Discovery
Health Medical Scheme

2023
HIGHLIGHTS OF DISCOVERY HEALTH MEDICAL SCHEME'S RESULTS

Discovery Health Medical Scheme registration number 1125

This document contains highlights of the Scheme's performance for the year ended 31 December 2023, extracted from the 2023 Integrated Report, and audited Annual Financial Statements as audited by PricewaterhouseCoopers Inc (PwC). PwC issued an unqualified audit opinion on 30 April 2024.

Who we are

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

DHMS is a registered open medical scheme that any member of the public can join, subject to the Scheme Rules. Covering 2 788 242 beneficiaries at 31 December 2023, DHMS is the largest open medical scheme in South Africa, with an open medical scheme market share of 57.8%[2].

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

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

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

2 *Based on beneficiaries, according to the CMS Annual Report for the year ended December 2022 (https://www.medicalschemes.co.za/publications/#2009-3696-wpfd-2022-23-annual-report). At the end of 2022, there were 17 open schemes registered with the CMS, with approximately 54% of the total medical schemes market and 55 restricted schemes, with approximately 46% of the market. The Government Employees Medical Scheme is the largest restricted scheme with approximately 2.1 million beneficiaries. Source: Annexures to the CMS Annual Report 2022-2023.*

About IFRS 17 – the new insurance accounting standard

International Financial Reporting Standards (IFRS) govern how financial statements report transactions and events, enabling consistency, transparency, and comparability between businesses worldwide. To further enhance the comparability of financial results published by insurers, the new IFRS 17: Insurance Contracts standard became effective from 01 January 2023 and is applicable to medical schemes, replacing the interim standard IFRS 4, issued by the International Accounting Standards Board.

Although IFRS 17 introduces significant changes to the terminology and presentation of our Financial Statements, there are no changes for members, to the nature or operations of the Scheme, its business model, any processes applied by the Scheme in fulfilling its obligation to members, or to how we manage the Scheme's reserves.

IFRS 17 only impacts the accounting treatment[1] of (medical aid) contracts[2] issued by the Scheme, which fall within the definition of insurance contracts in terms of IFRS.

Although not legally defined as such, medical schemes are regarded as mutual entities for purposes of accounting reporting when applying IFRS 17, as they present similar attributes to mutual entities, but there have been no changes to regulatory or legislative requirements applicable to medical schemes.

As mutual entities under IFRS 17, medical schemes' "accumulated member funds/reserves" are now referred to as "Insurance Contract Liabilities due to future members" and classified as liabilities in the financial statements. This is a fundamental change in the classification and presentation of the Scheme's reserves in the Statement of Financial Position in the Financial Statements.

An example of a notable change, albeit not material to the Scheme's overall financial position, is the introduction of a risk adjustment to be applied to what was previously known as the Incurred But Not yet Reported (IBNR) claims provision, which is now referred to as the Liability for Incurred Claims (LIC). The purpose of the risk adjustment is to allow for uncertainty in the estimated future cash flows related to the claims provision.

We have included a list of terminology changes below for ease of reference.

IFRS 4	IFRS 17
Accumulated funds	Insurance liability to future members
Outstanding claims provision	Insurance contract liability
Personal Medical Savings Account liabilities	Insurance contract liability
Incurred But Not Yet Reported (IBNR)	Liability for Incurred Claims (LIC)
Risk contribution income	Insurance revenue
Relevant healthcare expenditure	Insurance service expense
Net healthcare result	Insurance service result

1 *The prescribed manner or method in which accountants record and present a specific business transaction or event in the company's Financial Statements.*

2 *In other words, membership agreements.*

Scan the QR code or click here to access our **2023 Integrated Report**, incorporating our Annual Financial Statements:

Items of interest within the Report may include:

Why join DHMS?

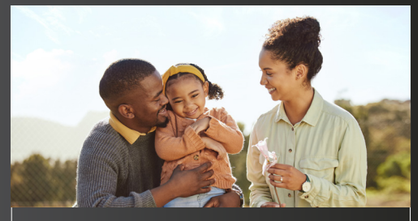
Quality of care is key to our membership proposition

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

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

We exist for our members

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



We'll be here for you

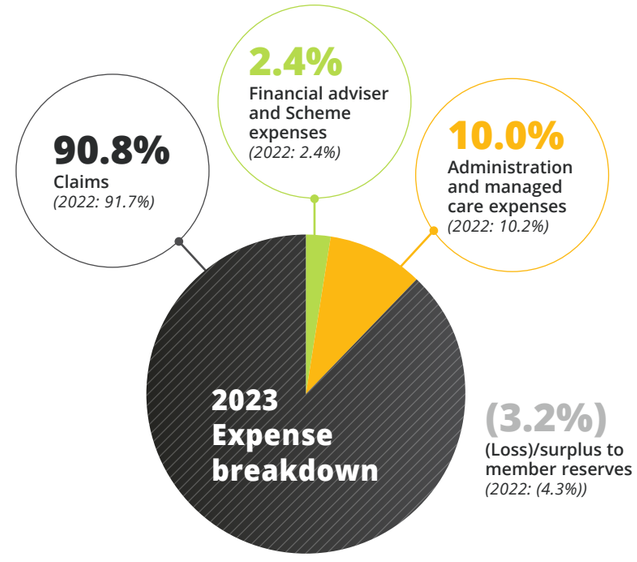
Financial strength and sustainability are key factors when selecting a medical scheme. Sound financial control and risk management enable the Scheme to maintain its required solvency reserve levels which ensure its ability to pay claims even when they are unexpectedly high.

We make sure your investment in membership takes care of you

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

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

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



We provide excellent cover to our members and compare well to other schemes

AVERAGE CONTRIBUTIONS FOR 2024

11.1% lower[2]

than the next seven largest open medical schemes

(2023: 12.3%)[3].

IN 2022, WE PAID

96%

of in-hospital claims, vs 91% for all other open schemes[4].

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

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

3 *The differential reported for 2023 has been updated from 12.2% to 12.3% to reflect the interim contribution increase effective 01 May 2023 by Sizwe-Hosmed.*

4 *Based on claimed amounts. Source: CMS Annual Report 2022-2023. Comparative data not yet available for the 2023 year.*

Our Principal Officer's review

Our continued focus is to prioritise our members' health and wellness needs, in balance with the sustainability of the Scheme. We serve 2 788 242[1] beneficiaries, whose healthcare needs we must support in a manner that ensures quality of care.

MS CHARLOTTE MBEWU

In a complex environment spurred by economic volatility, changing demographics and affordability constraints, we have achieved the following on their behalf:

- Launched new benefits to increase health promotion and disease prevention, and to manage the reduced health-seeking behaviour emanating from the COVID-19 pandemic era.
- Enhanced benefits to assist members in funding their healthcare needs.
- Maintained the Scheme's strong solvency position.
- Maintained the Scheme's leading position and market share.

This has allowed the Scheme to maintain a strong operational performance, albeit in a complex operating environment.

The **IFRS 17 accounting standard** is now applicable to the Scheme, and changes have therefore been made to the **terminology and presentation** of our Financial Statements. This introduces some **new terms into the main body of this Report as well as the Financial Statements**.

For the period under review, the Scheme generated an insurance revenue (previously contribution income) of R73 328 million. Taking claims paid on behalf of members and other expenses directly attributable to membership into account, the Scheme generated an insurance service result before amounts attributable to future members of negative R2 252 million (2022: R2 493 million negative). This is a strong performance in the context of demographic risk and economic headwinds. In terms of our investment strategy, the Scheme generated investment income of R2 418 million (2022: R2 222 million), which strongly supported our financial position despite challenging and unpredictable market conditions.

As budgeted, insurance liability to future members (previously member funds) decreased to R28.7 billion (2022: R28.9 billion) with WELLTH Fund expenditure being funded through excess solvency, resulting in solvency of 30.60% (2022: 35.04%[2]) as at 31 December 2023. This is well above the 25% solvency level required by regulations. The Scheme is therefore in a strong position to meet members' needs, and to continue the WELLTH Fund that extends members' access to screening and additional day-to-day benefits.

Our governance processes were enhanced and bedded down, and we continued to optimise our arrangements with Discovery Health. In particular, this relates to effectively assessing and adopting innovations by Discovery Health, and ensuring ongoing alignment with best practice governance and the fiduciary duties of our Trustees. The Scheme Office's culture of development and learning in a values-driven environment continues to be highly effective in the hybrid work model we have implemented.

Specific challenges we face include addressing the demographic profile of the Scheme, containing healthcare costs and ensuring membership growth, needed by the Scheme for cross-subsidisation between members and for Scheme sustainability; and policy and regulatory developments where the NHI Bill may still undergo constitutional review. Also due to regulatory barriers, medical schemes have been unable to implement low-cost, primary care-based benefit plans that would expand private healthcare access to many more South Africans.

The demographic pressure on the Scheme, driven by an increasing burden of chronic disease together with membership affordability constraints in the current economic climate, shape our ongoing conversations about utilisation, membership growth, and strategies to better support the health and wellness needs of our members while enhancing healthcare expenses management. The ability to offer our members value for their contributions and be responsive to their changing needs is essential. Given healthcare inflation of 11.7% in 2023, and an expected range of consumer price index (CPI) + 4-7% in 2024, our challenge is to match contribution increases as closely as possible to utilisation, which is driven by supply- and demand-side factors, demographic risk, and tariff increases (which increase in line with healthcare inflation).

Accordingly, for 2024 we have had to carefully consider and balance these aspects. The performance of the Delta and Essential Comprehensive plan options indicated a need to consolidate the Comprehensive series, leaving the Classic Comprehensive and Classic Smart Comprehensive as our two plans. Some non-emergency exclusions have been added to the KeyCare plans, as well as a requirement for KeyCare members and members registered on the Chronic Illness Benefit to nominate a single primary care provider for 2024. There is evidence showing that patients experience improved health outcomes when their primary care is co-ordinated through a single primary care GP, so this change is in line with the Scheme's focus of promoting value in healthcare.

The Scheme also reduced some Personal Medical Savings Account (PMSA) percentages to enable us to have a lower overall contribution increase, informed by the utilisation levels of the PMSAs, while simultaneously adding risk benefits to reduce the pressure on PMSAs for members. These additional benefits, previously frequently utilised through a PMSA, include mental health preventative screening and access to internet-based Cognitive Behavioural Therapy in support of and complimentary to benefits already in place within the Mental Health Programme. We have also added access to virtual urgent care. Access to these benefits and others is supported through the new member app, designed to offer a more personalised healthcare journey.

We endeavour to continuously expand our members' access to programmes aimed at improving or maintaining their health and wellness. To this end, we are working with Discovery Health to utilise technology and data to build personalised health pathways for our members. These are grounded in credible research conducted in collaboration with the London School of Economics (LSE)[3]. These pathways will predict and encourage members to take steps that are most important to improving their current and future health. This ground-breaking innovation will help us to manage our demographics and burden of disease, as well as assist our members with individually tailored information.

We continue to engage closely with our regulator, the Council for Medical Schemes, and thank them for their ongoing drive to protect medical scheme members. We look forward to work underway to promote the improved functioning of the medical schemes industry through initiatives such as the review of Prescribed Minimum Benefits. We also closely monitor and, wherever possible, make submissions on policy changes such as the NHI Bill. We remain concerned that in its present form, it will not support sufficient reform and improvements to healthcare in South Africa. As such, we have proposed that proper consideration be given to a model allowing for multiple funders of healthcare, which is lower risk and more appropriate in the South African context. We have also asked for clarity on the intended role of medical schemes under the NHI Bill. While we do not anticipate any immediate changes for our members should the Bill be written into law, we will continue to support our government in moving towards universal health coverage, while advocating for the most constructive, appropriate and workable legislation to achieve this crucial national objective.

Finally, I thank our Trustees and Independent Committee Members for their thoughtful engagement in governing and overseeing the Scheme. Their support and guidance are invaluable to me and my team. The Scheme Office has again performed with dedication and excellence in an environment where carefully balancing operational and strategic objectives in the immediate and long-term interests of our members is essential.

C Mbewu

MS CHARLOTTE MBEWU
Principal Officer

1 *As at 31 December 2023.*
2 *Previously reported as 35.11%, restated due to the implementation of IFRS 17.*
3 *Work done with the LSE produced robust results on the reduction in the risk of developing type 2 diabetes and severe cancer through forming activity habits. https://www.dailymaverick.co.za/article/2024-03-12-get-moving-to-reduce-your-health-risks-and-cut-medical-costs-vitality-habit-index/.*

Ensuring the Scheme's sustainability

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

Growth and sustainability

MEMBERSHIP GROWTH

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

Net membership decrease
0.12%
(2022: 1.67% increase)

Net beneficiary decrease
0.81%
(2022: 0.94% decrease)

Average age at year-end[1]
37.00
(2022: 36.57)

Pensioner ratio[2]
12.32%
(2022: 11.77%)

Annualised lapse rate
5.88%
(2022: 5.49%)

MEMBERSHIP SIZE

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

1 373 864
Principal members at 31 December 2023
(2022: 1 375 544)

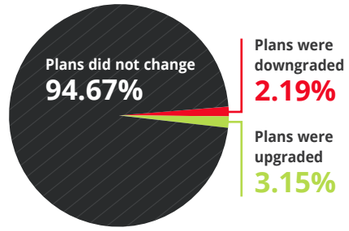
2 788 242
Beneficiaries at 31 December 2023
(2022: 2 810 992)

57.8%
Share of open scheme market
(2021: 57.6%)

PLAN MOVEMENTS

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

From December 2023 – January 2024:[3]



RELATIVE CONTRIBUTION LEVELS

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

Average contributions for 2024 are
11.1%
lower than the next seven largest open medical schemes[4]
(2023: 12.3%[5]).

ABSOLUTE RESERVES

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

Accumulated funds expressed as a percentage of gross annual contributions
30.60%
(2022: 35.04%)[6]
exceeding the statutory solvency requirement of 25%.

AAA
Independent credit rating for claims paying ability[7]
(2022: AAA).

PRUDENT INVESTMENT MANAGEMENT

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

Gross return on investments
9.36%
(2022: 6.18%)

Financial strength and management

PRICING SUFFICIENCY

Surplus year-on-year reflects contribution levels that are in line with expected membership and claims. In 2023, the Scheme deferred the contribution increase to 01 April, providing relief to its members and passing on the benefit of excess reserves. The Scheme also introduced the WELLTH Fund, a temporary benefit, as a mechanism to release excess reserves to its members. The deferral of the increase and the implementation of the WELLTH Fund resulted in the Scheme generating a negative insurance service result for the year. The WELLTH Fund and deferred contribution increase contributed R490 million and R1.5 billion to the total comprehensive loss respectively.

Total insurance service result[8] for the year
R2 069 million
negative
(2022: R1 017 million negative)

Total comprehensive loss[9] for the year of
R183 million
(2022: R1 476 million surplus)

VALUE-ADDED ADMINISTRATION AND MANAGED CARE

For every R1.00 spent by DHMS on administration and managed care fees in 2022[10], our members received
R2.08
(2021: R2.02)
in value from the activities of Discovery Health (Pty) Ltd (Discovery Health). This is equivalent to nominal added value, over and above the fees paid, of R8.7 billion in 2022 (2021: R7.6 billion).

Administration fees
7.41%
of gross contributions
(2022: 7.56%)

Managed care fees
2.56%
of gross contributions
(2022: 2.64%)

1 *An increase of less than one year per annum is favourable as this indicates that young people are joining the Scheme.*
2 *Based on beneficiaries' dates of birth.*
3 *We monitor plan movements closely, especially when our contributions are increased and members are able to change their plans.*
4 *Source: publicly available contribution information for DHMS and the next seven largest open medical schemes. To ascertain the contribution differential between DHMS and competitors, we calculate an average contribution within each plan category for a principal member. These average contributions are then weighted (for DHMS and the next seven largest open schemes) according to the distribution of members across DHMS plans. This ensures that plans with similar benefits are being compared on a like-for-like basis, providing a reasonable estimate of the lower contribution that a typical member of DHMS pays relative to members of similar options in competitor schemes. Contribution rates on individual plans on other schemes vary and may be cheaper or more expensive than DHMS's equivalent plans..*
5 *The differential reported for 2023 was updated from 12.2% to 12.3% to reflect the interim contribution increase effective 01 May 2023 by Sizwe-Hosmed.*
6 *Restated due to IFRS 17 implementation. The figure disclosed in the 2022 Integrated Report was 35.11%.*
7 *Rating affirmed in April 2023; this refers to how many times the Scheme is able to cover its monthly claims expense with its liquid investments.*
8 *Total insurance service result excludes amounts attributable to future members. Amounts attributable to future members is R183 million (2022: R1 476 million).*
9 *Total comprehensive loss for the year excludes amounts attributable to future members.*
10 *As the assessment uses industry information reported by the Council for Medical Schemes (CMS), results are only available for the preceding year.*

Extracts from the audited Annual Financial Statements

Statement of Financial Position

AT 31 DECEMBER 2023

	Notes[1]	2023 R'000	Restated 2022 R'000	Restated 01 January 2022 R'000
Assets				
NON-CURRENT ASSETS		**25 022 693**	24 348 071	24 719 222
Property and equipment	1	**7 745**	8 317	9 658
Long-term employee benefit plan assets	25	**10 206**	8 314	7 998
Financial assets at fair value through profit or loss	3	**25 004 742**	24 331 440	24 701 566
CURRENT ASSETS		**12 281 727**	12 512 461	13 847 441
Financial assets at fair value through profit or loss	3	**7 865 155**	8 842 232	9 987 157
Derivative financial instruments	7	**65 826**	38 525	–
Trade and other receivables	4	**11 967**	6 040	10 728
Reinsurance contract assets	10	**3 043**	1 530	382
Cash and cash equivalents		**4 335 736**	3 624 134	3 849 174
– Personal Medical Savings Accounts trust assets arising from amalgamation	5	**–**	–	10 860
– Medical Scheme assets	6	**4 335 736**	3 624 134	3 838 314
TOTAL ASSETS		**37 304 420**	**36 860 532**	**38 566 663**
Liabilities				
NON-CURRENT LIABILITIES		**26 924 615**	25 292 164	25 356 256
Insurance liability to future members	11	**26 919 793**	25 284 429	25 347 585
Lease liability	2	**4 822**	7 735	8 671
CURRENT LIABILITIES		**10 379 805**	11 568 368	13 210 407
Lease liability	2	**1 654**	2 098	1 961
Insurance contract liability	9	**8 525 966**	7 886 759	8 126 348
Insurance liability to future members	11	**1 770 453**	3 588 451	5 001 301
Trade and other payables	8	**81 732**	91 060	80 797
TOTAL LIABILITIES		**37 304 420**	**36 860 532**	**38 566 663**

1 *Please refer to the Notes to the Financial Statements, pages 120 - 185, in the full Integrated Report, incorporating annual financial statements, available at http://www.discovery.co.za/info/DHMSReports.*

Statement of Comprehensive Income

FOR THE YEAR ENDED 31 DECEMBER 2023

	Notes[1]	2023 R'000	Restated 2022 R'000
Insurance revenue	12	**73 328 203**	65 637 399
Insurance service expense	12	**(75 483 071)**	(66 724 592)
Net income from risk transfer arrangement/reinsurance	12	**85 723**	70 201
INSURANCE SERVICE RESULT		**(2 069 145)**	(1 016 992)
Other income		**3 378 968**	2 256 202
Investment income	19	**2 417 940**	2 221 987
Net gain on financial assets	20	**924 517**	3 117
Sundry income	21	**36 511**	31 098
Other expenditure		**(1 309 823)**	(1 239 210)
Other administration fees	13	**(648 298)**	(592 049)
Other operating expenses	14	**(191 266)**	(182 813)
Asset management fees	22	**(83 041)**	(103 130)
Finance costs	23	**(922)**	(1 266)
Net finance expense from insurance contracts	24	**(386 296)**	(359 952)
TOTAL COMPREHENSIVE (LOSS)/INCOME FOR THE YEAR		**–**	–

Statement of Changes in Funds and Reserves

FOR THE YEAR ENDED 31 DECEMBER 2023

	2022 R'000
BALANCE AT 1 JANUARY 2022 (AS PREVIOUSLY REPORTED)	**30 418 845**
Transition restatement*	(30 418 485)
BALANCE AT 1 JANUARY 2022 (RESTATED)	**–**

* *Refer to the transition to IFRS 17 note in the accounting policies for the impact of the adoption of IFRS 17.*

Statement of Cash Flows

FOR THE YEAR ENDED 31 DECEMBER 2023

	Notes[1]	2023 R'000	Restated 2022 R'000
Cash flows from operating activities			
CASH RECEIPTS FROM MEMBERS AND PROVIDERS		**88 566 368**	79 343 630
Cash received from members – contributions	9	**88 566 796**	79 334 330
Cash (paid to)/received from members and providers – other	27	**(428)**	9 300
CASH PAID TO PROVIDERS, EMPLOYEES AND MEMBERS		**(91 379 654)**	(83 154 581)
Cash paid to providers and members – claims and directly attributable expenses	9	**(89 714 174)**	(81 624 054)
Cash paid to reinsurer	10	**(310 596)**	(312 068)
Cash paid to providers and employees – other administration fees and operating expenses	27	**(815 950)**	(729 069)
Cash paid to members – savings plan refunds	9	**(538 934)**	(489 390)
CASH USED IN OPERATIONS		**(2 813 286)**	(3 810 951)
Purchase of financial assets	27	**(3 967 570)**	(7 774 847)
Proceeds from disposal of financial assets	27	**5 383 974**	9 410 317
Increase in long-term employee plan asset	25	**(6 770)**	(5 770)
Interest received	27	**1 802 684**	1 588 235
Dividend income	27	**397 566**	473 318
Interest paid	23	**–**	(102)
Asset manager fees paid	22	**(83 041)**	(103 130)
NET CASH INFLOW/(OUTFLOW) FROM OPERATING ACTIVITIES		**713 557**	(222 931)
Cash flows from financing activities			
Purchases of right-of-use asset	1	**–**	(145)
Purchases of leasehold improvements	1	**(142)**	–
Payment of lease liabilities	2	**(1 813)**	(1 964)
Net cash outflow from financing activities		**(1 955)**	(2 109)
NET INCREASE/(DECREASE) IN CASH AND CASH EQUIVALENTS		**711 602**	**(225 040)**
Cash and cash equivalents at beginning of the year		**3 624 134**	3 849 174
CASH AND CASH EQUIVALENTS AT THE END OF THE YEAR		**4 335 736**	**3 624 134**

Solvency

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

At 31 December 2023, the Scheme's solvency level of 30.60%[1] (2022: 35.04%[2]) of gross annual contributions exceeded the 25% minimum statutory solvency requirement by R5 billion (2022: R8 billion).

R'000	2023	Restated[3] 2022
Insurance contract liability to future members	**28 690 246**	28 872 880
Less: cumulative unrealised net gain on re-measurement of investments	**(1 508 826)**	(1 002 934)
Accumulated funds (Regulation 29)	**27 181 420**	27 869 946
Gross annual contributions	**88 816 184**	79 542 906
Solvency ratio	**30.60%**	35.04%
Average accumulated funds per member at year-end	**19 785**	20 303

1 The planned decrease in solvency is due to the temporary WELLTH fund benefit introduced in 2023 which is funded from Insurance contract liability to future members (Reserves), as well as the shorter deferral period for the contribution increases in 2023 (3 months) relative to 2022 (9 months) impacting on the gross annual contributions utilised in calculating solvency.

2 Previously reported as 35.11%, restated due to the implementation of IFRS 17.

3 Restated due to the implementation of IFRS 17.

Financial assets at fair value through profit or loss
Accounting policy:

The Scheme's investment strategy (business model objective) is determined by means of an allocation across different asset classes and grouping of financial assets into specific portfolios. Independent asset managers manage these portfolios under fully discretionary, active mandates with performance evaluated at the respective portfolio level on a fair value basis. All asset managers are remunerated based on the fair value of the portfolio under management.

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

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

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

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

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

R'000	2023	2022
The Scheme's financial assets at fair value through profit or loss are summarised by measurement classes as follows:		
– Offshore cash and bonds	**2 340 515**	2 196 242
– Equities	**9 565 664**	8 937 682
– Short duration bonds	**5 353 666**	5 488 733
– Flexible fixed income bonds	**9 719 048**	8 639 881
– Money market instruments	**5 229 427**	7 313 485
– Property	**661 577**	597 649
	32 869 897	33 173 672
Open ended, available on demand (Included as non-current)	**25 004 742**	24 331 440
Expected to settle within twelve months (Included as current)	**7 865 155**	8 842 232
	32 869 897	**33 173 672**
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	**33 173 672**	34 688 723
Acquisition and income earned	**4 182 983**	7 930 674
Disposals and expenses incurred	**(5 460 688)**	(9 410 317)
Net gains/ (losses) on revaluation of financial assets at fair value through profit or loss (Note 20)	**973 930**	(35 408)
AT THE END OF THE YEAR	**32 869 897**	**33 173 672**

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

Operational statistics per benefit plan[1]

FOR THE YEAR ENDED 31 DECEMBER 2023

2023	COMPREHENSIVE				PRIORITY		SAVER		
	EXECUTIVE	CLASSIC COMP	ESSENTIAL COMP	CLASSIC SMART COMP	CLASSIC PRIORITY	ESSENTIAL PRIORITY	CLASSIC SAVER	ESSENTIAL SAVER	COASTAL SAVER
Number of members at the end of the accounting period	7 206	95 212	11 196	435	68 062	4 748	330 822	177 222	163 822
Number of beneficiaries at the end of the accounting period	14 327	196 143	19 672	819	147 688	9 353	719 088	372 386	360 436
Average number of members for the accounting period	7 386	98 065	11 519	434	69 307	4 776	331 425	171 936	165 313
Average number of beneficiaries for the accounting period	14 734	202 778	20 294	807	150 582	9 404	720 587	362 105	364 297
Average risk contributions per member per month (R')	11 180.77	8 953.22	7 563.37	8 541.39	6 072.58	5 424.84	4 765.33	3 875.48	4 329.92
Average risk contributions per beneficiary per month (R')	5 605.15	4 329.85	4 293.03	4 593.51	2 794.97	2 754.99	2 191.76	1 840.18	1 964.85
Average net claims incurred per member per month (R')	13 937.53	9 539.52	7 889.62	5 346.32	5 406.30	3 405.18	4 070.01	2 726.76	3 937.60
Average net claims incurred per beneficiary per month (R')	6 987.17	4 613.39	4 478.21	2 875.22	2 488.30	1 729.31	1 871.95	1 294.73	1 786.83
Average administration costs per member per month (R')	432.26	432.26	432.26	432.26	432.26	432.26	432.26	432.26	432.26
Average administration costs per beneficiary per month (R')	216.70	209.04	245.35	232.47	198.95	219.52	198.81	205.25	196.15
Average managed care: management services per member per month (R')	138.84	138.84	138.84	138.84	138.84	138.84	138.84	138.84	138.84
Average managed care: management services per beneficiary per month (R')	69.60	67.14	78.81	74.67	63.90	70.51	63.86	65.92	63.00
Average family size	1.99	2.06	1.76	1.88	2.17	1.97	2.17	2.10	2.20
Loss ratio (%)	125.93%	108.15%	106.19%	64.23%	91.34%	65.35%	88.34%	73.98%	94.17%
Total non-healthcare expenses as a percentage of risk contributions (%)	5.02%	6.29%	7.45%	6.56%	9.27%	10.35%	11.78%	14.21%	12.90%
Average non-healthcare expenses per member per month	456.44	456.43	456.44	456.45	456.45	456.46	456.51	456.59	456.48
Average non-healthcare expenses per beneficiary per month	228.82	220.73	259.08	245.48	210.09	231.81	209.97	216.80	207.14
Average age of beneficiaries (years)	48.74	45.98	51.13	41.21	42.44	40.55	36.62	33.73	37.90
Pensioner ratio (beneficiaries over 65 years)	31.29%	24.98%	35.36%	16.10%	18.66%	15.38%	11.42%	8.10%	12.43%
Average relevant healthcare expenses per member per month	14 080.49	9 682.95	8 031.27	5 486.06	5 546.74	3 545.11	4 209.85	2 866.90	4 077.30
Average relevant healthcare expenses per beneficiary per month	7 058.84	4 682.75	4 558.61	2 950.37	2 552.94	1 800.37	1 936.27	1 361.28	1 850.22
Net surplus/(deficit) per benefit plan	(293 381)	(1 343 956)	(121 719)	13 984	94 961	84 265	578 579	1 259 823	(306 646)

2023	CORE			SMART		KEYCARE			TOTAL
	CLASSIC CORE	ESSENTIAL CORE	COASTAL CORE	CLASSIC SMART	ESSENTIAL SMART	KEYCARE PLUS	KEYCARE CORE	KEYCARE START	
Number of members at the end of the accounting period	44 523	53 200	67 687	65 466	57 415	203 323	16 799	6 726	**1 373 864**
Number of beneficiaries at the end of the accounting period	94 782	116 018	151 704	132 581	67 339	349 177	27 901	8 828	**2 788 242**
Average number of members for the accounting period	44 657	51 612	68 295	64 243	53 517	201 661	16 093	6 215	**1 366 455**
Average number of beneficiaries for the accounting period	95 209	112 969	153 492	129 943	62 362	346 801	26 772	8 092	**2 781 229**
Average risk contributions per member per month (R')	5 045.17	3 999.00	4 327.35	3 824.54	1 990.28	2 617.45	2 158.20	1 702.73	**4 473.09**
Average risk contributions per beneficiary per month (R')	2 366.39	1 827.02	1 925.41	1 890.83	1 708.00	1 522.02	1 297.36	1 307.71	**2 197.69**
Average net claims incurred per member per month (R')	4 364.70	3 192.91	4 125.92	2 969.11	1 141.59	2 725.02	1 720.24	926.77	**4 001.28**
Average net claims incurred per beneficiary per month (R')	2 047.22	1 458.74	1 835.78	1 467.91	979.68	1 584.57	1 034.09	711.77	**1 965.88**
Average administration costs per member per month (R')	432.26	432.26	432.26	432.26	432.26	251.34	147.46	251.34	**401.38**
Average administration costs per beneficiary per month (R')	202.75	197.49	192.33	213.71	370.95	146.15	88.64	193.03	**197.20**
Average managed care: management services per member per month (R')	138.84	138.84	138.84	138.84	138.84	137.99	137.99	137.99	**138.70**
Average managed care: management services per beneficiary per month (R')	65.12	63.43	61.78	68.64	119.15	80.24	82.95	105.98	**68.15**
Average family size	2.13	2.18	2.24	2.03	1.17	1.72	1.66	1.31	**2.03**
Loss ratio (%)	89.23%	83.34%	98.57%	81.27%	64.34%	108.16%	86.10%	61.82%	**92.47%**
Total non-healthcare expenses as a percentage of risk contributions (%)	10.87%	13.60%	12.65%	14.16%	25.43%	13.02%	10.44%	18.63%	**11.57%**
Average non-healthcare expenses per member per month	456.47	456.55	456.47	456.55	456.66	275.58	171.77	275.76	**425.63**
Average non-healthcare expenses per beneficiary per month	214.10	208.58	203.10	225.71	391.89	160.24	103.25	211.78	**209.12**
Average age of beneficiaries (years)	43.20	40.05	42.08	33.31	36.18	32.09	36.49	36.10	**37.00**
Pensioner ratio (beneficiaries over 65 years)	20.12%	15.97%	18.19%	6.57%	5.53%	9.24%	14.50%	10.12%	**12.32%**
Average relevant healthcare expenses per member per month	4 501.81	3 332.59	4 265.56	3 108.23	1 280.51	2 831.02	1 858.23	1 052.62	**4 136.21**
Average relevant healthcare expenses per beneficiary per month	2 111.53	1 522.56	1 897.92	1 536.69	1 098.90	1 646.20	1 117.04	808.42	**2 032.17**
Net surplus/(deficit) per benefit plan	98 590	194 167	(242 953)	281 081	254 054	(881 375)	51 460	39 251	**(239 816)**

1. Efficiency discount options (Delta, KeyCare Start Regional) are incorporated into their parent plans for operational statistics reporting purposes. For 2024, the Comprehensive series was simplified into two plans: Classic Comprehensive and Classic Smart Comprehensive. This was done in order to ensure the sustainability of the Comprehensive series and its extensive benefit offering. For more information on 2024 plans and benefits, see https://www.discovery.co.za/medical-aid/product-benefit-enhancements.

Matters of non-compliance

FOR THE YEAR ENDED 31 DECEMBER 2023

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

During 2023, the Scheme did not comply with the following Sections and Regulations of the Act, and a directive issued by the CMS.

Sustainability of benefit plans

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

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

For the year ended 2023 the following plans did not comply with Section 33 (2):

Benefit plan	Net healthcare result (R'000)	Net deficit (R'000)
Executive	**(301 978)**	**(292 395)**
Classic Comprehensive	**(1 462 107)**	**(1 335 117)**
Essential Comprehensive	**(135 661)**	**(120 781)**
Coastal Core	**(359 507)**	**(239 624)**
Coastal Saver	**(514 720)**	**(299 467)**
KeyCare Plus	**(1 275 850)**	**(876 032)**

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

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

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

Investments in employer groups and medical scheme administrators

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

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

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

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

Contributions received after due date

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

Claims paid in excess of 30 days

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

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

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.

Duplicate transactions for the same commission month resulted an overpayment to the broker that resulted in the maximum amount payable to a broker being exceeded. The quantification of the overpayment represents less than 0.05% of the total broker fees paid for the year.

In the instances where more than one broker was paid; the value is negligible. The administrator has developed exception reporting to identify and correct these transactions and has a well-established claw-back system to rectify commission overpayments.

Prescribed minimum benefits

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

Direct or indirect borrowing of money

In terms of Section 35 (6) (c) of the Act, a medical scheme shall not directly or indirectly borrow money without the prior approval of the CMS or may only do so subject to directives the CMS may issue. There were two instances during the year where the Scheme inadvertently went into an overdrawn position due to the timing of inflows from the Scheme's investments not matching the timing of outflows. Additional processes have been implemented to mitigate the risk of re-occurrence.

Non-compliance to the CMS directive issued in circular 26 of 2022 – brokers may not receive broker commission on own policies

During 2022 CMS published Circular 26 of 2022: Brokers and Brokerages who earn commission in respect of their own health or medical scheme policies. The CMS directive stated that all arrangements in terms of which any broker is receiving broker commission, whether directly or indirectly, related to their own health or medical scheme policy, must be terminated by 30 June 2022.

During the year, there were fourteen identified instances (2022: two) where brokers earned commission on their own health policies after 30 June 2022. These represent less than 0.001% of total broker fees paid for the year. The identified policies were correctly assigned to non-commissionable status and additional quality assurance measures implemented to prevent recurrences in the future.

Binding force of rules

Section 32 of the Act states that the rules of a medical scheme and any amendment thereof shall be binding on the medical scheme concerned, its members, officers and on any person who claims any benefit under the rules or whose claim is derived from a person so claiming.

Rule 7.1.2.2.2 states that the member must pay the requisite contribution in respect of such child as from the first day of the month following the birth or adoption.

The addition of the newborn rule was incorrectly applied on the policy administration system resulting in an additional month of free cover. The incorrect application of the Scheme Rule was based on the incorrect underwriting guideline stating that if the newborn is registered within 30 days, the member's contribution will be up to date.

The system rule was updated to align with the Scheme billing rule.

A monitoring and oversight exception report was created (which will validate the date of birth against the cover start date and billing date) and will run for 3 months post the implementation of the system enhancement.

The value of the uncorrected contributions is negligible.

Discovery Health Medical Scheme

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