ANGLO MEDICAL SCHEME

ANNUAL REPORT

FOR THE YEAR ENDED

31 DECEMBER 2023

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

	Page
Scheme Details	
Report of the Board of Trustees	1 - 23
Statement of Responsibility by the Board of Trustees	24
Statement of Corporate Governance by the Board of Trustees	25
Independent Auditor's Report	26 - 31
Statement of Financial Position	32
Statement of Comprehensive Income	33
Statement of changes in funds and reserves	33
Statement of Cash Flows	34
Notes to the Annual Financial Statements	35 - 83

SCHEME DETAILS

for the year ended 31 December 2023 (Registration no. 1012)

BOARD OF TRUSTEES as at 31 December 2023

Trustee	Capacity
Coetzer JP (Chairman)	Employer Appointed (Appointed Chairman 24 March 2023)
Elliott CC (Chairman)	Member Elected (Resigned as Chairman 24 March 2023)
Fox Dr FH (Vice-Chairman)	Member Elected
Ameer KN	Employer Appointed (A)
Farrell MR*	Member Elected
Hosking S	Member Elected
Liston JB	Employer Appointed
Mamabolo NM	Employer Appointed
Mason-Gordon NJ	Member Elected
Matemera TS	Employer Appointed (A)
McKie Thomson CMT*	Member Elected (A)
Mhlongo QP	Member Elected
Moodley R	Employer Appointed
Preston GP*	Member Elected (A)
Ragolane NS	Member Elected (A)
Thompson HM	Employer Appointed
van der Bijl BD	Employer Appointed
van Vugt TD	Employer Appointed (A)

(A) Alternate trustee

* see point 10.1 of the Report of the Board of Trustees for trustee movements

PRINCIPAL OFFICER	Mrs JC le Roux	Appointed 1 November 2023
	Mrs FK Robertson	Retired 15 December 2023
REGISTERED OFFICE	7th Floor 144 Oxford Road Melrose Rosebank 2191	
POSTAL ADDRESS	PO Box 746 Rivonia 2128	
AUDITOR Registered address	PricewaterhouseCoopers Inc. 4 Lisbon Lane Waterfall City Jukskei View 2090	
ADMINISTRATOR Registered address	Discovery Health (Pty) Ltd 1 Discovery Place Sandton 2146	

REPORT OF THE BOARD OF TRUSTEES
for the year ended 31 December 2023

The Board of Trustees hereby presents its report for the year ended 31 December 2023.

1. DESCRIPTION OF THE MEDICAL SCHEME

1.1. Terms of registration

The Anglo Medical Scheme (the Scheme) 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 Corporate Services South Africa (Pty) Limited, Mondi South Africa (Pty) Limited and Mpact Limited.

At 31 December 2023 the Scheme provided benefits to 8,605 members and 9,001 dependants. 51.05% of the members and dependants are female. Members are located primarily in Gauteng (41%), KwaZulu-Natal (32%) and the Western Cape (13%). The balance of membership is spread across South Africa with a small number outside of 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 2023, Managed Care Plan serving 5,759 beneficiaries, average age 58.84 years, Standard Care Plan, 9,196 beneficiaries, average age 34.75 years and Value Care Plan 2,651 beneficiaries, average age 26.13 years old.

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

  This is a comprehensive plan that offers unlimited cover for hospitalisation paid at 100% of the Scheme Reimbursement Rate and an additional top-up benefit which pays up to 230% of the Scheme Reimbursement Rate for specialist services rendered in hospital. Radiology and Pathology are unlimited and funded by the Scheme up to 100% of the Scheme Reimbursement Rate. Medical and surgical appliances, wheelchairs, hearing aids, chronic non-PMB medication and frail care are funded by the Scheme, subject to family and individual limits. Discretionary spend for out of hospital services are covered by the members' Medical Savings Accounts (MSA). Out of hospital specialist consultations and procedures are reimbursed up to 125% of the Scheme Reimbursement Rate.

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

  This is a traditional medical plan with defined benefits and out of hospital family limits. Out of hospital benefits are limited and grouped by service under individual limits reimbursed at 100% of the Scheme Reimbursement Rate. Hospital cover is unlimited and paid at 100% of the Scheme Reimbursement Rate, subject to the network facilities.

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

  This is a primary health care plan providing services through a capitated arrangement with Kaelo Prime Cure (Pty) Ltd. Members may only obtain services from Kaelo Prime Cure facilities or network providers. Benefits are managed through limits, pre-authorisation and the application of Kaelo Prime Cure managed care protocols.

1. DESCRIPTION OF THE MEDICAL SCHEME (continued)

1.3. Registered office

7th Floor
144 Oxford Road
Melrose
Rosebank
2191

PO Box 746
Rivonia
2128

1.4. **Scheme administrator** in office during the year under review

Discovery Health (Pty) Ltd
1 Discovery Place
Sandton
2146

1.5. **Investment managers** 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

Ninety One SA (Pty) Ltd
36 Hans Strydom Avenue, Foreshore
Cape Town
8001

Abax Investments (Pty) Ltd
The Oval, 1 Oakdale Road
Newlands
7700

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. DESCRIPTION OF THE MEDICAL SCHEME (continued)

1.7. **Actuarial advisors** in office during the year under review

3One Consulting Actuaries
199 Bryanston Drive
Northview Building, Ground Floor, Bryanston Place Office Park,
Bryanston
2191

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 IFRS® Accounting 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, in all material respects, prepared 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. SCOPE OF THE REPORT (continued)

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 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 (Board) 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 biannually 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 coming 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 for 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 Administrator's Internal and Scheme's External Auditors regularly. 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 Scheme's significantly higher than industry average membership age has been pre-funded to ensure the Scheme's sustainability and the contributions and benefits remain market-related and competitive.

4. SCHEME STRATEGY

To achieve the vision of offering quality, cost effective and competitive benefits to meet the lifelong healthcare needs of the members, the Scheme has adopted several strategies as set out below.

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 (24.1% compared to 9.28% - CMS report 2023) increases the expected overall cost of providing adequate healthcare benefits to our members.

4. SCHEME STRATEGY (continued)

4.1. Long term funding (continued)

The Scheme previously entered into an arrangement with the participating employer groups and received funding to meet the ongoing and the future cost of providing benefits for the higher than usual 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 by when the pensioner ratio is expected to have normalised and be more in line with the market.

In performing the actuarial valuation, the Scheme's actuaries make 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 the annual financial statements.

The value of the Scheme's long term funding assets as at 31 December 2023 was R3.574 billion (2022 - R3.302 billion). This compares to the gross long-term liability calculated by the Scheme's consultants and actuaries of R2.520 billion (2022 - R2.466 billion), for the period to 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 to 31 December 2023 (p.a.)	11.4%	5.6%	9.1%
5 Years (p.a.)	7.8%	5.1%	8.6%
23 Years (p.a.) (since inception)	10.4%	5.5%	9.0%

The 2023 financial year saw a recovery in markets from the preceding year.The 5-year return (net of fees) for the Scheme's assets has therefore improved from 5.4% p.a. in 2022 to 7.8% p.a. for the period under review.

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 members carrying the burden of these higher costs, an amount is budgeted annually, which is drawn from the reserves, to provide for the shortfall between the budgeted risk contribution income and claims incurred. In 2023 this amounted to R80 million (2022 - R75 million). This increase in the shortfall from 2022 to 2023 was significantly lower than actuarially projected and reflected a slower than expected return to the normal claiming patterns by members which, in turn, increased the funding ratio.

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 need of members over their lifetime, the Scheme's actuaries annually determine the Scheme's liability which is matched against the level of reserving. The Liability for Future Members (formerly known as Accumulated Funds) as at 31 December 2023 is R3.574 billion.

The table below shows the funding ratio as at 31 December and the projected figure as at 31 December as per the actuarial valuation.

	2023 R'000	**2022 R'000**
Total long-term liabilities	2,520,293	2,465,903
Net value of assets	3,573,960	3,302,061
Current long-term funding ratio	141.8%	133.7%

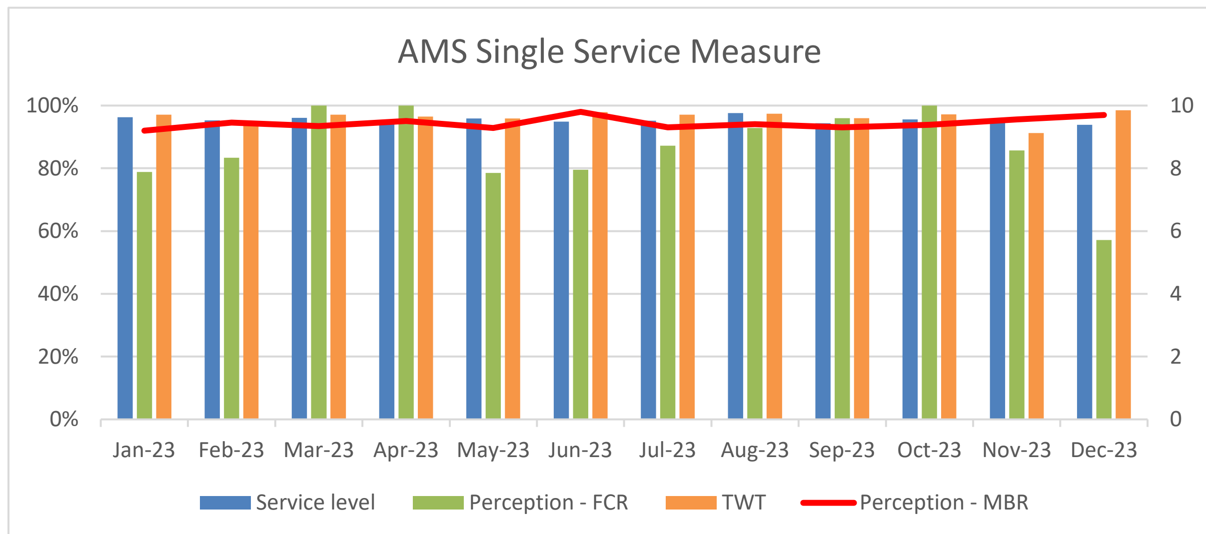
5.2. Unlike most open schemes who measure their size, market share, annual growth, solvency levels etcetera, the Scheme closely monitors its value proposition to members and employers. The performance of the Scheme is measured by the contribution increase that is effected annually, coupled with benefit changes. The aim of the Scheme is to continue to maintain contribution increases close to the generally accepted medical inflation rate of CPI plus 3%, as seen in the table below.

Year	**2024**	**2023**	**2022**	**2021**	**2020**
Average annual contribution increase per member	6.9%	8.0%	6.0%	3.9%	9.5%
CPI + 3%	8.6%	8.1%	10.2%	6.2%	7.5%

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 2023 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. KEY PERFORMANCE MEASURES

5.4. During 2023 the Scheme's administrator, Discovery Health, maintained service levels above the required 90%, thus meeting the service excellence promise to members. The graph below depicts the various single service measures applicable. The information is provided by the administrator and is presented and review by the Board on a frequent basis.



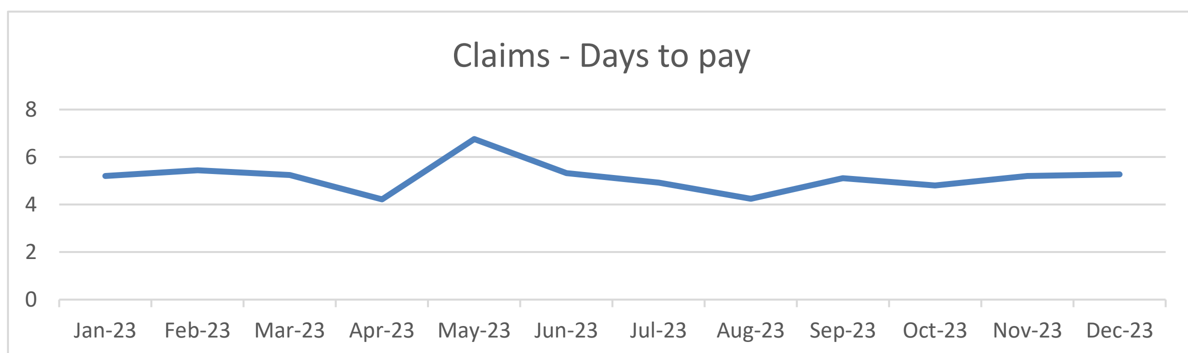
SL: Service Level

MBR: Member Based Research measures member happiness

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

TWT: Today's work today (Turnaround time)

The graph below measures the average number of days between a claim being received and paid. The information is provided by the administrator and is presented and reviewed by the Board on a frequent basis.



5.5. The Council for Medical Schemes requires that non-healthcare costs are kept below 10% of gross contribution income. The 2023 non-healthcare cost compared well against previous years and is well below the Council's requirements.

Year	**2023**	**2022**	**2021**	**2020**	**2019**
Non-healthcare costs as a percentage of gross contribution income#	6.1%	5.7%	5.8%	5.7%	5.7%
*Industry average**	*5.6%*	*5.4%*	*5.4%*	*6.5%*	*5.5%*

\# *The calculation of non-healthcare cost has been kept consistent with prior years for the sake of comparability*

* *Industry average percentage for restricted membership medical schemes as reported by the Council for Medical Schemes*

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 investment income and the draw down from the reserves required to cover the expected contribution shortfall.

	2023 R'000	2022 R'000
Insurance service result (see Note 19 of the Annual Financial Statements)	(91,036)	(66,482)
Managed Care Plan	(99,433)	(78,040)
Standard Care Plan	5,761	10,801
Value Care Plan	2,635	757
Amounts attributable to future members (formerly net result) (see note 5.1 of the Annual Financial Statements)	271,899	67,965

The adult and child contributions are rebalanced annually (as required) 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. For the period under review, the increases and contributions were as follows:

	2023 R		2022 R	
Average contribution increase 8.0% (2022 - 6.0%)	Adult	Child	Adult	Child
Managed Care Plan	5,885	1,360	5,450	1,260
Standard Care Plan	3,220	965	2,980	895
Value Care Plan	1,235	285	1,075	265

6.2. Outstanding risk claims

Movements in the outstanding risk claims provision are included in the Insurance Contract Liability set out in Note 5 to the financial statements. The basis of calculation is consistent with the prior year except for the inclusion of a risk adjustment for non-financial risk. See disclosure in the financial statements.

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

6.3. Liability for Future Members

Movements in the Liability for Future Members (formerly known as Accumulated Funds) are set out in Note 5 of the Annual Financial Statements.

	2023 R'000	2022 R'000 Restated
Liability for Future Members per Statement of Financial Position	3,573,960	3,302,061
Less: Cumulative unrealised net gain on measurement of investments to fair value	(572,030)	(470,889)
Accumulated funds per Regulation 29 of the Act	3,001,930	2,831,172
Gross contribution income	639,892	614,208
Accumulated funds ratio per Regulation 29 (including unrealised gains)	558.5%	537.6%
Accumulated funds ratio per Regulation 29 (excluding unrealised gains)	469.1%	460.9%
Minimum ratio required by Regulation 29 of the Act	25.0%	25.0%

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

The average Liability for future members per member as at 31 December 2023 was R415,335 (2022: R376,991).

6.4. Medical Savings Accounts

The liability to members in respect of the Medical Savings Accounts is reflected as part of the Insurance Contract 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		
	2023	2022	%	2023	2022	%	2023	2022	%	2023	2022	%
Number of members at end of accounting period	3,394	3,623	-6%	4,048	4,064	0%	1,163	1,072	8%	8,605	8,759	-2%
Average (avg) number of members for the period	3,508	3,684	-5%	4,055	3,983	2%	1,125	1,005	12%	8,688	8,672	0%
Beneficiaries at end of accounting period	5,759	6,240	-8%	9,196	9,281	-1%	2,651	2,397	11%	17,606	17,918	-2%
Average (avg) number of beneficiaries for the period	5,958	6,343	-6%	9,207	9,116	1%	2,541	2,249	13%	17,706	17,708	0%
Beneficiaries per member at end of accounting period	1.70	1.72	-1%	2.27	2.28	-1%	2.28	2.24	2%	2.05	2.05	0%
Avg age of beneficiaries	58.84	58.34	1%	34.75	34.52	1%	26.13	25.97	1%	41.53	41.68	0%
Pensioner ratio (beneficiary > 65 years)	52.70%	51.60%	2%	11.50%	11.20%	3%	1.90%	1.70%	12%	23.80%	24.10%	-1%
Avg gross Insurance revenue per member per month (R)	8,421	8,029	5%	5,369	5,011	7%	1,781	1,636	9%	6,137	5,902	4%
Avg gross Insurance revenue per beneficiary per month (R)	4,958	4,663	6%	2,365	2,190	8%	789	731	8%	3,011	2,890	4%
Avg gross Insurance service expense per member per month (R)	10,685	9,676	10%	5,308	4,829	10%	1,332	1,259	6%	6,964	6,474	8%
Avg gross insurance expense per beneficiary per month (R)	6,291	5,620	12%	2,338	2,110	11%	590	563	5%	3,417	3,171	8%
Avg gross administration cost per member per month (R)	414	374	11%	415	375	11%	83	75	11%	372	339	10%
Avg gross administration cost per beneficiary per month (R)	244	217	12%	183	164	12%	37	33	12%	182	166	10%
Insurance service expense as a % of Insurance revenue	136.2%	128.5%	6%	98.9%	96.4%	3%	74.8%	77.0%	-3%	116.3%	112.3%	4%
Administration cost as a % of gross contributions	4.9%	4.7%	5%	7.7%	7.5%	3%	4.7%	4.3%	8%	6.1%	5.7%	5%

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 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, quality products and services that are market related to meet employer 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.

The short to medium term pandemic risk impact on the healthcare costs and the investment returns will continue to work through the system without the need to change strategic direction.

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, pandemics 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 20 and 21 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;
- Assesses 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 controls 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 analyses 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 (reinsurance)

Refer to Notes 6 and 8 of the financial statements.

In line with the vision to soundly manage the claims risk, the Scheme has entered into risk transfer 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 arrangements were in place for the year:

Organisation	Services capitated	Plan
Kaelo 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 a network of dentists providing 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 IFRS® Accounting Standards and all the relevant legislative requirements.

10. MANAGEMENT

10.1. Board of Trustees in office during 2023:

Coetzer JP	Employer Appointed (appointed Chairman 24 March 2023)
Elliott CC (Chairman)	Member Elected (resigned as Chairman 24 March 2023)
Fox Dr FH (Vice-Chairman)	Member Elected
Ameer KN	Employer Appointed (A)
Farrell MR	Member Elected
Hosking S	Member Elected
Liston JB	Employer Appointed
Mamabolo NM	Employer Appointed
Mason-Gordon NJ	Member Elected
Matemera TS	Employer Appointed (A)
McKie Thomson CMT	Member Elected (A)
Mhlongo QP	Member Elected
Moodley R	Employer Appointed
Preston GP	Member Elected (A)
Ragolane NS	Member Elected (A)
Thompson HM	Employer Appointed
van der Bijl BD	Employer Appointed
van Vugt TD	Employer Appointed (A)

(A) Alternate trustee

10. MANAGEMENT (continued)

10.2. Management Committee in office during the year under review:

Fox FH (Chairman); Coetzer JP; Elliott CC; Liston JB; Mhlongo QP; van der Bijl BD.

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

Prinsloo J (Chairman, Independent); Kapp G (Independent); Mamabolo NM; Moodley R; van Zyl C (Independent).

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

Fox Dr FH (Chairman); Farrell MR; Hoskings S; Mhlongo QP; Mamabolo NM; Pienaar J (Independent).

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

Mason-Gordon NJ (Chairman); Clark B (Independent); Liston JB; Mamabolo NM; Thompson HM

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

Badenhorst C (Member elected); Laubscher PA (Independent); Tivana E (Member elected)

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

Elliott CC (Chairman); Coetzer JP

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

Le Roux JC	Principal Officer	Scheme employed	(Appointed 1 November 2023)
Robertson FK	Principal Officer	Scheme employed	(Retired 15 December 2023)
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.

11. COMMITTEES OF THE BOARD OF TRUSTEES (continued)

11.1. Audit Committee (continued)

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 Administrator's Internal Auditor attends meetings and reports findings to the Committee.

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.

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 Terms of Reference;
- The External Auditor has confirmed their independence;
- The assurances provided by Administrator management, the External Auditor and the Internal Auditor 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 at the Annual General Meeting.

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, and includes an independent member. The Scheme appointed Willis Towers Watson as independent investment consultants to assist the Committee. The current investment managers of the Scheme are Ninety One SA (Pty) Ltd, Coronation Asset Management (Pty) Ltd, Allan Gray South Africa (Pty) Ltd and Abax Investments (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 seven 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 financial hardship of the individual member and medical necessity where benefits are not provided for or expressly excluded from the rules of the Scheme.

This committee consists of five Trustees of which one is an alternate Trustee and also an independent 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.

11.5. 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 the administrator of the Scheme.

No meetings were held for the year.

11. COMMITTEES OF THE BOARD OF TRUSTEES (continued)

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 or Alternate Trustee, employer and member representative and meets at least annually. 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 active and retired members.

11.6. Remuneration committee

The Remuneration Committee (the Committee) is an independent Committee and comprises two members who were appointed by the Board of Trustees.

The primary responsibility of the Remuneration Committee is to ensure sound people management of Scheme employees by providing oversight, assessment, and review of the maintenance of relevant Human Resources and Remuneration policies of the Scheme. In addition, the Committee's responsibilities include advising the Board on the annual cost of living adjustment for Scheme employees; the criteria to be used in benchmark exercises pertaining to remuneration surveys, the remuneration rates applicable to employees, trustees and independent committee members; the implementation of performance reward measures for employees and overseeing the disclosure of the remuneration of trustees, independent committee members and members of the Head Office in the annual integrated report.

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

	Board of Trustees		Audit Committee		Investment Committee		Manage-ment Committee		Ex-gratia Committee		Remune-ration Committee	
Trustees	A	B	A	B	A	B	A	B	A	B	A	B
Elliott CC	7	4	-	-	-	-	4	4	-	-	3	3
Coetzer JP	7	7	-	-	-	*1	4	4	-	-	3	3
Fox Dr FH	7	7	-	-	-	-	4	4	4	4	-	-
Farrell MR	7	6	-	-	-	-	-	-	4	4	-	-
Hosking S	7	7	-	-	-	-	-	-	4	4	-	-
Liston JB	7	6	-	-	4	4	4	3	-	-	-	-
Mamabolo NM	7	7	3	3	4	4	-	-	-	-	-	-
Mason-Gordon NJ	7	7	-	-	4	4	-	-	-	-	-	-
Mhlongo QP	7	7	-	-	-	-	4	3	4	4	-	-
Moodley R	7	7	3	2	-	-	-	-	-	-	-	-
Thompson HM	7	4	-	-	4	4	-	-	-	-	-	-
van der Bijl BD	7	6	-	-	-	-	4	4	-	-	-	-
Alternate Trustees and Consultants												
Ameer KN	-	*3	-	-	-	-	-	-	-	-	-	-
Clark B	-	-	-	-	4	3	-	-	-	-	-	-
Kapp G	-	-	3	3	-	-	-	-	-	-	-	-
Matemera TS	-	*1	-	-	-	-	-	-	-	-	-	-
Mckie Thomson CC	-	*1	-	-	-	-	-	-	-	-	-	-
Pienaar J	-	-	-	-	-	-	-	-	4	4	-	-
Preston GP	-	*2	-	-	-	-	-	-	-	-	-	-
Prinsloo J	-	-	3	3	-	-	-	-	-	-	-	-
Ragolane NS	-	-	-	-	-	-	-	-	-	-	-	-
van Vugt TD	-	-	-	-	-	-	-	-	-	-	-	-
van Zyl C	-	-	3	2	-	-	-	-	-	-	-	-

A = maximum possible attendance

B = actual attendance

* = voluntary attendance

13. ACTUARIAL SERVICES

The Scheme's actuaries are contracted 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) which is included in the Insurance Contract Liability in the financial statements. The Scheme's long-term funding valuation is calculated and reviewed annually by the actuaries.

14. GUARANTEES RECEIVED BY THE SCHEME FROM A THIRD PARTY

No guarantees were received by the Scheme from any third parties.

15. INVESTMENTS IN PARTICIPATING EMPLOYERS AND OTHER RELATED PARTIES

Refer to related parties disclosure in Note 17 of the financial statements.

16. RELATED PARTY TRANSACTIONS

Refer to related parties disclosure in Note 17 of the financial statements. Trustee remuneration is disclosed in Note 18 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 (CMS) to achieve compliance. Although exemptions have been obtained from the CMS, it is a regulatory requirement to disclose all non-compliance matters.

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

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 through pooled investment vehicles.

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. This exemption is valid until 30 November 2025.

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 through pooled investment vehicles.

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. This exemption is valid until 30 November 2025.

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

18.4. 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 2023, the Managed Care plan incurred a deficit before investment income as set out in Note 18 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.

18.5. 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 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.

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

18.6. Investment in equities in territories outside the Republic of South Africa

Nature and impact

In terms of Category 4(b) of Annexure B to the Regulations of the Act, investments in equities in territories outside the Republic of South Africa (RSA) are prohibited.

Causes for failure

The Scheme has exposure to equities in territories outside the Republic of South Africa through its Ninety-One investment portfolio.

Corrective action

The Scheme had applied to the Council for Medical Schemes and received an exemption from this section of the Act. A renewal application was lodged with the Council for Medical Schemes.

18.7. Variance in co-payment required for non-contracted network service provider per brochure and CMS approved Scheme rules

Nature and impact

In terms of Section 33(1) of the Act states that a Medical Scheme shall apply to the Registrar for the approval of any benefit option if such a medical scheme provides members with more than one benefit option.

Causes for failure

One co-payment on the Value Care Plan previously approved by the CMS was incorrectly displayed in the benefit brochure to members.

Corrective action

The Scheme's Rules for 2024 were submitted taking this change into account. The benefit brochure makes provision for this change.

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 2023, the statement of comprehensive income, 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 IFRS® Accounting 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 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 reviewed the Scheme's budget for the year ending 31 December 2024. 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 and authorised for issue by the Trustees on 3 April 2024 and are signed on their behalf by:

Mr JP Coetzer	Dr FH Fox	Ms JC le Roux
Chairman	Vice-Chairman	Principal Officer

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.

Mr JP Coetzer	Dr FH Fox	Ms JC le Roux
Chairman	Vice-Chairman	Principal Officer

3 April 2024

STATEMENT OF FINANCIAL POSITION | **ANGLO MEDICAL SCHEME**

as at 31 December 2023 | (Registration no. 1012)

	Notes	2023	31 December 2022 Restated	1 January 2022 Restated
		R'000	R'000	R'000
ASSETS				
Investments held at fair value through profit or loss	**2**	3,702,884	3,381,965	3,349,525
Financial assets at amortised cost	**3**	2,437	2,477	3,667
Cash and cash equivalents	**4**	154,667	199,623	147,123
Total assets		**3,859,988**	**3,584,065**	**3,500,315**
LIABILITIES				
Total insurance contract liability		3,857,226	3,581,522	3,497,594
Insurance liability for current members*	**5**	283,266	279,461	263,498
Insurance liability for future members*	**5.1**	3,573,960	3,302,061	3,234,096
Financial liabilities at amortised cost	**7**	2,762	2,543	2,721
Total funds and liabilities		**3,859,988**	**3,584,065**	**3,500,315**

* see Mutual Entity disclosure under Note 1.3

STATEMENT OF COMPREHENSIVE INCOME **ANGLO MEDICAL SCHEME**
for the year ended 31 December 2023 (Registration no. 1012)

	Notes	2023 R'000	2022 R'000
Insurance revenue	**8**	**565,356**	**539,569**
Insurance service expense	**8**	**(929,680)**	**(674,077)**
Net income from reinsurance contracts	**8**	**1,389**	**61**
Insurance service result		**(362,935)**	**(134,447)**
Interest income from financial assets not measured at fair value through profit or loss	**10**	3,713	2,288
Investment income from investments held at fair value through profit or loss	**10**	135,611	125,995
Fair value gains from investments held at fair value through profit or loss	**10**	274,918	45,867
Net investment income		**414,242**	**174,150**
Finance expenses from insurance contracts issued - PMSA	**11**	(19,803)	(12,434)
Net insurance finance expense		**(19,803)**	**(12,434)**
Net insurance and investment result		**31,504**	**27,269**
Asset management fees		(15,444)	(14,020)
Other operating expenses	**9**	(17,693)	(15,297)
Sundry income	**12**	1,633	2,048
Net result for the year		**0**	**0**

STATEMENT OF CHANGES IN FUNDS AND RESERVES
as at 31 December 2023

	R'000
Balance at 1 January 2022 (as previously reported)	3,230,062
Transition restatement (see Note 1.2, impact of the adoption of IFRS 17)	(3,230,062)
Balance at 1 January 2022 (restated)	**-**

	Notes	2023	2022 Restated*
		R'000	R'000
CASH FLOWS FROM OPERATING ACTIVITIES			
Cash receipts from members and providers		633,739	615,994
Cash receipts from members - contributions	5.1	633,701	614,645
Cash receipts from members and providers - other		38	1,349
Cash paid to members and providers		(757,698)	(692,090)
Cash paid to members and providers - claims and directly attributable expenses	5.1	(675,925)	(619,419)
Cash paid to providers - other operating expenses		(16,963)	(14,493)
Cash paid to providers - reinsurance expenses	6	(49,988)	(46,071)
Cash paid to members - savings plan refunds	5.1	(14,822)	(12,107)
Sundry income		1,121	1,067
Net cash utilised in operating activities		**(122,838)**	**(75,029)**
CASH FLOWS FROM INVESTING ACTIVITIES			
Acquisition of investments		(1,264,077)	(671,386)
Proceeds on disposal of investments		1,224,193	688,735
Interest received		91,258	73,842
Dividends received		41,952	50,358
Asset management fees		(15,444)	(14,020)
Net cash generated through investing activities		**77,882**	**127,529**
Net (decrease)/increase in cash and cash equivalents		**(44,956)**	**52,500**
Cash and cash equivalents at beginning of the year		**199,623**	**147,123**
Cash and cash equivalents at end of the year		**154,667**	**199,623**

* Some prior year cash flows have been restated in line with IFRS 17 Insurance contract liabilities restatements. These restatements have not had any impact on the net cash flows in operating and investing activities.

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.

1.1 BASIS OF PREPARATION

The Financial Statements have been prepared in accordance with IFRS® Accounting Standards (IFRS) and IFRIC® Interpretations, which are set by the International Accounting Standards Board (IASB). The 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 Financial Statements are set out below. These policies have been applied consistently to all years presented, except for changes required by the mandatory adoption of new and revised IFRS.

The preparation of the Financial Statements in conformity with IFRS® Accounting Standards 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 Financial Statements are prepared in accordance with the going concern principle using the historical cost basis except for certain financial assets and liabilities, which include:

- Financial instruments at fair value through profit or loss; and
- Insurance and reinsurance assets and liabilities – measured in terms of IFRS 17.

Due to the short-term nature of the financial assets and liabilities, all values are shown as current unless otherwise stated.

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

1.2 IMPLEMENTATION OF NEW STANDARDS

New standards, amendments and interpretations not yet effective in 2023 relevant to the Scheme:

Title	Effective date - financial year commencing on or after
Amendments to IAS 1- Non-current liabilities with covenants - These amendments clarify how conditions with which an entity must comply within twelve months after the reporting period affect the classification of a liability. The amendments also aim to improve information an entity provides related to liabilities subject to these conditions. This amendment has no further impact on the Scheme.	1 Jan 2024

1.2 IMPLEMENTATION OF NEW STANDARDS (continued)

New standards, amendments and interpretations not yet effective in 2023 relevant to the Scheme:

Title	Effective date - financial year commencing on or after
Narrow scope amendments to IAS 1 'Presentation of Financial Statements', Practice statement 2 and IAS 8 'Accounting Policies, Changes in Accounting Estimates and Errors' - The amendments aim to improve accounting policy disclosures and to help users of the financial statements to distinguish changes in accounting policies from changes in accounting estimates. The scheme discloses the accounting policy for each note as well as the critical judgements and estimates applicable to the individual financial statement line items. The standard has no further impact on the Scheme.	1 Jan 2024
Amendments to IAS21 Lack of Exchangeability (Amendments to IAS21) - An entity is impacted by the amendments when it has a transaction or an operation in a foreign currency that is not exchangeable into another currency at a measurement date for a specified purpose. A currency is exchangeable when there is an ability to obtain the other currency (with a normal administrative delay), and the transaction would take place through a market or exchange mechanism that creates enforceable rights and obligations. This amendment has no further impact on the Scheme.	1 Jan 2025

Implementation of IFRS 17 *Insurance contracts*

Introduction

The effective date of IFRS 17 Insurance Contracts is for reporting periods beginning on or after 1 January 2023. IFRS 17 is mandatory for the Scheme effective from 1 January 2023.

IFRS 17 is a new accounting standard for insurance contracts that provides guidelines on recognising, measuring, presenting, and disclosing insurance contracts. It was introduced by the International Accounting Standards Board (IASB) in May 2017. IFRS 17 replaces the previous standard, IFRS 4 Insurance Contracts, issued in 2005 as an interim standard with limited prescribed changes to pre-existing insurance accounting practices applied by insurers.

IFRS 17 represents a positive step towards enhancing transparency, comparability, and understanding of how insurers earn profits from insurance contracts, namely insurance service result and financial results. The framework established by IFRS 17 outlines the specific requirements that entities must adhere to when reporting information related to both the insurance contracts they issue and the reinsurance contracts they hold. One of the noteworthy distinctions introduced by IFRS 17 pertains to the level of granularity at which insurance contracts are recognised and measured.

IFRS 17 is not limited to insurance companies but also those entities that issue any contract that results in transfer of significant insurance risk. Contracts issued by the Scheme fall within the scope of IFRS 17. These contracts are entirely aligned with those recognised under the previous standard IFRS 4.

Whilst the underlying contractual terms and economic risks and rewards of each insurance contract remain unaltered, IFRS 17 impacts the accounting treatment of insurance contracts and most notably the timing of recognition of insurance related profits and losses for accounting purposes. Importantly, it also separates the insurance related profit or losses between those arising from insurance service results and those arising from financial results.

1.2 IMPLEMENTATION OF NEW STANDARDS (continued)

Implementation of IFRS 17 *Insurance contracts* (continued)

Transition to IFRS17

Upon first-time adoption, IFRS 17 requires the standard to be applied fully retrospectively as if the standard always applied unless impracticable. If impracticable to do so, the entity can elect to either apply a modified retrospective approach or use the fair value approach.

The Scheme has determined that reasonable and supportable information was available for all contracts in force at the transition date that were issued within three years prior to the transition and is in a position to apply a fully retrospective restatement from inception for its groups of insurance contracts issued. The fully retrospective approach requires that the Scheme identify, recognise, and measure groups of insurance contracts as if IFRS 17 had always applied, derecognising any existing balances that would not exist had IFRS 17 always applied and recognise any resulting net difference in the Insurance liability for future members.

The retrospective approach has limited impact on the Scheme, with the most significant impact being applying the treatment under IFRS 17 for mutual entities and a risk adjustment for non-financial risk to insurance cash flows. The purpose of the risk adjustment is to measure the effect of uncertainty in the fulfilment cash flows that arise from insurance contracts, other than uncertainty arising from financial risk.

The Scheme has applied the retrospective transition provision in IFRS 17 and has not disclosed the impact of the adoption of IFRS 17 on each financial statement line item.

The net impact of the retrospective application on the Scheme's Statement of Financial Position is summarised as follows:

	R'000
Accumulated funds as at 31 December 2021	
Audited and previously reported	**3,230,062**
IFRS 17 adjustment	
Adjustment as a result of the risk adjustment for non financial risk on insurance contracts	(2,153)
Adjustment as a result of the revision to the best estimate liability of claims incurred but not yet reported	6,187
Liability for future members as at 31 December 2021 (Restated)	**3,234,096**
Liability for future members as at 31 December 2022	**3,306,641**
IFRS 17 adjustment	
Adjustment as a result of the risk adjustment for non financial risk on insurance contracts	(3,883)
Adjustment as a result of the revision to the best estimate liability of claims incurred but not yet reported	(697)
Liability for future members as at 31 December 2022 Restated	**3,302,061**

1.2 IMPLEMENTATION OF NEW STANDARDS (continued)

Implementation of IFRS 17 ***Insurance contracts*** (continued)

Change in accounting policy due to IFRS 17 implementation

Classification of contribution receivables

The Scheme has accounted for all contribution debtors that relate to insurance services already rendered in the Liability for Remaining Coverage (LFRC) at year end.

Contributions received in advance and where no insurance service has yet been provided is accounted for in the LFRC.

Classification of expenditure/income outstanding at year end that meet the definition of financial liabilities or financial assets

The fulfilment cash flows may include expenditure incurred in accounting standards other than IFRS 17, for example administration fees payable. When administration fees is outstanding, this would meet the definition of a financial liability. Where expenditure/income outstanding at year end meet the definition of financial liabilities or financial assets, the Scheme has an accounting policy choice to either include the payable/receivables in the insurance contract liabilities or to recognise it as a separate IFRS 9 liability/asset such as trade and other payables/receivables. The Scheme has chosen to include these payables in the insurance contract liabilities.

1.3 SIGNIFICANT JUDGEMENTS AND ESTIMATES

In the application of the Scheme's accounting policies, which are described below and in the notes, the Board of Trustees is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from these estimates. The estimates and underlying assumptions are reviewed on an ongoing basis. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period, or in the period of the revision and future periods if the revision affects both current and future periods.

Following are the significant judgements, apart from those involving estimations (which are dealt with separately below), that have been made in the process of applying the Scheme's accounting policies and that have the most significant effect on the amounts recognised in financial statements.

1.3 SIGNIFICANT JUDGEMENTS AND ESTIMATES (continued)

Significant Judgements

Unit of account

Judgement has been applied to how the Scheme determined the unit of account for the measurement of its insurance contracts. Management has assessed their portfolio as the scheme as a whole due to the holistic pricing methodologies and risk management strategy that manages the risk on a scheme level.

The above is demonstrated by the following:

- Hospital claims are managed on a scheme level.
- Chronic conditions are managed on a scheme level, i.e. no matter the option the member will have access to the chronic condition management benefit.
- Risk transfer arrangements are based on conditions and not on benefit options.
- Pricing and benefit option changes are determined at a scheme level to manage member migration between different benefit options to ensure each option is sustainable.
- Risk (utilisation and concentration) is managed holistically.

Risk adjustments - liability for incurred claims

The risk adjustment for non-financial risk is applied to the present value of the estimated future cash flows and reflects the compensation the Scheme requires for bearing the uncertainty about the amount and timing of the cash flows from non-financial risk as the Scheme fulfils insurance contracts. Because the risk adjustment represents compensation for uncertainty, estimates are made on the degree of diversification benefits and expected favourable and unfavourable outcomes in a way that reflects the Scheme's degree of risk aversion. The Scheme estimates an adjustment for non-financial risk separately from all other estimates.

The risk adjustment was calculated at the portfolio level as the Scheme does not have groups due to laws that constrain the Scheme's ability to set a price for different members. The confidence level method was used to derive the overall risk adjustment for non-financial risk. In the confidence level method, the risk adjustment is determined by applying a confidence level to run-off triangles used to calculate the liability for incurred claims. The confidence level is set to 75%.

The Scheme will present the changes in the risk adjustment for non-financial risk in the insurance service result.

The methods and assumptions used to determine the risk adjustment for non-financial risk were not changed in 2022 and 2023.

Risk adjustments - risk transfer arrangements (reinsurance)

For risk transfer arrangements held, the risk adjustment for non-financial risk represents the amount of risk being transferred by the Scheme to the reinsurer. The same methodology applies to the risk transfer agreements as for the insurance contracts with regards to the determination of the risk adjustment.

1.3 SIGNIFICANT JUDGEMENTS AND ESTIMATES (continued)

Significant Judgements (continued)

Assessment as to whether the Scheme is a mutual entity

A medical scheme is not legally defined as a mutual entity and the assessment as to whether a medical scheme is a mutual entity was done based on the principles set out in IFRS.

IFRS 3 defined a "mutual entity" as "An entity, other than an investor-owned entity, that provides dividends, lower costs or other economic benefits directly to its owners, members or participants. For example, a mutual insurance company, a credit union and a co-operative entity are all mutual entities."

IFRS 17 does not define a "mutual entity" however it provides a key characteristic of a mutual entity in the basis of conclusion to the standard. IFRS 17 paragraph BC265 explains that "a defining feature of an insurer that is a mutual entity is that the most residual interest of the entity is due to a policyholder and not a shareholder." The Act is not explicit that members (i.e. policyholders) hold a residual interest or are entitled to the residual interest upon the liquidation of the medical scheme. Section 64 of the Act requires the medical scheme rules to be followed in the event of liquidation.

The rules of the Scheme do not contain specific guidance on how the assets of the scheme should be distributed on liquidation. The Act prohibits the disposal of assets of a medical scheme except in limited, listed circumstances, one of them being the liquidation of the scheme. Members can opt for voluntary liquidation and can distribute the scheme's remaining assets amongst themselves. As the Scheme does not have shareholders, the current members will access the reserves through economic benefits such as funding reductions in contributions or deferral of contribution increases.

Consequently the statement of profit or loss and other comprehensive income reflects no total comprehensive income for the year. The movement in the insurance liability attributable to future members are included in the insurance service expenses.

Due to the Scheme being a mutual entity, the assessment of onerous contracts are also affected.

Although the rules do not specify how the assets should be distributed on liquidation, IFRS 17 states that "contracts can be written, oral or implied by an entity's customary business practices. Contractual terms include all terms in a contract, explicit or implied, but an entity shall disregard terms that have no commercial substance (i.e. no discernible effect on the economics of the contract). Implied terms in a contract include those imposed by law or regulation" (IFRS 17.2). Therefore, based on customary business practices, the remaining assets of a scheme should be distributed to the members on liquidation if there are any and if the scheme does not amalgamate with another scheme. Even if the assets are distributed by a regulator or by the policyholders to an independent third party e.g. another medical scheme, an administrator or a charity, the important aspect is that the choice resides with the members or the regulator acting on behalf of the members, not with an equity holder.

The substance of the legal framework issued regarding insurance contracts and observed practice is that once a contribution is paid to the medical scheme, the contribution is used to provide benefits to members. The benefits are provided by the medical scheme (or amalgamated schemes) through insurance coverage, reduced contributions, or payment to members on liquidation (based on votes taken by members).

It is therefore expected that the remaining assets of the scheme will be used to pay current and future members. Based on the above, the Scheme meets the definition of a mutual entity in IFRS.

1.3 SIGNIFICANT JUDGEMENTS AND ESTIMATES (continued)

Significant Judgements (continued)

Assessment as to whether the Scheme is a mutual entity (continued)

The Scheme has therefore developed an accounting policy in terms of the IFRS 17 guidance for mutual entities and the educational material as issued by the IASB and the Scheme recognises any cumulative profit or losses as part of the insurance liability attributable to future members (which forms part of the insurance contract liabilities on the face of the statement of financial position).

Significant estimates

The preparation of financial statements requires the use of accounting estimates, which, by definition, will seldom equal the actual results. This note provides an overview of items that are more likely to be materially adjusted due to changes in estimates and assumptions in subsequent periods. Detailed information about each of these estimates is included in the notes below, together with information about the basis of calculation for each affected line item in the financial statements.

In applying IFRS17 measurement requirements, the following inputs and methods were used that include significant estimates. The present value of future cash flows is estimated using deterministic scenarios.

The sensitivities with regard to the assumptions made that have the most significant impact on measurement under IFRS17, are detailed in the Insurance Risk Management note in the Financial Statements.

Estimates of future cash flows to fulfil insurance contracts

Included in the measure of the Liability for Incurred Claims of a group of contracts are all the future cash flows within the boundary of the group of contracts. The estimates of these future cash flows are based on probability weighted expected future cash flows. The Scheme estimates which cash flows are expected and the probability that they will occur as at the measurement date. In making these expectations, the Scheme uses information about past events, current conditions and forecasts of future conditions. The Scheme's estimate of future cash flows is the mean of a range of scenarios that reflect the full range of possible outcomes. Each scenario specifies the amount, timing, and probability of cash flows. The probability weighted average of the future cash flows is calculated using a deterministic scenario representing the probability weighted mean of a full range of scenarios.

The uncertainty in the insurance contracts lies in the number, severity, and timing of claims.

Assumptions used to develop estimates about future cash flows are reassessed at each reporting date and adjusted where required.

Methods used to measure the insurance contracts

The Scheme estimates insurance liabilities in relation to claims incurred for healthcare contracts.

Judgement is involved in assessing the most appropriate technique to estimate insurance liabilities for the claims incurred. The actuarial methodology used in assessing the estimated claims outcome of insurance liabilities is the chain ladder method.

1.3 SIGNIFICANT JUDGEMENTS AND ESTIMATES

Methods used to measure the insurance contracts (continued)

The chain ladder method involves an analysis of historical claims development factors and the selection of estimated development factors based on this historical pattern. The selected development factors are then applied to cumulative claims data for each period (in the Scheme's case, for the four months post year-end) that is not yet fully developed to produce an estimated ultimate claims cost for each healthcare year. The chain ladder method is the most appropriate for this claim pattern.

Run-off triangles are used in situations where it takes time after the treatment date for the full extent of the claims to become known. It is assumed that payments will emerge in a similar way in each service month. The proportional increase in known cumulative payments from one development month to the next can then be used to calculate payments for future development months.

The following was taken into account when estimating the Liability for incurred claims:
- The homogeneity of the data.
- Changes in pattern of claims.
- Changes in the composition of members and their beneficiaries.
- Changes in benefit limits.
- Changes in the prescribed minimum benefits.

1.4 INSURANCE CONTRACTS SCOPE AND GROUPING

Definition and classification

Contracts under which the Scheme accepts significant insurance risk from another party (the member) by agreeing to compensate the member or other beneficiary if a specified uncertain future event (the insured event) adversely affects the member or other beneficiary are classified as insurance contracts. In making this assessment, all substantive rights and obligations, including those arising from law or regulation, are considered on a contract-by-contract basis. The Scheme uses judgement to assess whether a contract transfers insurance risk and whether the accepted insurance risk is significant.

Separating components within insurance contracts

Before the Scheme accounts for an insurance contract it analyses whether the contract contains components that should be separated. There are three categories of components that have to be accounted for separately:
- cash flows relating to embedded derivatives that are required to be separated;
- cash flows relating to distinct investment components; and
- promises to transfer distinct goods or distinct non-insurance services.

The Scheme does not have contracts with specified embedded derivatives. Certain of the contracts with members contain a Personal Medical Savings Account (PMSA) component. The PMSA, an investment component, and the insurance component of the insurance contract is highly interrelated.

The PMSA is a non-distinct investment component with the balances included in Insurance Contract Liabilities in the Statement of Financial Position. While the cash flows are not recorded in the Statement of Comprehensive Income, they are considered in assessing onerous contracts.

1.4 INSURANCE CONTRACTS SCOPE AND GROUPING (continued)

Level of aggregation

The level of aggregation has a significant impact on accounting for the insurance contract, including the measurement of insurance contracts and the extent of offsetting or cross subsidisation to determine onerous contracts. A portfolio comprises contracts subject to similar risks and managed together. These are then divided into groups depending on their level of profitability. Once the group of insurance contracts has been established, it becomes the unit of account.

The contracts issued by the Scheme are subject to similar risks and managed together thus falling into the same portfolio with no further disaggregation into groups. The level of aggregation is assessed to be at a Scheme level.

Contract boundary

The Scheme uses the concept of contract boundary to determine what cash flows should be considered in the measurement of groups of insurance contracts. This assessment is reviewed every reporting

Cash flows are within the boundary of an insurance contract if they arise from the rights and obligations that exist during the period in which the member is obligated to pay contributions, or the Scheme has a substantive obligation to provide the member with insurance coverage or other services. A substantive obligation ends when both of the following criteria are satisfied:

- the Scheme has the practical ability to reassess the risks of the portfolio of insurance contracts and set a price or level of benefits that fully reflects the risks of that portfolio; and
- the pricing of contributions related to coverage to the date when risks are reassessed does not reflect the risks related to periods beyond the reassessment date.

In assessing the practical ability to reprice, risks transferred from the member to the Scheme are considered; other risks, such as lapse or surrender and expense risk, are not included.

Cash flows outside the insurance contract boundary relate to future insurance contracts and are recognised when those contracts meet the recognition criteria.

The Scheme has assessed its portfolio of insurance contracts to have a contract boundary of one year, which coincides with the Scheme's financial year.

Recognition and derecognition

The group of insurance contracts issued are initially recognised from the earliest of the following:

- the beginning of the coverage period;
- the date when the first payment from the member is due or actually received, if there is no due date; and
- when the Scheme determines that a group of contracts becomes onerous.

An insurance contract is derecognised when it is:

- extinguished (i.e. when the obligation specified in the insurance contract expires or is discharged or cancelled); or
- if the terms are modified due to an agreement between the Scheme and its member or by regulation and the modification terms meet the requirement in IFRS17.

If the modification does not comply with all the requirements of IFRS17 the Scheme shall treat the changes in cash flow as changes in estimates of fulfilment cash flows.

1.4 INSURANCE CONTRACTS SCOPE AND GROUPING (continued)

Initial and subsequent measurement

The coverage period of each contract in the Scheme's portfolio of insurance contracts is one year or less. Therefore, the Scheme has made the accounting policy choice to simplify the measurement of its group of contracts using the Premium Allocation Approach.

For insurance contracts issued, on initial recognition, the Scheme measures the Liability for remaining coverage at the amount of contributions received.

The carrying amount of the group of insurance contracts issued at each reporting period is the sum of:

- the Liability for remaining coverage decreased by any investment component paid or transferred to the liability for incurred claims; and
- the Liability for incurred claims, comprising the fulfilment cashflows related to past service allocated to the group at the reporting date.

For insurance contracts issued, at each of the subsequent reporting dates, the Liability for remaining coverage is:

- increased for contributions received in the period;
- decreased by any investment component paid or transferred to the liability for incurred claims; and
- decreased for the amounts of expected contributions received recognised as insurance revenue for the services provided in the period.

For insurance contracts issued at each of the subsequent reporting dates the Liability for incurred claims is:

- profitability weighted estimate of the present value of the future cash flows; and
- risk adjustment for non-financial risk.

Refer to Judgements and Estimates earlier in this note for the significant judgements and estimates used to determine the Liability for incurred claims and the estimates to determine the fulfilment cash flow.

Onerous contract assessment

In the consideration of whether facts and circumstances indicate that a group of insurance contracts is onerous, the Scheme considers whether the expected deficit of the following year exceeds the insurance liability attributable to future members. In the rare scenario where the following year’s deficit exceeds the insurance liability attributable to future members – the contracts written would be onerous and an onerous contract liability raised. Where the amounts attributable to future members exceed the following year’s deficit the contracts would not be determined as onerous, and no provision raised as a liability is already recognised.

Insurance revenue

As the Scheme provides services under the group of insurance contracts, it reduces the Liability for remaining coverage and recognises insurance revenue. The amount of insurance revenue recognised in the reporting period depicts the transfer of promised services at an amount that reflects the portion of consideration the Scheme expects to be entitled to in exchange for those services.

For the group of insurance contracts measured under the Premium Allocation Approach, the Scheme recognises insurance revenue based on the passage of time over the coverage period of the group of contracts.

1.4 INSURANCE CONTRACTS SCOPE AND GROUPING (continued)

Insurance Service Expenses

Insurance service expenses include:

- incurred claims and benefits excluding investment components;
- other incurred directly attributable insurance service expenses;
- changes that relate to past service (i.e. changes in the fulfilment cashflows relating to the Liability for incurred claims);
- changes that relate to future service (i.e. losses/reversals on onerous groups of contracts from changes in the loss components); and
- amounts attributable to future members

Net of:

- Recoveries from third parties (including reimbursement from the Road Accident Fund).

Cash flows that are not directly attributable to a group of insurance contracts, such as some product development and training costs, are recognised in other operating expenses as incurred.

Other incurred directly attributable insurance service expenses include:

Accredited managed care healthcare services (no risk transfer)

Accredited managed healthcare services (no risk transfer) fees comprise amounts paid or payable to a third party for managing the utilisation, costs and quality of healthcare services to the members of the Scheme and are expensed as incurred. Accredited managed healthcare services are part of healthcare expenditure as they directly impact on the delivery of cost-effective and appropriate healthcare benefits to beneficiaries of the Scheme.

Accredited administration services

Expenses for accredited administration services are paid to the Scheme administrator.

Cash flows that are not directly attributable to a group of insurance contracts are recognised in other operating expenses as incurred and include the Scheme’s operating expenses and other administration services fees paid to the Scheme administrator.

Insurance interest income and expenses

The non-distinct investment component (PMSA) accrues interest. This is disclosed within the insurance finance expense line item.

Interest payable on members' Personal Medical Savings Accounts is expensed when incurred.

1.5 RISK TRANSFER ARRANGEMENTS (REINSURANCE)

Definition

Risk transfer arrangements are contractual arrangements entered into by the Scheme with a provider. The provider is paid a fixed fee per member to cover the risk of the number of incidents that occur during a specified period and the cost of providing the service. Risk transfer arrangements do not reduce the Scheme's primary obligations to its members and their dependents.

Unit of account

Groups of reinsurance contracts held are assessed for aggregation separately from groups of insurance contracts issued. Applying the grouping requirements to reinsurance contracts held, the Scheme aggregates reinsurance contracts held concluded within a calendar year (annual cohorts) into groups of contracts for which there is a net gain at initial recognition.

Reinsurance contracts held are assessed for aggregation requirements on an individual contract basis. The Scheme tracks internal management information reflecting historical experiences of such contracts' performance. This information is used for setting pricing of these contracts such that they result in reinsurance contracts held in a net cost position without a significant possibility of a net gain arising subsequently.

Recognition and derecognition

The reinsurance contract held that covers the losses of separate insurance contracts on a proportionate basis is recognised at the later of:

- the beginning of the coverage period of the group; or
- the initial recognition of any underlying insurance contract.

The Scheme does not recognise their reinsurance contract held until it has recognised at least one of the underlying insurance contracts.

Initial and subsequent measurement

The coverage period of each reinsurance contract in the Scheme's group of reinsurance contracts, is one year or less. Therefore the Scheme has made the accounting policy choice to simplify the measurement of it's group of reinsurance contracts using the PAA.

For reinsurance contracts held, on initial recognition, the Scheme measures the remaining coverage at the amount of ceding contributions paid.

The carrying amount of a group of reinsurance contracts held at the end of each reporting period is the sum of:

- the remaining coverage; and
- the incurred claims, comprising the fulfilment cashflows related to past service allocated to the group at the reporting date.

Subsequent measurement of the remaining coverage for reinsurance contracts held is:

- increased for ceding contributions paid in the period; and
- decreased for the amounts of ceding contributions recognised as reinsurance expenses for the services received in the period.

The Scheme does not adjust the asset for the remaining coverage for reinsurance contracts held for the effect of the time value of money. The reinsurance contributions are due within coverage periods which are one year or less.

1.5 RISK TRANSFER ARRANGEMENTS (REINSURANCE) (continued)

Contract boundary

For groups of reinsurance contracts held, cash flows are within the contract boundary if they arise from substantive rights and obligations that exist during the reporting period in which the Scheme is compelled to pay amounts to the reinsurer or in which the Scheme has a substantive right to receive services from the reinsurer.

The Scheme's capitation agreements held have a duration of one year or less.

Net income/(expense) from reinsurance contracts held

The amount that depicts the value the insurer benefits from entering into a risk transfer arrangement (i.e. the value of services received from the capitation provider).

Reinsurance expenses consist of:

- reinsurance expenses;
- effect of changes in risk of reinsurer non-performance.

Reinsurance expenses are recognised similarly to insurance revenue. The amount of reinsurance expenses recognised in the reporting period depicts the transfer of received services at an amount that reflects the portion of ceding contributions the Scheme expects to pay in exchange for those services.

For groups of reinsurance contracts held measured under the Premium Allocation Approach, the Scheme recognises reinsurance expenses based on the passage of time over the coverage period of a group of contracts.

1.6 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, derivatives, and other receivables. Other receivables are receivables other than those arising from insurance contracts and include sundry accounts receivable and interest receivable. Other 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.

1.6 CLASSIFICATION, RECOGNITION, PRESENTATION AND DERECOGNITION OF FINANCIAL INSTRUMENTS (continued)

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.

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

1.7 INSURANCE LIABILITY TO FUTURE MEMBERS

The insurance liability to future members represents the accumulated funds of the Scheme. The funds are mainly held as statutory reserves in lieu of the solvency requirement as required by the Act.

1.8 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.

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

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

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

IFRS 12 Unconsolidated investment structures

The Scheme has determined that its investments in pooled funds and collective investment schemes ("funds") are investments in unconsolidated structured entities. The Scheme invests in these funds, whose objectives range from achieving medium to long-term capital growth and whose investment strategy do not include the use of leverage. The funds are managed by unrelated asset managers and apply various investment strategies to accomplish their respective investment objectives.

1.9 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:
- 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.

1.10 IMPAIRMENT OF OTHER 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 Other Receivables. To measure the expected credit losses, Other Receivables are grouped based on shared credit risk characteristics and days past due. For the year under review the Scheme does not expect any credit losses on these balances and no provision has been made.

1.11 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.

1.12 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.

1.13 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 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.

1.14 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.

1.15 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.

1.16 ALLOCATION OF INCOME AND EXPENDITURE TO BENEFIT OPTIONS

The following items are directly allocated to benefit options:

- Insurance revenue
- Insurance service expenses
- Insurance interest expense

The risk adjustment for non-financial risk is calculated at Scheme level. The allocation to benefit options is done based on the proportion of the claims provision included in the LIC.

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 insurance revenue and membership.

2. INVESTMENTS HELD AT FAIR VALUE THROUGH PROFIT OR LOSS

	2023 R'000	2022 R'000
Fair value at the beginning of the year	3,381,965	3,349,525
Additions	1,270,195	675,309
Dividend income	41,952	50,358
Interest income	93,659	75,636
Acquisition of investments	1,134,584	549,315
Disposals	(1,050,417)	(637,143)
Expenses for asset management services rendered	(15,444)	(14,020)
Proceeds on disposal of investments	(1,034,973)	(623,123)
Movement on revaluation to market value	101,141	(5,726)
Fair value at the end of the year	**3,702,884**	**3,381,965**
Current	2,302,382	2,360,925
Non-current	1,400,502	1,021,040

The investments included above represent investments in:

	2023 R'000	2022 R'000
Bonds	1,309,975	1,149,238
Collective Investment Schemes	613,440	483,540
Commodities	54,860	58,908
Equities	1,145,118	1,118,310
Linked Insurance Policies	389,896	444,042
Money market instruments	189,595	127,927
	3,702,884	**3,381,965**

The investments were managed by the following asset managers at year-end:

	2023 R'000	2022 R'000
Coronation Asset Management (Pty) Ltd	681,674	598,243
Allan Gray South Africa (Pty) Ltd	567,108	511,992
Ninety One SA (Pty) Ltd	1,805,187	1,705,402
Abax Investments (Pty) Ltd	648,915	566,328
	3,702,884	**3,381,965**

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

	2023 R'000	2022 R'000
3. FINANCIAL ASSETS AT AMORTISED COST		
Trade and other receivables		
Interest receivable	314	316
Prepaid expenditure	1,935	1,821
Sundry accounts receivable	188	340
Financial assets at amortised cost	**2,437**	**2,477**

At 31 December 2023, the carrying amounts of trade and other receivables approximate their fair values due to the short-term maturities of these assets.

4. CASH AND CASH EQUIVALENTS

	2023 R'000	2022 R'000
Cash held in segregated portfolios	104,810	122,782
Current accounts	49,857	76,841
	154,667	**199,623**

The weighted average effective interest rate on cash and cash equivalents was 6.30% (2022 - 5.78%). The call accounts have an average maturity of 1 day (2022 - 1 day) as these are used as a clearing facility.

5. INSURANCE CONTRACT LIABILITY

5.1. INSURANCE LIABILITY FOR CURRENT MEMBERS

Insurance contracts issued (R'000)	2023				2022			
	Liability for remaining coverage	Liability for incurred claims (LIC)		Total	Liability for remaining coverage	Liability for incurred claims (LIC)		Total
		Present value of future cash flows	Risk adjustment			Present value of future cash flows	Risk adjustment	
Net opening balance	**(4,097)**	**279,675**	**3,883**	**279,461**	**(3,904)**	**265,249**	**2,153**	**263,498**
Insurance service result	(565,356)	658,417	(636)	92,425	(539,569)	604,382	1,730	66,543
Insurance revenue	(565,356)			(565,356)	(539,569)			(539,569)
Insurance service expenses	-	658,417	(636)	657,781	-	604,382	1,730	606,112
Incurred claims and directly attributable expenses	-	641,392	-	641,392	-	571,779	-	571,779
Changes in fulfilment cash flows relating to the liability for incurred claims - past service	-	(5,490)	(3,883)	(9,373)	-	2,322	(2,153)	169
Changes in fulfilment cash flows relating to the liability for incurred claims - current service	-	22,515	3,247	25,762	-	30,281	3,883	34,164
Finance income from insurance contracts issued	-	19,803	-	19,803	-	12,434	-	12,434
Total amount recognised in comprehensive income	**(565,356)**	**678,220**	**(636)**	**112,228**	**(539,569)**	**616,816**	**1,730**	**78,977**
Investment component - PMSA	(74,536)	74,536	-	-	(75,268)	75,268	-	-
Total movement	**(639,892)**	**752,756**	**(636)**	**112,228**	**(614,837)**	**692,084**	**1,730**	**78,977**
Cash flows								
Contributions received	633,701	-	-	633,701	614,644	-	-	614,644
Claims and directly attributable expenses paid	-	(690,747)	-	(690,747)	-	(631,526)	-	(631,526)
Claims related to recoveries from reinsurance (Note 6)	-	(51,377)	-	(51,377)	-	(46,132)	-	(46,132)
Total cash flows	**633,701**	**(742,124)**	**-**	**(108,423)**	**614,644**	**(677,658)**	**-**	**(63,014)**
Net closing balance	**(10,288)**	**290,307**	**3,247**	**283,266**	**(4,097)**	**279,675**	**3,883**	**279,461**

	2023 R'000	2022 R'000

5. INSURANCE CONTRACT LIABILITY (continued)

Breakdown of cash flows

	2023 R'000	2022 R'000
Contributions received	**633,701**	**614,645**
Risk contributions	559,165	539,376
MSA contributions	74,449	74,639
MSA transferred from other schemes	86	630
Claims and directly attributable expenses	690,747	631,526
Risk claims	589,058	532,111
MSA claims	68,305	67,643
Expenses	33,384	31,772

Included in the Insurance Contract liability:

	2023 R'000	2022 R'000
Medical Savings Accounts liability	**250,039**	**238,828**
Balance at the beginning of the year	238,828	230,875
Plus:		
MSA contributions received	74,449	74,639
Interest on MSA accounts	19,803	12,434
Transfers received from other schemes	86	630
Less:		
MSA claims	(68,305)	(67,643)
Refunds on death or resignation	(14,822)	(12,107)

5.1. INSURANCE LIABILITY FOR FUTURE MEMBERS

	2023 R'000	2022 R'000
Opening balance	3,302,061	3,234,096
Amounts attributable to future members (note 8)	271,899	67,965
Closing balance	**3,573,960**	**3,302,061**
Current	-	-
Non-current	3,573,960	3,302,061

6. REINSURANCE CONTRACT ASSETS

	2023				2022			
	Remaining coverage component	Incurred claims for contracts under the PAA			Remaining coverage component	Incurred claims for contracts under the PAA		
Reinsurance contracts issued (R'000)		Present value of future cash flows	Risk adjustment	Total		Present value of future cash flows	Risk adjustment	Total
Net opening balance	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Net income/(expense) from reinsurance contracts held	**(49,988)**	**51,377**	**-**	**1,389**	**(46,071)**	**46,132**	**-**	**61**
Reinsurance expenses	(49,988)	-	-	(49,988)	(46,071)	-	-	(46,071)
Changes in fulfilment cash flows relating to past service	-	-	-	-	-	-	-	-
Changes in fulfilment cash flows relating to current service	-	-	-	-	-	-	-	-
Claims recovered	-	51,377	-	51,377	-	46,132	-	46,132
Total amounts recognised in comprehensive income	**(49,988)**	**51,377**	**-**	**1,389**	**(46,071)**	**46,132**	**-**	**61**
Cash flows								
Premiums paid	49,988	-	-	49,988	46,071	-	-	46,071
Recoveries from reinsurance*	-	(51,377)	-	(51,377)		(46,132)	-	(46,132)
Total cash flows	**49,988**	**(51,377)**	**-**	**(1,389)**	**46,071**	**(46,132)**	**-**	**(61)**
Net closing balance	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**

* Recoveries from reinsurance represent the value of the services provided by the reinsurer. This represents a non-cash transaction.

7. FINANCIAL LIABILITIES AT AMORTISED COST

	2023 R'000	2022 R'000
Trade and other payables		
Accruals	1,988	1,511
Unallocated funds	774	1,032
Total arising from financial liabilities	**2,762**	**2,543**

At 31 December 2023, the carrying amounts of these financial liabilities approximate their fair values due to the short-term maturities of these liabilities.

8. INSURANCE REVENUE AND SERVICE EXPENSES

	2023 R'000	2022 R'000
Insurance revenue	**565,356**	**539,569**
Insurance revenue from contracts measured under the PAA	565,356	539,569
Insurance service expense		
Incurred claims	(624,397)	(574,340)
Risk claims incurred	(624,908)	(575,067)
Third party claim recoveries	511	727
Directly attributable expenses	(33,384)	(31,772)
Accredited administration services	(21,056)	(20,012)
Accredited managed healthcare services (no risk transfer)	(12,328)	(11,760)
Incurred claims and directly attributable expenses	(657,781)	(606,112)
Amounts attributable to future members	(271,899)	(67,965)
Insurance service expense	**(929,680)**	**(674,077)**
Net income from risk transfer arrangement/reinsurance		
Net income from reinsurance contracts held	1,389	61
Reinsurance expense	(49,988)	(46,071)
Reinsurance income	51,377	46,132
Net income from risk transfer arrangement/reinsurance	**1,389**	**61**
Total insurance service result	**(362,934)**	**(134,447)**

8. INSURANCE REVENUE AND SERVICE EXPENSES (continued)

Detail of accredited administration services, accredited managed healthcare services and net income/(expense) from reinsurance contracts held has been provided below:

	2023 R'000	2022 R'000
Accredited administration services		
Customer services	10,604	10,079
Information management and data control	3,893	3,700
Claims management	2,401	2,282
Member record management	2,172	2,064
Contribution management	1,909	1,814
Financial management	77	73
	21,056	**20,012**
Accredited managed healthcare services (no risk transfer)		
Chronic medicine management services	1,309	1,243
Disease management services	3,525	3,365
Hospital management services	3,416	3,260
Pharmaceutical benefit management services	1,102	1,052
Provider network management services	2,976	2,840
	12,328	**11,760**
Net income/(expense) from reinsurance contracts held		
Made up as follows:		
Netcare 911 (Pty) Ltd	788	890
Reinsurance expense	(2,889)	(2,720)
Reinsurance income	3,677	3,610
Kaelo Prime Cure (Pty) Ltd	(3,437)	(3,783)
Reinsurance expense	(20,303)	(16,356)
Reinsurance income	16,866	12,573
Centre for Diabetes and Endocrinology	3,601	2,662
Reinsurance expense	(22,227)	(22,604)
Reinsurance income	25,828	25,266
Dental Risk Company	437	292
Reinsurance expense	(4,569)	(4,391)
Reinsurance income	5,006	4,683
	1,389	**61**

	2023 R'000	2022 R'000
9. OTHER OPERATING EXPENSES		
Administration services	1,788	1,698
Other services		
Forensic investigations and recoveries	386	367
Internal audit services	322	306
Actuarial services	185	176
Governance and compliance	64	61
Additional services		
Quality management and monitoring services	303	288
Advanced data analytics	254	241
Digital service offering	94	89
Product innovation	61	58
Enhanced service offering	52	49
Enterprise risk management services	52	49
Legal services	15	14
Staff costs	3,950	3,782
Principal Officer remuneration and related expenses	3,295	2,730
Consulting fees	2,036	2,061
Electronic checking fees	1,389	1,315
Audit fees	1,856	993
Publications	666	859
Trustee remuneration and considerations	726	525
Head office rental and management fees	485	467
General expenses	996	436
Council for Medical Schemes expenses	416	386
Travel and entertainment	90	30
Trustee election expenses	-	15
	17,693	**15,297**

	2023 R'000	2022 R'000
10. INVESTMENT INCOME		
Interest income from financial assets not at fair value through profit or loss	3,713	2,288
Income from financial assets at fair value through profit or loss	410,529	171,861
Interest income	93,659	75,636
Dividend income	41,952	50,358
Net realised gains on fair value adjustments	173,777	53,028
Movement in fair value adjustments	101,141	(7,161)
Finance income from insurance contracts issued	**414,242**	**174,150**

	2023 R'000	2022 R'000
11. INSURANCE FINANCE EXPENSES		
Finance expenses from insurance contracts issued - PMSA	**19,803**	**12,434**
12. SUNDRY INCOME		
Long-term funding	1,121	1,067
Prescribed income	512	981
	1,633	**2,048**

13. FIDELITY COVER

Anglo Medical Scheme, its Trustees and employees are covered by the insurer of the sponsoring employer company, Anglo American plc and Subsidiaries and Corporate Trustee Company (ies), for professional indemnity to an aggregated limit of USD 35,000,000 for the period ended 31 December 2023. (2022: USD 35,000,000)

14. COMMITMENTS AND CONTINGENT LIABILITIES

The Scheme does not have any commitments or contingent liabilities outstanding at 31 December 2023 (2022: Nil).

15. CONTINGENT ASSET

As at 31 December 2023, the Scheme had pending motor vehicle accident medical claims to the value of R9,299,457 (2022: R9,566,018) 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.

16. EVENTS AFTER THE REPORTING DATE

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

17. 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

Discovery Health (Pty) Ltd has significant influence over the Scheme, as it provides administration and managed care services as well as financial and operational information on which policy decisions are based.

The Scheme contracted with Discovery Third Party Recovery Services (Pty) Ltd (DTPRS), a wholly owned subsidiary of Discovery Health (Pty) Ltd, to manage the identification and collection of third party recoveries from the Road Accident Fund.

The Scheme has a risk transfer arrangement contract in place with Kaelo Prime Cure (Pty) Ltd making provision for an agreed structure of day-to-day benefits, including treatment of chronic conditions, for members registered on the Value Care Plan.

Medikredit (Pty) Ltd has significant influence over the Scheme, as it provides managed care services to the Scheme.

Anglo Corporate Services South Africa (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.

Transactions with key management personnel	**2023 R'000**	**2022 R'000**
Statement of Comprehensive Income transactions		
Gross contributions received	2,046	1,946
Gross claims paid	2,231	2,088
Interest on MSA balances	28	17
Key management personnel remuneration	7,245	6,512
Trustee remuneration and considerations	726	525
Statement of Financial Position		
Medical Savings Accounts	362	343

17. RELATED PARTY TRANSACTIONS (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 party as a member 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 interest rate equal to the Repo Rate. At 31 December 2023 this rate was 8,25% (2022: 7,00%) 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 predetermined interest rates, on an accrual basis. The amounts are all current and are payable on demand if an appropriate claim is received, or if the member resigns from the Scheme, as

	2023 R'000	2022 R'000
Transactions with parties with significant influence over the Scheme		
Statement of Comprehensive Income transactions		
Discovery Health (Pty) Ltd		
- administration fees	22,844	21,710
- managed care: management services fees	12,328	10,517
Medikredit (Pty) Ltd - electronic checking fees	1,389	1,315
Kaelo Prime Cure (Pty) Ltd - risk transfer arrangement fees	20,303	16,356
Anglo Corporate Services South Africa (Pty) Limited		
- head office rental and management fees	485	467
Statement of Financial Position		
Balance due to Discovery Health (Pty) Ltd	2,694	2,664
Balance due to Medikredit (Pty) Ltd	221	110
Indirect investment in employers	79,034	67,142

17. RELATED PARTY TRANSACTIONS (continued)

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

Administration and managed care agreements with Discovery Health (Pty) Ltd
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.

Managed care agreement with Medikredit (Pty) Ltd
The managed care agreement is in terms of the rules of the Scheme and in accordance with instructions given by the Board of Trustees. The agreement is automatically renewed each year unless notification of termination is received or following the cancellation of the managed care organisation'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 Managed Healthcare Organisation shall be entitled to terminate the agreement by giving notice in writing of not less than 90 days. The outstanding balance bears no interest.

Risk transfer arrangement agreement with Kaelo Prime Cure (Pty) Ltd
The agreement is in terms of the rules of the Scheme and in accordance with instructions given by the Board of Trustees. The agreement continues indefinitely unless notification of termination is received or following the cancellation of the organisation'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 Organisation shall be entitled to terminate the agreement by giving notice in writing of not less than 90 days. The outstanding balance bears no interest.

Head office rental with Anglo Corporate Services South Africa (Pty) Limited
The agreement is in terms of the rules of the Scheme and in accordance with instructions given by the Board of Trustees. The agreement period is a fixed period and the agreement shall endure until the end of the fixed period. The Scheme shall be entitled to renew the agreement on written notice. The outstanding balance bears no interest.

18. TRUSTEE REMUNERATION AND CONSIDERATIONS

Trustees	Fees for meeting attendance		Disbursements		Accommodation, travelling and meals		Total	
	2023 R'000	2022 R'000	2023 R'000	2022 R'000	2023 R'000	2022 R'000	2023 R'000	2022 R'000
Coetzer JP^	74	7	9	-	41	-	124	7
Elliott CC	119	87	18	17	3	4	140	108
Farrell MR	87	74	18	17	3	-	108	91
Fox Dr FH	159	145	18	17	38	0	215	162
Liston JB*	-	15	-	-	5	-	5	15
Mamabolo NM*	-	15	-	-	3	-	3	15
Mason-Gordon NJ	105	74	18	17	-	-	123	91
Mhlongo QP*	-	15	-	-	3	-	3	15
Moodley R*	-	7	-	-	-	-	-	7
Thompson HM*	-	7	-	-	-	-	-	7
Van der Bijl BD*	-	7	-	-	5	-	5	7
TOTAL	**544**	**453**	**81**	**68**	**101**	**4**	**726**	**525**

* Trustees' fees ceded to employers

^ Trustees' fees ceded to employer until 30 June 2023

19. (DEFICIT)/SURPLUS PER BENEFIT OPTION

2023	MANAGED CARE PLAN R'000	STANDARD CARE PLAN R'000	VALUE CARE PLAN R'000	TOTAL R'000
Insurance revenue	**280,030**	**261,277**	**24,049**	**565,356**
Insurance service expense (excluding Amounts attributable to future members(Note 8))	**(381,498)**	**(258,306)**	**(17,977)**	**(657,781)**
Net income from reinsurance contracts	**2,036**	**2,790**	**(3,437)**	**1,389**
Insurance service result	**(99,433)**	**5,761**	**2,635**	**(91,036)**
Interest income from financial assets not measured at fair value through profit or loss	1,575	1,707	431	3,713
Investment income from investments held at fair value through profit or loss	57,537	62,343	15,731	135,611
Fair value gains from investments held at fair value through profit or loss	116,641	126,386	31,891	274,918
Net investment income	**175,753**	**190,436**	**48,053**	**414,242**
Finance expenses on Medical Savings Account liability	(19,803)	-	-	(19,803)
Net insurance finance expense	**(19,803)**	**-**	**-**	**(19,803)**
Net insurance and investment result	**56,518**	**196,196**	**50,688**	**303,403**
Asset management fees	(6,552)	(7,100)	(1,792)	(15,444)
Other operating expenses	(7,917)	(9,153)	(623)	(17,693)
Sundry income	693	751	189	1,633
Net result for the year	**42,742**	**180,695**	**48,462**	**271,899**

19. (DEFICIT)/SURPLUS PER BENEFIT OPTION

2022	MANAGED CARE PLAN R'000	STANDARD CARE PLAN R'000	VALUE CARE PLAN R'000	TOTAL R'000
Insurance revenue	**280,319**	**239,520**	**19,730**	**539,569**
Insurance service expense (excluding Amounts attributable to future members(Note 8))	**(360,119)**	**(230,804)**	**(15,189)**	**(606,112)**
Net income from reinsurance contracts	**1,760**	**2,085**	**(3,784)**	**61**
Insurance service result	**(78,040)**	**10,801**	**757**	**(66,482)**
Interest income from financial assets not measured at fair value through profit or loss	971	1,052	265	2,288
Investment income from investments held at fair value through profit or loss	53,457	57,923	14,615	125,995
Fair value gains from investments held at fair value through profit or loss	19,460	21,086	5,321	45,867
Net investment income	**73,888**	**80,061**	**20,201**	**174,150**
Finance expenses on Medical Savings Account liability	(12,434)	-	-	(12,434)
Net insurance finance expense	**(12,434)**	**-**	**-**	**(12,434)**
Net insurance and investment result	**(16,586)**	**90,862**	**20,958**	**95,234**
Asset management fees	(5,958)	(6,438)	(1,624)	(14,020)
Other operating expenses	(7,236)	(7,862)	(199)	(15,297)
Sundry income	868	942	238	2,048
Net result for the year	**(28,912)**	**77,504**	**19,373**	**67,965**

20. 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

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 all 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.

20. 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	2023	2022	% Increase/ (decrease)
Length of stay (days)	4.49	4.54	(1.1%)
Average hospital cost per admission (R)	45,269	39,972	13.3%
Total cost per event (R)	74,659	66,048	13.0%
Total cost per life per month (R)	1,059	914	15.9%
Admissions per 1 000 lives	281	274	2.6%

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	2023	2022	% Increase/ (decrease)
Claimants per 1 000 lives	28.44	28.88	(1.5%)
Amount paid per life per month	155	154	0.6%

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.

20. INSURANCE RISK MANAGEMENT REPORT (continued)

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 programs addressing risk and 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:

2023 Age grouping (in years)	Hospital R	Chronic R	Day-to-day R	Total R
< 26	4,727	229	2,761	7,717
26 - 35	7,040	358	4,563	11,961
36 - 50	10,240	944	6,361	17,545
51 - 65	25,412	2,754	12,102	40,268
> 65	63,640	5,106	18,265	87,011

2022 Age grouping (in years)	Hospital R	Chronic R	Day-to-day R	Total R
< 26	5,550	223	2,734	8,507
26 - 35	7,688	405	4,905	12,998
36 - 50	10,618	1,054	6,269	17,941
51 - 65	19,631	2,774	10,482	32,887
> 65	51,748	4,800	15,882	72,430

Reinsurance contracts held

The Scheme has four reinsurance contracts (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 (Kaelo Prime Cure) covers day to day expenditure, including treatment of chronic conditions, and hospital admissions under R180,000 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 and the fourth arrangement with Dental Risk Company provides dental benefits to Standard Care plan members.

20. INSURANCE RISK MANAGEMENT REPORT (continued)

Risk in terms of reinsurance contracts held

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 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 following table provides a sensitivity on the insurance contract liabilities. The table provides the sensitivity before and after the impact of the Scheme being a mutual entity. As the Scheme is a mutual entity, the impact of any changes in the insurance liability to current members would impact the insurance liability to future members. The table presents information on how reasonably possible changes in risk confidence level made by the Scheme will impact the risk adjustment.

	2023 R'000		**2022 R'000**	
	LIC as at 31 December	**Impact on SOCI***	**LIC as at 31 December**	**Impact on SOCI**
Insurance contract liabilities	283,266	-	279,461	-
Change in LIC provision - 10% increase #	-	2,576	-	3,416

* Statement of comprehensive Income

The impact increases the LIC by the same value

Sensitivity of risk adjustment	**2023 R'000**	**2022 R'000**
Risk adjustment with a 75% confidence level - as reported	3,247	3,883
Risk adjustment with a 90% confidence level	4,681	6,555

21. 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.

21. 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. 15.4% (2022: 12.1%) 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 2023	ZAR R'000	Foreign currency R'000	TOTAL R'000
Investments held at fair value through profit or loss	3,130,092	572,792	3,702,884
Cash and cash equivalents	131,812	22,855	154,667
	3,261,904	595,647	3,857,551

As at 31 December 2022	ZAR R'000	Foreign currency R'000	TOTAL R'000
Investments held at fair value through profit or loss	2,968,051	413,914	3,381,965
Cash and cash equivalents	179,298	20,325	199,623
	3,147,349	434,239	3,581,588

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 table below illustrates the impact to the value of investments of the Scheme:

	% ZAR movement	2023 R'000	2022 R'000
Foreign currency	10%	59,565	43,424

21. 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, the below table illustrates the impact to the value of investments of the Scheme:

	% SA market movement	**2023 R'000**	**2022 R'000**
Investments held at fair value through surplus or deficit: Equities	10%	114,512	111,831

21. 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 2023	0 - 3 months R'000	3 - 12 months R'000	> 12 months R'000	Total R'000
Investments held at fair value through profit or loss	2,254,889	47,493	1,400,502	3,702,884
Cash and cash equivalents	154,667	-	-	154,667

As at 31 December 2022	0 - 3 months R'000	3 - 12 months R'000	> 12 months R'000	Total R'000
Investments held at fair value through profit or loss	2,156,434	204,492	1,021,040	3,381,965
Cash and cash equivalents	199,623	-	-	199,623

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

	2023 %	2022 %
Effective interest rate	6.30%	5.78%

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 as 2022.

	% change in interest rates	2023 R'000	2022 R'000
Investments held at fair value through profit or loss	1%	14,866	13,086
Cash and cash equivalents - Medical Scheme assets	1%	589	396

21. FINANCIAL RISK MANAGEMENT REPORT (continued)

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.

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

	2023 R'000	2022 R'000 Restated
Liability for future members per the Statement of Financial Position	3,573,960	3,306,641
Less: cumulative unrealised net gain on measurement of investments to fair value	(572,030)	(470,889)
Accumulated funds per Regulation 29	3,001,930	2,835,752
Gross contribution income (R'000)	639,892	614,208
Solvency margin = Accumulated funds/gross contribution income x 100	469.13%	461.69%

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 via pooled investment vehicles, 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.

21. FINANCIAL RISK MANAGEMENT REPORT (continued)

Breakdown of financial assets and financial liabilities

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

As at 31 December 2023	Financial assets and liabilities at fair value through profit or loss R'000	Financial assets at amortised cost R'000	Insurance contract liability R'000	Reinsurance contracts R'000	Financial liabilities at amortised cost R'000	Total carrying amount R'000
Held at fair value through profit or loss	3,702,884	-	-	-	-	3,702,884
Financial assets at amortised cost	-	2,437	-	-	-	2,437
Cash and cash equivalents	-	154,667	-	-	-	154,667
Insurance contract liabilities for current members	-	-	(283,266)	-	-	(283,266)
Insurance contract liabilities for future members	-	-	(3,573,960)	-	-	(3,573,960)
Financial liabilities at amortised cost	-	-	-	-	2,762	2,762
	3,702,884	157,104	(3,857,226)	-	2,762	5,524

As at 31 December 2022	R'000	R'000	R'000	R'000	R'000	R'000
Held at fair value through profit or loss	3,381,965	-	-	-	-	3,381,965
Financial assets at amortised cost	-	2,477	-	-	-	2,477
Cash and cash equivalents	-	199,623	-	-	-	199,623
Insurance contract liabilities for current members	-	-	(279,461)	-	-	(279,461)
Insurance contract liabilities for future members	-	-	(3,302,061)	-	-	(3,302,061)
Financial liabilities at amortised cost	-	-	-	-	2,543	2,543
	3,381,965	202,100	(3,581,522)	-	2,543	5,086

21. 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: These are assets measured using quoted prices in an active market
- Level 2: These are assets measured using inputs other than quoted prices included within Level 1 that are either directly or indirectly observable; and
- Level 3: These are assets measured using inputs that are not based on observable market data.

Fair value hierarchy for financial assets measured at fair value

	2023 R'000	2022 R'000
Level 1		
Bonds	1,309,975	1,149,238
Commodities	54,860	58,908
Equities	1,145,118	1,118,310
Level 2		
Collective Investment Schemes	613,440	483,540
Linked Insurance Policies	389,896	444,042
Money market instruments	189,595	127,927
	3,702,884	3,381,964

Credit risk

Credit risk is the risk of financial loss resulting from a counterparty's failure to meet their contractual obligations. The Scheme does not have significant credit risk arising from reinsurance contract assets or insurance assets. The capitation agreements are used to manage insurance risk. This does not, however, discharge the Scheme's liability as the primary insurer. If a reinsurer fails to pay a claim for any reason, the Scheme remains liable for the payment to the members. Exposures to individual members are managed by adhering to the requirements of Section 26(7) of the MSA i.e actively pursuing all contributions not received within three days of becoming due, suspending benefits for all members where contributions have not been received for 30 days and terminating benefits for all all members where contributions have not been received for 60 days. The credit risk is taken into account when the expected contribution is calculated.

Key areas where the Scheme is exposed to credit risk are:

- Insurance contract assets and trade and other receivables. The main components of insurance contract 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 Financial assets at amortised cost;
- Financial assets are valued at fair value through profit or loss. These assets comprise bond instruments, commodities, equities, collective investment schemes, policies of insurance and money market instruments. 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.

21. FINANCIAL RISK MANAGEMENT REPORT (continued)

Credit risk (continued)

The Scheme's receivables at 31 December 2023 comprise:

	2023 R'000	2022 R'000
Insurance contract assets	13,510	4,878
Contributions receivable (a)	10,289	4,098
Member and service provider claims receivables (b)	2,992	691
Forensic receivables	229	89
Trade and other receivables	2,437	2,477
Interest receivable	314	316
Prepaid expenditure	1,935	1,821
Sundry accounts receivable	188	340

a. Exposures to individual members are managed by adhering to the requirements of Section 26(7) of the Medical Schemes Act i.e actively pursuing all contributions not received within three days of becoming due, suspending benefits for all members where contributions have not been received for 30 days and terminating benefits for all all members where contributions have not been received for 60 days. The credit risk is taken into account when the expected contribution is calculated

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 Insurance contract receivables and 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 contract receivables which are due, past due (by number of days) and are used to project the insurance contract cash flows that are not recoverable.

Insurance contract receivables	Gross 2023 R'000	Gross 2022 R'000
Not past due	10,888	4,378
Past due 0 - 30 days	1,883	108
Past due 31 - 60 days	276	153
Past due 61 - 150 days	679	261
151 days to more than 1 year	1,065	661
	14,791	5,561

21. FINANCIAL RISK MANAGEMENT REPORT (continued)

Credit risk (continued)

Credit quality

Contribution receivables
The Scheme collected over 99% (2022: 99%) of outstanding debt in January 2024. Therefore we can reasonably conclude 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. The Scheme estimates that 61% (2022: 58%) of these receivables are not recoverable. This has been taken into account in the insurance contracts fulfilment cash flows.

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. The Scheme estimates that 30% (2022: 50%) of these receivables are not recoverable. This has been taken into account in the insurance contracts fulfilment cash flows.

Forensic receivables
This debt arose due to forensic investigations and claims reversals as a result thereof. The parties involved signed an Acknowledgement of Debt.

Cash and cash equivalents

	2023 R'000	2022 R'000
Invested with counterparties with high quality credit ratings	154,667	199,623

21. FINANCIAL RISK MANAGEMENT REPORT (continued)

Unconsolidated investment structures

The asset managers invest the Scheme's monies in reputable funds which generate returns for the Scheme. The Scheme views these funds as unconsolidated structured entities. The Scheme monitors the performance of the funds closely to ensure the Scheme earns high returns without unnecessary exposure to risk. The Scheme does not control these funds as it has no voting rights, is not able to call meetings and in addition, has no ability to direct the relevant activities of these funds. As the Scheme does not control these funds, its investments in these structured entities are not consolidated in the Scheme’s financial statements.

The Scheme has investments in certain pooled portfolios and collective investment schemes (the Funds) and exposure to these Funds as listed in the table below. The Scheme’s maximum exposure is limited to the total fair value of its investments in the Funds.

Fund	As at 31 December 2023		As at 31 December 2022	
	Fair value of fund assets held R'000	% Fund exposure attributable to Scheme	Fair value of fund assets held R'000	% Fund exposure attributable to Scheme
Ninety One Ial Internal Money Upf Z	113,764	2.6%	33,114	0.9%
Ninety One Ial Stable Money Fund	389,896	23.0%	444,042	26.5%
Ninety One Ial Money Market Fund	27,276	0.1%	37,755	0.1%
Ninety One Stefi Plus Fund Z	12,793	0.1%	11,702	0.1%
Ninety One GSF US Dollar Money Fund	59,622	0.2%	41,313	0.2%
Ninety One GSF Global Franchise Fund	176,374	0.1%	149,041	0.1%
Coronation Absolute Bond	172,479	3.8%	156,447	3.8%
ABAX SA Income Prescient Fund	24,691	7.7%	17,584	7.2%
Nedgroup Corporate Money Market Fund	26,442	0.1%	5,424	0.0%
ABAX Global Equity Prescient Fund	-	-	5,165	0.3%
ABAX Global Equity Prescient Feeder Fund	-	-	25,994	5.8%

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.

Members of the Scheme are required to submit their claims within 4 months of the service date. Therefore the liability attributable to current members is expected to be settled within 12 months.

21. FINANCIAL RISK MANAGEMENT REPORT (continued)

Liquidity risk (continued)

An expected maturity analysis for all liabilities is provided below:

As at 31 December 2023	Less than 1 month R'000	Between 2 and 4 months R'000	More than 4 months R'000	Total R'000
Insurance contract liability for current members	17,400	1,441	264,425	283,266
Insurance contract liability for future members	-	-	3,573,960	3,573,960
Financial liabilities at amortised cost	2,762	-	-	2,762
As at 31 December 2022				
Insurance contract liability for current members	25,040	2,074	252,347	279,461
Insurance contract liability for future members	-	-	3,302,061	3,302,061
Financial liabilities at amortised cost	2,543	-	-	2,543

22. 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 (CMS) to achieve compliance. Although exemptions have been obtained from the CMS, it is a regulatory requirement to disclose all non-compliance matters.

22.1 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.

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

22.2 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 through pooled investment vehicles.

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. This exemption is valid until 30 November 2025.

22.3 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 through pooled investment vehicles.

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. This exemption is valid until 30 November 2025.

22.4 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 2023, the Managed Care plan incurred a deficit before investment income as set out in Note 18 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.

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

22.4 Sustainability of benefit options (continued)

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.

22.5 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 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.

22.6 Investment in equities in territories outside the Republic of South Africa

Nature and impact

In terms of Category 4(b) of Annexure B to the Regulations of the Act, investments in equities in territories outside the Republic of South Africa (RSA) are prohibited.

Causes for failure

The Scheme has exposure to equities in territories outside the Republic of South Africa through its Ninety-One investment portfolio.

Corrective action

The Scheme had applied to the Council for Medical Schemes and received an exemption from this section of the Act. A renewal application was lodged with the Council for Medical Schemes.

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

22.7 Variance in co-payment required for non-contracted network service provider per brochure and CMS approved Scheme rules

Nature and impact

In terms of Section 33(1) of the Act states that a Medical Scheme shall apply to the Registrar for the approval of any benefit option if such a medical scheme provides members with more than one benefit option.

Causes for failure

One co-payment on the Value Care Plan previously approved by the CMS was incorrectly displayed in the benefit brochure to members.

Corrective action

The Scheme's Rules for 2024 were submitted taking this change into account. The benefit brochure makes provision for this change.