply for authorisation.

Need a document such as a tax certificate or membership certificate

www.discovery.co.za/medical-aid/find-documents. You will need to be logged into the website to find the information you need.

COMPLAINTS, COMPLIMENTS OR DISPUTES

DHMS is committed to providing you with the highest standard of service and your feedback is important to us. The following channels are available for you to communicate with us and we encourage you to follow the process.

STEP 1:

TO TAKE YOUR QUERY FURTHER

If you have already contacted us and feel that your query has still not been resolved, please complete our online complaints form at **www.discovery.co.za/corporate/contact-us#ContactDHMS**.

Alternately, email **healthinfo@discovery.co.za**, include your DHMS membership number and specify in your email that you would like a Client Relationship Manager to contact you. If you have reference numbers from previous emails related to the complaint, please include these as well.

We would also love to hear from you if we have exceeded your expectations.

STEP 2:

TO CONTACT THE PRINCIPAL OFFICER

If you are still not satisfied with the resolution of your complaint after following the process in step 1, you can escalate your complaint to the Principal Officer of DHMS. In the Contact Us section of the website, you can use the Contact the Principal Officer form at **www.discovery.co.za/corporate/contact-us#ContactDHMS**, or alternately email **principalofficer@discovery.co.za** or call **+27 11 529 2888** and ask for the Principal Officer of DHMS.

STEP 3:

TO LODGE A DISPUTE

If you have received a final decision from DHMS and want to challenge it, you may lodge a formal dispute.

Email **mydispute@discovery.co.za** or call **+27 11 529 2888** and ask to speak to a member of the Disputes team.

STEP 4:

TO CONTACT THE COUNCIL FOR MEDICAL SCHEMES

DHMS is regulated by the CMS. You may contact the CMS Council at any stage of the complaints process but are encouraged to follow the steps above to resolve your complaint before contacting the CMS directly.

Email **complaints@medicalschemes.com**, call **+27 12 431 0500** or **0861 123 267**.

FEEDBACK ON THE SCHEME'S INTEGRATED REPORT

We welcome any comments or specific feedback on the following:

- Was the Integrated Report (this Report) understandable to you?
- Were you able to find the information you were looking for, and if not, what were you looking for?
- Did this Report cover all the information relevant to your relationship with the Scheme?
- Was this Report presented in a format that worked for you, and if not, what you would prefer?

Email your feedback to dhms_stakeholders@discovery.co.za.

CHOOSING THE BEST PLAN FOR YOU AND YOUR FAMILY

Choosing a plan for your family can be confusing, given the amount of information you should consider. It is best to speak to your financial adviser, who will help you make the right decision based on your unique needs. It is also important to re-assess your plan every year before the annual cut-off date for plan changes, as your needs change and so do the contributions and benefits.

Financial advisers must be registered with the Financial Services Board and accredited by the CMS. The Scheme pays the financial adviser's commission.

You can also find information about the various health plans offered by the Scheme at **https://www.discovery.co.za/medical-aid/our-medical-aid-plans**.

REPORTING FRAUD OR UNETHICAL BEHAVIOUR

As the Scheme's Administrator and Managed Care Provider, Discovery Health (Pty) Ltd (Discovery Health) provides a fraud hotline and investigates possible instances of fraud. If you even slightly suspect someone of committing fraud or behaving unethically, report all information to the fraud hotline on the number below. You can also email our fraud department at **forensics@discovery.co.za** to investigate the matter.

You may remain anonymous if you prefer.

- Toll-free call: **0800 0045 00**
- Toll-free fax: **0800 00 77 88**
- Email: **discovery@tip-offs.com**
- Post: **Freepost DN298, Umhlanga Rocks, 4320**

REGISTERED ADDRESSES

PRINCIPAL OFFICER
Dr Nozipho Sangweni
Discovery Health Medical Scheme
1 Discovery Place,
Sandton, 2146

REGISTERED OFFICE ADDRESS AND POSTAL ADDRESS
Discovery Health Medical Scheme
Ground Floor, The Ridge,
Corner of Rivonia Road and Katherine Street,
Sandton, 2146
PO Box 786722,
Sandton, 2146

ADMINISTRATOR AND MANAGED CARE PROVIDER
Discovery Health (Pty) Ltd
1 Discovery Place,
Sandton, 2146
PO Box 786722,
Sandton, 2146

AUDITORS
PricewaterhouseCoopers Incorporated
4 Lisbon Lane,
Waterfall City, Jukskei View, 2090
Private Bag X36,
Sunninghill, 2157

PRINCIPAL BANKERS
FNB Corporate
4 First Place, FNB Bank City,
Cnr Pritchard & Simmonds Streets, Johannesburg, 2011
PO Box 7791,
Johannesburg, 2000

INVESTMENT MANAGERS

ABAX INVESTMENTS (PTY) LTD
Coronation House, The Oval,
1 Oakdale Road,
Newlands, 7700

ALUWANI CAPITAL PARTNERS (PTY) LTD
EPPF Office Park,
24 Georgian Crescent East,
Bryanston East, 2152

ALLAN GRAY INVESTMENTS (PTY) LTD
1 Silo Square,
V&A Waterfront,
Cape Town, 8001

FAIRTREE CAPITAL (PTY) LTD
Willowbridge Place,
Cnr Carl Cronje Drive & Old Oak Road,
Bellville, 7530

FUTUREGROWTH ASSET MANAGEMENT (PTY) LTD
3rd Floor, Great Westerford Building,
240 Main Road,
Rondebosch, 7700

INVESTEC ASSET MANAGEMENT (PTY) LTD
36 Hans Strijdom Avenue,
Foreshore, Cape Town, 8001

100 Grayston Drive,
Sandown, Sandton, 2196

LIBERTY CORPORATE
Libridge Building,
25 Ameshoff Street,
Braamfontein, 2001

MAZI ASSET MANAGEMENT (PTY) LTD
4th Floor North Tower,
90 Rivonia Road,
Sandton, 2196

SESFIKILE CAPITAL (PTY) LTD
2nd Floor, 18 The High Street,
Melrose Arch,
Johannesburg, 2076

STANLIB ASSET MANAGEMENT LTD
17 Melrose Boulevard,
Melrose Arch, 2076

TAQUANTA ASSET MANAGERS (PTY) LTD
7th Floor, Newlands Terraces,
Boundary Road,
Newlands, 7700

GLOSSARY

This glossary contains definitions of some of the terms used in this report, as well as some additional terms which may be of interest to readers. The list of terms is not exhaustive. See more at **https://www.discovery.co.za/medical-aid/terminology**.

ADMINISTRATION

Basic medical scheme administration services include the collection of contributions, member and provider support services, and the processing and paying of claims. Discovery Health provides DHMS with a broad range of additional administration services, such as research and development activities, actuarial and business analytics, benefit design, fraud and forensics investigation, and marketing and communication services. Discovery Health also provides DHMS with managed care services.

BENEFITS

Benefits (including medical services, procedures and/or medication) are offered by DHMS and relate to the healthcare cover a member receives in return for monthly contributions. DHMS has a wide range of plans designed to offer a variety of benefits to cater for individual requirements. Examples of DHMS benefits include hospital benefits, chronic illness benefits and day-to-day benefits.

BOARD OF TRUSTEES

The Board of Trustees (the Board or the Trustees) oversee the affairs of the Scheme in the best interest of its members and other stakeholders.

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

BROKERS

See financial advisers.

CLAIMS PAYING ABILITY

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

CLAIMS PROVISION

See incurred but not reported.

CONSUMER PRICE INDEX

The consumer price index (CPI) is the official measure of inflation in South Africa. CPI measures monthly changes in prices for a range of consumer products. Changes in CPI record the rate of inflation. CPI can also be used as a cost-of-living index.

COUNCIL FOR MEDICAL SCHEMES

The CMS is a statutory body responsible for regulating the medical schemes industry in South Africa. It administers and enforces the Medical Schemes Act 131 of 1998, as amended (the Act).

DEPENDANT

A member or person admitted as a dependant of a member. Beneficiaries of the Scheme include all members and their dependants.

DESIGNATED SERVICE PROVIDER

The hospitals and healthcare providers and professionals with whom DHMS has contracted to provide healthcare services to members. Designated Service Providers have a payment arrangement with DHMS to provide treatment or services at an agreed rate and without any co-payments required by members.

DISCOVERY LIMITED[1]

An international organisation made up of companies including Discovery Health, Discovery Life, Discovery Vitality, Discovery Card and Discovery Insure.

In 2015, Discovery was named by Fortune Magazine as one of the 51 companies globally that have made a sizeable impact on major global, social or environmental problems as part of their competitive strategy. Also in 2015, Discovery received the Geneva Forum for Health Award that recognises advances and contributions to healthcare systems.

Discovery Limited and Discovery Health make use of a shared value insurance model, based on a Harvard Business Review-published[2] framework to create economic value while addressing a societal need. In Discovery, this model aims to affect people's behaviour to make them more healthy, which in turn lowers insurance risk and keeps contributions lower for customers.

DHMS members have the option to join Discovery Vitality to take advantage of their wellness programmes as a complement to their medical aid.

DISCOVERY HEALTH (PTY) LTD

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

DISCOVERY HEALTH MEDICAL SCHEME[3]

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

DISCOVERY HEALTH MEDICAL SCHEME RULES

The Discovery Health Medical Scheme Rules (Scheme Rules or the Rules) are registered by the Registrar for Medical Schemes in terms of the Act, including the benefit plan and schedules. Together with the Act, the Rules dictate how DHMS operates.

1 *Discovery Ltd. Registration number: 1999/007789/06. Companies in the group are authorised financial service providers.*
2 *Michael E. Porter and Mark R. Kramer, Creating Shared Value, Harvard Business Review, January-February 2011.*
3 *Discovery Health Medical Scheme is regulated by the Council for Medical Schemes and is administered by Discovery Health (Pty) Ltd, registration number 1997/013480/07, an authorised financial services provider.*

DISCOVERY VITALITY
Discovery Vitality is a voluntary science-based wellness programme that encourages its members to get healthier by rewarding them for making healthy choices in support of wellness. Vitality is a separate wellness product sold and administered by Discovery Vitality (Pty) Ltd, registration number 1999/007736/07, an authorised financial services provider.

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

Financial advisers must be registered with the Financial Services Board and accredited by the CMS. The Scheme pays contracted financial advisers a legislated commission.

FORMULARY
See Medicine list.

GLOBAL CREDIT RATINGS
Global Credit Ratings (GCR) rates the full spectrum of security classes and accords both International Scale and National Scale credit ratings. Together with its international affiliates, GCR rates almost 3 000 organisations and debt issues spanning four continents. (Source: **https://globalratings.net/**).

GCR has issued DHMS with the highest possible credit rating in the medical scheme industry of AAA, confirming its financial strength and claims-paying ability.

INCURRED BUT NOT REPORTED
The incurred but not reported (IBNR or "outstanding claims provision") is the total amount of payments due by the Scheme in terms of its Rules to healthcare providers for claims incurred (such as healthcare services provided and medicine supplied) by its members and/or their dependants, but which have not been lodged/reported to the Scheme by the period end. The IBNR is an estimate and the Scheme makes use of various actuarial methods to reasonably predict such amounts at the period end. Further detail has been provided under Note 30 in the Annual Financial Statements.

INSTITUTE OF DIRECTORS IN SOUTHERN AFRICA
The Institute of Directors in Southern Africa (IoDSA) is a non-profit company that represents directors and professionals charged with corporate governance and governance in their individual capacities. The IoDSA offers a wide variety of governance resources, training and services and is the custodian of the King Reports in South Africa.

KING REPORTS
The various King Reports are a set of guidelines for the governance structures and operations of organisations in South Africa. They are non-legislative, being based on principles and practices. IoDSA introduced the King Code of Governance Principles and the King Report on Governance (King III) in 2009 and introduced the King IV Report on Corporate Governance for South Africa 2016 (King IV) in 2016.

MANAGED CARE
Managed care is the provision of appropriate, affordable, quality healthcare services through rules-based, clinical and disease management programmes. Discovery Health provides DHMS with managed care services for its members.

MATERIAL MATTERS
In integrated reporting, these are issues that impact on the Scheme's ability to create value. They are determined by considering their effect on the organisation's strategy, governance, performance or prospects. An understanding of the perspectives of key stakeholders is critical to identifying relevant matters.

MEDICAL SAVINGS ACCOUNT
The Medical Savings Account (MSA) is an amount that gets set aside for members at the beginning of each year or when they join the Scheme. Members who choose a health plan with an MSA can use it for day-to-day healthcare expenses like doctor's visits, optometry, medicine, pathology and radiology as long as they have money available in the account. MSA funds not used at the end of the year are carried over to the next year.

MEDICAL SCHEMES ACT
The Medical Schemes Act 131 of 1998, as amended regulates all registered schemes. DHMS operates according to the Act. See **https://www.medicalschemes.com/Content.aspx?130**.

MEDICINE LIST
A list of approved medicines that the Scheme covers in full. The list is also known as a formulary or preferred medicine list and includes an extensive range of high-quality medicines. The medicine list used by the Scheme for the Chronic Disease List complies with the guidelines issued by the CMS, and are safe, clinically appropriate, and cost-effective for the treatment of a specific condition.

MEMBER
A person who is admitted as a member in terms of the Rules of the Scheme, but does not include a dependant.

NETWORKS AND NETWORK PROVIDERS
Some health plans, benefits and healthcare services require members to use the Scheme's network providers. By using these providers, the Scheme can keep member contributions as affordable as possible while ensuring full cover at the same time.

NON-HEALTHCARE EXPENSES
The sum of non-healthcare fees paid to the Administrator, financial adviser commissions (acquisition costs) and other management expenses (which include advertising expenditure, staff costs, bad debts, impairments, etc.). Schemes are obligated to exercise a high degree of control over non-healthcare expenditure, as these can place additional pressure on their net healthcare performances, particularly in high-claiming years.

OPEN (UNRESTRICTED) SCHEME
A medical scheme that anyone can join, subject to the rules of the scheme (see restricted (closed) scheme).

PRESCRIBED MINIMUM BENEFIT CONDITIONS
In terms of the Act and its regulations, all medical schemes have to cover the costs related to the diagnosis, treatment and care of:

- Any life-threatening emergency medical condition;
- A defined set of 270 diagnosis and treatment pairs; and
- 27 chronic conditions.

These conditions and their treatments are known as the Prescribed Minimum Benefits (PMBs).

All medical schemes in South Africa must include the PMBs in the health plans they offer to their members. However, there are certain requirements that a member must meet before they can benefit from the PMBs, being:

1. The condition must be part of the list of defined PMB conditions;
2. The treatment needed must match the treatments in the defined benefits on the PMB list; and
3. Members must use the scheme's designated healthcare service providers, unless in an emergency, or they may be required to make a co-payment.

RESTRICTED (CLOSED) SCHEME
A medical scheme to which membership is restricted, based on employment by a particular employer or in a particular profession, trade or industry (see open (unrestricted) scheme).

SCHEME RULES
See Discovery Health Medical Scheme Rules.

SOLVENCY
The Act requires that each scheme retains a buffer of cash reserves to utilise against higher than expected claims resulting from random industry variations, including unexpected changes in membership profile, very large individual claims, and multiple claims arising from a catastrophic event or an epidemic. The minimum required solvency level to be maintained by a medical scheme is 25% of gross annual contributions.

VESTED® OUTSOURCING MODEL
Vested® is an outsourcing model, methodology, mindset and movement for creating highly collaborative business relationships that enable true win-win relationships in which both parties are equally committed to each other's success. When applied, a Vested® approach fosters an environment that sparks innovation, resulting in improved service, reduced costs and value that didn't exist before – for both parties. Vested® is based on award-winning research conducted by the University of Tennessee's College of Business Administration. (Source: **http://www.vestedway.com/**).

VITALITY
See Discovery Vitality.

More terms are available at https://www.discovery.co.za/medical-aid/terminology.

Discovery Health Medical Scheme

Contact Centre 0860 99 88 77 | healthinfo@discovery.co.za | www.discovery.co.za

Discovery
Health Medical Scheme