ANGLO MEDICAL SCHEME

ANNUAL REPORT

FOR THE YEAR ENDED

31 DECEMBER 2018

The reports and statements set out below comprise the financial statements:

BOARD OF TRUSTEES	Elliott CC (Chairman) McCallum DR (Vice-Chairman) Abramowitz DE du Bois MA (resigned 31 December 2018) Farrell MR Hosking S Howell GAE Laubscher PA Mckie Thomson CC Preston GJ van der Bijl BD Coetzer JP
PRINCIPAL OFFICER	Robertson FK
REGISTERED OFFICE	45 Main Street Johannesburg 2001
POSTAL ADDRESS	PO Box 62524 Marshalltown 2107
AUDITOR Registered address of auditor	PricewaterhouseCoopers Inc 4 Lisbon Lane Waterfall City Jukskei View 2090
ADMINISTRATOR Registered address of administrator	Discovery Health (Pty) Ltd 1 Discovery Place Sandton 2146

REPORT OF THE BOARD OF TRUSTEES
for the year ended 31 December 2018

The Board of Trustees hereby presents its report for the year ended 31 December 2018.

1. DESCRIPTION OF THE MEDICAL SCHEME

1.1. Terms of registration

The Anglo Medical Scheme (the Scheme)(AMS) is a not for profit restricted medical scheme registered in terms of the Medical Schemes Act 131 of 1998 (the Act), Registration number 1012. The Scheme was established by Anglo American South Africa and its purpose is to provide medical cover to the employees, retirees and continuation members of the participating employer groups and their affiliated companies. The principal participating employer groups are Anglo Operations (Pty) Limited, Mondi Limited, Mpact Limited, and E Oppenheimer and Son (Pty) Limited.

At 31 December 2018 the Scheme provided benefits to 8 880 members and 9 460 dependants. 51.04% of the members and dependants are female. Members are located primarily in Gauteng (40%), KwaZulu-Natal (36%) and the Western Cape (11%). The balance of membership is spread across South Africa.

1.2. Benefit options with Anglo Medical Scheme

Anglo Medical Scheme provides its members with a choice of three Plans; at 31 December 2018, Managed Care Plan serving 7 825 beneficiaries, average age 56.7 years, Standard Care Plan, 8 986 beneficiaries, average age 34.1 years and Value Care Plan 1 529 beneficiaries, average age 25.3 years old.

- **The Managed Care Plan (MCP)**

  This plan offers unlimited cover for hospitalisation and an additional top-up benefit which pays up to 230% of the Scheme Reimbursement Rate for specialist services rendered in hospital. With the exception of Radiology and Pathology, which are unlimited and paid by the Scheme, but up to 100% of the Scheme Reimbursement Rate, most out-of-hospital benefits are discretionary and are provided through the members' Medical Savings Accounts (MSA).

- **The Standard Care Plan (SCP)**

  This is a traditional plan with defined benefits and annual limits, reimbursed at 100% of the Scheme Reimbursement Rate. Hospital benefits are unlimited. Out-of-hospital benefits are limited, with Radiology and Pathology as stand alone benefits and consultations, medicines, auxiliary services being limited under a single benefit.

- **The Value Care Plan (VCP)**

  This a primary health care plan providing services through a capitated arrangement with Prime Cure. Members may only obtain services from Prime Cure facilities or network providers. Management is achieved through the Prime Cure protocols.

1.3. Registered office

45 Main Street	PO Box 62524
Johannesburg	Marshalltown
2001	2107

1. DESCRIPTION OF THE MEDICAL SCHEME (continued)

1.4. Scheme administrator in office during the year under review

Discovery Health (Pty) Ltd
1 Discovery Place
Sandton
2146

1.5. Investment managers and custodian bank in office during the year under review

Allan Gray South Africa (Pty) Ltd
1 Silo Square, V&A Waterfront
Cape Town
8001

Coronation Asset Management (Pty) Ltd
Mont Clare Place, 7th Floor, Cnr Campground and Main Roads
Claremont
7700

Investec Asset Management (Pty) Ltd
36 Hans Strydom Avenue, Foreshore
Cape Town
8001

Standard Bank of South Africa Limited
Investor Services, 2nd Floor, 25 Sauer Street
Johannesburg
2001

1.6. Investment advisor in office during the year under review

Willis Towers Watson
1st Floor, Illovo Edge, 1 Harries Road
Illovo
Johannesburg
2196

1.7. Actuarial advisors in office during the year under review

NMG Consultants and Actuaries (Pty) Ltd
NMG House, 411 Main Avenue
Randburg
2125

1. DESCRIPTION OF THE MEDICAL SCHEME (continued)

1.7. Actuarial advisors in office during the year under review (continued)

Discovery Health (Pty) Ltd
1 Discovery Place
Sandton
2146

1.8. External auditor for the year under review, as approved by the Annual General Meeting

PricewaterhouseCoopers Inc
4 Lisbon Lane
Waterfall City
Jukskei View
2090

2. SCOPE OF THE REPORT

2.1. Guidelines

The Anglo Medical Scheme adheres to the governance framework set out in the King Report.

The Scheme's financial policies and Annual Financial Statements comply with International Financial Reporting Standards (IFRS) as informed by the Medical Schemes Accounting Guide issued by the South African Institute of Chartered Accountants (SAICA) and the regulatory requirements as set out in the Act and its supporting Regulations.

2.2. Assurance

The Scheme's Actuaries comply with the best practice guideline issued in the Professional Guidance Note published by the Actuarial Society of South Africa.

The External Auditor expresses an audit opinion on whether the financial statements are prepared in all material respects in accordance with IFRS and the requirements of the Medical Schemes Act of South Africa. The External Auditor complies with International Standards on Auditing (ISA) in conducting the audit.

2.3. Independence

The External Auditor has adopted independence standards in compliance with the requirement of the International Federation of Accountants, Code of Ethics (IFAC).

3. CORPORATE RESPONSIBILITY AND SUSTAINABILITY

Anglo Medical Scheme offers comprehensive healthcare benefits and services to its members which are high-quality, market competitive, cost-effective and consumer focused. These are supported by sound financial and risk management, administrative efficiency and the active participation of the members and employers. This ensures the Scheme's active compliance with the spirit of the law, ethical standards and international norms.

The affairs of the Scheme are managed by the Board of Trustees in compliance with the Scheme Rules in a manner that is fair, transparent, non-discriminatory and upholds the rights, values and dignity of members and other stakeholders. The Board performs its duties in accordance with the Board Charter and the Code of Conduct against which the Trustees biennially evaluate their performance and the performance of the Board as a whole. The Board shall at all times avoid conflicts of interests and Trustees are required to declare any interest they may have in any particular matter serving before the Board.

The Board has delegated some of its responsibilities to the duly appointed and constituted committees (the Committees). It determines the Terms of Reference of the Committees, approves all policies proposed by the Committees and receives quarterly reports from the Committees. The Committees do not relieve the Trustees of any of their responsibilities, but assist them to fulfil those responsibilities.

The Audit Committee meets independently with the Internal and External Auditors at least annually. Based on the review of the internal controls and risk management, the assurance and results of the audit and the recommendation of the Audit Committee, the Board of Trustees is of the opinion that the accounting policies, the internal control systems and the financial reporting practices are adequate and effective and that the basis for the preparation of the financial statements is sound.

The Scheme has supported aspects of the participating employers' social responsibility initiatives by adopting a progressive stand in the fight against HIV/AIDS and diseases such as diabetes and cancer. The Scheme regularly communicates with the membership on health and benefit matters in the recognition that a healthy, educated workforce becomes a sustainable asset to a participating employer.

The commitment to the long-term sustainability of the Scheme and its members remains the guiding principle of the Scheme. This has been strongly supported by the employers participating in the Scheme. To this end, the liability of the ageing population of the Scheme has been pre-funded to ensure the Scheme's sustainability and the premiums and benefits remain market-related and competitive.

4. SCHEME STRATEGY

To achieve the vision of offering high-quality, cost effective and competitive benefits to meet the lifelong healthcare needs of the members, the Scheme has adopted several strategies, the first and foremost is to address the significantly higher than average age profile of the membership.

4.1. Long term funding

The Council for Medical Schemes' (CMS) definition of a pensioner is a beneficiary over the age of 65. The Scheme's significantly higher beneficiary pensioner ratio than the industry average (26.5% compared to 8.4% - CMS report October 2018) increases the expected overall cost of providing adequate healthcare benefits at market related rates to our members.

The Scheme previously entered into an arrangement with the participating employer groups for a once off grant to be made at the employer's discretion, to meet the ongoing and the future cost of providing benefits for the large proportion of pensioner members. Annual actuarial valuations are performed in order to calculate the funding needed to continue to provide market related benefits to all members. In 2015 the Board of Trustees revised the Strategy ensuring long term funding (LTF) for a thirty year period, with the undertaking to review it thoroughly every five years thereafter. The objective is to provide market related benefits and contributions over the period. The policy regarding the LTF of the ageing membership has remained unchanged for the period under review.

In performing the actuarial valuation, the actuary makes long-term assumptions which may differ from those used during the Scheme's annual short-term budget process, as disclosed elsewhere in the notes to these annual financial statements.

The value of the Scheme's total assets as at 31 December 2018 was R2.754 billion. This compares against the gross long-term liability calculated by the Scheme's consultants and actuaries of R2.648 billion, the current long-term funding term is until 2045.

4.2. Investment strategy

The Scheme's investment strategy has been, and remains, aimed at maximising the annual return at an acceptable level of risk within the constraints of the Act. The Scheme believes that this risk should be managed, in part, by holding a conservative, yet diversified portfolio with a significant proportion of the assets providing returns that offer protection against inflation over the longer term.

The investment objective is to earn a return, net of fees, which exceeds the Consumer Price Index by at least 3.5% p.a. over a rolling five year period.

Period	Portfolio Performance	Consumer Price Index	CPI plus 3,5% p.a.
1 January - 31 December 2018 (p.a.)	-0.4%	4.5%	8.0%
5 Years (p.a.)	5.4%	5.3%	8.8%
18 Years (p.a.) (since inception)	11.1%	5.6%	9.1%

4. SCHEME STRATEGY (continued)

4.2. Investment strategy (continued)

The poor performance of the assets and the ongoing market volatility have received considerable attention, an alternative strategy to explore the possibility of reducing risk through asset diversification in the expectation of improved returns. The Trustees remain confident that the overall long term strategy will provide for the healthcare needs of the Scheme members into the foreseeable future.

4.3. Rate of contribution increase strategy

Due to the average age of the Scheme membership being significantly higher than the average age of the industry, healthcare costs are also significantly higher. Likewise, contributions and annual increases would need to be higher than the industry average to fund the payment of claims. To prevent the member carrying the burden of these increased costs, an amount is budgeted annually, which is funded from reserves, to provide for the shortfall between the budgeted risk contribution income and claims incurred. In 2018 this amounted to R130 million (2017: R80 million), a significant increase on the previous period as a result of the higher than expected healthcare costs. The projected shortfall is expected to increase annually for several years which will slowly erode the high level of reserving before starting to reduce and return the Scheme to a market related reserving level (around 25%) and a profitable position.

5. KEY PERFORMANCE MEASURES

5.1. To ensure the Scheme has sufficient reserves to cover the liability of the cost of providing for the healthcare needs of members over their lifetime, the actuaries annually determine the Scheme's liability which is compared against the level of reserving. The total LTF liability was updated during the course of 2018. This valuation serves as a risk management tool which enables the Scheme to make informed decisions regarding future benefit design, budgeting, reserving and long-term funding.

The table below shows the funding ratio as at 31 December 2017 and the projected figure as at 31 December 2018.

	2018 R'000	2017 R'000
Total long-term liabilities	2,648,228	2,570,152
Total value of assets	2,754,400	3,055,900
Current long-term funding ratio	104.0%	118.9%

The funding ratio declined significantly due to the lower than expected returns on the Scheme's assets and the higher than expected healthcare costs.

5. KEY PERFORMANCE MEASURES (continued)

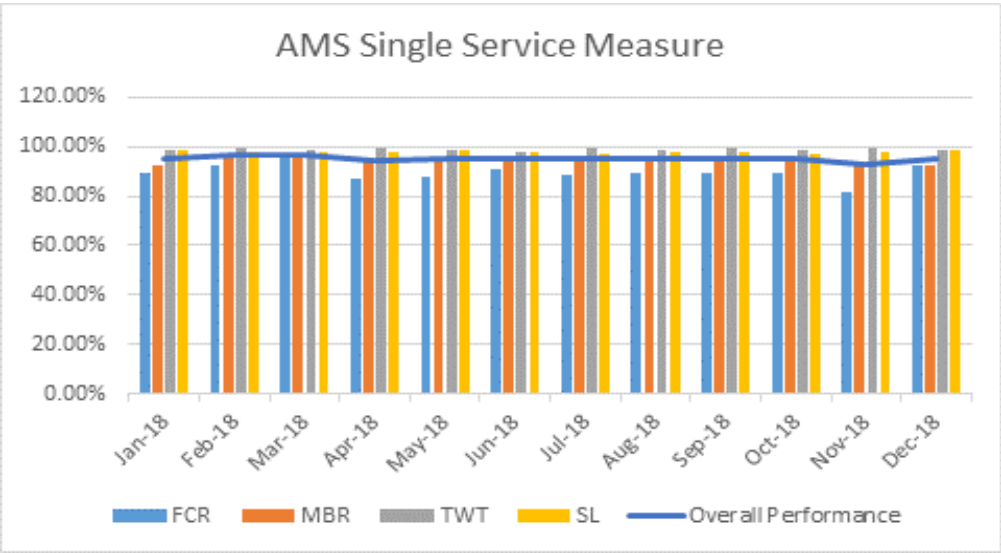
5.2. Unlike most open schemes who measure their size, market share, annual growth, solvency levels etcetera, the Scheme closely monitors its value proposition to members and employers. The performance of the Scheme is measured by the contribution increase that is effected annually coupled with benefit changes. The 2014, 2015 and 2016 benefit improvements, together with the 2015 and earlier years' low contribution increases, established the value offering of richer benefit than a member could buy in the open market for the same contribution. The aim of the Scheme is to continue to maintain contribution increases closer to the industry average and the generally accepted medical inflation rate of CPI plus 3%, as seen in the table below.

Year	2019	2018	2017	2016	2015
Average annual contribution increase per member	9.5%	8.9%	11.4%	8.5%	6.5%
CPI	5.2%	4.7%	5.3%	6.4%	4.6%
*Industry gross average increase per beneficiary **	*9.3%*	*8.2%*	*11.3%*	*9.9%*	*9.4%*

* *The industry figure quoted serves as a guide only. It reflects the industry average percentage increase in the gross contribution income per beneficiary as reported by the Council for Medical Schemes.*

5.3. The Scheme aims to provide members with better value for money than they would be able to purchase in the open market. The three Plans are independently evaluated against eight to ten similar competitor products annually to ensure this aim is met. The benefits provided in 2018 scored higher than average across all three Plans, and were all offered at lower than average contribution rates, indicating better value for money than could be purchased in the market.

5.4. 2018 saw the Scheme's administrator, Discovery Health, deliver above average service on almost all the contracted service level metrics, thus meeting the service excellence promise to members. The graph below depicts the various single service measures applicable.



FCR: First Call Resolution measures percentage of calls resolved on first contact

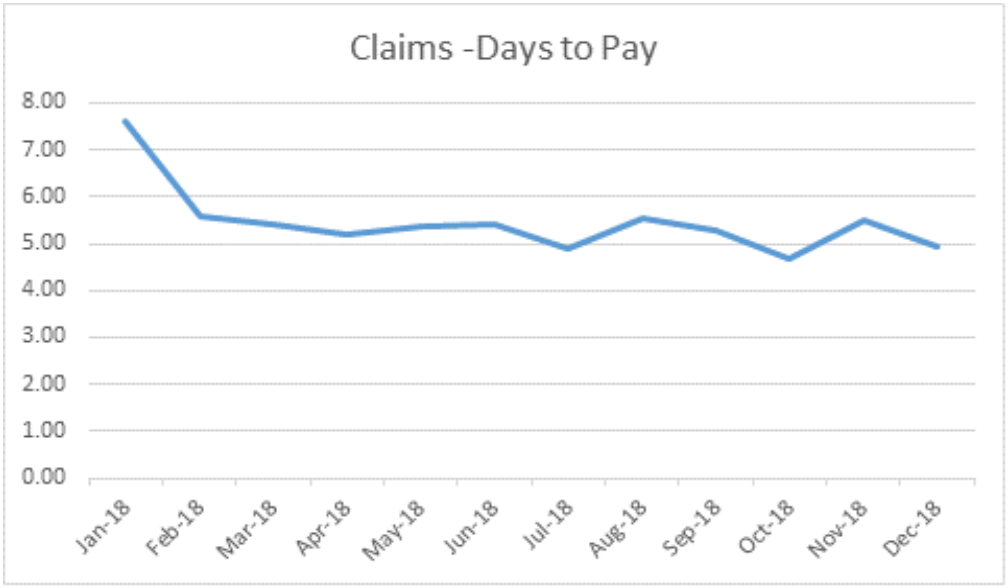
MBR: Member Based Research measures member happiness

TWT: Today's work today

SL: Service Level

5. KEY PERFORMANCE MEASURES (continued)

The graph below measures the number of days between a claim being received and paid.



5.5. The Council for Medical Schemes requires that non-healthcare costs are kept below 10% of gross contribution income. The Scheme aims to maintain this percentage in line or below the Council's requirement. The 2018 non-healthcare cost compared well against previous years.

Year	2018	2017	2016	2015
Non-healthcare costs as a percentage of gross contribution income	6.2%	5.9%	6.2%	6.4%
Industry average	- *	*6.0%*	*6.3%*	*6.0%*

* *Industry average percentage for restricted membership medical schemes as reported by the Council for Medical Schemes. The 2018 information is made available later in 2019.*

6. REVIEW OF THE ACCOUNTING PERIOD'S ACTIVITIES

6.1. Operational results

The Scheme budgets a small surplus each year after taking into consideration the interest and dividend income. 2018 proved to be an exceptionally tough year for both the Scheme and the industry. The Scheme's net healthcare result was in line with expectations. The investment returns were however under considerable pressure during this period.

	2018 R'000	2017 R'000
Net healthcare result	(139,008)	(108,374)
Managed Care Plan	(115,441)	(94,719)
Standard Care Plan	(21,820)	(12,960)
Value Care Plan	(1,747)	(695)
Add: Net investment movements and other (expenditure)/income	(23,762)	208,009
Net (deficit)/surplus for the year	(162,770)	99,635

The adult and child contributions are rebalanced annually by Plan, adjusting for changes in family size and ageing trends. Cognisance is taken of the employee salary increases and the claims experience of each Plan when determining contribution increases ensuring affordability. For the period under review the increases and contributions were as follows:

	2018 R		2017 R	
Average contribution increase 8.9%	**Adult**	**Child**	**Adult**	**Child**
Managed Care Plan	4,125	955	3,800	880
Standard Care Plan	2,255	680	2,060	620
Value Care Plan	820	200	750	185

6.2. Outstanding risk claims

Movements in the outstanding risk claims provision are set out in Note 5 to the financial statements. The basis of calculation is consistent with the prior year.

6. REVIEW OF THE ACCOUNTING PERIOD'S ACTIVITIES (continued)

6.3. Accumulated funds

Movements in the accumulated funds are set out in the Statement of Changes in Accumulated Funds as reflected on page 32 of this document.

	2018 R'000	2017 R'000
Total members' funds per Statement of Financial Position	2,777,993	2,940,763
Less: cumulative unrealised net gain on measurement of investments to fair value	(275,309)	(479,662)
Accumulated funds per Regulation 29 of the Act	2,502,684	2,461,101
Gross contribution income (Note 8)	529,093	505,213
Accumulated funds ratio per Regulation 29 (including unrealised gains)	525.0%	582.1%
Accumulated funds ratio per Regulation 29 (excluding unrealised gains)	473.0%	487.1%
Minimum ratio required by Regulation 29 of the Act	25.0%	25.0%

Refer to Note 4.1 of this report for the reasons for this level of funding.

The average accumulated funds per member as at 31 December 2018 was R312 837 (2017: R325 341).

6.4. Medical Savings Accounts

Refer to Note 1.6 and Note 6 of the annual financial statements.

The liability to members in respect of the savings accounts is reflected as a current liability in the annual financial statements, repayable in terms of Regulation 10 of the Act.

6.5. OPERATIONAL STATISTICS

The detailed statistics per plan are reflected in the table below:

	Managed Care Plan			Standard Care Plan			Value Care Plan			Total		
	2018	2017	%	2018	2017	%	2018	2017	%	2018	2017	%
Number of members at end of accounting period	4,345	4,595	-5%	3,834	3,818	0%	701	615	14%	8,880	9,028	-2%
Average (avg) number of members for the period	4,441	4,660	-5%	3,830	3,848	0%	656	581	13%	8,927	9,089	-2%
Beneficiaries at end of accounting period	7,825	8,448	-7%	8,986	9,036	-1%	1,529	1,366	12%	18,340	18,850	-3%
Beneficiaries per member at end of accounting period	1.80	1.84	-2%	2.34	2.37	-1%	2.18	2.22	-2%	2.07	2.09	-1%
Avg age of beneficiaries	56.70	55.39	2%	34.11	33.89	1%	25.25	25.3	0%	43.01	42.9	0%
Pensioner ratio (beneficiary > 65 years)	48.84%	46.34%	5%	11.41%	11.18%	2%	1.24%	0.88%	41%	26.53%	26.19%	1%
Avg gross contribution per member per month	6,377	5,963	7%	3,903	3,546	10%	1,250	1,150	9%	4,939	4,632	7%
Avg gross contribution per beneficiary per month*	3,529	3,075	15%	1,662	1,592	4%	566	520	9%	2,392	2,228	7%
Avg gross claim per member per month	7,916	7,101	11%	4,057	3,541	15%	1,349	1,141	18%	5,778	5,213	11%
Avg gross claim per beneficiary per month*	4,381	3,662	20%	1,728	1,589	9%	610	516	18%	2,799	2,508	12%
Avg administration cost per member per month	308	285	8%	309	283	9%	118	108	10%	294	273	8%
Avg administration cost per beneficiary per month*	171	147	17%	131	127	4%	54	49	10%	143	131	9%
Risk claims as a % of risk contributions	138.5%	131.4%	5%	103.9%	99.9%	4%	107.9%	99.2%	9%	123.9%	118.6%	4%
Administration cost as a % of gross contributions	4.8%	4.8%	1%	7.9%	8.0%	-1%	9.5%	9.4%	1%	5.1%	5.2%	-3%

* the significant change in beneficiaries, especially the withdrawal of child dependants have a big impact on the average figures per month.

7. RISK

The Board of Trustees is responsible for the total risk management of the Scheme and has determined the risk strategy and policies based on the Scheme's appetite or tolerance for risk in line with the governance framework as set out in the King Report.

The Scheme has implemented a robust risk management framework, which ensures an effective ongoing process of evaluation of both the potential and current risks on a long-term and a daily basis. Assessments are completed enabling the Scheme and the management of the administrator to proactively identify, assess, monitor and manage the risks to which the Scheme is exposed.

The Internal Control risk assessment process provides a structured methodology to identify the key risks within each area of business and assess the controls upon which management relies to mitigate these risks.

The Board of Trustees identified the primary risks facing the Scheme to be as follows:

7.1. Strategic risk

The potential loss of value to the members and employer groups due to the Scheme's inability to provide competitive, cost-effective, high-quality products and services that are market related to meet employee and member needs.

Factors driving this risk relate to the Scheme's inability to remain competitive due to financial pressures such as the investments not delivering the required returns and escalation of healthcare costs. Much of this risk management and mitigation is discussed under Strategy, point 4 and under Committees of the Board of Trustees, point 11.

The risk of a long term funding strategy is that legislative changes might impact the Scheme's ability to provide for the lifelong healthcare needs of the members. The proposed National Health Insurance policy and the amendments to the Medical Schemes Act may have a profound impact on the way the Scheme operates.

7.2. Operational risks

The risk of loss arising from failed or inadequate internal processes, people, systems and/or external events. This category includes legal risk, project risk, business continuity risk, data risk, information technology risk, and human capital risk. The day-to-day management of the Scheme in accordance with all legislative requirements and best practice guidelines is monitored and measured on an ongoing basis and is discussed under point 8.

7. RISK (continued)

7.3. Investment risk

The Scheme has identified investment risk as the risk of a decline in the net realisable value of investment assets as a result of adverse movements in market prices or factors specific to an investment itself which may impact on the Scheme's long term objectives. These may arise due to movements in interest rates, exchange rates, or equity and commodity prices and may be a result of macro global trends or internal domestic fluctuations.

7.4. Compliance risk

As defined in the Act, the business of a scheme is to undertake liability in return for a premium or contribution and to grant assistance in defraying expenditure incurred in obtaining any relevant health service. Compliance risk is the risk of statutory or regulatory sanction or material financial losses as a result of a failure to comply with applicable laws, regulations or supervisory requirements.

8. RISK MANAGEMENT AND MITIGATION

Refer to Notes 24 and 25 of the annual financial statements.

The Scheme maintains a sound system of risk management and internal control providing reasonable assurance in the achievement of the organisational objectives with respect to:

- Effectiveness and efficiency of operations;
- Safeguarding of the Scheme's assets (including information);
- Compliance with applicable laws, regulations and supervisory requirements;
- Supporting business sustainability under normal and adverse operating conditions;
- Reliability of reporting; and
- Behaving responsibly towards all stakeholders.

The risk assessment process:

- Focuses on the underlying causes of risks and not just the financial impacts;
- Facilitates the assessment of existing controls;
- Identifies priority areas so that effective testing of controls can take place;
- Assists management to determine the actions required to address the key risks identified;
- Assists in forecasting the Scheme's potential risk exposure in the future; and
- Allocates actions to staff that are able to effectively oversee the required activities.

The Board ensures that a systematic and documented assessment of the processes and outcomes surrounding key risks is undertaken annually and at appropriately considered intervals for the purpose of making its public statement on risk management.

Risk management and internal control are practiced throughout the Scheme, and are embedded in day-to-day activities.

8. RISK MANAGEMENT AND MITIGATION (continued)

Several methods are employed to assess and monitor risk exposure for individual types of risks insured and overall risks. These methods include the use of internal risk measurement models, sensitivity and scenario analyses all of which are subject to strict audit criteria.

In addition to the Scheme's other compliance and enforcement activities, the Board has implemented a confidential reporting process ("whistleblowing").

The Board has delegated the risk management process to the Management Committee and the oversight of the risk management to the Audit Committee and Investment Committee. These Committees are answerable to the Board and do not relieve the Trustees of any of their responsibilities, but assists them to fulfil those responsibilities.

8.1. Risk transfer arrangements

Refer to Note 10 of the financial statements.

In line with the vision to soundly manage the claims risk, the Scheme has entered into risk-sharing agreements with third party service providers to ensure cost effective services. This provides the Scheme with the ability to mitigate an identified risk by agreement with a third party service provider. The principle is based on the sharing of predefined potential claims loss in return for exclusivity of delivering the service.

The following risk transfer capitation arrangements were in place for the year:

Organisation	Services capitated	Scheme benefit option
Prime Cure (Pty) Ltd	Provides primary healthcare services at Healthcare centres and contracted network service providers, including a limited hospital benefit.	Value Care Plan
Netcare 911 (Pty) Ltd	Provides emergency transport services and other ambulance services.	Managed Care Plan Standard Care Plan
Centre for Diabetes and Endocrinology (CDE)	Provides diabetes related medical services including related hospitalisation expenses.	Managed Care Plan Standard Care Plan
Dental Risk Company	Provides dental related medical services.	Standard Care Plan

9. GOVERNANCE

The Scheme vision is supported by the Board Charter wherein the Board commits to act in good faith with utmost due care, diligence and skill. Each Trustee is required to aspire to the core ethical principles of fairness, transparency, honesty, non-discrimination, accountability and respect for human dignity and rights.

The Board delegates the duty of delivery and operation of the functions to the duly constituted Committees while remaining fully responsible for the performance of the Scheme and accountable to the membership. The principles of good governance and sound business ethics are firmly adhered to through the adoption of the King guidelines, a culture of rigorous risk and financial management and a stringent auditing process.

The Scheme complies with International Financial Reporting Standards and all the relevant legislative requirements.

10. MANAGEMENT

10.1. Board of Trustees in office during 2018:

Elliott CC (Chairman)	Employer Appointed
McCallum DR (Vice-Chairman)	Employer Appointed
Abramowitz DE	Member Elected
du Bois MA (resigned 31 December 2018)	Employer Appointed
Farrell MR	Member Elected
Hosking S	Member Elected
Howell GAE	Employer Appointed
Laubscher PA	Member Elected
Mckie Thomson CC	Member Elected
Preston GJ	Member Elected
van der Bijl BD	Employer Appointed
Coetzer JP	Employer Appointed

10. MANAGEMENT (continues)

10.2. Alternate Trustees in office during 2018:

Liston J	Member Elected
Mason-Gordon N	Employer appointed
Mbekeni C	Employer Appointed
Sanford L	Member Elected

10.3. Management Committee in office during 2018:

McCallum DR (Chairman); du Bois MA; Farrell MF; Liston J; Mbekeni C; McKie Thomson CC; van der Bijl B; Coetzer JP

10.4. Audit Committee in office during the year under review:

Brown M (Chairman, Independent, Retired 31 December 2018); Howell GAE; McCallum DR; Prinsloo J (Independent); van Zyl C (Independent).

10.5. Ex Gratia Committee in office during the year under review:

Laubscher PA (Chairman); Farrell MR; Hosking S; Mbekeni C; Mckie Thomson CC; Pienaar J (Independent); Preston G.

10.6. Investment Committee in office during the year under review:

Mason-Gordon N (Chairman); Abramowitz DE; Clark B (Independent); du Bois MA; Elliott CC; Liston J; Thompson HM (Employer appointed representative).

10. MANAGEMENT (continues)

10.7. Disputes Committee in office during the year under review:

Badenhorst C (member elected); Barnard G (member elected); Hunt RW (member elected)

10.8. Principal Officer and staff in office during the year under review:

Robertson FK	Principal Officer	Scheme employed
Gröpp-Els E	Scheme and Clinical Manager	Scheme employed
Friese J	Communications Manager	Scheme employed
Landsberg Y	Scheme Secretary	Scheme employed

11. COMMITTEES OF THE BOARD OF TRUSTEES

11.1. Audit Committee

The Audit Committee (the Committee) is established in accordance with the provisions of the Act and is mandated by the Board of Trustees by written terms of reference as to its membership, authority and duties. The Committee consists of five members, two of whom are members of the Board of Trustees.

The majority of the Committee, including the chairperson, is independent and does not serve on the Board of the Scheme or act on behalf of the administrator.

In accordance with the provisions of the Act, the primary responsibility of the Committee is to assist the Board of Trustees in carrying out its duties relating to the Scheme's accounting policies, internal control systems and financial reporting practices.

The External Auditor formally reports to the Committee on critical findings arising from the statutory audit. The Internal Auditor of the administrator attends meetings and reports findings to the Committee. The Scheme's External Auditor appointment with KPMG ended and PWC was appointed from May 2018.

The Committee met regularly during the year and both the Internal and External Auditor are invited to attend all Committee meetings and they also had unrestricted access to the Chairman of the Committee at all times.

11. COMMITTEES OF THE BOARD OF TRUSTEES (continued)

11.1. Audit Committee (continued)

The Committee is pleased to report that:

- It has carried out its duties in terms of the Act and the Board of Trustees written Committee Charter;
- The External Auditor has confirmed their independence;
- The assurances provided by Administrator management, the External Auditor and the Internal Auditor of the administrator have satisfied the Committee that the controls are adequate and effective;
- It has ensured the co-ordination of the approaches of the Internal and External Auditor and has had oversight of the financial reporting process;
- It has evaluated the effectiveness of the risk management and governance;
- It has received the assurance from the External and Internal Auditors that nothing had come to their attention that compromised the effectiveness of the controls as they apply to the annual financial statements; and
- It has reviewed the approach taken to the application of King and has found no material weakness.

The Committee has reviewed the Scheme's annual financial statements, reviewed the accounting policies, obtained assurances from the External Auditor and recommended the adoption of the annual financial statements by the Board of Trustees for presentation to members.

The audit committee Chairman, Malcolm Brown, retired at 31 December 2018. Gert Kapp was appointed to the audit committee in 2019.

11.2. Investment Committee

The Investment Committee (the Committee) is a duly constituted committee of the Board of Trustees and has the responsibility to assist the Board of Trustees in carrying out their duties relating to the Scheme's investment policy and strategy. It is mandated by means of written terms of reference as to its membership, authority and duties.

The Committee consists of six members, 50% of whom are Trustees. The Scheme appointed Willis Towers Watson as independent investment consultants to assist the Committee. The current investment managers of the Scheme are Investec Asset Management (Pty) Ltd, Coronation Asset Management (Pty) Ltd and Allan Gray South Africa (Pty) Ltd.

The Committee met regularly during the year and the investment consultant attended all Committee meetings with the investment managers each attending at least one meeting per annum.

The Committee reviews the strategy regularly in accordance with the mandate set by the Board of Trustees and advises on the structure of the portfolio as well as risk mitigation to ensure sustainability of the Scheme's long-term liability funding requirements.

11. COMMITTEES OF THE BOARD OF TRUSTEES (continued)

11.3. Management Committee

The Management Committee (the Committee) is mandated by the Board of Trustees to oversee and review the management of the day-to-day administrative and financial risk management (with the exception of investment risk management), and financial functions of the Scheme by means of written terms of reference as to its membership, authority and duties.

This Committee is chaired by the Vice Chairman of the Scheme and comprises six Trustees and two Alternate Trustees who meet a minimum of four times a year to review key indicators and make formal proposals and recommendations to the Board of Trustees. The Chairman of the Scheme is invited to attend the meetings ex-officio.

Administrative risk management measures are employed to ensure good governance of the access to benefits; these include, but are not limited to pre-authorisation, case management, service provider profiling, billing audits and interventions in respect of fraud.

11.4. Ex Gratia Committee

The Ex Gratia Committee (the Committee) is mandated by the Board of Trustees to assist members by awarding ex gratia payments where services were either denied or rejected due to limited or uncovered benefits as deemed appropriate according to the individual merits of each case. These awards are granted against an approved budget on the basis of the exceptional clinical circumstances of the case and/or financial hardship of the individual member.

The Committee is governed by means of written terms of reference as to its membership, authority and duties. This Committee meets every two months.

11. COMMITTEES OF THE BOARD OF TRUSTEES (continued)

11.5. Disputes Committee

The Disputes Committee (the Committee) is an independent Committee and comprises three members who are appointed by members at the Annual General Meeting. The appointed members may not be administrators, trustees or officers of the Scheme.

The main function of the Committee is to deal with member disputes where the member is dissatisfied with any decision taken by the Board or a Committee or an administrator of the Scheme. No disputes were raised in 2018, therefore no meetings were held during the year.

11.6. Regional Committees

Regions are established based on the number of members represented in a specific region. Business units are defined and designated by participating employers in each region.

There are currently three regions, namely; Central Region (Gauteng, Limpopo and Mpumalanga), Eastern Region (KwaZulu Natal) and the Southern Region (Western Cape, Eastern Cape and Northern Cape).

Each Regional Committee comprises a chairperson, Trustee, employer and member representative and meets biannually. The main function of these Committees is to provide feedback from the Board of Trustees meetings to the participating employers of the Scheme; who in turn provide feedback to all their respective employees and retired members.

12. TRUSTEE AND NON-TRUSTEE MEMBERS ATTENDANCE AT COMMITTEE MEETINGS

	Board of Trustees		Audit Committee		Investment Committee		Manage-ment Committee		Ex-gratia Appeals Committee	
Trustees	A	B	A	B	A	B	A	B	A	B
Elliott CC	6	4								
McCallum DR	6	6	5	4			6	6		
Abramowitz DE	6	4			4	4				
Coetzer JP	6	5					6	5		
du Bois MA #	6	5					6	5		
Farrell MR	6	5					6	6	6	6
Hosking S	6	6							6	6
Howell GAE	6	5	5	5						
Laubscher PA	6	5							6	6
Mckie Thomson CC	6	6					6	6	6	6
Preston GJ	6	6							6	5
van der Bijl BD	6	4					6	4		
Alternate Trustees and Consultants										
Brown M #			5	5						
Clark B					4	2				
Liston J	0	4*			4	4	6	5		
Mason-Gordon NJ	1	3* 1**			4	3				
Mbekeni C	0	2*					6	3	6	4
Pienaar J									6	6
Prinsloo J			5	5						
Sanford L	0	3*								
Thompson HM					4	3				
Van Zyl C			5	4						

A = maximum possible attendance

B = actual attendance

* = voluntary attendance

** = attendance in Trustee's stead

= retired 31 December 2018

13. ACTUARIAL SERVICES

The administrator's actuaries are responsible to identify and monitor health related risks, establish claiming patterns and recommend contribution and benefit levels. They also participate in the monthly and annual calculations of the outstanding claims incurred, but not yet reported and paid by the Scheme (IBNR).

The Scheme's independent actuaries, NMG Consultants and Actuaries (Pty) Ltd, are contracted to calculate and review the long-term funding valuation annually. They also do an independent review of the IBNR.

14. GUARANTEES RECEIVED BY THE SCHEME FROM A THIRD PARTY

None.

15. INVESTMENTS IN AND LOANS TO EMPLOYERS OF MEMBERS OF THE SCHEME AND TO OTHER RELATED PARTIES

Refer to related parties disclosure in Note 21 of the financial statements.

16. RELATED PARTY TRANSACTIONS

Refer to related parties disclosure in Note 21 of the financial statements. Trustee remuneration is disclosed in Note 22 of the annual financial statements.

17. SUBSEQUENT EVENTS

The Trustees confirm that no events have occurred subsequent to the end of the accounting period to the date of this report that affect the annual financial statements that should be brought to the attention of the members of the Scheme.

18. NON-COMPLIANCE WITH THE MEDICAL SCHEMES ACT

The Trustees are of the opinion that there are no material deviations from the Act as a result of the Scheme having obtained the necessary exemptions from the Council for Medical Schemes to achieve compliance.

18.1. Outstanding contributions

Nature and impact

In terms of Section 26(7) of the Act, contributions should be received in accordance with the rules of the Scheme. Per the Scheme rules, contributions are required to be received within three days after their due date. Instances were noted where contributions were received late.

Causes for failure

Balances after three days are due to reconciling discrepancies between the participating employers and the Scheme. The risk of default on payments due to the Scheme is small because of the restricted nature of the Scheme and employer base. The Trustees consider this to be immaterial.

Corrective action

Suspension policies are in place and applied where contributions are outstanding for individual paying members outside the participating employers' obligation.

18.2. Investment in participating employer

Nature and impact

Section 35(8)(a) of the Act states that a medical scheme shall not invest any of its assets in a participating employer. During the year the Scheme had exposure to investments in participating employer groups.

Causes for failure

The Scheme invests in pooled investment vehicles which allow investment managers discretion to invest in a combination of shares and bonds that will best achieve their stipulated benchmark. Given this approach, the Scheme was exposed to participating employer shares.

Corrective action

The Scheme applies annually to the Council for Medical Schemes and received an exemption from this section of the Act.

18. NON-COMPLIANCE WITH THE MEDICAL SCHEMES ACT (continued)

18.3. Investment in administrator

Nature and impact

Section 35(8)(c) of the Act states that a medical scheme shall not invest any of its assets in any administrator. During the year the Scheme had exposure to such investments.

Causes for failure

The Scheme invests in pooled investment vehicles which allow investment managers discretion to invest in a combination of shares and bonds that will best achieve their stipulated benchmark.

Corrective action

The Scheme applies annually to the Council for Medical Schemes and received an exemption from this section of the Act.

18.4. Investment limitations

Nature and impact

Regulation 30(3) states that a medical scheme shall not invest more than 40% of its assets in local equities. The Scheme exceeds this limit periodically.

Causes for failure

The Act makes provision for medical schemes to exceed the limit of 40% on local equities under certain circumstances. The Board of Trustees decided to exceed the limit after complying with all the required circumstances. The purpose is to maximise investment income on a long-term basis.

Corrective action

The Scheme submitted a certified statement prepared by its consultants to the Council for Medical Schemes to state that an alternative percentage of 75% should apply to the excess assets as permitted in Regulation 30(3).

18. NON-COMPLIANCE WITH THE MEDICAL SCHEMES ACT (continued)

18.5. Sustainability of benefit options

Nature and impact

In terms of section 33(2) of the Act, each benefit option shall be self-supporting in terms of membership and financial performance. At 31 December 2018, all three benefit options incurred deficits before investment income as set out in Note 23 to the financial statements.

Causes for failure

The Board of Trustees annually maintain market related benefit offerings and competitive contribution increases. Due to the Scheme demographics, this gives rise to the non-compliance.

Corrective action

Anglo American South Africa sold numerous subsidiaries over a period of time resulting in the loss of active employees and retention of pensioners. To compensate the Scheme for the resultant high pensioner ratio and expected deterioration of the claiming profile, the participating employers pre-funded the additional liability to the extent that the Scheme could maintain market related benefits and contribution increases into the future. The Scheme meets its responsibility to the members by subsidising the expected claims excess over contributions from the reserves. The Trustees will continue to review the investment returns to align with the strategy ensuring sustainability.

The Council for Medical Schemes is aware of the Scheme's strategy and approves the benefits and contributions annually without any requirement to take further corrective action.

18.6. Payment of claims within 30 days

Nature and impact

In terms of section 59(2) of the Act a member or provider claim should be settled within 30 days of submission. Instances were noted where settlements took more than 30 days.

Causes for failure

Delays can occur when accounts are referred for clinical audit or other investigations. These are however the exceptions, and claims are generally paid within the prescribed time.

Corrective action

The Scheme is aware of the requirements and complies as far as possible. It is however an inherent part of the industry that a limited number of problematic claims may exceed the payment requirement of 30 days.

STATEMENT OF CORPORATE GOVERNANCE BY THE BOARD OF TRUSTEES

Anglo Medical Scheme (the Scheme) is committed to the principles and practice of responsibility, accountability, fairness and transparency in its dealings with all stakeholders and applies good governance principles.

The Scheme is committed to ensuring compliance within recognised frameworks and conducting its affairs based on ethical values, by the adoption of risk assessment, evaluation and management processes and regular monitoring of third party administrators and providers in accordance with contractual service level agreements. This includes evaluating the performance of the Board and the Board committees against agreed terms of reference and performance targets, the establishment and management of internal controls by assessing the adequacy and effectiveness through the reports of the internal auditor and calling on expert and professional advice when required.

BOARD OF TRUSTEES

The Board of Trustees and its committees meet regularly and monitor the performance of the Administrator and other service providers. They address a range of key issues and ensure discussion on items of policy, strategy and performance are informed and constructive.

All Trustees have access to the advice and services of the Principal Officer and, where appropriate, the Board may seek independent professional advice at the cost of the Scheme.

INTERNAL CONTROL

The Administrators of the Scheme maintain internal controls and systems designed to provide reasonable assurance of the integrity and reliability of the financial statements and to safeguard, verify and maintain accountability for its assets. Such controls are based on established policies and procedures and are implemented by trained personnel with the appropriate segregation of duties.

No event or item has come to the attention of the Board of Trustees that indicates any material breakdown in the functioning of the key internal controls and systems during the year under review.

Mrs CC Elliott	Mr DR McCallum	Mrs FK Robertson
Chairman	Vice-Chairman	Principal Officer

10 April 2019

STATEMENT OF RESPONSIBILITY BY THE BOARD OF TRUSTEES

The Trustees are responsible for the preparation and fair presentation of the annual financial statements of the Anglo Medical Scheme (the Scheme), set out on pages 32 to 83, comprising the statement of financial position at 31 December 2018, the statements of comprehensive income, statement of changes in funds and reserves, statement of cash flows for the year then ended and the notes to the financial statements, which include a summary of significant accounting policies and other explanatory notes, in accordance with International Financial Reporting Standards (IFRS) and the requirements of the Medical Schemes Act of South Africa. In addition, the Trustees are responsible for preparing the report of the Board of Trustees.

The Trustees are also responsible for such internal control as the Trustees determine is necessary to enable the preparation of annual financial statements that are free from material misstatement, whether due to fraud or error, and for maintaining adequate accounting records and an effective system of risk management.

The Trustees have made an assessment of the Scheme's ability to continue as a going concern and have no reason to believe the business will not be a going concern in the year ahead.

The auditor is responsible for reporting on whether the financial statements are fairly presented in accordance with the applicable financial reporting framework.

Approval of the annual financial statements

The annual financial statements of Anglo Medical Scheme, as identified in the first paragraph, were approved by the Trustees on 10 April 2019 and are signed on their behalf by:

Mrs CC Elliott
Chairman

Mr DR McCallum
Vice-Chairman

Ms FK Robertson
Principal Officer

pwc

Independent Auditor's Report

To the Members of Anglo Medical Scheme

Report on the financial statements

Opinion

We have audited the financial statements of Anglo Medical Scheme (the "Scheme"), set out on pages 32 to 83, which comprise the statement of financial position as at 31 December 2018, and the statement of comprehensive income, the statement of changes in funds and reserves and the statement of cash flows for the year then ended, and notes to the financial statements, including a summary of significant accounting policies.

In our opinion, these financial statements present fairly, in all material respects, the financial position of the Scheme as at 31 December 2018, and its financial performance and cash flows for the year then ended in accordance with International Financial Reporting Standards and the requirements of the Medical Schemes Act of South Africa.

Basis for Opinion

We conducted our audit in accordance with International Standards on Auditing (ISAs). Our responsibilities under those standards are further described in the *Auditor's Responsibilities for the Audit of the Financial Statements* section of our report. We are independent of the Scheme in accordance with the Independent Regulatory Board for Auditors *Code of Professional Conduct for Registered Auditors (IRBA Code)* and other independence requirements applicable to performing audits of financial statements in South Africa. We have fulfilled our other ethical responsibilities in accordance with the IRBA Code and in accordance with other ethical requirements applicable to performing audits in South Africa. The IRBA Code is consistent with the International Ethics Standards Board for Accountants *Code of Ethics for Professional Accountants* (Parts A and B). We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Key Audit Matters
Key audit matters are those matters that, in our professional judgement, were of most significance in our audit of the financial statements of the current period. These matters were addressed in the context of our audit of the financial statements as a whole, and in forming our opinion thereon, and we do not provide a separate opinion on these matters.

Key audit matter	How our audit addressed the key audit matter
Outstanding risk claims provision The Outstanding risk claims provision of R17 million at year-end as described in Note 5 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 administrator's actuaries which is reviewed by management and the Audit Committee as part of the financial statements review process and	We obtained an understanding from the administrator's actuaries regarding the process to calculate the outstanding claims provision. The actuarial model applied by the Scheme is one that is generally applied within the medical scheme industry. We obtained the actual claims data from the member administration system covering the year ended 31 December 2018.

recommended to the Board of Trustees for approval. The administrator'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 the Basic Chain Ladder ("BCL") method. The claim service date, processing date and amount are used to derive claim development patterns. These historical patterns are then used to estimate the outstanding claims provision. We identified this to be a matter of most significance to the audit because of the uncertainty in the projected claims pattern. A change in the projected claims pattern can cause a material change to the amount of the provision.	For a sample of actual claims received by the Scheme in the 31 December 2018 financial year, we tested the accuracy of the service and process dates. No material inconsistencies were noted. We substantively tested a sample of claims against the relevant Scheme rules and assessed completeness of the claims data. The claims data that was included in the Scheme's actuarial model was agreed to the above actual claims data with no material inconsistencies noted. To assess the reasonableness of the administrator's actuaries' estimation process, we compared the actual claim results in the current year to the prior year provision. Based on our assessment, the estimation process was considered reasonable. We have evaluated management's experts by assessing their competence, capability, and objectivity and noted no aspects requiring further consideration. We also obtained the outstanding claims provision report from the administrator's actuaries and assessed whether the inputs, assumptions, methodology and findings per the report were consistent with our testing above. Based on the results of our assessment we accepted the inputs, assumptions, methodology and findings as reasonable. We obtained the actual claims run-off report up to 28 February 2019 from the Scheme's administrator. For a sample of claims from the report, we tested the occurrence and accuracy of the claims as well as the accuracy of the related service dates and we identified no material inconsistencies. We enquired from the Scheme's administrator whether there were delays in processing claims at year-end that could possibly impact the claims run-off pattern subsequent to year-end. The administrator confirmed that there were no such delays. We obtained the treatment pre-authorisations approved prior to year-end from the administrator and selected a sample to assess if any of the selected claims were excluded from

	the actual claims run-off report up to 28 February 2019. No material inconsistencies were noted.

Other Information

The Scheme's trustees are responsible for the other information. The other information comprises the information included in the Anglo Medical Scheme Annual Report for the year ended 31 December 2018. The other information does not include the financial statements and our auditor's report thereon.

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

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

Responsibilities of the Scheme's Trustees for the Financial Statements

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

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

Auditor's Responsibilities for the Audit of the Financial Statements

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

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

- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, design and perform audit procedures responsive to those risks, and obtain audit evidence that is sufficient and appropriate to provide a basis for our opinion. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control.
- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Scheme's internal control.

pwc

- 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:

1. Non-compliance with Section 33(2) – Sustainability of Benefit Plans; and
2. Non-compliance with Regulation 30(3) - Investments limits.

Refer to Note 27 of the financial statements.

Audit Tenure

As required by the Council for Medical Schemes' Circular 38 of 2018, Audit Tenure, we report that PricewaterhouseCoopers Inc. has been the auditor of Anglo Medical Scheme for one year.
The engagement partner, Julanie Basson, has been responsible for Anglo Medical Scheme's audit for one year.

PricewaterhouseCoopers Inc

PricewaterhouseCoopers Inc.
Director: Julanie Basson
Registered Auditor
Johannesburg
26 April 2019

STATEMENT OF FINANCIAL POSITION **ANGLO MEDICAL SCHEME**

as at 31 December 2018 (Registration no. 1012)

	Notes	2018 R'000	2017 R'000
ASSETS			
Investments held at fair value through profit or loss	2	2,213,116	2,210,663
Trade and other receivables	3	6,249	4,376
Cash and cash equivalents	4	787,416	926,691
Total assets		**3,006,781**	**3,141,730**
FUNDS AND LIABILITIES			
Accumulated funds		2,777,993	2,940,763
Liabilities		228,788	200,967
Outstanding risk claims provision	5	17,004	13,350
Medical Savings Account liability	6	194,491	173,891
Trade and other payables	7	17,293	13,726
Total funds and liabilities		**3,006,781**	**3,141,730**

STATEMENT OF COMPREHENSIVE INCOME
for the year ended 31 December 2018

ANGLO MEDICAL SCHEME
(Registration no. 1012)

	Notes	2018 R'000	2017 R'000
Risk contribution income	8	**444,375**	**421,911**
Relevant healthcare expenditure		**(550,553)**	**(500,229)**
Net claims incurred		(544,823)	(494,473)
Risk claims incurred	9	(546,995)	(498,244)
Third party claims recoveries		2,172	3,771
Net income on risk transfer arrangements	10	4,973	4,974
Risk transfer arrangement fees/premiums paid		(38,782)	(31,652)
Recoveries from risk transfer arrangements		43,755	36,626
Managed care: management services	11	(10,703)	(10,730)
Gross healthcare result		**(106,178)**	**(78,318)**
Administration expenses	12	(31,536)	(29,724)
Net impairment losses	13	(1,294)	(332)
Net healthcare results		**(139,008)**	**(108,374)**
Investment and other income		7,594	238,918
Investment income	14	6,689	237,949
Sundry income	15	905	969
Other expenditure		(31,356)	(30,909)
Expenses for asset management services rendered		(16,582)	(16,657)
Interest paid on Medical Savings Accounts		(14,774)	(14,252)
Net (deficit)/surplus for the year		**(162,770)**	**99,635**
Total comprehensive (expense)/income for the year		**(162,770)**	**99,635**

STATEMENT OF CHANGES IN FUNDS AND RESERVES
for the year ended 31 December 2018

ANGLO MEDICAL SCHEME
(Registration no. 1012)

	Accumulated funds R'000
Balance as at 1 January 2017	**2,841,128**
Total comprehensive surplus for the year	99,635
Balance as at 31 December 2017	**2,940,763**
Total comprehensive deficit for the year	(162,770)
Balance as at 31 December 2018	**2,777,993**

STATEMENT OF CASH FLOWS **ANGLO MEDICAL SCHEME**

for the year ended 31 December 2018 (Registration no. 1012)

	Notes	2018 R'000	2017 R'000
CASH FLOWS FROM OPERATING ACTIVITIES			
Cash flows from operations before working capital changes	16	(139,008)	(108,374)
Working capital changes			
• Increase in trade and other receivables		(1,804)	(258)
• Increase in Medical Savings Account liability		20,600	20,625
• Increase/(decrease) in outstanding claims provision		3,654	(2,716)
• Increase in trade and other payables		3,567	5,277
Interest paid on Medical Savings Accounts		(14,774)	(14,252)
Net cash outflows from operating activities		**(127,765)**	**(99,699)**
CASH FLOWS FROM INVESTING ACTIVITIES			
Purchase of investments		(894,441)	(518,219)
Proceeds on sale of investments		780,483	529,972
Interest received		66,021	68,514
Dividend received		52,105	47,393
Sundry income		905	969
Expenses for asset management services rendered		(16,582)	(16,657)
Net cash (outflows)/inflows from investing activities		**(11,509)**	**111,973**
NET (DECREASE)/INCREASE IN CASH AND CASH EQUIVALENTS		**(139,274)**	**12,274**
Cash and cash equivalents at the beginning of the year		926,690	914,416
CASH AND CASH EQUIVALENTS AT THE END OF THE YEAR		**787,416**	**926,690**

GENERAL INFORMATION

The Anglo 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 on the JSE Limited.

The Scheme is a restricted membership medical scheme registered in terms of the Medical Schemes Act No.131 of 1998, as amended, (the Act) and is domiciled in South Africa.

1. PRINCIPAL ACCOUNTING POLICIES

The principal accounting policies applied in the preparation of these financial statements are set out below. These policies have been consistently applied to all years presented, unless otherwise stated.

1.1 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 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 26.

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.

All monetary information and figures presented in these financial statements are stated in thousands of rand (R'000), unless otherwise indicated.

IMPLEMENTATION OF NEW STANDARDS

IFRS9: Financial instruments

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

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

1.1 BASIS OF PREPARATION (continued)

IMPLEMENTATION OF NEW STANDARDS (continued)

IFRS9: Financial instruments (continued)

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.

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

The Scheme does not apply hedge accounting and the hedge accounting changes introduced have no 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 deemed appropriate to be applied in determining impairment of Loans and Receivables. In determing impairment of Insurance Receivables, the incurred loss model adopted under IFRS 4: Insurance Contracts has been assessed and is reasonable and appropriate to determine impairment of Insurance Receivables and this model will continue to be applied and the expected credit loss model not adopted to determine impairment of Insurance Receivables.

Following the implementation of IFRS 9, the Scheme applies the IFRS 9 simplified approach to measure expected credit losses which uses a lifetime expected loss allowance for Loans and Receivables. For the year under review the Scheme does not expect an credit losses on these balances and no provision has been made.

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

IFRS 15: Revenue from contracts from customers

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

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

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

1.1 BASIS OF PREPARATION (continued)

IMPLEMENTATION OF NEW STANDARDS (continued)

New standards, amendments and interpretations not yet effective in 2018 relevant to the Scheme:

Title	Effective date - financial year commencing on or after
IAS 1: Presentation of Financial Statements - Disclosure Initiative: The amendments clarify and align the definition of 'material' and provide guidance to help improve consistency in the application of that concept whenever it is used in IFRS Standards.	1 Jan 2020
IAS 8: Accounting Policies, Changes in Accounting Estimates and Errors - Disclosure Initiative: The amendments clarify and align the definition of 'material' and provide guidance to help improve consistency in the application of that concept whenever it is used in IFRS Standards.	1 Jan 2020
IFRS 17 - Insurance contracts - The IASB issued IFRS 17, 'Insurance contracts', and thereby started a new epoch of accounting for insurers, which includes medical schemes. Whereas the current standard, IFRS 4, allows insurers to use their local GAAP, IFRS 17 defines clear and consistent rules that will significantly increase the comparability of financial statements. For insurers, the transition to IFRS 17 will have an impact on financial statements and on key performance indicators.	1 Jan 2022

1.2 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.

1.3 CLASSIFICATION, RECOGNITION, PRESENTATION AND DERECOGNITION OF FINANCIAL INSTRUMENTS

The Scheme recognises a financial instrument when, and only when, it becomes a party to the contractual provisions of the instrument. The Scheme classifies its financial instruments into the following categories: financial assets or financial liabilities at fair value through profit or loss, and loans and receivables. Loans and receivables are receivables other than those arising from insurance contracts and include sundry accounts receivable and interest receivable. Loans and receivables are disclosed under Trade and other receivables.

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

Offsetting financial instruments

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

Derecognition of financial assets and liabilities

The Scheme derecognises a financial asset when the contractual rights to the asset expire, where there is a transfer of the contractual rights that comprise the asset, or the Scheme retains the contractual rights of the asset but assumes a corresponding liability to transfer these contractual rights to another party and consequently transfers substantially all the risks and benefits associated with the asset.

If a transfer does not result in derecognition because the Scheme has retained substantially all the risks and rewards of ownership of the transferred asset, the Scheme continues to recognise the transferred asset in its entirety and recognises a financial liability for the consideration received. In subsequent periods, the Scheme recognises any income on the transferred asset and any expense incurred on the financial liability.

Where the Scheme neither transfers nor retains substantially all the risks and rewards of ownership of the financial asset, the Scheme determines whether it has retained control of the financial asset. In this case:

(i) If the Scheme has not retained control, it derecognises the financial asset and recognises separately as assets or liabilities any rights and obligations created or retained in the transfer; and

(ii) If the Scheme has retained control, it continues to recognise the financial asset to the extent of its continuing involvement in the financial asset.

The Scheme derecognises a financial liability when the contractual obligations are discharged or expire.

1.4 FINANCIAL ASSETS

Investments held at fair value through profit or loss

The Scheme recognises a financial asset at fair value through profit or loss when 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.

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. The Scheme holds its Insurance Receivables and Loans and Receivables with the objective to collect the contractual cash flows and therefore measures them subsequently at amortised cost using the effective interest method, less provision for impairment.

Trade and other receivables comprise Insurance Receivables, arising from the Scheme's insurance contracts with its members and Loans and Receivables. As part of the implementation of IFRS 9: Financial Instruments, the classification between Insurance receivables and Loan and Receivables was reassessed. Based on the reassessment, the balance relating to Forensic receivables, previously classified as Loans and receivables as part of Sundry accounts receivables were reclassified to Insurance receivables.

1.5 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:

- Money market instruments;
- Call accounts; and
- Current accounts.

Cash and cash equivalents include items held for the purpose of investing and meeting short-term cash commitments and are carried at cost, which, due to their short-term nature, approximates fair value.

1.6 IMPAIRMENT OF FINANCIAL ASSETS

Impairment of insurance receivables

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.

The Scheme first assesses whether objective evidence of impairment exists individually for financial assets 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 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 asset's 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 surplus or deficit.

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 surplus or deficit.

Impairment of Loans and receivables

Prior to the implementation of IFRS 9, the Scheme applied an incurred loss model to assess impairment of Loans and Receivables. Following the implementation of IFRS 9, the Scheme applies the IFRS 9 simplified approach to measure expected credit losses which uses a lifetime expected loss allowance for Loans and Receivables. To measure the expected credit losses, Loans and Receivables are grouped based on shared credit risk characteristics and days past due.

1.7 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 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.

Trade and other payables

Trade payables are obligations to pay for goods or services that have been acquired in the ordinary course of business from suppliers.

Insurance payables

Insurance payables are measured initially at fair value (which approximates cost) and subsequently measured at amortised cost using the effective interest method.

Medical Savings Account liabilities

Members' Medical Savings Accounts, 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' Medical Savings Accounts is expensed when incurred.

1.8 PROVISIONS

The Scheme recognises provisions 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; and
- 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 risk 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' 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.

1.9 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.

1.10 MEMBER INSURANCE CONTRACTS

Contracts under which the Scheme accepts significant insurance risk from another party (the member and respective registered dependents) by agreeing to extend benefits to member or another 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 relevant healthcare expenses incurred.

1.11 LIABILITY ADEQUACY TEST

At the reporting date, liability adequacy tests are performed to ensure the adequacy of the member insurance contract liability.

Liabilities for insurance contracts are tested for adequacy by discounting current estimates of all future cash flows and comparing this amount to the carrying amount of the liabilities net of any related assets. Where a shortfall is identified, an additional provision is made and charged to surplus or deficit.

1.12 RISK CONTRIBUTION INCOME

Gross contributions comprise risk contributions and Medical Savings Account (MSA) contributions.

Risk contributions on member insurance contracts are accounted for monthly when their collection in terms of the insurance contract is reasonably assured. Risk contributions are earned from the date of attachment of insurance risk, over the indemnity period on a straight-line basis and are recognised as revenue.

1.13 RELEVANT HEALTHCARE EXPENDITURE

Relevant healthcare expenditure consists of risk claims incurred and net income or expense from risk transfer arrangements.

Risk Claims incurred

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

Risk claims incurred (net of claims from members' savings accounts, recoveries from members for co-payments, recoveries from third parties (such as motor vehicle accident and forensic recoveries and discounts received from service providers) comprise:

- Risk claims submitted and accrued for services rendered during the year;
- Payments under provider contracts (managed care) for services rendered to members;
- Over or under provision relating to prior year risk claims estimates;
- Risk claims incurred but not yet reported; and
- Risk claims settled in terms of risk transfer arrangements.

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

1.13 RELEVANT HEALTHCARE EXPENDITURE (continued)

Risk transfer arrangements

Risk transfer arrangements are contractual arrangements whereby a third party 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 decrease the loss the Scheme may incur as a result of carrying on the business of a medical scheme.

Risk transfer arrangement fees are recognised as an expense over the indemnity period on a straight-line basis.

Risk transfer claims and benefits reimbursed are presented in surplus or deficit and in the Statement of Financial Position on a gross basis. Only contracts that give rise to a significant transfer of insurance risk are accounted for as a risk transfer arrangement. Amounts recoverable under such contracts are recognised in the same year as the related claim.

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 provisions, claims reported not yet paid, and settled claims associated with the risk transfer arrangement.

Managed care: Management services fees

Managed care: management services fees comprise amounts paid or payable to a third party for managing the utilisation, costs and quality of health care services to the members of the Scheme. Managed care fees are expensed as incurred.

1.14 SHORT-TERM EMPLOYEE BENEFITS

Short-term employee benefit obligations are measured on an undiscounted basis and are expensed as the related service is provided.

A liability is recognised for the amount expected to be paid under short-term cash bonus or profit-sharing plans if the Scheme has a present legal or constructive obligation to pay this amount as a result of past service provided by the employee and the obligation can be estimated reliably.

1.15 INVESTMENT INCOME

Investment income comprises dividends and interest received and accrued on investments, interest on cash and cash equivalents and fair value movement on financial assets at fair value through surplus or deficit.

Interest income is recognised on the effective interest method.

Dividend income from investments is recognised when the right to receive payment is established - this is the ex dividend date for equity securities.

Fair value movement on financial assets at fair value through surplus or deficit include realised and unrealised gains and losses on disposal of assets and revaluation at fair value respectively. The gains and losses are recognised through the statement of comprehensive income in the period in which they arise.

1.16 INTEREST PAID ON MEDICAL SAVINGS ACCOUNTS (MSA)

The interest paid on Medical Savings Accounts is recognised in surplus or deficit using the effective interest method.

1.17 LONG-TERM FUNDING

Additional contributions received from participating employers are intended to compensate for the above average cross-subsidisation of pensioners by active members. Amounts received from participating employers are recognised as other income on a cash receipt basis as there is no legal obligation to refund the amounts to the employer. Long-term funding is recognised in sundry income.

1.18 INCOME TAX

In terms of Section 10(1)(d) of the Income Tax Act, No 58 of 1962, as amended, receipts and accruals of a benefit fund are exempt from income tax. A medical scheme is included in the definition of a benefit fund and consequently the Scheme is exempt from income tax.

1.19 ALLOCATION OF INCOME AND EXPENDITURE TO BENEFIT OPTIONS

The following items are directly allocated to benefit options:

- Risk contribution income;
- Risk claims incurred;
- Risk transfer arrangement fees;
- Administration fees; and
- Managed care: management services.

For disclosure purposes, the remaining items are apportioned based on the number of members on each option, except for Value Care Plan which is allocated on an average of its proportion of contribution income and membership.

	2018 R'000	2017 R'000
2. INVESTMENTS HELD AT FAIR VALUE THROUGH PROFIT OR LOSS		
Fair value at the beginning of the year	2,210,663	2,100,288
Additions	894,441	518,219
Disposals	(668,882)	(491,024)
Movement on revaluation to market value	(223,106)	83,180
Fair value at the end of the year	**2,213,116**	**2,210,663**
The investments included above represent investments in:		
Bonds - local	930,790	721,714
Bonds - foreign	31,228	35
Commodities	76,058	84,383
Listed equities	1,153,212	1,358,474
Derivatives	21,828	46,057
Fair value at the end of the year	**2,213,116**	**2,210,663**
The investments were managed by the following asset managers at year-end:		
Coronation Asset Management (Pty) Ltd	700,157	729,057
Allan Gray South Africa (Pty) Ltd	610,603	645,292
Investec Asset Management (Pty) Ltd	902,356	836,314
	2,213,116	**2,210,663**

A register of investments is available at the registered office of the Scheme

	2018 R'000	2017 R'000
3. TRADE AND OTHER RECEIVABLES		
Insurance receivables		
Contribution receivables	3,129	990
Member and service provider claims receivable	554	1,572
Amount due	2,808	2,650
Less: Allowance for impairment	(2,254)	(1,078)
Forensic receivables	251	287
Receivables arising from insurance contracts	3,934	2,849
Loans and receivables		
Interest receivable	255	187
Prepaid expenditure	2,060	-
Sundry accounts receivable	-	1,340
Receivables arising from loans and receivables	2,315	1,527
Total trade and other receivables	**6,249**	**4,376**

At 31 December 2018, the carrying amounts of loans and receivables approximate their fair values due to the short-term maturities of these assets.

4. CASH AND CASH EQUIVALENTS		
Call accounts	47,212	45,750
Current accounts	86,779	172,829
Money market accounts	653,425	708,112
	787,416	**926,691**

The weighted average effective interest rate on cash and cash equivalents was 7.06% (2017 - 7.29%). The call accounts have an average maturity of 1 day (2017 - 1 day) as these are used as a clearing facility.

	2018 R'000	2017 R'000

5. OUTSTANDING RISK CLAIMS PROVISION

Outstanding risk claims provision - not covered by risk transfer arrangements	**17,004**	**13,350**
Analysis of movement in outstanding risk claims provision		
Balance at beginning of year	13,350	16,066
Payments in respect of prior year	(12,707)	(15,424)
Over provision in respect of prior year	643	642
Movement for the current year	16,361	12,708
Outstanding risk claims provision	**17,004**	**13,350**
Analysis of outstanding risk claims provision		
Estimated gross claims	17,624	14,233
Less: Estimated recoveries from MSA (Note 6)	(620)	(883)
Total outstanding risk claims provision at year end	**17,004**	**13,350**

A liquidity adequacy test was performed and no additional provision was required.

Basis for determining the outstanding risk claims provision

The outstanding risk claims provision is a provision for the estimated cost of healthcare benefits that have occurred before the reporting date but have not been reported to the Scheme by that date. The provision is determined as accurately as possible based on a number of assumptions which are outlined below.

5. OUTSTANDING RISK CLAIMS PROVISION (continued)

Process used to determine the assumptions

The process used to determine the assumptions is intended to result in a realistic estimate of the most likely or expected outcome. The sources of data used as inputs for the assumptions are internal, using detailed studies of historical claiming patterns to establish a "claims run-off" period per discipline. More emphasis is placed on recent information, particularly where current claims do not appear to follow prior year trends. Where, in prior years, there is insufficient information to make a reliable best estimate of claims development, prudent assumptions are used.

To the extent that historical claims development is used to determine the claims "run-off period", it is assumed that this pattern will occur again in future. There are reasons why this may not be the case, which, insofar as they can be identified, have been allowed for by modifying the methods. Such reasons, inter alia, include:

- Changes in processes that affect the development or recording of claims paid and incurred (such as changes in claims submission mechanisms);
- Changes in membership profile of the Scheme;
- Random fluctuations; and
- Legislative changes (e.g. expansion of the definition of a Prescribed Minimum Benefit ("PMB")/Chronic Disease List ("CDL") condition).

Notified claims are assessed with due regard to the claim circumstances, medical discipline, anticipated development, expected seasonal fluctuations, and information available from managed care: management services (specifically hospital pre-authorisation). The provision is a best estimate based on the most recent information available and may be affected by the differing claims run-off periods between the various medical disciplines. Estimates calculated on the "run-off" period of disciplines with lower utilisations may be subject to a higher degree of volatility due to the relatively small claims history. This is largely negated by the medical disciplines where the majority of the risk claims are incurred and which therefore constitute the bulk of the provision.

Assumptions

The assumptions that have the greatest effect on the measurement of the outstanding risk claims provision, are the claims "run-off periods" for the most recent benefit years (split by discipline), in particular the in-hospital category. The run-off factor relates to the emergence and settlement patterns of risk claims and is expressed as the percentage of risk claims settled in respect of total claims expected to emerge in a specific service month. This factor is then used to project the remainder of the outstanding risk claims relating to the specified service month. A "seasonality factor" is further incorporated into the calculation, also based on past claims experience. Consistent assumptions have been used for assessing the outstanding risk claims provisions for the 2017 and 2018 benefit years.

5. OUTSTANDING RISK CLAIMS PROVISION (continued)

Changes in assumptions

The table below outlines the sensitivity of insured liability estimates to particular movements in assumptions used in the estimation process. It should be noted that this is a deterministic approach with no correlations between the key variables. Where variables are considered to be immaterial, no impact has been assessed for changes to these variables. Particular variables may not be considered material at present. However, should the materiality level of an individual variable change, assessment of changes to that variable in the future may be required.

An analysis of sensitivity around various scenarios for the general medical insurance business provides an indication of the adequacy of the estimation process. The Trustees believe that the liability for risk claims reported in the statement of financial position is adequate. However, they recognise that the process of estimation is based upon certain variables and assumptions which could differ when claims arise. Consequently, if for example the estimates of the unreceived portion of risk claims costs for the year was 5% inaccurate, the impact on the net surplus of the Scheme would be as follows:

Impact on reported profits due to changes in key variables:

	Change in variables	Change in claims cost 2018 R'000	Change in claims cost 2017 R'000
In-hospital claims incurred	5%	69	91
Out-of-hospital claims incurred	5%	23	36
Chronic claims incurred	5%	8	12

This analysis has been prepared for a change in run-off factors with other assumptions remaining constant. The change in liability also represents the absolute change in result for the period. It should be noted that an increase in liabilities will result in a decrease in the result and vice versa.

The sensitivity of the estimation process is reduced by the value of the risk claims paid subsequent to the year end related to the period ended 31 December 2018, as detailed in the table below:

	2018 R'000	2017 R'000
Outstanding risk claims provision	17,004	13,350
Portion of outstanding risk claims provision paid to 28 February 2019 (2017: 28 February 2018)	(15,007)	(10,573)
Residual estimate of risk claims incurred but not paid	1,997	2,777

		2018 R'000	2017 R'000
6.	**MEDICAL SAVINGS ACCOUNT (MSA) LIABILITY**		
	Balance on MSA liability at the beginning of the year	173,891	153,266
	Add:		
	MSA contributions received for the current year (Note 8)	84,718	83,302
	Transfers received from other medical schemes	55	104
	Interest accrued on MSA funds	14,774	14,252
	Less:		
	Claims paid to or on behalf of members (Note 9)	(68,409)	(68,339)
	Refunds on death or resignation	(10,538)	(8,694)
	Balance on MSA liability at the end of the year	**194,491**	**173,891**

In accordance with the rules of the Scheme, the MSA is underwritten by the Scheme.

MSAs contain a demand feature. In terms of Regulation 10 of the Act, any credit balance on a member's MSA must be taken as a cash benefit when the member terminates his or her membership of the Scheme or benefit option, and enrols in another benefit option or medical scheme without a MSA, or does not enrol in another medical scheme.

Estimated claims to be paid out of members' MSA in 2019 in respect of claims incurred in 2018 but not yet reported (Note 5)	620	883

At 31 December 2018, the carrying amount of the MSA liability approximates its fair value, since it is payable on demand. These amounts were not discounted to present values due to their demand feature.

	2018 R'000	2017 R'000
7. TRADE AND OTHER PAYABLES		
Insurance liabilities		
Reported claims not yet paid	12,774	8,478
Stale cheques	64	344
Unpresented cheques	368	602
Total liabilities arising from insurance contracts	13,206	9,424
Financial liabilities		
Balances due to related party - Discovery Health (Pty) Ltd	2,329	3,750
Accruals	1,156	510
Unallocated funds	602	42
Total arising from financial liabilities	4,087	4,302
Total trade and other payables	**17,293**	**13,726**

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

8. RISK CONTRIBUTION INCOME		
Gross contributions per registered rules	529,093	505,213
Less: MSA contributions received*	(84,718)	(83,302)
Risk contribution income per statement of comprehensive income	**444,375**	**421,911**

* The MSA contributions are received by the Scheme in terms of Regulation 10(1) and the Scheme's registered rules. Refer to Note 6 for more detail.

	2018 R'000	2017 R'000
9. RISK CLAIMS INCURRED		
Claims incurred excluding claims in respect of related risk transfer arrangements		
Current year claims per registered rules	555,288	517,249
Movement in outstanding risk claims provision	16,361	12,708
Over provision in respect of prior year (Note 5)	(643)	(642)
Adjustment for current year (Note 5)	17,004	13,350
Claims paid from MSA (Note 6)	(68,409)	(68,339)
	503,240	461,618
Claims incurred in respect of risk transfer arrangements		
Netcare 911		
Current year claims	2,489	2,051
Prime Cure		
Current year claims	13,164	10,388
Centre for Diabetes and Endocrinology (CDE)		
Current year claims	25,093	24,187
Dental Risk Company		
Current year claims	3,009	-
	43,755	36,626
Risk claims per statement of comprehensive income	**546,995**	**498,244**

	2018 R'000	2017 R'000
10. NET INCOME ON RISK TRANSFER ARRANGEMENTS		
Capitation fees paid to third party providers	(38,782)	(31,652)
Recoveries under risk transfer arrangements	43,755	36,626
	4,973	**4,974**
Made up as follows:		
Netcare 911	149	20
Capitation fees paid	(2,340)	(2,031)
Recovery from service provider	2,489	2,051
Risk transfer arrangement providing ambulance services (air and land) for members registered on the Managed Care and Standard Care Plan.		
Prime Cure	4,124	3,146
Capitation fees paid	(9,040)	(7,242)
Recovery from service provider	13,164	10,388
Risk transfer arrangement providing an agreed structure of day-to-day benefits, including treatment of chronic conditions, for members registered on the Value Care Plan. The contract excludes the provision of treatment, per event, for any hospital admissions above R65,000 in private facilities.		
Centre for Diabetes and Endocrinology	1,406	1,808
Capitation fees paid	(23,687)	(22,379)
Recovery from service provider	25,093	24,187
Risk transfer arrangement covering treatment for members registered on the Managed Care and Standard Care Plan, diagnosed with diabetes including diabetic related hospital admissions.		
Dental Risk Company	(706)	-
Capitation fees paid	(3,715)	-
Recovery from service provider	3,009	-
Risk transfer arrangement for protection against and transfer of all risks relating to basic dental benefits for members registered on the Standard Care Plan. This contract was entered into in 2018.		
	4,973	**4,974**

10. NET INCOME ON RISK TRANSFER ARRANGEMENTS (continued)

The Scheme has entered into selective risk transfer arrangements with these third party providers in order to reduce their exposure to claims risk and receive specialist case management. These arrangements form a relatively small component of the total claims cost of the Scheme.

Recoveries from service providers are calculated based on the services provided to members, multiplied by the Scheme re-imbursement rate.

	2018 R'000	2017 R'000
11. MANAGED CARE: MANAGEMENT SERVICES		
Chronic medicine management services	1,123	952
Disease management services	2,988	3,485
Hospital management services	3,057	2,869
Pharmaceutical benefit management services	955	925
Provider network management services	2,580	2,499
	10,703	**10,730**
12. ADMINISTRATION EXPENSES		
Administration fees	19,476	18,820
Staff costs	3,156	3,075
Principal Officer remuneration and related expenses	2,184	2,150
Consulting fees	2,109	1,867
Trustee remuneration and considerations	1,198	884
Electronic checking fees	1,182	967
Publications	648	557
Audit fees	452	324
Travel and entertainment	438	392
Council for Medical Schemes expenses	327	321
Head office rental and management fees	267	253
General expenses	99	114
	31,536	**29,724**

	2018 R'000	2017 R'000
13. NET IMPAIRMENT LOSSES		
Insurance receivables		
Members claims debt	(81)	(42)
Movement in allowance account	37	(25)
Written off	(118)	(17)
Suppliers claims debt	(1,213)	(290)
Movement in allowance account	(1,213)	(290)
	(1,294)	**(332)**
14. INVESTMENT INCOME		
Medical Scheme funds		
Interest income on current accounts	2,247	2,346
Income on other	208,805	136,366
Interest income	63,842	66,081
Dividend income	52,105	47,393
Net realised gains on fair value adjustments	92,858	22,892
Fair value adjustments on investments at fair value through profit or loss	(204,363)	99,237
	6,689	**237,949**
15. SUNDRY INCOME		
Long-term funding	878	836
Prescribed income	27	133
	905	**969**

	2018 R'000	2017 R'000
16. CASH FLOWS FROM OPERATING ACTIVITIES BEFORE WORKING CAPITAL CHANGES		
Net (deficit)/surplus for the year	(162,770)	99,635
Adjustments for:		
Investment income excluding fair value losses (Note 14)	(211,052)	(138,712)
Interest paid on Medical Savings Accounts	14,774	14,252
Unrealised losses/(gains) on investments (Note 14)	204,363	(99,237)
Sundry income (Note 15)	(905)	(969)
Expenses for asset management services rendered	16,582	16,657
Cash flows from operations before working capital changes	**(139,008)**	**(108,374)**

17. FIDELITY COVER

The Scheme participates in fidelity guarantee and Trustees professional indemnity insurance arranged by Anglo American South Africa Ltd amounting to USD 35 million.

18. COMMITMENTS AND CONTINGENT LIABILITIES

The Scheme does not have any commitments or contingent liabilities outstanding at 31 December 2018 (2017: Nil).

19. CONTINGENT ASSET

As at 31 December 2018, the Scheme had pending motor vehicle accident medical claims submitted to the Road Accident Fund (RAF) for assessment. This will only be accounted for when an amount is certain to be received from the RAF.

20. EVENTS AFTER THE REPORTING DATE

There have been no facts or circumstances of a material nature that have occurred between the accounting date and the date of this report.

21. RELATED PARTY TRANSACTIONS

The Scheme is controlled by the Board of Trustees who are appointed by the participating employers or elected by the members of the Scheme.

Key management personnel

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 Board of Trustees and the Principal Officer.

Close family members include close family members of the Board of Trustees and Principal Officer, and are also related parties.

Parties with significant influence over the Scheme

Administrator and managed care organisation
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 and managed care services.

Employer
Anglo Operations (Pty) Ltd receives from the Scheme market related reimbursement for head office rental and management services provided.

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 year.

	2018 R'000	2017 R'000
Transactions with key management personnel		
Statement of Comprehensive Income transactions		
Gross contributions received	1,464	1,252
Gross claims paid	1,166	946
Interest on MSA balances	18	21
Key management personnel remuneration	5,340	5,225
Trustee remuneration and considerations	1,198	884
Head office rental and management fees	267	253
Statement of Financial Position		
Medical Savings Accounts	252	217
Head office rental and management fees	31	-
Trustee remuneration and considerations	3	18
Investment in employers	41,366	38,471

21. RELATED PARTY TRANSACTIONS (continued)

Transactions with related parties (continued)

The terms and conditions of the above related party transactions were as follows:

Transactions	*Nature of transactions and their terms and conditions*
Gross contributions received	This constitutes the contributions paid by the related parties as members of the Scheme, in their individual capacity. All contributions were on the same terms as applicable to all members.
Gross claims paid	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 all members.
Interest on MSA balances	Interest is earned on positive MSA balances at an average effective interest rate of 8,50% (2017: 8,11%) per annum.
Medical Savings Accounts	The amounts owing to the related parties relate to MSA balances. In line with the terms applied to all members, the balances earn interest monthly at market interest rates, on an accrual basis. The amounts are all current and are payable on demand if an appropriate claim is issued, or if the member resigns from the Scheme, as applicable to all members.

	2018 R'000	2017 R'000
Discovery Health (Pty) Ltd - Administrator		
Statement of Comprehensive Income transactions		
Administration fees	19,476	18,820
Statement of Financial Position		
Balance due to Discovery Health (Pty) Ltd	1,544	2,987
Discovery Health (Pty) Ltd - Managed care organisation		
Statement of Comprehensive Income transactions		
Managed care: management services	9,552	9,253
Statement of Financial Position		
Balance due to Discovery Health (Pty) Ltd	785	763

The terms and conditions of the above transactions with entities with significant influence over the Scheme were as follows:

Administration and managed care agreements
The administration and managed care management service agreements are in terms of the rules of the Scheme and in accordance with instructions given by the Board of Trustees. The agreements are automatically renewed each year unless notification of termination is received or following the cancellation of the Administrator's accreditation or the issue of a lawful directive to this effect by the Council for Medical Schemes in terms of the Act. The Scheme and the Administrator/Managed Healthcare Organisation shall be entitled to terminate the agreement by giving notice in writing of not less than 90 days and not more than 180 days. The outstanding balance bears no interest and is due within 7 days.

22. TRUSTEE REMUNERATION AND CONSIDERATIONS

Trustees	Fees for meeting attendance		Disbursements		Accommodation, travelling and meals		Conference fees		Total	
	2018 R'000	2017 R'000	2018 R'000	2017 R'000	2018 R'000	2017 R'000	2018 R'000	2017 R'000	2018 R'000	2017 R'000
Abramowitz D*	48	48	-	-	-	8	-	15	48	71
du Bois MA*^	65	80	14	-	32	-		-	111	80
Coetzer J*	65	-	-	-	-	-		-	65	-
Elliott CC*	32	42	-	-	-	-	-	-	32	42
Farrell MR*	27	85	-	-	-	-	-	-	27	85
Farrell MR	81	-	10	-	13	-	15	-	119	-
Ghavalas D*	-	25	-	-	-	-	-	-	-	25
Hosking S*	73	48	-	-	20	11	-	-	93	59
Howell GA*	62	48	-	-	-	-	-	-	62	48
Hunt RW*	-	18	-	-	-	-	-	-	-	18
Laubscher PA*	78	49	-	-	-	-	-	-	78	49
Liston J*	58	59	-	-	2	-	-	-	60	59
Mason-Gordon N*	29	28	-	-	-	-	-	-	29	28
Mbekeni C*	44	41	-	-	2	-	-	-	46	41
McCallum DR*	117	79	-	-	2	-	-	-	119	79
Mckie Thomson CC	114	99	14	6	2	-	-	-	130	105
Preston GJ	68	48	14	13	22	6	-	-	104	67
Van der Bijl B*	51	28	-	-	9	-	15	-	75	28
TOTAL	**1,012**	**825**	**52**	**19**	**104**	**17**	**30**	**-**	**1,198**	**884**

* Trustees fees ceded to employers

^ Mr du Bois retired 31 December 2018

23. SURPLUS/(DEFICIT) PER BENEFIT OPTION

2018	MANAGED CARE PLAN R'000	STANDARD CARE PLAN R'000	VALUE CARE PLAN R'000	TOTAL R'000
Risk contribution income	255,129	179,402	9,844	444,375
Relevant healthcare expenditure	(353,476)	(186,457)	(10,620)	(550,553)
Net claims incurred	(346,567)	(183,512)	(14,744)	(544,823)
Risk claims incurred	(348,017)	(184,234)	(14,744)	(546,995)
Third party claims recoveries	1,450	722	-	2,172
Net (expense)/income on risk transfer arrangements	(1,164)	2,013	4,124	4,973
Risk transfer arrangement fees/premiums paid	(16,021)	(13,721)	(9,040)	(38,782)
Recoveries from risk transfer arrangements	14,857	15,734	13,164	43,755
Managed care: management services	(5,745)	(4,958)	-	(10,703)
Gross healthcare result	(98,347)	(7,055)	(776)	(106,178)
Administration expenses	(16,420)	(14,183)	(933)	(31,536)
Net impairment losses	(674)	(582)	(38)	(1,294)
Net healthcare results	(115,441)	(21,820)	(1,747)	(139,008)
Investment and other income	4,344	2,963	287	7,594
Other expenditure	(17,939)	(12,233)	(1,184)	(31,356)
Net deficit for the year	(129,036)	(31,090)	(2,644)	(162,770)
Number of members at year-end	4,345	3,834	701	8,880

23. SURPLUS/(DEFICIT) PER BENEFIT OPTION (continued)

2017	MANAGED CARE PLAN R'000	STANDARD CARE PLAN R'000	VALUE CARE PLAN R'000	TOTAL R'000
Risk contribution income	250,159	163,732	8,020	421,911
Relevant healthcare expenditure	(328,772)	(163,501)	(7,956)	(500,229)
Net claims incurred	(324,019)	(159,352)	(11,102)	(494,473)
Risk claims incurred	(326,563)	(160,579)	(11,102)	(498,244)
Third party claims recoveries	2,544	1,227	-	3,771
Net income on risk transfer arrangements	1,150	678	3,146	4,974
Risk transfer arrangement fees/premiums paid	(15,370)	(9,040)	(7,242)	(31,652)
Recoveries from risk transfer arrangements	16,520	9,718	10,388	36,626
Managed care: management services	(5,903)	(4,827)	-	(10,730)
Gross healthcare result	(78,613)	231	64	(78,318)
Administration expenses	(15,928)	(13,045)	(751)	(29,724)
Net impairment losses	(178)	(146)	(8)	(332)
Net healthcare results	(94,719)	(12,960)	(695)	(108,374)
Investment and other income	136,695	93,202	9,021	238,918
Other expenditure	(17,684)	(12,058)	(1,167)	(30,909)
Net surplus for the year	24,292	68,184	7,159	99,635
Number of members at year-end	4,595	3,818	615	9,028

24. 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 legislative requirements.

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 adverse experience is diluted by a larger group of members whose claims are more 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
In-hospital benefits cover costs incurred by members, while they are in hospital to receive authorised treatment for certain medical conditions. This includes accommodation, theatre, professional services, medication, equipment and consumables.

Chronic benefits
Prescribed Minimum Benefits (PMB): medication and consultations including defined procedures are funded i.e. high blood pressure, cholesterol and asthma. Non-PMB chronic conditions: medication funded.

Day-to-day benefits
Day-to-day benefits cover the cost of out of hospital medical attention, such as visits to general practitioners, dentists and specialists as well as prescribed non-chronic medicines other than those funded from members' savings accounts.

24. INSURANCE RISK MANAGEMENT REPORT (continued)

The risks associated to the Scheme with the types of benefits offered to members are addressed below:

Hospital benefit risk

The main factors affecting 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. 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 table shows various factors that impact hospital claims:

Key indicators	2018	2017	% Increase/ (decrease)
Length of stay (days)	4.17	3.93	6.1%
Average hospital cost per admission (R)	32,860	29,362	11.9%
Total cost per event (R)	51,416	44,943	14.4%
Total cost per life per month (R)	953	824	15.7%
Admissions per 1 000 lives	348	336	3.6%

Chronic benefit risk

The main factors impacting the frequency and severity of chronic claims are the number of claimants and the cost per claimant. An increase/decrease in the number of claimants results in an increase/decrease in the frequency of claims. Higher increases in claimants and severity of claims may be attributed to increases in the number of claimants at older ages or beneficiaries who are more sickly. Conversely, lower prevalence rates may be indicative of a healthier membership.

The mix between the various chronic conditions impacts the frequency and severity of claims. Certain factors that impact chronic cost are shown below:

Key indicators	2018	2017	% Increase/ (decrease)
Claimants per 1 000 lives	32.72	32.59	0.4%
Amount paid per life per month	181	178	1.4%

24. INSURANCE RISK MANAGEMENT REPORT (continued)

Day-to-day benefit risk

The main factors impacting the frequency and severity of day-to-day claims are the number of claimants and the cost per claimant. An increase in the cost of claims results from an increase in the frequency and/or severity of claims. The mix of members between the different benefit options will also have an impact on the claims.

Risk management

The Scheme has various initiatives that are used to manage risks associated with claims experience. These include:

- All hospital admissions have to be authorised. There have also been amendments to the pre-authorisation length of stay benchmarks;
- Case managers monitor members with hospital stays that are longer than expected to ensure that members are discharged at appropriate times;
- Out-of-hospital programmes addressing risk, preventing re-admissions; and
- Protocols guiding access to expensive technologies and medication.

Concentration of insurance risk

The following table summarises the concentration of insurance risk per beneficiary per annum, with reference to the carrying amount, net of adjustments, of the insurance claims incurred by age group and in relation to the type of risk covered/benefits provided:

2018 Age grouping (in years)	Hospital R	Chronic R	Day-to-day R	Total R
< 26	4,080	362	2,498	6,940
26 - 35	7,059	572	4,844	12,475
36 - 50	10,637	1,599	7,473	19,709
51 - 65	18,063	3,320	8,915	30,298
> 65	41,190	5,064	11,441	57,695

2017 Age grouping (in years)	Hospital R	Chronic R	Day-to-day R	Total R
< 26	3,716	330	2,275	6,321
26 - 35	6,430	521	4,413	11,364
36 - 50	9,689	1,457	6,807	17,953
51 - 65	16,453	3,024	8,120	27,597
> 65	37,519	4,613	10,421	52,553

24. INSURANCE RISK MANAGEMENT REPORT (continued)

Risk transfer arrangements

The Scheme has four risk transfer agreements in which suppliers are paid to provide certain minimum benefits to Scheme members. These arrangements fix the cost to the Scheme of providing these benefits.

The first risk transfer arrangement (Prime Cure) covers day to day expenditure, including treatment of chronic conditions, and hospital admissions under R65,000 for members on the Value Care Plan. The second arrangement (Netcare 911), provides emergency transport to all members on the Standard Care and Managed Care plans. The third arrangement with CDE covers the treatment for members diagnosed with diabetes (type I and II) on the Standard Care and Managed Care plans, including diabetic related hospital admissions and the fourth arrangement with Dental Risk Company provides basic dental benefit to Standard Care plan members.

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. The Scheme also monitors the performance of the suppliers, assesses the quality of care provided and has access to data on the underlying fee-for-service claims that 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 is 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 determining 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, another method using the estimated cost per event and pre-authorised admissions is also utilised/applied.

The table below outlines the sensitivity of insured liability estimates to particular movements in assumptions used in the estimation process. It should be noted that this is a deterministic approach with no correlations between the key variables. For each sensitivity illustrated, all other assumptions have been left unchanged.

Impact on the outstanding claims provision and reported surplus or deficit caused by changes in key variables:

	Change in variable	2018 R'000	2017 R'000
In-hospital claims incurred	5% change in claims cost	69	91
Out-of-hospital claims incurred		23	36
Chronic claims incurred		8	12

25. FINANCIAL RISK MANAGEMENT REPORT

Overview

The Scheme is exposed to financial risk through its financial 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 potentially adverse effects on the financial performance of the investments that the Scheme holds to meet its obligations to its members.

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 (the Committee) of the Board of Trustees, determines, recommends, implements and maintains investment policies and procedures. The Committee advises the Board of Trustees on the strategic and operating matters in respect of the investment of Scheme funds and meets at least quarterly;
- The Scheme has appointed reputable external asset managers to manage its investments and their performance is monitored regularly; and
- 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.

25. FINANCIAL RISK MANAGEMENT REPORT (continued)

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.

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

Currency risk is the risk that the value of a financial instrument will fluctuate due to changes in foreign exchange rates. The Scheme operates in South Africa and therefore its cash flows are denominated in South African Rand (ZAR). In terms of the diversified investment strategy operated by the investment committee and the restrictions imposed by the Medical Schemes Act, the Scheme has a relatively small number of investments off-shore. The Scheme is exposed to foreign exchange risk arising from currency exposures. 3,3% (2017: 3,2%) of total investments were invested in foreign investments.

The following table illustrates the concentration of direct currency risk to which the Scheme is currently exposed:

As at 31 December 2018	**ZAR R'000**	**Foreign currency R'000**	**TOTAL R'000**
Investments held at fair value through profit or loss	2,181,888	31,228	2,213,116
Cash and cash equivalents	718,647	68,769	787,416
	2,900,535	99,997	3,000,532

As at 31 December 2017	**ZAR R'000**	**Foreign currency R'000**	**TOTAL R'000**
Investments held at fair value through profit or loss	2,210,663	-	2,210,663
Cash and cash equivalents	830,903	95,788	926,691
	3,041,566	95,788	3,137,354

There has been significant movement in the ZAR against major currencies during the year. Holding all other variables constant, and adjusting currencies with 10% for the year, the below table illustrates the impact to the value of investments of the Scheme:

	% ZAR movement	**2018 R'000**	**2017 R'000**
Foreign currency	10%	10,000	9,579

25. FINANCIAL RISK MANAGEMENT REPORT (continued)

Equity risk

Equity risk is the risk that the value of a financial instrument will fluctuate as a result of changes in the market place.

Equities are reflected at market values, which are susceptible to fluctuations. The Scheme manages its equity risk by employing the following procedure:

- Mandating a specialist fund manager to invest in equities, where there is an active market and where access is gained to a broad spectrum of financial information relating to the companies invested in;
- Diversifying across many securities to reduce risk. Diversification is guided by the Medical Schemes Act; and
- Considering the risk-reward profile of holding equities and bearing the risk in order to obtain higher expected returns on assets.

If the South African equities market were to move by 10%, assuming all other variables remain constant, and the recent past is predictive of the future, the below table illustrates the impact to the value of investments of the Scheme:

	% SA market movement	2018 R'000	2017 R'000
Investments held at fair value through profit or loss: Equities	10%	115,321	135,847

25. FINANCIAL RISK MANAGEMENT REPORT (continued)

Interest rate risk

Interest rate risk is the exposure that the Scheme has to changes in interest rates. As the Scheme holds no debt with the exception of the members' saving liability on which interest is paid, the main exposure to the Scheme would be a reduction in interest income on investments if interest rates were to decrease. In order to reduce the impact of any potential interest rate changes, the Scheme holds a diversified portfolio of both long and short term investments.

The table summarises the Scheme's exposure to interest rate risks. Included in the table are the Scheme's investments at carrying amounts, categorised by the earlier of contractual repricing or maturity dates:

As at 31 December 2018	0 - 3 months R'000	3 - 12 months R'000	> 12 months R'000	Total R'000
Cash and cash equivalents	774,092	6,015	7,309	787,416
Investments held at fair value through profit or loss	1,336,207	14,237	862,672	2,213,116

As at 31 December 2017	0 - 3 months R'000	3 - 12 months R'000	> 12 months R'000	Total R'000
Cash and cash equivalents	920,416	6,275	-	926,691
Investments held at fair value through profit or loss	1,591,035	-	619,628	2,210,663

Cash and cash equivalents include investments with Coronation Asset Managers (Pty) Ltd which have cash instruments with a maturity date of 2020. These are marketable investments easily convertible into cash.

The following table summarises the effective interest rate for monetary financial instruments:

	2018 %	2017 %
Cash and cash equivalents - Medical Scheme assets	7.06%	7.29%

A change of 100 basis points in interest rates at the reporting date would have an effect on surplus or deficit by the amounts shown below. This analysis assumes that all other variables remain constant. The analysis is performed on the same basis for 2017.

	% change in interest rates	2018 R'000	2017 R'000
Cash and cash equivalents - Medical Scheme assets	1%	9,361	9,387

25. FINANCIAL RISK MANAGEMENT REPORT (continued)

Fair value estimation

The fair value of publicly traded financial instruments held as investments at fair value through profit or loss, is based on quoted market prices at the statement of financial position date. As such, all financial assets are considered level 1 assets.

The carrying value, less impairment provision of trade receivables and payables are assumed to approximate their fair values due to their short-term nature.

The members' Medical Savings Accounts contain a demand feature. In terms of Regulation 10 of the Act, any credit balance on a member's 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' Medical Savings Accounts are deemed to be equal to their fair values, which is the amount payable on demand.

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 contributions to be 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 at market related contribution rates. The high solvency margin results from a grant made by employers to effectively increase the Scheme's reserves to pre-fund the ageing liability of the Scheme.

The calculation of the regulatory capital requirement is set out below:

	2018 R'000	2017 R'000
Total Members' Funds per the Statement of Financial Position	2,777,993	2,940,763
Less: cumulative unrealised net gain on measurement of investments to fair value	(275,309)	(479,662)
Accumulated funds per Regulation 29	2,502,684	2,461,101
Gross contribution income (R'000)	529,093	505,213
Solvency margin = Accumulated funds/gross contribution income x 100	473.01%	487.14%

25. FINANCIAL RISK MANAGEMENT REPORT (continued)

Investment risk

Investment risk is the risk that the investment returns on accumulated assets will not be sufficient to cover future liabilities. Continuous monitoring takes place to ensure that appropriate assets are held where the Scheme's liabilities are dependent upon the performance of the investment portfolio and that a suitable match of assets exists for all liabilities.

The Scheme's investment objectives are to maximise the return on its investments on a long-term basis at minimal risk, subject to any constraints imposed by legislation or the Board of Trustees. The Scheme diversifies its investment portfolio by investing in short-term deposits, bond, money market and equity portfolios managed by reputable asset managers.

To assist the Regulator in monitoring the Scheme's compliance with Annexure B of the Act, the Scheme submits detailed investment schedules to the Council for Medical Schemes, supplemented by the Scheme's asset manager's reports on a quarterly basis.

25. FINANCIAL RISK MANAGEMENT REPORT (continued)

Breakdown of investments

The following table compares the fair value and carrying amounts of financial assets and financial liabilities per class of assets and liabilities:

As at 31 December 2018	Financial assets and liabilities at fair value through profit or loss R'000	Loans and receivables R'000	Insurance receivables and (payables) R'000	Financial liabilities at amortised cost R'000	Total carrying amount R'000	Fair value amount R'000
Investments held at fair value through profit or loss	2,213,116	-	-	-	2,213,116	2,213,116
Cash and cash equivalents	-	787,416	-	-	787,416	787,416
Trade and other receivables	-	2,315	3,934	-	6,249	6,249
Medical Savings Account liability	-	-	(194,491)	-	(194,491)	(194,491)
Trade and other payables	-	-	(13,206)	(4,087)	(17,293)	(17,293)
	2,213,116	789,731	(203,763)	(4,087)	2,794,997	2,794,997

As at 31 December 2017	R'000	R'000	R'000	R'000	R'000	R'000
Investments held at fair value through profit or loss	2,210,663	-	-	-	2,210,663	2,210,663
Cash and cash equivalents	-	926,691	-	-	926,691	926,691
Trade and other receivables	-	1,527	2,849	-	4,376	4,376
Medical Savings Account 'trust' liability	-	-	(173,891)	-	(173,891)	(173,891)
Trade and other payables	-	-	(9,424)	(4,302)	(13,726)	(13,726)
	2,210,663	928,219	(180,466)	(4,302)	2,954,112	2,954,112

25. FINANCIAL RISK MANAGEMENT REPORT (continued)

Assets measured at fair value

The fair value assets are classified using a fair value hierarchy that reflects the significance of the inputs used in determining the measurements:

- Level 1: Quoted market price (unadjusted in an active market for an identical instrument);
- Level 2: Valuation techniques based on observable inputs, either directly (i.e. as prices) or indirectly (i.e. derived from prices). This category includes instruments valued using: quoted market prices in active markets for similar instruments; quoted prices for identical or similar instruments in markets that are considered less than active; or other valuation techniques where all significant inputs are directly or indirectly observable from market data; and
- Level 3: Valuation techniques using significant unobservable inputs. This category includes all instruments where the valuation technique includes inputs not based on observable data and the unobservable inputs have a significant effect on the instrument's valuation. This category includes instruments that are valued based on quoted prices for similar instruments where significant unobservable adjustments or assumptions are required to reflect differences between the instruments.

The Scheme's financial instruments, measured at fair value at the end of the reporting period, are all categorised as Level 1 investments.

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:

- Trade and other receivables comprising 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 and suppliers in respect of claims debt. The Scheme has exposure from its loans and receivables.
- Financial assets are valued at fair value through surplus or deficit. These assets comprise bond instruments, commodities and equities. The Scheme is exposed to the issuer's credit standing on these instruments. Exposure to credit risk is monitored and minimum credit ratings for these investments are set. Reputable asset managers have been appointed to manage these instruments; and
- Cash and cash equivalents comprise of fixed deposits, deposits held on call with banks and other short term liquid investments. The risks associated with these deposits are managed by monitoring the Scheme's exposure to external financial institutions against approved deposit limits per institution.

25. FINANCIAL RISK MANAGEMENT REPORT (continued)

Credit risk (continued)

The Scheme's Trade and other receivables at 31 December 2018 comprise:

	2018 R'000	2017 R'000
Insurance receivables	3,934	2,849
Contributions receivable (a)	3,129	990
Member and service provider claims receivables (b)	2,808	2,650
Less: Allowance for Impairment losses	(2,254)	(1,078)
Forensic receivables	251	287
Loans and receivables	2,315	1,527
Interest receivable	255	187
Prepaid expenditure	2,060	-
Sundry accounts receivable	-	1,340

a. Contributions receivable are not credit rated by the Scheme as exposure to any single member is insignificant. Contributions receivable comprise amounts receivable from individuals and corporates and are collected by means of debit orders or cash payments. They are actively pursued if not received within three days of becoming due. Benefits are suspended on member accounts when contributions have not been received for 30 days and membership are terminated when contributions have not been received for 60 days.

b. Member and service provider claims receivable are amounts recoverable in respect of claims debt. They are not credit rated by the Scheme as exposure to any single party is insignificant. Member receivables are separated between active and withdrawn members.

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 highlight insurance receivables within Trade and other receivables which are due, past due (by number of days) and impaired.

Insurance receivables	Gross 2018 R'000	Impairment 2018 R'000	Gross 2017 R'000	Impairment 2017 R'000
Not past due	3,557	-	1,464	-
Past due 0 - 30 days	155	-	332	-
Past due 31 - 60 days	113	-	931	-
Past due 61 - 150 days	218	216	289	263
151 days to more than 1 year	2,145	2,039	911	815
	6,188	2,254	3,927	1,078

25. FINANCIAL RISK MANAGEMENT REPORT (continued)

Credit risk (continued)

Impairment losses

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 counterparties.

Below is the movement in the impairment for each component of Trade and other receivables during the year ended 31 December 2018:

	Member and service provider claims debtors R'000
Balance as at 1 January 2018	1,078
Movement in impairment allowance	1,294
Amounts utilised during the year	(118)
Balance as at 31 December 2018	**2,254**

Balance as at 1 January 2017	762
Movement in impairment allowance	333
Amounts utilised during the year	(17)
Balance as at 31 December 2017	**1,078**

Based on past experience, the Scheme believes that no provision for impairment is required in respect of Contribution debtors. For member and service provider claims debtors that are past due and outstanding for less than 90 days, past experience has indicated that no provision is required.

25. FINANCIAL RISK MANAGEMENT REPORT (continued)

Credit risk (continued)

Credit quality

The credit quality of financial assets that are neither past due nor impaired can be assessed by historical information about counterparty default rates:

Insurance receivables	**2018 R'000**	**2017 R'000**
Contributions receivable	3,129	990
Member and service provider claims receivable		
Active member claims receivable	153	147
Withdrawn member claims receivable	27	33
Service provider claims receivable	374	1,392
Forensic receivables	251	287
	3,934	2,849

Contribution receivables
The Scheme collected over 99% (2017: 99%) of outstanding debt in January 2019. Therefore we can reasonably establish that the credit quality of contribution debtors is high. Consequently no additional disclosure of the credit quality is provided.

Active member claim receivables
These debtors are active members of the Scheme. No further provision for impairment is therefore necessary.

Withdrawn member claim receivables
These amounts are due from members that have withdrawn from the Scheme. An impairment allowance covering 88% (2017: 87%) of the total amount due has been raised and the Trustees are satisfied that this is adequate.

Service provider claim receivables
These debtors are the healthcare providers of the Scheme. The amounts due to the Scheme are offset against future payments to be made to these providers. An impairment allowance covering 85% (2016: 38%) of the total amount due has been raised and the Trustees are satisfied that this is adequate.

Cash and cash equivalents	**2018 R'000**	**2017 R'000**
Invested with counterparties with high quality credit ratings	787,416	926,691

25. 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 objectives 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 99% 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.

An expected maturity analysis for financial liabilities, including insurance liabilities is provided below:

	Less than 1 month	Between 2 and 4 months	More than 4 months	Total
As at 31 December 2018	**R'000**	**R'000**	**R'000**	**R'000**
Medical Savings Account liability	1,689	2,365	190,437	194,491
Trade and other payables	17,293	-	-	17,293
Outstanding risk claims provision	10,657	6,295	52	17,004
As at 31 December 2017				
Medical Savings Account liability	1,371	1,920	170,600	173,891
Trade and other payables	13,726	-	-	13,726
Outstanding risk claims provision	10,573	2,736	41	13,350

26. CRITICAL ACCOUNTING ESTIMATES AND JUDGEMENTS

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 5.

Other risk transfer arrangements

The critical estimates and judgements relating to other risk transfer arrangements are set out under Note 10.

27. NON-COMPLIANCE WITH THE MEDICAL SCHEMES ACT

The Trustees are of the opinion that there are no material deviations from the Act as a result of the Scheme having obtained the necessary exemptions from the Council for Medical Schemes to achieve compliance.

27.1 Outstanding contributions

Nature and impact

In terms of Section 26(7) of the Act, contributions should be received in accordance with the rules of the Scheme. Per the Scheme rules, contributions are required to be received within three days after their due date. Instances were noted where contributions were received late.

Causes for failure

Balances after three days are due to reconciling discrepancies between the participating employers and the Scheme. The risk of default on payments due to the Scheme is small because of the restricted nature of the Scheme and employer base. The Trustees consider this to be immaterial.

Corrective action

Suspension policies are in place and applied where contributions are outstanding for individual paying members outside the participating employers' obligation.

27. NON-COMPLIANCE WITH THE MEDICAL SCHEMES ACT (continued)

27.2 Investment in participating employer

Nature and impact

Section 35(8)(a) of the Act states that a medical scheme shall not invest any of its assets in a participating employer. During the year the Scheme had exposure to investments in participating employer groups.

Causes for failure

The Scheme invests in pooled investment vehicles which allow investment managers discretion to invest in a combination of shares and bonds that will best achieve their stipulated benchmark. Given this approach, the Scheme was exposed to participating employer shares.

Corrective action

The Scheme applies annually to the Council for Medical Schemes and received an exemption from this section of the Act.

27.3 Investment in administrator

Nature and impact

Section 35(8)(c) of the Act states that a medical scheme shall not invest any of its assets in any administrator. During the year the Scheme had exposure to such investments.

Causes for failure

The Scheme invests in pooled investment vehicles which allow investment managers discretion to invest in a combination of shares and bonds that will best achieve their stipulated benchmark.

Corrective action

The Scheme applies annually to the Council for Medical Schemes and received an exemption from this section of the Act.

27. NON-COMPLIANCE WITH THE MEDICAL SCHEMES ACT (continued)

27.4 Investment limitations

Nature and impact

Regulation 30(3) states that a medical scheme shall not invest more than 40% of its assets in local equities. The Scheme exceeds this limit periodically.

Causes for failure

The Act makes provision for medical schemes to exceed the limit of 40% on local equities under certain circumstances. The Board of Trustees decided to exceed the limit after complying with all the required circumstances. The purpose is to maximise investment income on a long-term basis.

Corrective action

The Scheme submitted a certified statement prepared by its consultants to the Council for Medical Schemes to state that an alternative percentage of 75% should apply to the excess assets as permitted in Regulation 30(3).

27.5 Sustainability of benefit options

Nature and impact

In terms of section 33(2) of the Act, each benefit option shall be self-supporting in terms of membership and financial performance. At 31 December 2018, all three benefit options incurred deficits before investment income as set out in Note 23 to the financial statements.

Causes for failure

The Board of Trustees annually maintain market related benefit offerings and competitive contribution increases. Due to the Scheme demographics, this gives rise to the non-compliance.

Corrective action

Anglo American South Africa sold numerous subsidiaries over a period of time resulting in the loss of active employees and retention of pensioners. To compensate the Scheme for the resultant high pensioner ratio and expected deterioration of the claiming profile, the participating employers pre-funded the additional liability to the extent that the Scheme could maintain market related benefits and contribution increases into the future. The Scheme meets its responsibility to the members by subsidising the expected claims excess over contributions from the reserves. The Trustees will continue to review the investment returns to align with the strategy ensuring sustainability.

The Council for Medical Schemes is aware of the Scheme's strategy and approves the benefits and contributions annually without any requirement to take further corrective action.

27. NON-COMPLIANCE WITH THE MEDICAL SCHEMES ACT (continued)

27.6 Payment of claims within 30 days

Nature and impact

In terms of section 59(2) of the Act a member or provider claim should be settled within 30 days of submission. Instances were noted where settlements took more than 30 days.

Causes for failure

Delays can occur when accounts are referred for clinical audit or other investigations. These are however the exceptions, and claims are generally paid within the prescribed time.

Corrective action

The Scheme is aware of the requirements and complies as far as possible. It is however an inherent part of the industry that a limited number of problematic claims may exceed the payment requirement of 30 days.