AMS | ANGLO MEDICAL SCHEME

ANNUAL REPORT

For the year ended 31 December

2022

Anglo Medical Scheme
Registration Number. 1020

Contents

The reports and statements set out below comprise the Annual Financial Statements:

Scheme Details for the year ended 31 December 2022

Board of Trustees

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 FK Robertson**
Registered office	7th Floor 144 Oxford Road Melrose, Rosebank, 2191
Postal address	PO Box 746 Rivonia, 2128
Auditor	**PricewaterhouseCoopers Inc.**
Registered address	4 Lisbon Lane Waterfall City, Jukskei View, 2090
Administrator	**Discovery Health (Pty) Ltd**
Registered address	1 Discovery Place Sandton, 2146

Report of the Board of Trustees for the year ended 31 December 2022

The Board of Trustees hereby presents its report for the year ended 31 December 2022.

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 2022 the Scheme provided benefits to 8 759 members and 9 159 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 the 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 2022, Managed Care Plan serving 6 240 beneficiaries, average age 58.34 years, Standard Care Plan, 9 281 beneficiaries, average age 34.52 years and Value Care Plan 2 397 beneficiaries, average age 25.97 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.

1.3. 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

1.7. **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 International Financial Reporting Standards (IFRS) as informed by the Medical Schemes Accounting Guide issued by the South African Institute of Chartered Accountants (SAICA) and the regulatory requirements as set out in the Act and its supporting Regulations.

2.2. Assurance

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

The External Auditor expresses an audit opinion on whether the Financial Statements are, 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.

2.3. 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 worked closely in support of, and with, the employers in the communication and management of Covid-19. 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.

The Covid-19 pandemic continued to cause uncertainty during 2022, increasing both country and business risk. Medical scheme claims experience normalised to a large extent towards the end of 2022, with the Scheme experiencing a relatively positive year, with respect to healthcare costs, for the duration of 2022. The residual post pandemic health risk remains unknown and, together with the continued financial market uncertainties on the Long Term Funding, are continuously monitored.

There was a R280 million decrease in comprehensive income for the year when compared to that seen in 2021 largely due to a decrease in investment income and movements in unrealised gains. Investment income was particularly high in 2021 due to the market correction following the negative impact on the market at the onset of the Covid-19 pandemic.

A lower than budgeted 2022 claims experience has informed a lower level of budgeted future claims, resulting in an increased long term funding ratio from 120.3% to 133.7%. The Board of Trustees has comfort that, as claims normalise, the Scheme strategy will not require any significant changes in 2023. The Scheme will remain vigilant in monitoring and reviewing the progression of the pandemic, the resulting normalised level of claims cost experience post-pandemic and its long term consequences on the Scheme.

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 9.0% - CMS report 2022) increases the expected overall cost of providing adequate healthcare benefits to our members.

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. With the advent of the Covid-19 pandemic in 2020, the LTF was reviewed in 2022 and will be closely monitored until the full impact of the pandemic can be assessed.

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 2022 was R3.298 billion (2021 - R3.230 billion). This compares to the gross long-term liability calculated by the Scheme's consultants and actuaries of R2.466 billion (2021 - R2.685 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 2022 (p.a.)	4.7%	7.2%	10.7%
5 Years (p.a.)	5.4%	4.9%	8.4%
21 Years (p.a.) (since inception)	10.4%	5.5%	9.0%

Whilst 2021 saw a significant recovery in markets (from the lows in 2020 during the worst of the Covid- 19 pandemic), market conditions in 2022 were plagued by uncertainty amidst global geopolitical turmoil, high inflation, rising interest rates and recession fears. As a result, the first nine months of 2022 were a brutal period for both local and global investments, and equity markets in particular delivered strongly negative returns. The 5-year return (net of fees) for the Scheme's assets has therefore deteriorated slightly from 6% p.a. in 2021 to 5.4% 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 2022 this amounted to R75 million (2021 - R25 million). This increase in the shortfall from 2021 to 2022 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 Accumulated Funds as at 31 December 2022 is R3.298 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.

	2022 R'000	2021 R'000
Total long-term liabilities	2,465,903	2,685,000
Net value of assets	3,297,723	3,230,062
Current long-term funding ratio	133.7%	120.3%

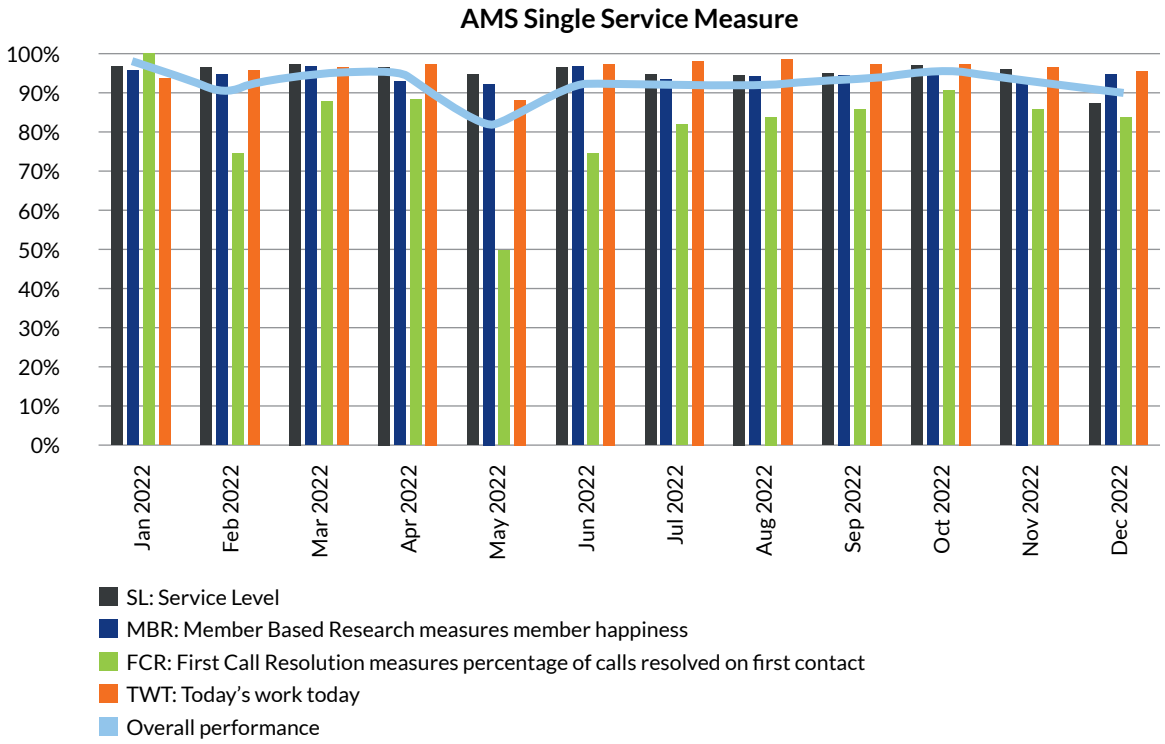
5.2. Unlike most open schemes who measure their size, market share, annual growth, solvency levels etcetera, the Scheme closely monitors its value proposition to members and employers. The performance of the Scheme is measured by the contribution increase that is effected annually, coupled with benefit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

Year	2023	2022	2021	2020	2019
Average annual contribution increase per member	8.0%	6.0%	3.9%	9.5%	9.5%
CPI	5.4%	7.2%	3.2%	4.5%	4.1%
*Industry gross average increase per beneficiary **	-	*3.6%*	*7.0%*	*9.6%*	*9.3%*

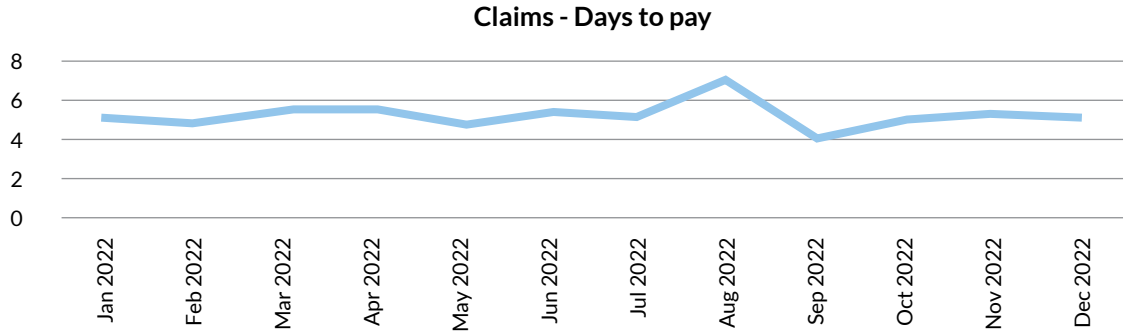
* The industry figure quoted serves as a guide only. It reflects the industry average percentage increase in the gross contribution income per beneficiary as reported by the Council for Medical Schemes. The industry figure however does not include the effect of mid-year increases by medical schemes.

5.3. The Scheme aims to provide members with better value for money than they would be able to purchase in the open market. The three Plans are independently evaluated against eight to ten similar competitor products annually to ensure this aim is met. The benefits provided in 2022 scored higher than average across all three Plans, and were all offered at lower than average contribution rates, indicating better value for money than could be purchased in the market.

5.4. During 2022 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 reviewed by the Board on a frequent basis.



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 review by the Board on a frequent basis.



5.4. The Council for Medical Schemes requires that non-healthcare costs are kept below 10% of gross contribution income. The 2022 non-healthcare cost compared well against previous years and is well below the Council's requirements.

Year	2022	2021	2020	2019	2018
Non-healthcare costs as a percentage of gross contribution income	5.7%	5.8%	5.7%	5.7%	6.2%
*Industry average**	-	*5.4%*	*6.5%*	*5.5%*	*5.7%*

* 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.

	2022 R'000	2021 R'000
Net healthcare result	(73,165)	(75,748)
Managed Care Plan	(78,612)	(70,460)
Standard Care Plan	4,890	(5,924)
Value Care Plan	557	636
Add: Net investment and other income	149,744	423,342
Net surplus for the year	76,580	347,594

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:

	2022 R		2021 R	
Average contribution increase 6.0%	Adult	Child	Adult	Child
Managed Care Plan	5,450	1,260	5,140	1,190
Standard Care Plan	2,980	895	2,810	845
Value Care Plan	1,075	265	1,015	250

6.2. Outstanding risk claims

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

6.3. Accumulated funds

Movements in the accumulated funds are set out in the Statement of Changes in Accumulated Funds as reflected on page 34 of this document.

	2022 R'000	2021 R'000
Total accumulated funds per Statement of Financial Position	3,306,641	3,230,062
Less: Cumulative unrealised net gain on measurement of investments to fair value	(470,889)	(478,050)
Accumulated funds per Regulation 29 of the Act	2,835,752	2,752,012
Gross contribution income (Note 8)	614,208	588,792
Accumulated funds ratio per Regulation 29 (including unrealised gains)	538.4%	548.6%
Accumulated funds ratio per Regulation 29 (excluding unrealised gains)	461.7%	467.4%
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 accumulated funds per member as at 31 December 2022 was R376,475 (2021: R375,719).

6.4. Medical Savings Accounts

Refer to Note 1.7 and Note 6 of the Financial Statements.

The liability to members in respect of the Medical Savings Accounts is reflected as a 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		
	2022	2021	%	2022	2021	%	2022	2021	%	2022	2021	%
Number of members at end of accounting period	3,623	3,754	-3%	4,064	3,871	5%	1,072	972	10%	8,759	8,597	2%
Average (avg) number of members for the period	3,684	3,833	-4%	3,983	3,905	2%	1,005	940	7%	8,672	8,678	0%
Beneficiaries at end of accounting period	6,240	6,485	-4%	9,281	8,879	5%	2,397	2,167	11%	17,918	17,531	2%
Average (avg) number of beneficiaries for the period	6,343	6,619	-4%	9,116	8,935	2%	2,249	2,091	8%	17,708	17,645	0%
Beneficiaries per member at end of accounting period	1.72	1.73	0%	2.28	2.29	0%	2.24	2.23	0%	2.05	2.04	0%
Avg age of beneficiaries	58.34	58.43	0%	34.52	34.6	0%	25.97	25.66	1%	41.68	42.31	-1%
Pensioner ratio (beneficiary > 65 years)	51.61%	51.80%	0%	11.16%	11.52%	-3%	1.73%	1.38%	25%	24.10%	25.17%	-4%
Avg gross contribution per member per month - taking into consideration all Plan changes (R)	8,029	7,638	5%	5,011	4,697	7%	1,636	1,541	6%	5,902	5,654	4%
Avg gross contribution per beneficiary per month (R)	4,663	4,423	5%	2,190	2,053	7%	731	693	6%	2,890	2,781	4%
Avg gross claim per member per month (R)	9,278	8,628	8%	4,537	4,467	2%	1,520	1,417	7%	6,201	5,974	4%
Avg gross claim per beneficiary per month (R)	5,388	4,996	8%	1,982	1,952	2%	679	637	7%	3,037	2,938	3%
Avg administration cost per member per month (R)	374	357	5%	375	354	6%	70	67	5%	339	324	5%
Avg administration cost per beneficiary per month (R)	217	207	5%	164	155	6%	32	30	4%	166	159	4%
Relevant healthcare expenses as a % of risk contributions	122.2%	119.4%	2%	90.5%	95.1%	-5%	92.9%	91.9%	1%	107.1%	108.1%	-1%
Administration cost as a % of gross contributions	4.7%	4.7%	0%	7.5%	7.5%	-1%	4.3%	4.4%	-1%	5.7%	5.7%	0%

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.

7.3. 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 24 and 25 of the Annual Financial Statements.

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

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

The risk assessment process:

- Focuses on the underlying causes of risks and not just the financial impacts;
- 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.

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

Refer to Note 10 of the Financial Statements.

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

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

Organisation	Services capitated	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 International Financial Reporting Standards and all the relevant legislative requirements.

10. Management

10.1. Board of Trustees in office during 2022:

Coetzer JP	Employer Appointed (appointed Chairman 24 March 2023)
Elliott CC (Chairman)	Member Elected (resigned as Chairman 24 March 2023)
McCallum DR (Vice-Chairman)	Member Elected (resigned 5 January 2022)
Fox Dr FH (Vice-Chairman)	Member Elected (appointed 6 January 2022)
Ameer KN	Employer Appointed (A)
Farrell MR	Member Elected (appointed 2 February 2022)
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) (appointed 31 January 2022)
Mhlongo QP	Member Elected
Moodley R	Employer Appointed
Preston GP	Member Elected (A) (appointed 31 January 2022)
Ragolane NS	Member Elected (A)
Thompson HM	Employer Appointed
van der Bijl BD	Employer Appointed
van Vugt TD	Employer Appointed (A)

(A) Alternate trustee

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

Fox Dr 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 Dr JA (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); PA Laubscher (Independent); Payne N (Member elected);

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

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

11. Committees of the Board of Trustees

11.1. Audit Committee

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

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

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

The External Auditor formally reports to the Committee on critical findings arising from the statutory audit. The 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.

11.3. 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.

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.

12. Trustee and non-Trustee members attendance at Committee meetings

	Board of Trustees		Audit Committee		Investment Committee		Management Committee		Ex-gratia Committee		Disputes Committee	
Trustees	**A**	**B**	**A**	**B**	**A**	**B**	**A**	**B**	**A**	**B**	**A**	**B**
Elliott CC	5	5					4	3				
Coetzer JP	5	5					4	3				
Fox Dr FH	5	5					4	4	5	5		
Farrell MR	5	4							5	4		
Hosking S	5	5							3	3		
Liston JB	5	4			4	4	4	3				
Mamabolo NM	5	5	2	2	4	4			2	2		
Mason-Gordon NJ	5	3			4	4						
Mhlongo QP	5	3					4	4	5	5		
Moodley R	5	4	3	3								
Thompson HM	5	4			4	4						
van der Bijl BD	5	3					4	4				
Alternate Trustees and Consultants												
Ameer KN		*4										
Clark B					4	4						
Kapp G			3	3								
Matemera TS		*0										
Mckie Thomson CC		*1										
Payne N												
Pienaar Dr JA									5	5		
Preston GP												
Prinsloo J			3	3								
Ragolane NS		*2										
van Vugt TD		*3										
van Zyl C			3	3								

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). 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 21 of the Financial Statements.

16. Related party transactions

Refer to related parties disclosure in Note 21 of the Financial Statements. Trustee remuneration is disclosed in Note 22 of the Annual Financial Statements.

17. Subsequent events

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

18. Non-compliance with the Medical Schemes Act

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

18.2. 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.

18.4. 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 2022, the Managed Care plan incurred a deficit before investment income as set out in Note 23 to the Financial Statements.

Causes for failure

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

Corrective action

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

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

18.5. 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.

18.6. 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. The exemption expires on 30 April 2025.

18.7. Benefits indicated in the brochure that are not included in the 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 struck out and the Scheme was requested to review the percentage members were liable to pay.

Corrective action

The Scheme's Rules for 2023 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 84, comprising the statement of financial position at 31 December 2022, the statement of comprehensive income, statement of changes in funds and reserves, statement of cash flows for the year then ended and the notes to the Financial Statements, which include a summary of significant accounting policies and other explanatory notes, in accordance with International Financial Reporting Standards (IFRS) and the requirements of the Medical Schemes Act of South Africa. In addition, the Trustees are responsible for preparing the report of the Board of Trustees.

The Trustees are also responsible for such internal control as the Trustees determine is necessary to enable the preparation of 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 2023. 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 5 April 2023 and are signed on their behalf by:

Colleen Elliott	Dr FH Fox	FK Robertson
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

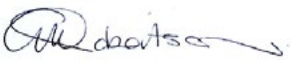
The Board of Trustees and its committees meet regularly and monitor the performance of the Administrator and other service providers. They address a range of key issues and ensure discussion on items of policy, strategy and performance are informed and constructive.

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.



Colleen Elliott	Dr FH Fox	FK Robertson
Chairman	Vice Chairman	Principal Officer

5 April 2021

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Independent Auditor's Report

To the Members of Anglo Medical Scheme

Report on the financial statements

Opinion

We have audited the financial statements of Anglo Medical Scheme (the Scheme), set out on pages 32 to 84, which comprise the statement of financial position as at 31 December 2022, and the statement of comprehensive income, the statement of changes in members' funds and the statement of cash flows for the year then ended, and notes to the financial statements, including a summary of significant accounting policies.

In our opinion, these financial statements present fairly, in all material respects, the financial position of the Scheme as at 31 December 2022, and its financial performance and cash flows for the *year* then ended in accordance with International Financial Reporting Standards and the requirements of the Medical Schemes Act of South Africa.

Basis for Opinion

We conducted our audit in accordance with International Standards on Auditing (ISAs). Our responsibilities under those standards are further described in the *Auditor's Responsibilities for the Audit of the Financial Statements* section of our report.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Independence

We are independent of the Scheme in accordance with the Independent Regulatory Board for Auditors' Code of Professional Conduct for Registered Auditors (IRBA Code) and other independence requirements applicable to performing audits of financial statements in South Africa. We have fulfilled our other ethical responsibilities in accordance with the IRBA Code and in accordance with other ethical requirements applicable to performing audits in South Africa. The IRBA Code is consistent with the International Ethics Standards Board for Accountants' International Code of Ethics for Professional Accountants (including International Independence Standards).

Key Audit Matters

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

Key audit matter	How our audit addressed the key audit matter
Outstanding claims provision The outstanding claims provision of R29,585,000 at year-end as described in Note 5 to the financial statements, is a provision recognised for the estimated cost of healthcare benefits that have been incurred prior to year-end but that were only reported to the Scheme after year-end.	We obtained an understanding from the Scheme's actuaries regarding the process followed in calculating the outstanding claims provision, which included the design and implementation of controls within the process. The actuarial method applied by the

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Chief Executive Officer: L S Machaba
The Company's principal place of business is at 4 Lisbon Lane, Waterfall City, Jukskei View, where a list of directors' names is available for inspection.
Reg. no. 1998/012055/21, VAT reg.no. 4950174682.

Key audit matter	How our audit addressed the key audit matter
The outstanding claims provision is calculated by the Scheme's actuaries which is reviewed by management and the Audit Committee and recommended to the Board of Trustees for approval. The Scheme's actuaries use an actuarial model, based on the Scheme's actual claim development patterns throughout the year, to project the *year* end provision. This model applies the Basic Chain Ladder ("BCL"). The claim service date, processing date and amount are used to derive claim development patterns. These historical patterns are then used to estimate the outstanding claims provision. We identified this to be a matter of most significance to the audit because of the uncertainty in the projected claims pattern. A change in the projected claims pattern could cause a material change to the amount of the provision.	Scheme is one that is generally applied within the medical scheme industry. We obtained the actual claims data from the member administration system covering the year ended 31 December 2022. The actual claims data reflects the most recent claims patterns, including the impact of COVID-19, and is taken into account in calculating the outstanding claims provision. We assessed the completeness of the claims data on the member administration system by understanding management's controls and selecting claim transactions from the claim source and agreeing these to the member administration system. No material inconsistencies were noted. We substantively tested a sample of claims received by the Scheme in the 31 December 2022 financial year, selected from the member administration system, and confirmed the accuracy of the service and process dates and the validity of the claim against the relevant Scheme rules. No material inconsistencies were noted. We assessed the completeness of the claims data in the Scheme's actuarial model by understanding management's controls and testing the reconciliation between the claims data per the member administration system and the claims data per the actuarial model. No material inconsistencies were noted. To assess the reasonableness of the Scheme actuaries' estimation process, we compared the actual claim results in the current year to the prior year provision. We noted no matters for further consideration with respect to the estimation process. We performed the following procedures to assess the adequacy of the outstanding claim provision; • We obtained the actual claims run-off report up to 31 March 2023 from the Scheme's administrator and compared the claims paid post year-end to the outstanding claims provision at year-end as part of subsequent event procedures. No material inconsistencies were noted.

Key audit matter	How our audit addressed the key audit matter
	• For a sample of claims from the claims run-off report, we tested the occurrence and accuracy of the claims as well as the accuracy of the related service dates by agreeing the claims to underlying supporting documents on the policy administration system and we identified no material inconsistencies. • We inquired from the Scheme's administrator whether there were delays in processing claims at year-end that could possibly impact the claims run-off pattern subsequent to year-end. No such delays were identified. • We obtained a list of pre-authorisations approved prior to year-end from the administratorFor a sample of pre-authorisations with a service date before year-end, we requested the related claim documentation and assessed if the related claim had been included correctly in the claims run-off report up to 31 March 2023. No material inconsistencies were noted.

Other Information

The Scheme's trustees are responsible for the other information. The other information comprises the information included in the document titled "Anglo Medical Scheme Annual Report for the year ended 31 December 2022" The other information does not include the financial statements and our auditor's report thereon.

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

In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit, or otherwise appears to be materially misstated.

If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact. We have nothing to report in this regard.

Responsibilities of the Scheme's Trustees for the Financial Statements

The Scheme's trustees are responsible for the preparation and fair presentation of the financial statements, in accordance with International Financial Reporting Standards and the requirements of the Medical Schemes Act of South Africa, and for such internal control as the Scheme's trustees determine is

necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

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

Auditor's Responsibilities for the Audit of the Financial Statements

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

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

- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, design and perform audit procedures responsive to those risks, and obtain audit evidence that is sufficient and appropriate to provide a basis for our opinion. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control.
- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Scheme's internal control.
- Evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by the Scheme's trustees.
- Conclude on the appropriateness of the Scheme's trustees' use of the going concern basis of accounting and based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the Scheme's ability to continue as a going concern. If we conclude that a material uncertainty exists, we are required to draw attention in our auditor's report to the related disclosures in the financial statements or, if such disclosures are inadequate, to modify our opinion. Our conclusions are based on the audit evidence obtained up to the date of our auditor's report. However, future events or conditions may cause the Scheme to cease to continue as a going concern.
- Evaluate the overall presentation, structure and content of the financial statements, including the disclosures, and whether the financial statements represent the underlying transactions and events in a manner that achieves fair presentation.

We communicate with the Scheme's trustees regarding, among other matters, the planned scope and timing of the audit and significant audit findings, including any significant deficiencies in internal control that we identify during our audit.

From the matters communicated with the Scheme's trustees, we determine those matters that were of most significance in the audit of the financial statements of the current period and are therefore the key audit matters. We describe these matters in our auditor's report, unless law or regulation precludes public disclosure about the matter or when, in extremely rare circumstances, we determine that a matter should not be communicated in our report because the adverse consequences of doing so would reasonably be expected to outweigh the public interest benefits of such communication.

Report on Other Legal and Regulatory Requirements

Non-compliance with the Medical Schemes Act of South Africa

As required by the Council for Medical Schemes, we report that there are no material instances of non-compliance with the requirements of the Medical Schemes Act of South Africa that have come to our attention during the course of our audit.

Audit Tenure
As required by the Council for Medical Schemes' Circular 38 of 2018, Audit Tenure, we report that PricewaterhouseCoopers Inc. has been the auditor of Anglo Medical Scheme for five years.

The engagement partner, Julanie Basson, has been responsible for Anglo Medical Scheme's audit for five years.

PricewaterhouseCoopers Inc.

PricewaterhouseCoopers Inc.
Director: Julanie Basson
Registered Auditor
Johannesburg, South-Africa
26 April 2023

Statement of Financial Position for the year ended 31 December 2022

	Notes	2022 R'000	2021 R'000
Assets			
Non-current assets			
Investments held at fair value through profit or loss	2	1,021,041	1,134,702
Current assets		2,567,902	2,370,442
Investments held at fair value through profit or loss	2	2,360,924	2,214,823
Trade and other receivables	3	7,356	8,496
Cash and cash equivalents	4	199,623	147,123
Total assets		**3,588,943**	**3,505,144**
Funds and liabilities			
Accumulated funds		3,306,641	3,230,062
Current liabilities		282,302	275,082
Outstanding risk claims provision	5	29,585	30,592
Medical Savings Account liability	6	238,828	230,875
Trade and other payables	7	13,889	13,615
Total funds and liabilities		**3,588,943**	**3,505,144**

Statement of Comprehensive Income for the year ended 31 December 2022

	Notes	2022 R'000	2021 R'000
Risk contribution income	**8**	**539,569**	**515,425**
Relevant healthcare expenditure		**(577,673)**	**(557,166)**
Net claims incurred		(565,974)	(546,201)
Risk claims incurred	9	(566,701)	(547,268)
Third party claims recoveries		727	1,067
Net income on risk transfer arrangements	10	61	396
Risk transfer arrangement fees/premiums paid		(46,071)	(45,485)
Recoveries from risk transfer arrangements		46,132	45,881
Managed care: management services	11	(11,760)	(11,361)
Gross healthcare result		**(38,104)**	**(41,741)**
Administration fees	13	(21,710)	(20,919)
Administration expenses	12	(13,599)	(12,843)
Net impairment gains/(losses)	14	248	(245)
Net healthcare results		**(73,165)**	**(75,748)**
Investment and other income		176,198	445,042
Investment income	15	174,150	442,668
Sundry income	16	2,048	2,374
Other expenditure		(26,454)	(21,700)
Expenses for asset management services rendered		(14,020)	(13,407)
Interest paid on Medical Savings Accounts		(12,434)	(8,293)
Total comprehensive income for the year		**76,579**	**347,594**

Statement of Changes in Funds and Reserves for the year ended 31 December 2022

	Accumulated funds R'000
Balance as at 1 January 2021	**2,882,468**
Total comprehensive income for the year	347,594
Balance as at 31 December 2021	**3,230,062**
Total comprehensive income for the year	76,579
Balance as at 31 December 2022	**3,306,641**

Statement of Cash Flows for the year ended 31 December 2022

	2022 R'000	2021 R'000
Cash flows from operating activities		
Cash receipts from members and providers	618,188	591,166
Cash receipts from members - contributions	614,014	589,268
Cash receipts from members and providers - other	4,174	1,898
Cash paid to members and providers	(694,284)	(663,288)
Cash paid to members and providers - claims	(646,835)	(611,913)
Cash paid to providers - non-healthcare expenditure	(35,342)	(33,947)
Cash paid to members - savings plan refunds	(12,107)	(17,428)
Sundry income	1,067	1,017
Net cash utilised in operating activities	**(75,029)**	**(71,105)**
Cash flows from investing activities		
Acquisition of investments	(671,386)	(761,139)
Proceeds on disposal of investments	688,735	674,297
Interest received	73,842	**50,418**
Dividends received	50,358	38,594
Asset management fees	(14,020)	(13,407)
Net cash generated through/(utilised in) investing activities	**127,529**	**(11,237)**
Net decrease in cash and cash equivalents	**52,500**	**(82,342)**
Cash and cash equivalents at beginning of the year	**147,123**	**229,465**
Cash and cash equivalents at end of the year	**199,623**	**147,123**

Notes to the Financial Statements for the year ended 31 December 2022

General information

The Anglo Medical Scheme (the Scheme) offers the insurance of hospital, chronic illness and day-to-day benefits and is administered by Discovery Health (Pty) Ltd, a wholly owned subsidiary of Discovery Limited, listed on the JSE Limited.

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

1. Principal accounting policies

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

1.1 Basis of preparation

The Financial Statements have been prepared in accordance with International Financial Reporting Standards (IFRS), 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 consistently applied to all years presented.

The preparation of Financial Statements in conformity with IFRS requires the use of certain critical accounting estimates. It also requires management to exercise its judgement in the process of applying the Scheme's accounting policies. The areas involving a higher degree of judgement, or areas where estimates are significant to the Financial Statements, are disclosed in Note 26.

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 held at fair value through profit or loss. All monetary information and figures presented in these Financial Statements are stated in thousands of rand (R'000), unless otherwise indicated.

Implementation of new standards

New standards, amendments and interpretations not yet effective in 2022 relevant to the Scheme:

Title	Effective date - financial year commencing on or after
IFRS 17 - Insurance contracts - The Standard was issued in May 2017 and supersedes IFRS 4 'Insurance Contracts'. The Standard creates one accounting model for all insurance contracts and establishes principles for the recognition, measurement, presentation and disclosure of insurance contracts issued. The Standard requires insurance contracts to be measured using updated estimates and assumptions that reflect the timing of cash flows and takes into account any uncertainty relating to insurance contracts.	1 Jan 2023
Insurance contracts The primary objective of the standard is to identify insurance contracts within the Scheme. The contracts issued by the Scheme are insurance contracts, indemnifying members and their dependants against the risk of loss arising as a result of a health event. Certain of these contracts contain a Personal Medical Savings Account which were previously accounted for as financial instruments. Under IFRS 17 these will be accounted for as part of the insurance contracts. **Level of aggregation** Insurance contracts are aggregated into groups, or portfolios, of individual contracts when being measured and assessed as onerous on not. The level of aggregation has an impact on accounting for the insurance contracts, including the extent of offsetting and cross subsidisation to determine the appropriate level of aggregation in order to ultimately identify onerous contracts. A portfolio of insurance contracts comprises contracts subject to similar risks that are managed together. Once the portfolio of insurance contracts has been established, it becomes the unit of account to which the requirements of IFRS 17 are applied. All member contracts issued by the Scheme are subject to similar risks and are managed together, and therefore fall into the same portfolio, with no further disaggregation required. **Contract boundary** The contracts issued by the Scheme are in line with its financial year and therefore no contracts will be issued for a financial year after the end of that specific financial year. In addition, as no contract will exceed 12 months, no discounting will be applied. Insurance contracts issued shall be recognized from the earliest of the following: (a) The beginning of the coverage period; (b) The date when the first payment from a policyholder becomes due; and (c) For onerous contracts, when the contracts become onerous. With the insurance contracts being included in a single portfolio, and the coverage period aligning with the reporting period (financial year), the insurance contracts will be recognised from 1 January or from inception of cover should the member join the Scheme after 1 January. An exception to this would be where the Scheme as a whole is priced for a deficit position. This would mean that all contracts would be onerous and the loss would need to be recognised when the contracts become onerous. As pricing for the Scheme is done in September for the following year, the onerous contract test would be assessed at this time, with the following year's loss being recognised in the current financial year.	1 Jan 2023

Title	Effective date - financial year commencing on or after
Measurement The Standard further provides for a simplified approach, the "premium allocation approach", for the measurement of a group of insurance contracts under certain conditions. One of those conditions is that at the inception of the group of contracts, the entity reasonably expects that the simplification will produce measurement of the liability for remaining coverage that would not differ materially from that produced using the 'general measurement' model. Another condition is that the coverage period is one year or less. The Scheme has opted for the simplified "premium allocation approach". **Risk adjustment** The Standard requires an adjustment for non-financial risk. The Scheme shall adjust the estimate of the present value of the future cash flows in order to provide for the possible financial implications of the Scheme bearing the uncertainty of the amount and timing of cash flows that may arise from non-financial risk. The objective of the risk adjustment provision for non-financial risk is to reflect the Scheme's perception of the possible economic burden which may be the result of non-financial risks. IFRS 17 requires that the Standard is implemented retrospectively. This requires the identification, recognition and measurement of each group of insurance contracts as if the standard had always been applied. This also results in the derecognition of current balances that would not exist under IFRS 17, and the recognition of the resulting difference in Members' funds. **Financial impact** *Onerous contracts* With the requirement to implement the Standard retrospectively, the opening balances of 2021 and 2022 will be impacted by the budgeted deficits (onerous contracts) for the respective years. The 2021 budgeted deficit unwinds in 2021 with the 2022 budgeted deficit unwinding in 2022. The original budgets, with IFRS17 adjustments, will be the starting point in calculating the onerous contract loss. *Risk margin on onerous contracts* In addition to the "best estimate" onerous contract provision above, a risk margin amount reflecting potential adverse claims experience is required. It is required that a confidence interval approach is used. A confidence interval is a range of values into which one would expect an outcome to fall with a given chance.	1 Jan 2023

Title	Effective date - financial year commencing on or after
Historic variations from budget as a percentage of claims are used to calculate a 'standard error' deviation from budget, which is then used along with the Value at Risk (VaR) formula for claims variability in the Risk Based Solvency Assessment. The Value at Risk reflects a maximum financial loss which could be expected with a given probability i.e. a 90% VaR figure would be one that the scheme only has a 1 in 10 chance of performing worse than. This margin is expected to have a material impact on the onerous contract value. The Scheme has made extensive progress in the development of the necessary principles, policies and methodologies required to implement IFRS 17. Management are confident that the Scheme will be fully prepared to apply IFRS 17 to the Annual Financial Statements for the financial year ending 31 December 2023, including the required comparative figures arising from the 2022 financial year end.	1 Jan 2023
Amendment to IAS 1 'Presentation of Financial Statements' on Classification of Liabilities as Current or Non-current - The amendment clarifies that liabilities are classified as either current or non-current, depending on the rights that exist at the end of the reporting period. Classification is unaffected by expectations of the entity or events after the reporting date. The amendment has no material impact on the Annual Financial Statements.	1 Jan 2024

1.2 Foreign Currency Translation

Functional and presentation currency

Items included in the Financial Statements are measured using the currency of the primary economic environment in which the entity operates (functional currency).

The functional and presentation currency of the Scheme is the South African Rand (R).

Transactions and balances

Foreign currency transactions are translated into the functional currency using the exchange rates prevailing at the dates of the transactions. Foreign exchange gains and losses resulting from the settlement of such transactions and from the translation at year-end exchange rates of monetary assets denominated in foreign currencies are recognised in the Statement of Comprehensive Income.

1.3 Classification, recognition, presentation and derecognition of financial instruments

The Scheme recognises a financial instrument when, and only when, it becomes a party to the contractual provisions of the instrument. The Scheme classifies its financial instruments into the following categories: financial assets or financial liabilities at fair value through profit or loss, and trade 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.

Derecognition of financial assets and liabilities

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

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

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

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

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

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

1.4 Financial Assets

Investments held at fair value through profit or loss

The Scheme recognises a financial asset at fair value through profit or loss when upon initial recognition the Scheme designated the asset as fair value through profit or loss.

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.

Trade and other receivables

Receivables are non-derivative financial assets with fixed or determinable payments that are not quoted in an active market, other than those the Scheme intends to sell in the short term.

Trade and other receivables (continued)

Receivables are initially recognised at fair value plus transaction costs. The Scheme holds its Insurance Receivables and Other Receivables with the objective to collect the contractual cash flows and therefore measures them subsequently at amortised cost using the effective interest method, less provision for impairment. Trade and other receivables comprise Insurance Receivables, arising from the Scheme's insurance contracts with its members and Other Receivables.

1.5 Cash and cash equivalents

Cash and cash equivalents are short-term, highly liquid instruments that are readily convertible to known amounts of cash and are subject to an insignificant risk of changes in value.

In the Statement of Cash Flows, cash and cash equivalents comprise:

- Call accounts; and
- Current accounts.

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

1.6 Impairment of financial assets

Insurance receivables

The Scheme assesses at each reporting date, whether there is objective evidence that a financial asset is impaired. A financial asset, or group of financial assets, is impaired and impairment losses are incurred if, and only if, there is objective evidence of impairment as a result of one or more events that occurred after the initial recognition of the asset (a "loss event") and that loss event (or events) has an adverse impact on the estimated future cash flows of the financial asset that can be reliably estimated.

The Scheme first assesses whether objective evidence of impairment exists individually for financial assets such as service provider debtors. In the case of assets which are not individually significant, such as contribution debtors, financial assets are grouped on the basis of similar credit characteristics, such as asset type and past-due status. These characteristics are used in the estimation of future cash flows.

If there is objective evidence that an impairment loss on a financial asset has been incurred, the amount of the loss is measured as the difference between the asset's carrying amount and the present value of estimated future cash flows discounted at the financial asset's original effective interest rate. The carrying amount of the asset is reduced and the amount of the loss is recognised in surplus or deficit.

If, in a subsequent period, the amount of the impairment loss decreases and the decrease can be related objectively to an event occurring after the impairment was recognised, the previously recognised impairment loss is reversed by adjusting the allowance account. The amount of the reversal is recognised in surplus or deficit.

Impairment of 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.

1.7 Financial liabilities

Financial liabilities are initially recognised at fair value net of transaction costs incurred. After initial recognition, the financial liabilities are measured at amortised cost, using the effective interest method. In addition, the Scheme is not permitted to borrow, in terms of Section 35(6)(c) of the Act. The Scheme therefore has no long-term financial liabilities.

Trade and other payables

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

Trade payables are recognized initially at fair value and subsequently measured at amortised cost using the effective interest method.

Insurance payables

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

Medical Savings Account liabilities

Members' Personal Medical Savings Accounts, represent savings contributions (which are a deposit component of the insurance contracts), and accrued interest thereon, net of any savings claims paid on behalf of members in terms of the Scheme's registered Rules. The deposit component has been unbundled since the Scheme can measure the deposit component separately and the Scheme's accounting policies do not otherwise require recognition of all obligations and rights arising from the deposit component.

The savings accounts contain a demand feature and are initially measured at fair value plus transaction costs, which is the amount payable to a member on demand, discounted from the first date that the amount could be required to be paid. Subsequent to initial measurement, the liability is measured at amortised cost using the effective interest rate method.

Unspent savings at year end are carried forward to meet future expenses for which the members are responsible. In terms of the Act, balances standing to the credit of members are refundable only in terms of Regulation 10 of the Act.

Advances on savings contributions are funded from the Scheme's funds, and the risk of impairment is carried by the Scheme.

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

1.8 Provisions

The Scheme recognises provisions once the following conditions are met:

- It has a present legal or constructive obligation as a result of past events;
- It is probable that an outflow of resources embodying economic benefits will be required to settle the obligation; and
- A reliable estimate of the amount of the obligation can be made.

Provisions are measured as the present value of management's best estimate of the expenditure required to settle the obligation at the reporting date. Where the effect of discounting to present value is material, provisions are adjusted to reflect the time value of money.

Outstanding risk claims provision

Claims outstanding comprise provisions for the Scheme's best estimate of the ultimate cost of settling all claims incurred but not yet reported at the reporting date. Claims outstanding are determined as accurately as possible based on a number of factors. These include previous experience in claims patterns, claims settlement patterns, trends in claims frequency, changes in the claims processing cycle, and variations in the nature and average cost incurred per claim.

Claims handling expenses are not separately accounted for as this service is provided by the Administrator and a fixed fee is paid for the full administration service including claims handling. No provision for claims handling expenses is required as the Scheme has no further liability to the Administrator at year end.

Estimated co-payments and payments from members' Personal Medical Savings Accounts are deducted in calculating the outstanding claims provision. The Scheme does not discount its provision for outstanding claims since the effect of the time value of money is not considered material.

1.9 Unallocated funds

Unallocated funds arise on the receipt of unidentified deposits in favour of the Scheme.

Unallocated funds that have legally prescribed, that is funds older than three years, are written back and are included under Sundry income on the face of the Statement of Comprehensive Income.

A liability for unallocated funds that have not legally prescribed is recognised and disclosed under Trade and other payables. The liability is measured at amortised cost using the effective interest rate method.

1.10 Member insurance contracts

Contracts under which the Scheme accepts significant insurance risk from another party (the member and respective registered dependants) by agreeing to extend benefits to the member or another beneficiary if a specified uncertain future event (the insured event) adversely affects the member or other beneficiary, are classified as insurance contracts.

The contracts issued compensate the Scheme's members in terms of the Scheme Rules for healthcare expenses incurred and are detailed in Note 24.

1.11 Risk contribution income

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

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

1.12 Relevant healthcare expenditure

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

Risk Claims incurred

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

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

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

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

Risk transfer arrangements

Risk transfer arrangements are contractual arrangements whereby a third party undertakes to indemnify the Scheme against all or part of the loss that the Scheme may incur as a result of carrying on the business of a medical scheme. Risk transfer arrangements do not reduce the Scheme's primary obligations to its members and their dependants, but the arrangements decrease the loss the Scheme may incur as a result of carrying on the business of a medical scheme.

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

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

Assets relating to risk transfer arrangements include balances due under risk transfer arrangements for outstanding claims provisions and claims reported not yet paid. Amounts recoverable under risk transfer arrangements are estimated in a manner consistent with the outstanding claims provisions, claims reported not yet paid, and settled claims associated with the risk transfer arrangement.

Managed care: Management services fees

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

1.13 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 Investment income

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

Interest income is recognised on the effective interest method.

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

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

1.15 Interest paid on Medical Savings Accounts (MSA)

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

1.16 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.

1.17 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.

1.18 Allocation of income and expenditure to benefit options

The following items are directly allocated to benefit options:

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

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

2. Investments held at fair value through profit or loss

	2022 R'000	2021 R'000
Fair value at the beginning of the year	3,349,525	2,908,962
Additions		
Dividend income	50,358	38,594
Interest income	75,636	63,409
Acquisition of investments	549,315	674,172
Disposals		
Expenses for asset management services rendered	(14,020)	(13,407)
Proceeds on disposal of investments	(623,123)	(586,012)
Movement on revaluation to market value	(5,726)	263,805
Fair value at the end of the year	3,381,965	3,349,525
Less: Short-term portion shown in current assets	(2,360,924)	(2,214,823)
	1,021,041	**1,134,702**
The investments included above represent investments in:		
Bonds	1,149,238	1,072,629
Collective Investment Schemes	483,540	430,201
Commodities	58,908	57,562
Equities	1,118,310	1,148,545
Linked Insurance Policies	444,042	502,518
Money market instruments	127,927	138,070
	3,381,965	**3,349,525**
The investments were managed by the following asset managers at year-end:		
Coronation Asset Management (Pty) Ltd	598,243	602,928
Allan Gray South Africa (Pty) Ltd	511,992	467,137
Ninety One SA (Pty) Ltd	1,705,402	1,721,350
Abax Investments (Pty) Ltd	566,328	558,110
	3,381,965	**3,349,525**

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

3. Trade and other receivables

	2022 R'000	2021 R'000
Insurance receivables		
Contribution receivables	4,098	3,904
Member and service provider claims receivable	691	792
Amount due	1,374	2,857
Less: Allowance for impairment	(683)	(2,065)
Forensic receivables	89	133
Receivables arising from insurance contracts	**4,878**	**4,829**
Other receivables		
Interest receivable	**316**	**158**
Prepaid expenditure	1,821	1,954
Sundry accounts receivable	340	1,555
Receivables arising from Other receivables	2,477	3,667
Total trade and other receivables	**7,355**	**8,496**

At 31 December 2022, 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

Call accounts	122,782	31,138
Current accounts	76,841	115,985
	199,623	**147,123**

The weighted average effective interest rate on cash and cash equivalents was 5.78% (2021 - 4.59%). The call accounts have an average maturity of 1 day (2020 - 1 day) as these are used as a clearing facility.

5. Outstanding risk claims provision

	2022 R'000	2021 R'000
Outstanding risk claims provision - not covered by risk transfer arrangements	**29,585**	**30,592**
Analysis of movement in outstanding risk claims provision		
Balance at beginning of year	30,592	23,074
Payments in respect of prior year	(26,727)	(21,704)
Over provision in respect of prior year	3,865	1,370
Movement for the current year	25,721	29,222
Outstanding risk claims provision	**29,585**	**30,592**
Analysis of outstanding risk claims provision		
Estimated gross claims	30,560	31,746
Less: Estimated recoveries from MSA (Note 6)	(975)	(1,154)
Total outstanding risk claims provision at year end	**29,585**	**30,592**

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

Basis for determining the outstanding risk claims provision

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

Process used to determine the assumptions

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

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

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

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

Assumptions

The assumptions that have the greatest effect on the measurement of the outstanding risk claims provision, are the claims "run-off periods" for the most recent benefit years (split by discipline), in particular the in-hospital category. The run-off factor relates to the emergence and settlement patterns of risk claims and is expressed as the percentage of risk claims settled in respect of total claims expected to emerge in a specific service month. This factor is then used to project the remainder of the outstanding risk claims relating to the specified service month. A "seasonality factor" is further incorporated into the calculation, also based on past claims experience. Consistent assumptions have been used for assessing the outstanding risk claims provisions for the 2021 and 2022 benefit years.

Changes in assumptions

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

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

Impact on reported profits due to changes in key variables:

	Change in variables	Change in claims cost 2022 R'000	Change in claims cost 2021 R'000
In-hospital claims incurred	5%	275	272
Out-of-hospital claims incurred	5%	110	116
Chronic claims incurred	5%	25	28

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

The sensitivity of the estimation process is reduced by the value of the risk claims paid subsequent to the year end related to the period ended 31 December 2022, as detailed in the table below:

	2022 R'000	2021 R'000
Outstanding risk claims provision	**29,585**	**30,592**
Portion of outstanding risk claims provision paid to 28 February 2023 (2021: 28 February 2022)	(21,401)	(22,282)
Residual estimate of risk claims incurred but not paid	8,184	8,310

The Scheme may be liable for COVID-19 vaccine costs for 2022 and 2021 that were incurred by Scheme members where services were rendered by the State. To date, these claims have not all been processed. An additional provision of R3,9m (2021: R3.9m) has been made for these claims and is included above.

6. Medical Savings Account (MSA) liability

	2022 R'000	2021 R'000
Balance on MSA liability at the beginning of the year	230,875	231,229
Add:		
MSA contributions received for the current year (Note 8)	74,639	73,367
Transfers received from other medical schemes	630	402
Interest accrued on MSA funds	12,434	8,293
Less:		
Claims paid to or on behalf of members (Note 9)	(67,643)	(64,988)
Refunds on death or resignation	(12,107)	(17,428)
Balance on MSA liability at the end of the year	**238,828**	**230,875**

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

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

Estimated claims to be paid out of members' MSA in 2023 in respect of claims incurred in 2022 but not yet reported: (Note 5)	975	1,154

At 31 December 2022, the carrying amount of the MSA liability approximates its fair value, since it is payable on demand. These amounts were not discounted to present values due to their demand feature.

7. Trade and other payables

	2022 R'000	2021 R'000
Insurance liabilities		
Reported claims not yet paid	8,682	8,375
Total liabilities arising from insurance contracts	**8,682**	**8,375**
Financial liabilities		
Balances due to related party - Discovery Health (Pty) Ltd	2,664	2,519
Accruals	1,511	2,041
Unallocated funds	1,032	680
Total arising from financial liabilities	5,207	5,240
Total trade and other payables	**13,889**	**13,615**

At 31 December 2022, the carrying amounts of other liabilities approximate their fair values due to the short-term maturities of these liabilities.

8. Risk contribution income

Gross contributions per registered Rules	614,208	588,792
Less: MSA contributions received*	(74,639)	(73,367)
Risk contribution income per statement of comprehensive income	**539,569**	**515,425**

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

9. Risk claims incurred

	2022 R'000	2021 R'000
Claims incurred excluding claims in respect of related risk transfer arrangements		
Current year claims per registered Rules	562,492	537,153
Movement in outstanding risk claims provision	25,721	29,222
Over provision in respect of prior year (Note 5)	(3,865)	(1,370)
Adjustment for current year (Note 5)	29,585	30,592
Claims paid from MSA (Note 6)	(67,643)	(64,988)
	520,570	501,387
Claims incurred in respect of risk transfer arrangements		
Netcare 911		
Current year claims	3,610	3,141
Kaelo Prime Cure		
Current year claims	12,573	12,748
Centre for Diabetes and Endocrinology (CDE)		
Current year claims	25,266	25,615
Dental Risk Company		
Current year claims	4,683	4,377
	46,132	45,881
Risk claims per statement of comprehensive income	**566,701**	**547,268**

10. Net income on risk transfer arrangements

	2022 R'000	2021 R'000
Capitation fees paid to third party providers	(46,071)	(45,485)
Recoveries under risk transfer arrangements	46,132	45,881
	61	**396**
Made up as follows:		
Netcare 911 (Pty) Ltd	890	520
Capitation fees paid	(2,720)	(2,621)
Recovery from service provider	3,610	3,141
Risk transfer arrangement providing ambulance services (air and land) for members registered on the Managed Care and Standard Care Plans.		
Kaelo Prime Cure (Pty) Ltd	(3,783)	(2,066)
Capitation fees paid	(16,356)	(14,814)
Recovery from service provider	12,573	12,748
Risk transfer arrangement providing an agreed structure of day-to day benefits, including treatment of chronic conditions, for members registered on the Value Care Plan. The contract excludes the provision of treatment, per event, for any hospital admissions above R173,000 in private facilities.		
Centre for Diabetes and Endocrinology	2,662	1,704
Capitation fees paid	(22,604)	(23,911)
Recovery from service provider	25,266	25,615
Risk transfer arrangement covering treatment for members regsitered on the Managed Care and Standard Care Plans, diagnosed with diabetes including diabetic related hospital admissions.		
Dental Risk Company	292	238
Capitation fees paid	(4,391)	(4,139)
Recovery from service provider	4,683	4,377
Risk transfer arrangement for protection against and transfer of all risks relating to dental benefits for members registered on the Standard Care Plan.		
	61	**396**

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

The cost of providing the capitated services was estimated by calculating Per Life Per Month (PLPM) estimates for services covered under these risk transfer arragements and multiplying them by the number of members exposed for the period to the respective programmes.

11. Managed care: management services

	2022 R'000	2021 R'000
Chronic medicine management services	1,243	1,205
Disease management services	3,365	3,249
Hospital management services	3,260	3,148
Pharmaceutical benefit management services	1,052	1,016
Provider network management services	2,840	2,743
	11,760	**11,361**

12. Administration expenses

Staff costs	3,782	3,668
Principal Officer remuneration and related expenses	2,730	2,516
Consulting fees	2,061	2,077
Electronic checking fees	1,315	1,276
Audit fees	993	449
Publications	859	664
Trustee remuneration and considerations	525	952
Head office rental and management fees	467	336
General expenses	436	197
Council for Medical Schemes expenses	386	384
Travel and entertainment	30	297
Trustee election expenses	15	27
	11,760	**11,361**

13. Administration fees

	2022 R'000	2021 R'000
Accredited services		
Customer services	10,079	9,705
Information management and data control	3,700	3,563
Claims management	2,282	2,197
Member record management	2,064	1,987
Contribution management	1,814	1,746
Financial management	73	71
Other services		
Forensic investigations and recoveries	367	369
Internal audit services	306	295
Actuarial services	176	169
Governance and compliance	61	58
Additional services		
Quality Management and Monitoring Services	288	278
Advanced Data Analytics	241	232
Digital Service Offering	89	86
Product Innovation	58	55
Enhanced Service Offering	49	47
Enterprise risk management services	49	47
Legal Services	14	13
	21,710	**20,919**

14. Net impairment gains/(losses)

Insurance receivables		
Members claims debt	(1,212)	(248)
Movement in allowance account	(78)	55
Impairment write off	(1,134)	(303)
Suppliers claims debt	1,460	3
Movement in allowance account	1,460	3
	248	**(245)**

15. Investment income

	2022 R'000	2021 R'000
Interest income from current accounts	2,288	1,983
Income from investments	179,023	174,487
Interest income	75,636	63,409
Dividend income	50,358	38,594
Net realised gains on fair value adjustments	53,028	72,484
Movement in fair value adjustments	(7,161)	266,198
	174,150	**442,668**

16. Sundry income

Long-term funding	1,067	1,017
Prescribed income	981	1,357
	2,048	**2,374**

17. 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 2022. (2021: USD 35,000,000)

18. Commitments and contingent liabilities

The Scheme does not have any commitments or contingent liabilities outstanding at 31 December 2022 (2021: Nil).

19. Contingent asset

As at 31 December 2022, the Scheme had pending motor vehicle accident medical claims to the value of R9,566,018 (2021: R6,379,527) submitted to the Road Accident Fund (RAF) for assessment. This will only be accounted for when an amount is certain to be received from the RAF.

20. Events after the reporting date

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

21. Related party transactions

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

Key management personnel

Key management personnel are those persons having authority and responsibility for planning, directing and controlling the activities of the Scheme. Key management personnel include the Board of Trustees and the Principal Officer.

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

Parties with significant influence over the Scheme

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.

	2022 R'000	2021 R'000
Transactions with key management personnel		
Statement of Comprehensive Income transactions		
Gross contributions received	1,946	2,101
Gross claims paid	2,088	1,683
Interest on MSA balances	17	10
Key management personnel remuneration	6,512	6,184
Trustee remuneration and considerations	525	952
Statement of Financial Position		
Medical Savings Accounts	343	289

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 2022 this rate was 7,00% (2021: 3,75%) 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 applicable to all members.

	2022 R'000	2021 R'000
Transactions with parties with significant influence over the Scheme		
Statement of Comprehensive Income transactions		
Discovery Health (Pty) Ltd	21,710	20,919
- administration fees	10,517	10,157
- managed care: management services fees	1,315	1,276
Medikredit (Pty) Ltd - electronic checking fees	16,356	14,814
Kaelo Prime Cure (Pty) Ltd - risk transfer arrangement fees		
Anglo Corporate Services South Africa (Pty) Limited		
- head office rental and management fees	467	336
Statement of Financial Position		
Balance due to Discovery Health (Pty) Ltd	2,664	2,519
Balance due to Medikredit (Pty) Ltd	110	105
Balance due to Kaelo Prime Cure (Pty) Ltd	-	1,266
Anglo Corporate Services South Africa (Pty) Limited	-	51
Investment in employers	67,142	84,256

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.

22. Trustee remuneration and considerations

Trustees	Fees for meeting attendance		Disbursements		Accommodation, travelling and meals		Total	
	2022 R'000	2021 R'000	2022 R'000	2021 R'000	2022 R'000	2021 R'000	2022 R'000	2021 R'000
Abramowitz DE*	-	36	-	-	-	-	-	36
Coetzer JP*	7	50	-	-	-	-	7	50
Elliott CC	87	67	17	16	4	-	108	83
Farrell MR	74	28	17	-	-	-	91	28
Fox Dr FH	145	101	17	16	0	-	162	117
Hosking S*	-	14	-	-	-	-	-	14
Liston JB*	15	85	-	-	-	-	15	85
Mamabolo NM*	15	85	-	-	-	-	15	85
Mason-Gordon NJ	74	72	17	16	-	-	91	88
McCallum DR	-	101	-	16	-	-	-	117
Mhlongo QP*	15	71	-	-	-	-	15	71
Moodley R*	7	57	-	-	-	-	7	57
Thompson HM*	7	64	-	-	-	-	7	64
Van der Bijl BD*	7	57	-	-	-	-	7	57
TOTAL	**453**	**888**	**68**	**64**	**4**	**-**	**525**	**952**

* Trustees' fees ceded to employer

23. (Deficit)/surplus per benefit option

2022	Managed Care Plan R'000	Standard Care Plan R'000	Value Care Plan R'000	Total R'000
Risk contribution income	280,319	239,520	19,730	539,569
Relevant healthcare expenditure	(342,504)	(216,843)	(18,326)	(577,673)
Net claims incurred	(338,612)	(212,820)	(14,542)	(565,974)
Risk claims incurred	(339,047)	(213,094)	(14,560)	(566,701)
Third party claims recoveries	435	274	18	727
Net income/(expense) on risk transfer arrangements	1,760	2,085	(3,784)	61
Risk transfer arrangement fees/premiums paid	(12,650)	(17,064)	(16,357)	(46,071)
Recoveries from risk transfer arrangements	14,410	19,149	12,573	
Managed care: management services	(5,652)	(6,108)	-	(11,760)
Gross healthcare result	(62,185)	22,677	1,404	(38,104)
Administration fees	(10,111)	(10,926)	(673)	(21,710)
Administration expenses	(6,433)	(6,989)	(177)	(13,599)
Net impairment gains	117	128	3	248
Net healthcare results	(78,612)	4,890	557	(73,165)
Investment and other income	74,757	81,002	20,439	176,198
Other expenditure	(18,392)	(6,438)	(1,624)	(26,454)
Net (deficit)/surplus for the year	(22,247)	79,454	19,372	76,579
Number of members at year-end	3,623	4,064	1,072	8,759

23. (Deficit)/surplus per benefit option (continued)

2021	Managed Care Plan R'000	Standard Care Plan R'000	Value Care Plan R'000	Total R'000
Risk contribution income	277,931	220,113	17,381	515,425
Relevant healthcare expenditure	(331,846)	(209,338)	(15,982)	(557,166)
Net claims incurred	(327,438)	(204,846)	(13,917)	(546,201)
Risk claims incurred	(328,077)	(205,248)	(13,943)	(547,268)
Third party claims recoveries	639	402	26	1,067
Net income on risk transfer arrangements	1,252	1,209	(2,065)	396
Risk transfer arrangement fees/premiums paid	(15,231)	(15,440)	(14,814)	(45,485)
Recoveries from risk transfer arrangements	16,483	16,649	12,749	45,881
Managed care: management services	(5,660)	(5,701)	-	(11,361)
Gross healthcare result	(53,915)	10,775	1,399	(41,741)
Administration expenses	(10,115)	(10,200)	(604)	(20,919)
Administration expenses	(6,310)	(6,377)	(156)	(12,843)
Net impairment losses	(120)	(122)	(3)	(245)
Net healthcare results	(70,460)	(5,924)	636	(75,748)
Investment and other income	196,571	200,264	48,207	445,042
Other expenditure	(14,215)	(6,033)	(1,452)	(21,700)
Net surplus for the year	111,896	188,307	47,391	347,594
Number of members at year-end	3,754	3,871	972	8,597

24. Insurance risk management report

Nature and extent of risks arising from insurance contracts

The Scheme issues contracts that transfer insurance risk. The primary insurance activity carried out by the Scheme indemnifies covered members and their dependants against the risk of loss arising as a result of the occurrence of a health event, in accordance with the Scheme Rules and legislative requirements.

This section summarises these risks and the way in which they are managed.

Insurance risk

The risk under any insurance contract can be expressed as the probability that an insured event occurs, multiplied by the expected amount of the resulting claim. Insurance events are random and therefore the actual number and size of events during any year are unknown and vary from those estimated. The principal risk that the Scheme faces under its insurance contracts is that the actual claim payments exceed the projected amount of the insurance liabilities. This could occur because the frequency and severity of claims are greater than estimated.

A larger number of members will result in smaller variability of the actual claims experience relative to expected levels. This is because adverse experience is diluted by a larger group of members whose claims are more stable and thus predictable.

Factors that aggravate insurance risk include unanticipated demographic movements, adverse experience due to an unexpected epidemic, changes in members' disease profiles, unexpected price increases, prevalence of fraud, supplier-induced demand and the cost of new technologies or drugs.

The risks that the Scheme faces can be discussed for the different benefits offered. The three main types of benefits offered by the Scheme in return for monthly contributions are indicated below:

Hospital benefits
In-hospital benefits cover 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.

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	2022	2021	% Increase/ (decrease)
Length of stay (days)	4.54	4.87	(6.8%)
Average hospital cost per admission (R)	39,972	45,830	(12.8%)
Total cost per event (R)	66,048	73,442	(10.1%)
Total cost per life per month (R)	914	892	2.5%
Admissions per 1 000 lives	274	234	17.1%

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	2022	2021	% Increase/ (decrease)
Claimants per 1 000 lives	28.88	30.05	(3.9%)
Amount paid per life per month	154	165	(6.7%)

Day-to-day benefit risk

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

Risk management

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

- All hospital admissions have to be authorised. There have also been amendments to the pre- authorisation length of stay benchmarks;
- Case managers monitor members with hospital stays that are longer than expected to ensure that members are discharged at appropriate times;
- Out-of-hospital 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:

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	12,997
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

2021 Age grouping (in years)	Hospital R	Chronic R	Day-to-day R	Total R
< 26	3,844	238	2,701	6,783
26 - 35	6,659	405	5,224	12,288
36 - 50	10,289	1,231	6,729	18,249
51 - 65	27,310	2,831	10,290	40,431
> 65	44,006	4,969	14,598	63,573

Risk transfer arrangements

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

The first risk transfer arrangement (Kaelo Prime Cure) covers day to day expenditure, including treatment of chronic conditions, and hospital admissions under R173,000 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.

Risk in terms of risk transfer arrangements

The Scheme does however remain liable to its members to provide the benefits. If any supplier fails to meet the obligations of the risk transfer arrangement, the Scheme will cover the cost of the benefit.

When selecting a supplier, the Scheme assesses their ability to provide the relevant service. The Scheme also monitors the performance of the suppliers, assesses the quality of care provided and has access to data on the underlying fee-for-service claims that are included in the arrangement.

Claims development

Detailed claims development tables are not presented as the uncertainty regarding the amount and timing of claim payments is typically resolved within one year and in the majority of cases within three months. At year end, a provision is made for those claims outstanding that are not yet reported at that date.

The methodology followed in determining the outstanding claims provision is the generally accepted actuarial methodology of chain ladder estimation. This methodology is the most objective, but the accuracy of the estimate is sensitive to changes in the average time from treatment to payment of claims. For hospital claims in the latest service month, another method using the estimated cost per event and pre-authorised admissions is also utilised/applied.

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

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

	Change in variable	2022 R'000	2021 R'000
In-hospital claims incurred	5% change in claims cost	275	272
Chronic claims incurred		110	116
Out-of-hospital claims incurred		25	28

25. Financial risk management report

Overview

The Scheme is exposed to financial risk through its financial assets, financial liabilities and insurance liabilities. In particular the financial risk is that the proceeds, for any reason, from its financial assets are not sufficient to fund the obligations arising from its insurance contracts. The most important components of financial risk include market risk, interest rate risk, credit risk and liquidity risk.

The Scheme's overall risk management programme focuses on the unpredictability of financial markets and seeks to minimise potentially adverse effects on the financial performance of the investments that the Scheme holds to meet its obligations to its members.

The Board of Trustees has overall responsibility for the establishment and oversight of the Scheme's risk management framework.

The Scheme manages these risks through various risk management processes. These processes have been developed to ensure that the long-term investment return on assets supporting the insurance liabilities is sufficient to contribute towards funding members' reasonable benefit expectations.

The Scheme manages the financial risks as follows:

- The Investment Committee, a committee (the Committee) of the Board of Trustees, determines, recommends, implements and maintains investment policies and procedures. The Committee advises the Board of Trustees on the strategic and operating matters in respect of the investment of Scheme funds and meets at least quarterly;
- The Scheme has appointed reputable external asset managers to manage its investments and their performance is monitored regularly; and
- An external asset consulting company has been appointed to assist in formulating the investment strategy and to provide ongoing reporting and monitoring of the asset managers.

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. 12.1% (2021: 11.6%) 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 2022	ZAR R'000	Foreigncurrency 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
	3,147,348	434,239	3,581,588

As at 31 December 2021	ZAR R'000	Foreigncurrency R'000	TOTAL R'000
Investments held at fair value through profit or loss	2,962,524	387,001	3,349,525
Cash and cash equivalents	129,622	17,501	147,123
	3,092,146	404,502	3,496,648

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	2022 R'000	2021 R'000
Foreign currency	10%	43,424	40,450

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	2022 R'000	2021 R'000
Investments held at fair value through surplus or deficit: Equities	10%	111,831	114,854

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 2022	0 - 3 months R'000	3 - 12 months R'000	> 12 months R'000	Total R'000
Cash and cash equivalents	199,623	-	-	199,623

As at 31 December 2021	0 - 3 months R'000	3 - 12 months R'000	> 12 months R'000	Total R'000
Cash and cash equivalents	147,123	-	-	147,123

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

	2022 %	2021 %
Cash and cash equivalents - Medical Scheme assets	5.78%	114,854

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 2021.

	% change in interest rates	2022 R'000	2021 R'000
Cash and cash equivalents - Medical Scheme assets	1%	13,482	13,943

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:

	2022 R'000	2021 R'000
Total Accumulated Funds per the Statement of Financial Position	3,306,641	3,230,062
Less: cumulative unrealised net gain on measurement of investments to fair value	(470,889)	(478,050)
Accumulated funds per Regulation 29	2,835,752	2,752,012

Gross contribution income (R'000)	614,208	588,792
Solvency margin = Accumulated funds/gross contribution income x 100	461.69%	467.40%

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.

25. 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:

As at 31 December 2022	Financial assets and liabilities at fair value through profit or loss R'000	Other receivables R'000	Insurance receivables and (payables) R'000	Financial liabilities at amortised cost R'000	Total carrying amount R'000	Fair value amount R'000
Investments						
Held at fair value through profit or loss	3,381,965	-	-	-	3,381,965	3,381,965
Cash and cash equivalents	-	199,623	-	-	199,623	199,623
Trade and other receivables	-	2,477	4,878	-	7,355	7,355
Outstanding risk claims provision	-	-	(29,585)	-	(29,585)	(29,585)
Medical Savings Account liability	-	-	(238,828)	-	(238,828)	(238,828)
Trade and other payables	-	-	(8,682)	(5,207)	(13,889)	(13,889)
	3,381,965	**202,099**	**(272,217)**	**(5,207)**	**3,306,640**	**3,306,640**

As at 31 December 2021	R'000	R'000	R'000	R'000	R'000	R'000
Investments						
Held at fair value through profit or loss	3,349,525	-	-	-	3,349,525	3,349,525
Cash and cash equivalents	-	147,123	-	-	147,123	147,123
Trade and other receivables	-	3,667	4,829	-	8,496	8,496
Outstanding risk claims provision	-	-	(30,592)	-	(30,592)	(30,592)
Medical Savings Account liability	-	-	(230,875)	-	(230,875)	(230,875)
Trade and other payables	-	-	(8,375)	(5,240)	(13,615)	(13,615)
	3,349,525	150,790	(265,013)	(5,240)	3,230,062	3,230,062

25. Financial risk management report (continued)

Assets measured at fair value

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

- Level 1: 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

	2022 R'000	2021 R'000
Level 1		
Bonds	1,149,238	1,072,629
Commodities	58,908	57,562
Equities	1,118,310	1,148,545
Level 2		
Collective Investment Schemes	483,540	430,201
Linked Insurance Policies	444,042	502,518
Money market instruments	127,927	138,070
	3,381,96	3,349,525

Credit risk

Credit risk is the risk of financial loss to the Scheme, if a counterparty to a financial instrument fails to meet its contractual obligations.

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

- Trade and other receivables comprising insurance receivables and other receivables. The main components of insurance receivables are in respect of contributions due from members and amounts recoverable from members and suppliers in respect of claims debt. The Scheme has exposure from its other receivables;
- 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.

25. Financial risk management report (continued)

Credit risk (continued)

The Scheme's Trade and other receivables at 31 December 2022 comprise:

	2022 R'000	2021 R'000
Insurance receivables	4,878	4,829
Contributions receivable (a)	4,098	3,904
Member and service provider claims receivables (b)	1,374	2,857
Less: Allowance for Impairment losses	(683)	(2,065)
Forensic receivables	89	133
Other receivables	2,477	3,667
Interest receivable	316	158
Prepaid expenditure	1,821	1,954
Sundry accounts receivable	340	1,555

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

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

Exposure to credit risk

The carrying amount of Trade and other receivables represents the maximum credit exposure.

The Scheme ages and pursues unpaid accounts on a monthly basis. The tables below highlight insurance receivables within Trade and other receivables which are due, past due (by number of days) and impaired.

Insurance receivables	Gross 2022 R'000	Impairment 2022 R'000	Gross 2021 R'000	Impairment 2021 R'000
Not past due	4,378	-	3,579	-
Past due 0 - 30 days	108	-	346	-
Past due 31 - 60 days	153	-	179	-
Past due 61 - 150 days	261	133	749	194
151 days to more than 1 year	661	550	2,041	1,871
	5,561	683	6,894	2,065

25. Financial risk management report (continued)

Credit risk (continued)

Impairment losses

The Scheme establishes an allowance for impairment that represents its estimate of anticipated losses in respect of Trade and other receivables. The provision is based on the expected difference between the current carrying amount and the amount recoverable from the counterparties.

Below is the movement in the impairment for each component of Trade and other receivables during the year ended 31 December 2022:

	Member and service provider claims R'000
Balance as at 1 January 2022	2,065
Movement in impairment allowance	(248)
Amounts utilised during the year	(1,134)
Balance as at 31 December 2022	**683**

Balance as at 1 January 2021	2,123
Movement in impairment allowance	245
Amounts utilised during the year	(303)
Balance as at 31 December 2021	**2,065**

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

The Scheme applies the IFRS 9 simplified approach to measuring expected credit losses which uses a lifetime expected loss allowance for other receivables and cash and cash equivalents.

To measure the expected credit losses associated with other receivables and cash and cash equivalents, these have been grouped based on shared credit risk characteristics and the days past due. Other receivables comprise sundry accounts receivable and interest receivable and are all current and not in a past due status. Cash and cash equivalents consist of bank and call accounts. No expected loss rate is assigned to receivables that are not past due and no expected loss rate is assigned to cash and cash equivalents. Any loss associated to these receivables and cash and cash equivalents is negligible and no provision is raised.

25. Financial risk management report (continued)

Credit risk (continued)

Credit quality

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

Insurance receivables	2022 R'000	2021 R'000
Contributions receivable	4,098	3,904
Member and service provider claims receivable		
Active member claims receivable	67	209
Withdrawn member claims receivable	123	101
Service provider claims receivable	501	482
Forensic receivables	89	133
	4,878	4,829

Contribution receivables

The Scheme collected over 99% (2021: 99%) of outstanding debt in January 2023. 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. An impairment allowance covering 58% (2021: 48%) of the total amount due has been raised and the Trustees are satisfied that this is adequate.

Service provider claim receivables

These debtors are the healthcare providers of the Scheme. The amounts due to the Scheme are offset against future payments to be made to these providers. An impairment allowance covering 50% (2021: 80%) of the total amount due has been raised and the Trustees are satisfied that this is adequate.

Forensic receivables

These debt arose due to forensic investigations and claims reversals as a result thereof. The parties involved signed an Acknowledgement of Debt, and therefore no provision for impairment is necessary.

Cash and cash equivalents

	2022 R'000	2021 R'000
Invested with counterparties with high quality credit ratings	199,623	147,123

25. 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 2022		As at 31 December 2021	
	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	33,114	0.9%	13,909	0.6%
Ninety One Ial Stable Money Fund	444,042	26.5%	502,518	31.2%
Ninety One Ial Money Market Fund	37,755	0.1%	17,434	0.0%
Ninety One Stefi Plus Fund Z	11,702	0.1%	10,996	0.1%
Ninety One GSF US Dollar Money Fund	41,313	0.2%	31,349	0.2%
Ninety One GSF Global Franchise Fund	149,041	0.1%	179,010	0.1%
Coronation Absolute Bond	156,447	3.8%	148,947	3.4%
ABAX SA Income Prescient Fund	17,584	7.2%	16,498	7.2%
ABAX Global Equity Prescient Fund	5,165	0.3%	6,115	0.4%
ABAX Global Equity Prescient Feeder Fund	25,994	5.8%	-	-
Nedgroup Corporate Money Market Fund	5,424	0.0%	5,945	0.0%

Liquidity risk

Liquidity risk is the risk that the Scheme will not have sufficient liquid funds available to settle financial obligations as they fall due.

The Scheme's approach to managing liquidity is to ensure, with significant conservative margin, that it will always have sufficient liquidity to meet its liabilities when due, under both normal and stressed conditions, without incurring unacceptable losses or risking damage to the Scheme's reputation. In order to meet the objectives of enhancing returns while also providing high liquidity, the combined Scheme portfolios have explicit constraints that guarantee liquidity of at least 20% of the Scheme assets within a period of one week.

The Scheme has complied with the requirements regarding the nature and categories of assets as prescribed by Section 35 and Regulation 30 of the Act.

Approximately 99% of the Scheme's insurance claim liabilities are settled within three months after the claim was incurred and the balance of the claims liability is settled within six months.

25. Financial risk management report (continued)

Liquidity risk (continued)

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

As at 31 December 2022	Less than 1 month R'000	Between 2 and 4 months R'000	More than 4 months R'000	Total R'000
Medical Savings Account liability	975	2,074	235,779	238,828
Trade and other payables	13,889	-	-	13,889
Outstanding risk claims provision	21,401	8,094	90	29,585
As at 31 December 2021				
Medical Savings Account liability	1,154	2,005	227,715	230,874
Trade and other payables	13,615	-	-	13,615
Outstanding risk claims provision	22,282	8,217	93	30,592

26. Critical accounting estimates and judgements

The Scheme makes estimates and assumptions that affect the reported amounts of assets and liabilities within the next financial year. Estimates and judgements are continually evaluated and are based on historical experience and other factors, including expectations of future events that are believed to be reasonable under the circumstances.

Outstanding claims provision

The critical estimates and judgements relating to the outstanding claims provision are set out under Note 5.

Other risk transfer arrangements

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

Impairment of assets

The critical estimates made by the Scheme are set out under Note 25 and judgements relating to the impairment of assets are set out under Note 2.

27. Non-compliance with the medical schemes act

The Trustees are of the opinion that there are no material deviations from the Act as a result of the Scheme having obtained the necessary exemptions from the Council for Medical Schemes (CMS) to achieve compliance. Although exemptions have been obtained from the CMS, it is a regulatory requirement to disclose all non-compliance matters.

27.1 Outstanding contributions

Nature and impact

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

Causes for failure

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

Corrective action

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

27.2 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.

27.3 Investment in administrator

Nature and impact

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

27.4 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 2022, the Managed Care plan incurred a deficit before investment income as set out in Note 23 to the Financial Statements.

Causes for failure

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

Corrective action

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

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

27.5 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.

27.6 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. The exemption expires on 30 April 2025, and a renewal application was lodged with the Council for Medical Schemes.

27.7 Benefits indicated in the brochure that are not included in the 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 struck out and the Scheme was requested to review the percentage members were liable to pay.

Corrective action

The Scheme's Rules for 2023 were submitted taking this change into account. The benefit brochure makes provision for this change.

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