MALCOR MEDICAL AID SCHEME
Registration number: 330
Reference number: 1547

ANNUAL FINANCIAL STATEMENTS

FOR THE YEAR ENDED

31 DECEMBER 2023

MALCOR MEDICAL AID SCHEME

ANNUAL FINANCIAL STATEMENTS
for the year ended 31 December 2023

MALCOR MEDICAL AID SCHEME

ANNUAL FINANCIAL STATEMENTS
for the year ended 31 December 2023

STATEMENT OF RESPONSIBILITY BY THE BOARD OF TRUSTEES

The trustees are responsible for the preparation, integrity and fair presentation of the annual financial statements of Malcor Medical Aid Scheme ("the Scheme") which have been prepared in accordance with IFRS® Accounting Standards (IFRS) and the requirements of the Medical Schemes Act of South Africa. In addition, the trustees are responsible for preparing the report of the board of trustees.

The trustees:-

- consider that in preparing the annual financial statements they have used the most appropriate accounting policies, consistently applied and supported by reasonable and prudent judgements and estimates;
- are satisfied that the information contained in the annual financial statements fairly presents the results of operations and cash flows for the year and the financial position of the Scheme at year-end.
- are responsible for ensuring that adequate accounting records are kept. The accounting records disclose with reasonable accuracy the financial position of the Scheme to enable the trustees to ensure that the annual financial statements comply with the relevant legislation;
- are responsible for such internal controls as the trustees determine are necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error, and for maintaining an effective system of risk management.

The Scheme operates in a well-established control environment, which is well documented and regularly reviewed. This incorporates risk management and internal control procedures, which are designed to provide reasonable, but not absolute, assurance that assets are safeguarded and the risks facing the business are being controlled.

The going concern basis has been adopted in preparing the annual financial statements. The trustees have no reason to believe that the Scheme will not be a going concern in the foreseeable future, based on forecasts and available cash resources. These financial statements support the viability of the Scheme.

The Scheme's external auditors, Harris Dowden & Fontaine, are responsible for auditing the annual financial statements and their report is presented on pages 14 - 18.

Harris Dowden & Fontaine have unrestricted access to all financial records and related data, including minutes of all meetings of members, the trustees and the Audit and Risk Committee. The trustees believe that all their representations made to the independent auditors during their audit were accurate and appropriate.

The annual financial statements were approved by the board of trustees on 24 April 2024 and are signed on its behalf by:

A MARAIS
Chairman

A LOWES
Trustee

P DORFAN
Principal officer

STATEMENT OF CORPORATE GOVERNANCE BY THE BOARD OF TRUSTEES

The Malcor Medical Aid Scheme is committed to the principles and practice of fairness, responsibility, transparency and accountability in all dealings with its stakeholders. The Scheme complies with a recognised governance framework and conducts its affairs according to ethical values. The trustees are proposed and elected by the members of the Scheme.

The board of trustees view good governance not only as complying with legislative provisions and applying the relevant principles of King on corporate governance, but view it as integral to the success, sustainability and financial soundness of the Malcor Medical Scheme. The trustees are satisfied that the Scheme has in all material respects complied with the provisions and spirit of its rules, the Medical Schemes Act 131 of 1998, as amended and its regulations, other than those matters noted in the Board of Trustees report.

BOARD OF TRUSTEES

The board of trustees meets regularly and monitors the performance of the administrator and other service providers. They address a range of key issues and ensure discussion of 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, may seek independent professional advice at the cost of the Scheme.

RISK MANAGEMENT AND INTERNAL CONTROL

The trustees are accountable for the process of risk management and internal controls. Risks are reviewed and identified on an ongoing basis and appropriate strategies are implemented and monitored.

The trustees have established an Audit and Risk Committee ("ARC") mandated under terms of reference to oversee all risk and corporate governance issues pertaining to the Scheme in accordance with accepted corporate governance practices.

The administrators of the Scheme maintain internal controls and systems designed to provide reasonable assurance as to the integrity and reliability of the financial statements and to safeguard, verify and maintain accountability for its assets adequately. 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 controls and systems during the year under review.

PERFORMANCE MONITORING OF BUDGETS

The budget for the Scheme is set annually and approved by the trustees. The performance against budget is monitored monthly by the trustees and agreed remedial actions are implemented.

PERFORMANCE MONITORING OF TERMS OF REFERENCE

The trustees approve the terms of reference of the ARC and monitor its performance against it.

A MARAIS	A LOWES	P DORFAN
Chairman	Trustee	Principal Officer

24 April 2024

MALCOR MEDICAL AID SCHEME

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

The board of trustees ("the Board") hereby presents its report for the year ended 31 December 2023.

1. DESCRIPTION OF THE MEDICAL SCHEME

1.1. Terms of registration

The Malcor Medical Aid Scheme ("the Scheme") is a restricted membership scheme registered in terms of the Medical Schemes Act No 131 of 1998 ("the Act").

The Scheme operates for the benefit of its members and its trustees oversee and govern the business of the Scheme on behalf of its members.

1.2. Benefit options with Malcor Medical Aid Scheme

The Scheme offered 4 benefit options to its members during the year - Plans A, B, C and D.

Plans A, B and C are graded non-savings benefit options, while Plan D is a low-cost benefit option serviced by National HealthCare Group (Pty) Ltd ("National HealthCare"). National HealthCare has in return for a capitation fee, assumed the risk of providing the Plan D members with the medical benefits permitted by the Plan.

2. SCHEME MANAGEMENT AND THIRD PARTY SERVICE PROVIDERS

2.1 Board of trustees

The trustees are all elected by the members. Elections are held every three years and the most recent election was held during the 2023 financial year. The next election will be held during the 2025 financial year.

The Board are also entitled in terms of the Scheme rules to appoint a trustee to fill a vacancy during the financial year to hold office until the next annual general meeting.

The board of trustees during the year under review and at the date of this report were:

Name		Number of meetings attended during the year	
		A	B
A Marais (Chairman)		5	5
J Els		4	4
L James		5	5
A Lowes		4	4
W Scott	(Resigned: 21 June 2023)	3	3
C Van Zitters		5	5
R Verster	(Deceased 28 January 2023)	-	-
R Govender		4	4
R Govender		4	4
H Shapiro	(Appointed: 23 February 2023)	4	4
D Da Silva	(Appointed: 1 August 2023)	1	1
R Khan	(Appointed: 1 August 2023)	1	1
P Dorfan (Principal Officer)		5	5

A - Actual number of meetings attended
B - Total possible meetings

There were 5 trustee meetings held during the year under review and none of the trustees, other than the chairperson received remuneration relating to such services. The chairman received remuneration of R121,475 (2022: R97,122) for his services to the Scheme during the year.

2. SCHEME MANAGEMENT AND THIRD PARTY SERVICE PROVIDERS (continued)

2.2. Principal officer

P Dorfan

16 Jersey Drive
Longmeadow Business Estate East
Edenvale

P O Box 8012
Greenstone
1616

The principal officer received remuneration of R736,680 (2022: R724,122) for his services to the Scheme during the year.

2.3. Registered office and postal address of the Scheme

Discovery Health Head Office
1 Discovery Place
Sandton

P O Box 786722
Sandton
2146

2.4. Scheme administrator

Discovery Health (Pty) Ltd
Accreditation number: 19
Discovery Health Head Office
1 Discovery Place
Sandton

P O Box 786722
Sandton
2146

2.5. Managed care administrators

Discovery Health (Pty) Ltd
Managed care accreditation number: 6
Discovery Health Head Office
1 Discovery Place
Sandton

P O Box 786722
Sandton
2146

National HealthCare Group (Pty) Ltd
Managed care accreditation number: 22
Route 21 Corporate Park
72 Regency Drive
Irene

P O Box 11480
Queenswood
0121

2.6. Investment advisors

I Madjarova
Financial service provider number: 873
Sygnia Asset Management (Pty) Ltd
Katherine & West Building, West Street
Sandton
2196

7th Floor, The Foundry
Green Point
Cape Town
8001

2. SCHEME MANAGEMENT AND THIRD PARTY SERVICE PROVIDERS (continued)

2.7. Auditors

Harris Dowden & Fontaine
IRBA registration number: 943703
7 Pam Road
Morningside
Sandton

P O Box 651129
Benmore
2010

2.8. Scheme committees

In accordance with good corporate governance and the provisions of the Act, the Scheme has an Audit and Risk Committee ("ARC"). The ARC is appointed by the trustees and mandated by them by means of written terms of reference as to its membership, authority and duties. The ARC is required to have a minimum of five members the majority of whom, including the chairman, are not officers of the Scheme or its administrator.

The primary responsibility of the members of the ARC is to assist the board of trustees in carrying out its duty relating to the Scheme's accounting policies, internal control systems, financial reporting and corporate governance practices and risk management. The external and internal auditors formally report to the ARC on the critical findings arising from their audits.

The trustees monitor the performance of the ARC against its related terms of reference. No deficiencies were noted for the 2023 financial year.

The ARC in turn, make recommendations to the trustees arising from their abovementioned duties.

The ARC members during the year under review and at date of this report were:

Name	Number of meetings	
	A	B
Independent members:		
G Kapp (Chairperson)	3	3
J Englund	2	3
M Lorgat	3	3
J Forson	3	3
Trustee members:		
A Lowes	3	3
J Els	3	3
Principal Officer:		
P Dorfan	3	3

A - Actual number of meetings attended
B - Total possible meetings

2. SCHEME MANAGEMENT AND THIRD PARTY SERVICE PROVIDERS (continued)

2.8. Scheme committees (continued)

The principal officer of the Scheme and representatives of the administrators as well as the internal and external auditors are invited to attend all ARC meetings and have unrestricted access to the chairperson of the committee.

There were 3 ARC meetings held during the year under review and none of the ARC members, with the exception of the ARC chairperson, received any remuneration or was reimbursed for any expenditure relating to such services.

The chairman received remuneration of R50,238 (2022: R47,672) for his services to the Scheme during the year.

The ARC reported that:

- It carried out its duties in terms of the Act and its terms of reference approved by the Board.
- The external auditors have confirmed their independence.
- The combined assurance provided by management and the external and internal auditors has led them to conclude that the internal controls of the Scheme are adequate and effective.
- It has reviewed the Scheme's annual financial statements and accounting policies, obtained assurance from the external auditors in this regard and recommended the adoption of the annual financial statements by the Board for presentation to members.

3. MANAGEMENT OF RISK

3.1. Commercial reinsurance

Since inception of the Scheme the trustees have believed it is in the best interest of the members to have a stop-loss reinsurance cover to protect the Scheme from significant losses.

Prior to the 2013 financial year, the trustees arranged for the Scheme to have this cover with the approval of the Council for Medical Schemes ("Council"). The Scheme was then responsible for the related reinsurance premiums and was entitled to the proceeds of the related claims.

With effect from 1 January 2023 this stop-loss arrangement has been discontinued.

With effect from 1 January 2013, the individual employer groups elected to arrange for the stop-loss reinsurance to be entered into by the respective employers of the Scheme's members. Although the reinsurance premiums are borne by such employers, they have undertaken to continue to provide the Scheme with the benefit of any related reinsurance claims by paying such amounts into the Scheme by way of additional funding.

3.2 Risk transfer arrangements

National HealthCare Group (Pty) Ltd provides Plan D members with the medical benefits attributable to the Plan in return for a fixed fee per member per month.

The Scheme has also entered into a capitation agreement with Discovery Health (Pty) Ltd for the provision of Diabetes Management Services to benefit options A, B and C. The Scheme is paying a fixed fee per member per month for all members registered on this program.

The trustees monitor the performance of these service providers regularly and evaluate the economic benefit for the Scheme. The results of these agreements are disclosed in note 6 in the financial statements.

3. MANAGEMENT OF RISK (continued)

3.3. Investment strategy

The Scheme's investment strategy is to ensure there is a sum equivalent to at least two month's expected claims and administration costs in the Scheme's bank accounts and that the investments comply with the regulations of the Act. Within this overall strategy the objective is to invest no more than 40% in equities, 100% in cash or bonds and 5% in property holding investments. The Scheme adhered to the investment strategy and at year end had invested 16.87% (2022: 19.45%) of the Scheme's funds available for investment in equities, 79.88% (2022: 80.11%) in cash or bonds and 0.36% (2022: 0.44%) in equities in property holding investments. The return achieved on investments held at fair value through profit or loss as a percentage of the weighted average fair value per month for the year under review was 8.4% (2022: 4.6%).

All investments are in the name of the Scheme and no withdrawal or investment changes are permitted without the approval of the trustees and the written approval of the principal officer.

The trustees of the Scheme review the allocation and performance of investments on a quarterly basis to monitor the returns and ensure compliance with the Act and review the investment policy on an annual basis. Advice in respect of specific funds in which the Scheme is invested is taken from the Scheme's investment advisor and professional asset consultants. The Scheme has elected an investment sub-commitee during the current year.

The investment sub-commitee members during the year under review and at date of this report were:

Name	Number of meetings	
	A	B
A Marais (Chairman)	2	2
P Dorfan (Principal Officer)	2	2
F Thayer	2	2
R Govender	1	2
C Van Zitters	2	2

A - Actual number of meetings attended
B - Total possible meetings

Details of investments are set out in the annual financial statements.

3. MANAGEMENT OF RISK (continued)

3.4 Management of insurance risk

The primary insurance activity carried out by the Scheme assumes the risk of loss incurred by members and their dependants relating to medical care. These risks relate to the health of the Scheme members. As such the Scheme is exposed to the uncertainty surrounding the timing and severity of medical claims made by its members.

The Scheme manages its insurance risk through benefit limits and sub-limits, approval procedures for transactions that involve pricing guidelines, pre-authorisation and case management, service provider profiling, centralised management of the risk transfer arrangement, as well as the monitoring of emerging issues, and, as detailed under 3.1 above, by stop-loss reinsurance cover.

The Scheme uses several methods to assess and monitor insurance risk exposures for both individual types of risks insured and overall risks. The principal risk is that the frequency and severity of claims are greater than expected.

An assessment of the major risks affecting the Scheme and the most effective manner in which these risks may be mitigated is considered by the ARC and the Board on a regular basis.

Insurance events are, by their nature, random, and the actual number and size of events during any one year may vary from those estimated using established statistical techniques. There were no changes to assumptions used to measure insurance assets and liabilities that have a material effect on the annual financial statements and there were no terms and conditions of insurance contracts that have a material effect on the amount, timing and uncertainty of the Scheme's cash flows.

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

4. OPERATIONAL STATISTICS

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

	Plan A			Plan B			Plan C			Plan D			Total Scheme		
	2023	2022	%	2023	2022	%	2023	2022	%	2023	2022	%	2023	2022	%
Number of members at end of the year	578	610	-5%	3,081	3,046	1%	708	615	15%	139	137	1%	4,506	4,408	2%
Number of beneficiaries at the end of the year	1,338	1,425	-6%	7,784	7,819	0%	1,265	1,097	15%	242	259	-7%	10,629	10,600	0%
Average number of members per month	590	634	-7%	3,065	3,060	0%	657	611	8%	139	137	2%	4,451	4,441	0%
Average number of beneficiaries per month	1,371	1,498	-8%	7,812	7,847	0%	1,183	1,092	8%	251	257	-2%	10,617	10,693	-1%
Average number of beneficiaries per member at year-end	2.31	2.34	-1%	2.53	2.57	-2%	1.79	1.78	0%	1.74	1.89	-8%	2.36	2.40	-2%
Dependant ratio to members at year-end	1.31	1.34	-2%	1.53	1.57	-3%	0.79	0.78	0%	0.74	0.89	-17%	1.36	1.40	-3%
Average age of beneficiaries at the beginning of the year	46.0	45.6	1%	31.8	31.6	1%	31.8	31.8	0%	36.0	34.6	4%	33.7	33.6	0%
Pensioner ratio (beneficiaries >65 years)	20.1%	19.9%	1%	4.5%	4.5%	0%	7.0%	7.0%	0%	11.1%	9.3%	19%	7.0%	6.9%	1%
Number of beneficiaries registered for chronic conditions at year end	700	746	-6%	2,209	2,219	0%	234	203	15%	28	4	588%	3,172	3,172	0%
Average per month															
Risk contributions per member (R')	10,008	8,728	15%	6,585	5,740	15%	3,788	3,699	2%	2,116	2,090	1%	6,486	5,773	12%
Risk contributions per beneficiary (R')	4,307	3,694	17%	2,584	2,238	15%	2,104	2,070	2%	1,172	1,111	5%	2,719	2,398	13%
Relevant healthcare expenditure per member (R') *	10,213	10,051	2%	5,806	5,707	2%	3,040	2,196	38%	1,948	1,930	1%	5,848	5,728	2%
Relevant healthcare expenditure per beneficiary (R') *	4,395	4,254	3%	2,278	2,225	2%	1,688	1,229	37%	1,079	1,026	5%	2,452	2,379	3%
Non-healthcare expenditure per member (R')	321	331	-3%	321	316	2%	321	307	5%	152	159	-4%	316	312	1%
Non-healthcare expenditure per beneficiary (R')	138	140	-1%	126	123	2%	178	172	4%	84	85	0%	132	129	2%
Accumulated funds per member at year-end (R')	n/a	n/a		n/a	n/a		n/a	n/a		n/a	n/a		39,822	33,336	19%
Relevant healthcare expenditure as % of risk contribution income *	102.1%	115.2%	-11%	88.2%	99.4%	-11%	80.3%	59.4%	35%	92.5%	92.4%	0%	90.2%	99.2%	-9%
Managed care as % of risk contribution income	1.3%	1.4%	-7%	2.0%	2.1%	-7%	3.4%	3.3%	4%	-	-	-	2.0%	2.1%	-5%
Administration expenditure as % of risk contribution income	2.4%	2.6%	-7%	3.7%	4.0%	-7%	6.4%	6.1%	4%	6.8%	6.8%	0%	3.7%	3.9%	-5%
Non-healthcare expenditure as % of risk contribution income	3.8%	3.8%	-1%	5.4%	5.5%	-2%	9.0%	8.3%	8%	8.3%	7.6%	9%	5.0%	5.4%	-7%

* Relevant healthcare expenditure refers to insurance service expenses less the directly attributable administration expenses.

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

5. REVIEW OF RESULTS FOR THE YEAR

5.1. Results of operations

The results of the operations of the Scheme are set out in the annual financial statements, and the trustees believe that no further clarification is necessary.

5.2. Operational statistics for the Scheme

	2023 R'000	2022 R'000
Amount paid to administrators		
- Administration fee	12,808	11,986
- Managed care fee	6,717	6,326
Total	19,525	18,313

5.3. Solvency ratio

The solvency ratio is calculated as follows:		
Total insurance contract liability for future members per statement of financial position	179,439	146,946
Less: Cumulative unrealised fair value gain on investments	(24,579)	(14,189)
Accumulated funds per Regulation 29 of the Act	154,860	132,757
Annual gross contributions (insurance revenue)	346,439	307,699
Solvency ratio (Accumulated funds per Regulation 29/annual gross contribution x 100)	44.70%	43.15%

5.4. Liability for incurred claims

Movements in the liability for incurred claims are set out in the annual financial statements. There have been no unusual movements that the trustees believe should be brought to the attention of the members of the Scheme.

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

With the exception of the indirect investments in Aspen Pharmacare Holdings Limited and Discovery Holdings Limited, the Scheme did not hold shares in any related party or in companies whose employees are members of the Scheme. Refer to note 12.2 below.

7. RELATED PARTY TRANSACTIONS

Related party transactions are set out in Note 12 to the annual financial statements.

8. ACTUARIAL SERVICES

The Scheme's actuary was consulted in the determination of the contributions and benefit levels.

9. FIDELITY AND PROFESSIONAL INDEMNITY INSURANCE

In terms of section 33(3) of the Medical Schemes Act, Camargue Underwriting Managers Proprietary Limited, underwritten by Bryte Insurance Company Ltd, Compass Insurance Company Ltd and Lloyds Bank Of London Ltd, have provided professional indemnity and fidelity insurance of R30 million (2022: R30 million) to the Scheme.

10. INTERNAL AUDIT

Discovery Health Internal Audit provided the ARC with an annual internal audit plan for discussion, regular feedback on their findings, suggested improvements on internal controls as well as feedback on the progress of the audits against the approved audit plan. The external auditors also liaised with Discovery Health Internal Audit to ensure they could minimise their audit procedures in the areas covered by Discovery Health Internal Audit.

11. EVENTS AFTER THE REPORTING DATE

There were no other events after the reporting date that had a material impact on the Scheme.

12. AREAS OF NON COMPLIANCE WITH MEDICAL SCHEME LEGISLATION FOR THE YEAR UNDER REVIEW

Although they may not be material in amount or effect, the trustees are required by the Council for Medical Schemes to report on all matters of non-compliance with the Act irrespective of whether or not the external auditors consider the non-compliance as material. In accordance with this requirement, the trustees note:

12.1. Late payment of 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. In terms of the Scheme rules, contributions are required to be received no later than three days after their due date. During the financial year certain contributions were identified that were not paid to the Scheme within this deadline period.

Causes of failure
The failure was mainly caused due to administrative delays by certain participating employers in paying over their respective contributions to the Scheme.

Corrective action
Whilst every effort is made through credit control procedures to enforce this requirement, the onus is on the member/employer group to ensure compliance. The loss of interest to the Scheme from this delay is minimal.

12.2. Investments in participating employers and medical scheme administrators

Nature and impact
Section 35(8)(a), (c) and (d) of the Act states that a medical scheme shall not invest any of its assets in participating employers, medical scheme administrators or persons associated with these organisations. During the year the Scheme did have investments in certain of these organisations.

Causes of failure
The Scheme invests in investment vehicles which allow investment managers discretion to invest in organisations of their choice. Certain of these choices have resulted in the Scheme having investments in organisations which are in conflict with this Section of the Act.

Corrective action
The Scheme has received exemption from the provisions of this Section from Council on the grounds that the investments are made, without reference to the Scheme, by the asset managers in the portfolios in which the Scheme invests. These investment choices are therefore not influenced by the Scheme.

12. AREAS OF NON COMPLIANCE WITH MEDICAL SCHEME LEGISLATION FOR THE YEAR UNDER REVIEW (continued)

12.3. Late payment of claims

Nature and impact
Section 59(2) of the Act requires that medical schemes shall pay a member or a supplier of service, any benefit owing to that member or supplier of service within 30 days after the day on which the claim in respect of such benefit was received by the medical scheme.

Causes of failure
Late payment of claims usually resulted from members or providers submitting claims without the necessary details for these payments to be made timeously. These are isolated cases and thus do not have a material effect on the Scheme.

Corrective action
The necessary assistance is provided to the identified members and healthcare providers to ensure that these types of isolated cases are minimised.

12.4. 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 and be financially sound. At 31 December 2023 Plan A incurred a net insurance service deficit of R3.0 million (2022: deficit of R11.3 million).

Causes of failure
Plan A was deliberately costed to incur a deficit as the increase in contributions necessary to achieve a surplus would have been too onerous for members on this plan and might lead to members changing to other plans to the detriment of the Scheme as a whole.

Corrective action
The Trustees are expecting this trend for Plan A to continue in future. The performance of all benefit options is monitored on a continuous basis with a view to improving their financial outcomes, and the Scheme continually evaluates different strategies to address the deficit in these benefit options.

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

MALCOR MEDICAL AID SCHEME

STATEMENT OF FINANCIAL POSITION
as at 31 December 2023

	Notes	2023 R'000	Restated 2022 R'000	Restated 1 January 2022 R'000
ASSETS				
Financial assets at fair value through profit or loss	2	123,951	113,871	109,975
Financial assets at amortised cost	3	1,269	519	372
Cash and cash equivalents	4	88,478	63,984	62,338
TOTAL ASSETS		**213,698**	**178,374**	**172,685**
LIABILITIES				
Total insurance contract liability		212,972	177,748	170,672
Insurance contract liabilities	5.1	33,533	30,621	26,140
Insurance liability for future members	5.2	179,439	147,127	144,532
Trade and other payables	7	726	626	2,013
TOTAL LIABILITIES		**213,698**	**178,374**	**172,685**

MALCOR MEDICAL AID SCHEME

STATEMENT OF COMPREHENSIVE INCOME
for the year ended 31 December 2023

	Notes	2023 R'000	2022 R'000
Insurance revenue	8	346,439	307,699
Insurance service expense	8	(356,399)	(317,860)
Net (expense)/income from risk transfer arrangements	8	(785)	435
Risk transfer premium paid		(3,588)	(3,169)
Recovery from risk transfer arrangements		2,803	3,604
Insurance service result		**(10,745)**	**(9,726)**
Interest from financial assets not measured at fair value through profit and loss	9	1,297	835
Investment income from investments at fair value through profit and loss	9	15,109	6,653
Net investment income		**16,406**	**7,488**
Net healthcare result		**5,661**	**(2,238)**
Sundry income	10	109	7,824
Asset management fees		(632)	(605)
Other operating expenses	11	(5,138)	(4,981)
Net result		**0**	**0**
Total comprehensive income for the year		**0**	**0**
In terms of IFRS 17 and Mutual Entity disclosures, all surpluses or deficits are allocated to Insurance service expenses. The amounts allocated were as follows:		32,311	2,596

MALCOR MEDICAL AID SCHEME

STATEMENT OF CHANGES IN MEMBERS' FUNDS
for the year ended 31 December 2023

	R'000
Balance as at 1 January 2022 (as previously reported)	146,424
Transition restatement *	(146,424)
Balance at 1 January 2022 (restated)	**-**

* Refer accounting policy note describing the impact of the adoption of IFRS 17.

MALCOR MEDICAL AID SCHEME

STATEMENT OF CASH FLOWS
for the year ended 31 December 2023

	Notes	2023 R'000	2022 R'000
CASH FLOWS FROM OPERATING ACTIVITIES			
Cash receipts from members and providers		347,981	312,950
• Cash receipts from members - contributions		347,323	311,366
• Cash receipts from members and providers – other		658	1,584
Cash paid to providers, employees and members		(329,179)	(322,499)
• Cash paid to providers and members – claims		(307,640)	(305,368)
• Cash paid to providers and employees – non-healthcare expenditure		(21,539)	(17,131)
Sundry income		109	7,823
NET CASH FLOWS FROM OPERATING ACTIVITIES		**18,911**	**(1,726)**
CASH FLOWS FROM INVESTING ACTIVITIES			
Purchase of investments	**2**	(213)	(77)
Proceeds on disposal of investments held at fair value through profit or loss	**2**	522	218
Investment income		5,275	3,231
NET CASH FLOWS FROM INVESTING ACTIVITIES		**5,584**	**3,372**
NET INCREASE IN CASH AND CASH EQUIVALENTS		**24,494**	**1,646**
Cash and cash equivalents at the beginning of the year		63,984	62,338
CASH AND CASH EQUIVALENTS AT THE END OF THE YEAR	**4**	**88,478**	**63,984**

NOTES TO THE FINANCIAL STATEMENTS
for the year ended 31 December 2023

1. PRINCIPAL ACCOUNTING POLICIES

1.1 GENERAL INFORMATION

The principal accounting policies applied in the preparation of the financial statements are set out below and are in accordance with International Financial Reporting Standards (IFRS). These policies were consistently applied to the previous year, unless otherwise stated.

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 the Republic of South Africa.

1.2 BASIS OF PREPARATION

The Financial Statements have been prepared in accordance with International Financial Accounting 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 detailed accounting policies have been set out in the respective note to the Financial Statements, with the general accounting policies applied in the preparation of these Financial Statements set out below. These policies have been applied consistently to all years presented, except for changes required by the mandatory adoption of new and revised IFRS.

The preparation of the Financial Statements in conformity with IFRS Accounting Standards requires the use of certain critical accounting estimates. It also requires management to exercise its judgement in the process of applying the Scheme's accounting policies.

The Financial Statements are prepared in accordance with the going concern principle using the historical cost basis except for certain financial assets and liabilities, which include:

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

PRINCIPAL ACCOUNTING POLICIES (continued)

1.3 IMPLEMENTATION OF NEW STANDARDS

New standards, amendments and interpretations effective and relevant to the Scheme:

The following new standards, amendments and interpretations to the existing standards have been published and are not yet effective for the current financial year. The Scheme has not early adopted them and it is not expected that they will have any material impact on the Scheme's assets, liabilities and results but may result in additional disclosure in the Financial Statements.

Standard	Scope	Effective date
IAS 1 Presentation of Financial Statements	Classification of Liabilities as Current or Non-current. Under existing IAS 1 requirements, schemes classify a liability as current when they do not have an unconditional right to defer settlement of the liability for at least twelve months after the end of the reporting period. As part of its amendments, the Board has removed the requirement for a right to be unconditional and instead, now requires that a right to defer settlement must have substance and exist at the end of the reporting period.	1 January 2024
Narrow scope amendments to IAS 1 'Presentation of Financial Statements', Practice statement 2 and IAS 8 'Accounting Policies, Changes in Accounting Estimates and Errors'	The amendments aim to improve accounting policy disclosures and to help users of the financial statements to distinguish changes in accounting policies from changes in accounting estimates. The scheme discloses the accounting policy for each note as well as the critical judgements and estimates applicable to the individual financial statement line items. The standard has no further impact on the Scheme.	1 January 2024

Implementation of IFRS 17 Insurance Contracts

Introduction

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

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

PRINCIPAL ACCOUNTING POLICIES (continued)

Implementation of IFRS 17 Insurance Contracts (continued)

Introduction (continued)

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

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

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

Transition to IFRS 17

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

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

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

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

PRINCIPAL ACCOUNTING POLICIES (continued)

Implementation of IFRS 17 Insurance Contracts (continued)

Impact of transition to IFRS 17

The Scheme considered its substantive rights and obligations arising from its insurance contracts in applying IFRS 17. Medical schemes are not legally defined as mutual entities and the current regulatory and legislative requirements remain applicable to medical schemes. Medical schemes have similar attributes as mutual entities. When applying IFRS 17, payments to policyholders' form part of the fulfilment cash flows regardless of whether those payments are expected to be made to current or future policyholders. Thus, the fulfilment cash flows of an insurer that is a mutual entity generally include the rights of policyholders to the whole of any surplus of assets over liabilities. This means that, for an insurer that is a mutual entity, there should, in principle, be no equity remaining and no net comprehensive income reported in any accounting period.

The Scheme does not have any contracts with specified embedded derivatives.

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

	R'000
Accumulated funds as at 31 December 2021 (Audited and previously reported)	146,424
IFRS 17 adjustment	
Adjustment as a result of the risk adjustment for non-financial risk	(242)
Adjustment of Liability for Incurred Claims	(1,650)
Liability for future members as at 31 December 2021 (restated)	144,532
Net surplus reported in 2022	146,946
IFRS 17 adjustment	
Adjustment as a result of the risk adjustment for non-financial risk	(190)
Adjustment of Liability for Incurred Claims	371
Liability for future members as at 31 December 2022 (restated)	147,127

PRINCIPAL ACCOUNTING POLICIES (continued)

1.4 INSURANCE CONTRACTS SCOPE AND GROUPING

Definition and classification

Insurance contracts are contracts under which the Scheme accepts significant insurance risk from another party (the member/policyholder) by agreeing to compensate the policyholder should a specified uncertain future event (the insured event) adversely affect the policyholder.

A reinsurance contract transfers significant risk if it transfers substantially all the insurance risk resulting from the insured portion of the underlying insurance contracts, even if it does not expose the reinsurer to the possibility of a significant loss.

The Scheme determines whether it has assumed significant insurance risk by comparing benefits payable after an insured event with benefits payable if the insured event had not occurred. Insurance and reinsurance contracts can also expose the Scheme to financial risk, which is not taken into account in the determination of significant insurance risk.

Significant judgements and estimates

IFRS 17 does not specify what significant insurance risk is. The Scheme's policy defines significant insurance risk as follows: The possibility that the present value of losses arising on the insurance contract exceeds 10% of the present value of income and receipts collected when applying a worst-case scenario upon inception of the insurance contract.

Separating components within insurance contracts

IFRS 17 requires an analysis of whether the contract contains components that should be separated from the insurance contract and accounted for under different IFRS Accounting Standards. IFRS 17 requires that cash flows relating to embedded derivatives, cash flows relating to distinct investment components and promises to transfer distinct goods or distinct services, other than insurance contract services, be accounted for separately.

The Scheme presently has no contracts requiring further separation or a combination of insurance contracts. The Scheme does not have contracts with specified embedded derivatives.

Measurement models

- The default model is the General Measurement Model (GMM). The GMM is typically used for measuring long-term insurance risk and annuity contracts.
- The GMM is supplemented by the Variable Fee Approach (VFA) for contracts where policyholders have purchased investment linked insurance contracts integrated with insurance coverage (i.e. insurance contracts with direct participating features).
- The Premium Allocation Approach (PAA) is a simplified approach of the GMM for short-duration contracts such as group risk, personal lines and private medical insurance.

PRINCIPAL ACCOUNTING POLICIES (continued)

Measurement models (continued)

Insurers can elect to apply the premium allocation approach (PAA) to measure a group of insurance contracts issued or reinsurance contracts held if, at the inception of the group:

- The coverage period of each contract in the group of insurance contracts is one year or less, or
- The insurer reasonably expects that the PAA would produce a measurement of the LRC for a group of insurance contracts that would not differ materially from the measurement achieved by applying the GMM.

As permitted in IFRS 17, the Scheme has elected to apply the premium allocation approach. The Scheme reasonably expects that the PAA would produce a measurement of the LRC for a group of insurance contracts that would not differ materially from the measurement achieved by applying the GMM.

The PAA simplifies the general measurement model. At initial recognition, the insurance contract is measured as:

- The premiums, if any, received at initial recognition, and
- Plus/minus non-acquisition assets or liabilities previously recognised for cash flows related to the group of insurance contracts.

IFRS 17 permits an accounting policy election on a group-by-group basis:

- Not to adjust the components of the insurance contracts and onerous contracts for the time value of money (i.e. no discounting).
- An entity may elect to immediately expense insurance acquisition cash flows when incurred.

Under the PAA, the standard allows an entity to make a policy choice whether to account for the effect of the time value of money in the measurement of the liability for remaining coverage and the liability for incurred claims when:

- On initial recognition of the contract, the time between the coverage and due date of the related premium is less than a year.
- The cash flows arising from the liability for incurred claims are expected to be paid or received in less than one year from the date the claim is incurred.

The Scheme has elected not to account for the effect of the time value of money in the measurement of the liability for incurred claims and the liability for remaining coverage as both conditions have been met. In some instances, claims may be disputed.

The Scheme has elected to immediately expense insurance acquisition cash flows.

PRINCIPAL ACCOUNTING POLICIES (continued)

INSURANCE CONTRACTS SCOPE AND GROUPING (continued)

Expected fulfilment cash flows (EFCF)

The measurement of a group of insurance contracts includes all future cash flows expected to arise within the contract boundary of each contract in the group.

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

- The Scheme has the practical ability to reprice the group of contracts so that the price fully reflects the reassessed risk of that portfolio; and
- the pricing of contributions related to coverage to the date when risks are reassessed does not reflect the risks related to periods beyond the reassessment date.

In assessing the practical ability to reprice, risks transferred from the member to the Scheme are considered; other risks, such as lapse or surrender and expense risk, are not included. Cash flows outside the insurance contracts boundary relate to future insurance contracts and are recognised when those contracts meet the recognition criteria. The Scheme has assessed its group of insurance contracts and determined that the group has a boundary of one year.

EFCF include payments to (or on behalf) of policyholders, insurance acquisition cash flows and other directly attributable costs to fulfilling the group of insurance contracts.

The estimates of these future cash flows are based on probability-weighted expected future cash flows. The Scheme estimates which cash flows are expected and the probability that they will occur as at the measurement date. When estimating, the Scheme uses information about past events, current conditions and forecasts of future conditions.

Insurance acquisition cash flows arise from activities of selling, underwriting and commencing a group of contracts that are directly attributable to the portfolio of contracts.

Risk adjustment

The risk adjustment for non-financial risk for a group of insurance contracts, determined separately from the other estimates, is the compensation required for bearing uncertainty about the amount and timing of the cash flows that arise from non-financial risk as the Scheme fulfils insurance contracts. It measures the compensation that the entity would require to make it indifferent between:

- Fulfilling a liability that has a range of possible outcomes arising from non-financial risk and
- Fulfilling a liability that will generate fixed cash flows with the same expected present value as the insurance contract.

A lower risk adjustment would be observed for those insurance contracts with shorter duration, high frequency and low severity type products and narrow probability of distributions. Higher risk adjustment would be observed for insurance contracts that are longer in duration, have a low frequency and high severity and have a wide probability of distributions.

PRINCIPAL ACCOUNTING POLICIES (continued)

Risk adjustment (continued)

IFRS 17 does not prescribe methods for determining the risk adjustment for non-financial risk. Therefore, management's judgement is necessary to determine an appropriate risk adjustment technique.

When applying a confidence level technique, the first step in the process is to calculate the best estimate reserve, where there is an equal chance that the actual amount needed to pay future claims will be higher or lower than the calculated best estimate. The risk adjustment is then calculated such that there is a specified percentage probability that the reserves will be sufficient to cover future claims.

For the Scheme's insurance contracts the explicit risk adjustment for non-financial risk is estimated to measure the LIC. The risk adjustment will be determined by applying a confidence level technique set at a confidence level of 75%.

Unit of account, aggregation and recognition of insurance and reinsurance contracts

Under IFRS 17, the unit of account is defined as a group of insurance contracts. The manner in which insurance contracts are grouped affects the timing of profit recognition for insurance services but does not affect the measurement of the estimated cash flows to fulfil the insurance contracts. In terms of IFRS 17, the unit of account is determined by first establishing a portfolio of insurance contracts and then creating separate cohorts within the portfolio based on the date of origination. Each such cohort is further grouped into three groupings based on estimated profitability.

Portfolio
Insurance contracts that are subject to similar risks and managed together.

The Scheme offers insurance cover against the cost of a health event. One benefit option is offered by the Scheme.

Cohort
Only contracts issued within a given 12-month period (cohort) can be included in the same group. Annual cohorts are further grouped as follows.

Groups
- Onerous at initial recognition (Onerous)
- At initial recognition, no significant possibility of becoming onerous (Profitable)
- Other (Profitable at risk)

The Scheme has assessed its portfolio to be at a scheme level. The Scheme has applied the exemption not to perform profitability groupings as allowed by IFRS and included all contracts in the same group.

PRINCIPAL ACCOUNTING POLICIES (continued)

INSURANCE CONTRACTS SCOPE AND GROUPING (continued)

Onerous contract assessment

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

Recognition and derecognition

The group of insurance contracts issued are initially recognised from the earliest of the following:
- the beginning of the coverage period;
- the date when the first payment from the member is due or actually received, if there is no due date; and
- when the Scheme determines that a group of contracts becomes onerous.

An insurance contract is derecognised when it is:
- extinguished (i.e. when the obligation specified in the insurance contract expires or is discharged or cancelled); or
- if the terms are modified due to an agreement between the Scheme and its member or by regulation and the modification terms meet the requirement in IFRS 17.

If the modification does not comply with all the requirements of IFRS 17, the Scheme shall treat the changes in cash flow as changes in estimates of fulfilment cash flows.

Initial and subsequent measurement

For insurance contracts issued, on initial recognition, the Scheme measures the liability for remaining coverage at the amount of contributions received less any acquisition cash flows paid.

The carrying amount of the group of insurance contracts issued at each reporting period is the sum of:
- the liability for remaining coverage; and
- the liability for incurred claims, comprising the fulfilment cashflows related to past service allocated to the group at the reporting date.

For insurance contracts issued, at each of the subsequent reporting dates, the Liability for remaining coverage is:
- increased for contributions received in the period; and
- decreased for the amounts of expected contributions received recognised as insurance revenue for the services provided in the period.

PRINCIPAL ACCOUNTING POLICIES (continued)

Initial and subsequent measurement (continued)

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

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

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

If the group of contracts becomes onerous, the Scheme increases the carrying amount of the Liability for remaining coverage to the amounts of the fulfilment cashflows determined under the general measurement model with the amount of such an increase recognised in insurance service expenses. Subsequently, the Scheme amortises the amount of the loss component within the Liability for remaining coverage by decreasing insurance service expenses. The loss component amortisation is based on the passage of time over the remaining coverage period of contracts within an onerous group.

Insurance revenue

The Scheme recognises insurance revenue based on the passage of time over the coverage period of the group of insurance contracts in the statement of comprehensive income.

Insurance Service Expenses

Insurance service expenses include:

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

Net of:

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

PRINCIPAL ACCOUNTING POLICIES (continued)

Other incurred directly attributable insurance service expenses include:

Accredited managed care healthcare services (no risk transfer)

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

Insurance acquisition costs

The Scheme includes the acquisition cash flows within the insurance contract boundary that arise from selling, underwriting and starting a group of insurance contracts and that are costs directly attributable to individual contracts and the group of contracts.

Insurance acquisition costs are expensed by the Scheme when it incurs the cost.

Accredited administration services

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

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

1.5 RISK TRANSFER REINSURANCE

Definition

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

Unit of account

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

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

PRINCIPAL ACCOUNTING POLICIES (continued)

RISK TRANSFER REINSURANCE (continued)

Recognition and derecognition

The reinsurance contract held that covers the losses of separate insurance contracts on a proportionate basis is recognised at the later of:
- the beginning of the coverage period of the group; or
- the initial recognition of any underlying insurance contract.

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

Initial and subsequent measurement

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

The carrying amount of a group of reinsurance contracts held at the end of each reporting period is the sum of:
- the remaining coverage; and
- the incurred claims, comprising the fulfilment cashflows related to past service allocated to the group at the reporting date.

Subsequent measurement of the remaining coverage for reinsurance contracts held is:
- increased for ceding contributions paid in the period; and
- decreased for the amounts of ceding contributions recognised as reinsurance expenses for the services received in the period.

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

Contract boundary

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

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

PRINCIPAL ACCOUNTING POLICIES (continued)

RISK TRANSFER REINSURANCE (continued)

Net income/(expense) from reinsurance contracts held

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

Reinsurance expenses consist of reinsurance expenses, other incurred directly attributable insurance service expenses and the effect of changes in risk of reinsurer non-performance.

The Scheme recognises reinsurance expenses based on the passage of time over the coverage period of a group of contracts.

1.6 CLASSIFICATION, RECOGNITION, PRESENTATION AND DERECOGNITION OF FINANCIAL INSTRUMENTS

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

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

Offsetting financial instruments

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

The Scheme will disclose the net asset or liability in the Statement of Financial Position and on a gross basis in the accompanying notes if the above conditions are met.

Derecognition of financial assets and liabilities

The Scheme derecognises a financial asset or part of a financial asset when:
- The contractual right to the cash flows from the asset expires.
- The Scheme retains the contractual right to receive cash flows of the asset, but assumes the obligation to pay one or more third parties the cash flow without material delay.

- The Scheme transfers the asset, while transferring substantially all the risks and rewards of ownership.
- The Scheme neither transfers the financial asset nor retains significant risk and reward of ownership, but has transferred control of the financial asset.

The Scheme derecognises a financial liability when the obligation under the liability is discharged, cancelled or expires.

PRINCIPAL ACCOUNTING POLICIES (continued)

1.7 FINANCIAL ASSETS

IFRS 12 Unconsolidated investment structures

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

1.8 FINANCIAL LIABILITIES

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

1.9 PROVISIONS

The Scheme recognises a provision once the following conditions are met:
- It has a present legal or constructive obligation as a result of past events.
- It is probable that an outflow of resources embodying economic benefits will be required to settle the obligation.
- A reliable estimate of the amount of the obligation can be made.

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

1.10 CONTINGENT LIABILITY

The Scheme will disclose a contingent liability if one of the following conditions are met:
- A possible obligation arising from past events, the existence of which will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the Scheme.
- A present obligation that arises from past events but not recognised because:
  - It is not probable that an outflow of resources will be required to settle an obligation.
  - The amount of the obligation cannot be measured with sufficient reliability.

1.11 INCOME TAX

In terms of Section 10 (1)(d) of the Income Tax Act 58 of 1962, as amended, receipts and accruals of a benefit fund are exempt from normal tax. A medical scheme is included in the definition of a benefit fund and consequently the Scheme is exempt from income tax.

PRINCIPAL ACCOUNTING POLICIES (continued)

1.12 BROKER FEES

Brokers' fees are recognised as incurred.

1.13 REIMBURSEMENT FROM THE ROAD ACCIDENT FUND

The Scheme grants assistance to its members in defraying expenditure incurred in connection with rendering of any relevant health service. Such expenditure may be in connection with a claim that is also made to the Road Accident Fund (RAF), administered in terms of the Road Accident Fund Act No. 56 of 1996. If the member is reimbursed by the RAF they are obliged contractually to cede that payment to the Scheme to the extent that they have already been compensated.

Due to the uncertainty around the confirmation and value of the RAF amounts, the Scheme accounts for these amounts on a cash basis and recognises them as third party claim recoveries as a reduction of net claims incurred. Recoveries from the RAF are reflected in third party claim recoveries in the Statement of Comprehensive Income in the current year keeping in mind that some of these recoveries may pertain to prior year claims. The contingent assets are assessed continually to ensure any developments are appropriately reflected in the annual financial statements.

1.14 ALLOCATION OF INCOME AND EXPENDITURE TO BENEFIT OPTIONS

All allocations between benefit options are based on the actual income and expenditure per benefit option with the exception of:

- Administration expenditure - allocated on membership per benefit option;
- Investment income and asset management fees - allocated pro-rata to risk contribution income per benefit option;
- Managed care: management services - allocated on membership per benefit option;
- Risk adjustment - allocated pro-rata based on claims expenditure per benefit option.

2. FINANCIAL ASSETS AT FAIR VALUE THROUGH PROFIT OR LOSS

Accounting policy

The Scheme's investment strategy ("business model objective") is determined by means of an allocation across different asset classes and grouping of Financial assets into specific portfolios. Independent asset managers manage these portfolios under fully discretionary, active mandates with performance evaluated at 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 or loss.

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

The fair value of the financial instruments traded in an active market is determined by using quoted market prices or dealer quotes. The fair value of financial instruments not traded in an active market is determined by using valuation techniques that maximise the use of observable market data and rely as little as possible on entity specific estimates.

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

Note

The Scheme's Financial assets at fair value through profit or loss are summarised as follows:

	2023 R'000	2022 R'000
Cost at the beginning of the year	109,834	98,738
Gain on adjustments to fair value	4,037	11,237
Fair value at the beginning of the year	113,871	109,975
Additions	213	77
Acquisitions	-	-
Reinvestment of investment income	213	77
Disposals	(522)	(218)
Disposals at cost	(632)	(605)
Realised gains on sale of investment (Note 9)	110	387
Gain on adjustments to fair value	10,389	4,037
Fair value at the end of the year	**123,951**	**113,871**

2. FINANCIAL ASSETS AT FAIR VALUE THROUGH PROFIT OR LOSS (continued)

	2023 R'000	2022 R'000
The investments included above represent investments in:		
Linked insurance policies	123,951	113,872
Fair value at the end of the year	**123,951**	**113,872**
The investments were managed by the following asset managers at year-end:		
Sygnia Asset Management (Pty) Ltd	123,951	113,872
	123,951	**113,872**

The weighted average return for the year on investments at fair value through profit or loss was 9.2% (2022: 4.6%).

The asset management fees for the year comprised:		
• Asset management fees	632	605
• Investment advisor fees	13	-
	645	**605**

3. FINANCIAL ASSETS AT AMORTISED COST

Accounting policy

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

Receivables are initially recognised at fair value, plus transaction costs. The Scheme holds its other receivables with the objective to collect the contractual cash flows and measures them subsequently at amortised cost using the effective interest method.

Impairment of other receivables

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. There are no impairments of other receivables.

Note	2023 R'000	2022 R'000
Interest receivable	1,041	449
Forensic debtors	218	70
Sundy debtors	9	-
	1,269	519

4. CASH AND CASH EQUIVALENTS

Accounting policy

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

In the Statement of Cash Flows, cash and cash equivalents comprise:
- Money on call and short notice; and
- Balances with banks

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

Note	**2023 R'000**	**2022 R'000**
Current accounts	6,406	14,756
Short term cash deposits	82,072	49,228
	88,478	**63,984**

The weighted average interest rate for the year on current accounts was 7.66% (2022: 4.99%).

5.1 INSURANCE CONTRACT LIABILITY

2023

Insurance contracts issued R'000		**Liability for incurred claims (LIC)**		
	Liability for remaining coverage (LRC)	**Present value of future cash flows**	**Risk adjustment**	**Total**
Net opening balance	**20,076**	**10,355**	**190**	**30,622**
Insurance service result	**(346,439)**	**324,020**	**68**	**(22,351)**
Insurance revenue	(346,439)	-	-	(346,439)
Insurance service expense	-	324,020	68	324,088
Incurred claims and other directly attributable expenses	-	316,408	-	316,408
Changes in fulfilment cash flows relating to the liability for incurred claims - past service	-	(388)	(190)	(579)
Changes in fulfilment cash flows relating to the liability for incurred claims - current service	-	8,000	258	8,258
Total amounts recognised in comprehensive income	(346,439)	324,020	68	(22,351)
Total movement	**(346,439)**	**324,020**	**68**	**(22,351)**
Cash flows				
Contributions received	387,608	-	-	387,608
Claims and other directly attributable expenses paid	-	(322,193)	-	(322,193)
Total cash flows	**387,608**	**(322,193)**	**-**	**65,415**
Net closing balance	**21,093**	**12,182**	**258**	**33,533**

5.2 INSURANCE LIABILITY FOR FUTURE MEMBERS

Balance at the beginning of the year	147,128
Amounts attributable to future members	32,311
Balance at the end of the year	**179,439**

5.1 INSURANCE CONTRACT LIABILITY

2022

Insurance contracts issued R'000		**Liability for incurred claims (LIC)**		
	Liability for remaining coverage (LRC)	**Present value of future cash flows**	**Risk adjustment**	**Total**
Net opening balance	**16,407**	**9,491**	**242**	**26,140**
Insurance service result	**(307,699)**	**315,316**	**(52)**	**7,565**
Insurance revenue	(307,699)	-	-	(307,699)
Insurance service expense	-	315,316	(52)	315,264
Incurred claims and other directly attributable expenses	-	311,550	-	311,550
Changes in fulfilment cash flows relating to the liability for incurred claims - past service	-	(2,334)	(242)	(2,576)
Changes in fulfilment cash flows relating to the liability for incurred claims - current service	-	6,100	190	6,290
Total amounts recognised in comprehensive income	(307,699)	315,316	(52)	7,565
Total movement	**(307,699)**	**315,316**	**(52)**	**7,565**
Cash flows				
Contributions received	311,368	-	-	311,368
Claims and other directly attributable expenses paid	-	(314,452)	-	(314,452)
Total cash flows	**311,368**	**(314,452)**	**-**	**(3,084)**
Net closing balance	**20,076**	**10,355**	**190**	**30,621**

5.2 INSURANCE LIABILITY FOR FUTURE MEMBERS

Balance at the beginning of the year	144,532
Amounts attributable to future members	2,596
Balance at the end of the year	**147,128**

6. REINSURANCE CONTRACT ASSETS

2023	**Remaining Coverage Component**	**Incurred claims for contracts under the PAA**		**Total**
Healthcare Risk – Reinsurance contracts held R'000		**Present value of future cash flows**	**Risk adjustment**	
Net opening balance	**-**	**-**	**-**	**-**
Net income/(expenses) from reinsurance contracts held	**(3,588)**	**2,803**	**-**	**(785)**
Reinsurance expenses	(3,588)	-	-	(3,588)
Claims recovered	-	2,803	-	2,803
Total amounts recognised in comprehensive income	-	-	-	-
Cash flows				
Premiums paid	3,588	-	-	3,588
Recoveries from reinsurance	-	(2,803)	-	(2,803)
Total cash flows	**3,588**	**(2,803)**	**-**	**785**
Net closing balance	**-**	**-**	**-**	**-**
2022				
Net opening balance	**-**	**-**	**-**	**-**
Net income/(expenses) from reinsurance contracts held	**(3,169)**	**3,604**	**-**	**435**
Reinsurance expenses	(3,169)	-	-	(3,169)
Claims recovered	-	3,604	-	3,604
Total amounts recognised in comprehensive income	(3,169)	3,604	-	435
Total amounts recognised incomprehensive income	**(3,169)**	**3,604**	**-**	**435**
Cash flows				
Premiums paid	3,169	-	-	3,169
Recoveries from reinsurance	-	(3,604)	-	(3,604)
Total cash flows	**3,169**	**(3,604)**	**-**	**(435)**
Net closing balance	**-**	**-**	**-**	**-**

7. TRADE AND OTHER PAYABLES

Accounting policy

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 recognised initially at fair value and subsequently measured at amortised cost using the effective interest rate method.

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 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.

Note

	2023 R'000	2022 R'000
Financial liabilities		
Balances due to related parties	23	187
Principal Officer	-	26
Total Medical Aid Administrators (Pty) Ltd	23	161
Accruals	281	4
Audit fee accrual	422	435
Total arising from financial liabilities	**726**	**626**

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

8. INSURANCE REVENUE AND SERVICE EXPENSES	2023 R'000	2022 R'000
Insurance revenue	346,439	307,699
Insurance service expenses		
Incurred claims	(305,065)	(297,903)
Third party claim recoveries	773	633
Other directly attributable expenses	(18,494)	(17,109)
Accredited managed care services (no risk transfer)	(6,759)	(6,326)
Accredited administration services	(11,735)	(10,783)
Insurance acquisition cash flows	(1,302)	(885)
Claims and directly attributable expenses	(324,088)	(315,264)
Insurance contract liability to future members	(32,311)	(2,596)
Insurance service expenses	(356,399)	(317,860)
Net (expense)/income from risk transfer arrangements	(785)	435
Risk transfer premium paid	(3,588)	(3,169)
Recovery from risk transfer arrangements	2,803	3,604
Insurance service result	**(10,745)**	**(9,726)**
Included in other directly attributable expenses above		
Accredited managed healthcare services (no risk transfer)		
Disease management services	2,127	1,992
Hospital management services	2,149	2,010
Pharmaceutical benefit management services	671	628
Provider network management services	1,812	1,696
	6,759	**6,326**
Accredited administration services		
Customer services	4,344	3,987
Information management and data control	2,935	2,825
Claims management	1,339	1,020
Member record management	1,636	1,549
Contribution management	1,438	1,361
Financial management	43	41
	11,735	**10,783**

NOTES TO THE FINANCIAL STATEMENTS
for the year ended 31 December 2023

	2023 R'000	2022 R'000
9. INVESTMENT INCOME		
Interest earned	1,297	835
Interest on cash and cash equivalents	1,297	835
Income from investments at fair value through profit or loss	15,109	6,653
Interest income	4,610	2,229
Dividend income	-	-
Realised gains	110	387
Unrealised gains	10,389	4,037
	16,406	**7,488**
10. SUNDRY INCOME		
Prescribed amounts written back	44	31
Employer group reinsurance recoveries	65	7,793
	109	**7,824**

11. OTHER OPERATING EXPENDITURE

Accounting policy

Other operating expenses are expensed as incurred.

Note	2023 R'000	2022 R'000
Administration services	1,073	1,203
Other services		
Forensic investigations and recoveries	225	414
Internal audit services	180	170
Actuarial services	170	156
Governance and compliance	35	34
Additional services		
Quality Management and Monitoring Services	170	160
Advanced Data Analytics	141	130
Digital Service Offering	52	48
Product Innovation	34	31
Enhanced Service Offering	29	26
Enterprise risk management services	29	26
Legal Services	8	8
Audit fees	442	435
Audit committee chairman fees	50	48
Bank charges	111	113
Advisory fees	2,198	2,031
Council for Medical Schemes levies	209	207
Other administration expenses	84	68
Principal officers' fees	804	724
Professional indemnity insurance	46	55
Trustee remuneration *	121	97
	5,138	4,981

* Trustee payments represent fees paid to A Marais for his services as chairman to the Scheme and reimbursement of cost incurred in performing his duties.

12. RELATED PARTY TRANSACTIONS

The administrator and advisors of the Scheme are involved in organisations which provide contractual services to the industry including the Scheme and its members.

Key management personnel

Key management personnel are those persons having authority and responsibility for planning, directing, controlling and advising on the activities of the Scheme. Key management personnel comprise the board of trustees, principal officer and advisors and those providing administrative services to the Scheme. The administrator and advisor and their family members did not receive any preferential treatment from the Scheme or its administrator.

	2023 R'000	2022 R'000
Transactions with key management personnel		
Statement of comprehensive income transactions		
Principal officers' fees	804	724
Principal officer and trustees:		
- Risk contributions received	994	837
- Risk claims incurred	745	655
Trustee remuneration	121	97
Statement of financial position		
Principal officers' fees	-	26

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

Transactions	*Nature of transactions and their terms and conditions*
Risk contributions received	This constitutes risk contributions paid by the related parties as members of the Scheme. All contributions were on the same terms as applicable to other members.
Risk claims incurred	This constitutes risk claims incurred by the related parties as members of the Scheme. All claims were paid out in terms of the rules of the Scheme.

	2023 R'000	2022 R'000
Discovery Health Proprietary Limited		
Statement of comprehensive income transactions		
Administration fees	12,809	11,986
Managed care: management fees	6,717	6,287
Statement of financial position		
Balance due at year end	34	1,509

Discovery Health (Pty) Ltd provides administration and managed care services to the Scheme. Discovery Health (Pty) Ltd has significant influence over the Scheme and it participates in the Scheme's financial and operating policy decisions but does not control the Scheme.

12. RELATED PARTY TRANSACTIONS (continued)

Transactions with related parties (continued)	2023 R'000	2022 R'000
Discovery Third Party Recovery Services Proprietary Limited		
Statement of comprehensive income transactions		
Road Accident Fund recoveries	16	583

The Scheme has contracted Discovery Third Party Recovery Services Proprietary Limited (DTPRS), a wholly owned subsidiary of Discovery Health Proprietary Limited, to manage the indentification and collection of third party recoveries from the Road Accident Fund.

Total Medical Aid Administrators Proprietary Limited		
Statement of comprehensive income transactions		
Advisory fees	2,086	1,951
Statement of financial position		
Balance due at year end	176	161
National HealthCare Group Proprietary Limited		
Statement of comprehensive income transactions		
Risk transfer arrangement fees paid	3,336	3,169
Employer Groups		
Statement of comprehensive income transactions		
Reinsurance recoveries	65	7,793

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 Medical Schemes Act, No 131 of 1998, as amended. 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 balances bears no interest and is due within 7 days.

13. FIDELITY AND PROFESSIONAL INDEMNITY COVER

In terms of section 33(3) of the Medical Schemes Act, Camargue Underwriting Managers Proprietary Limited, underwritten by Bryte Insurance Company Ltd, Compass Insurance Company Ltd and Lloyds Bank Of London Ltd, have provided professional indemnity and fidelity insurance of R30 million (2022: R30 million) to the Scheme.

The staff of the administrator were covered against fidelity claims through their employer indemnity insurance.

14. CRITICAL ACCOUNTING JUDGEMENTS AND AREAS OF KEY SOURCES OF ESTIMATION UNCERTAINTY

The Scheme makes estimates and assumptions concerning the application of accounting policies and the reported amounts of assets, liabilities, income and expenses. The resulting accounting estimates will, by definition, rarely equal the related actual result. The estimates and assumptions that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year are outlined below.

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

14. CRITICAL ACCOUNTING JUDGEMENTS AND AREAS OF KEY SOURCES OF ESTIMATION UNCERTAINTY (continued)

The sensitivities with regard to the assumptions made that have the most significant impact on measurement under IFRS 17, are detailed in the Insurance Risk Management note in the Financial Statements.

Estimates of future cash flows to fulfil insurance contracts.

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

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

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

Methods used to measure the insurance contracts.

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

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

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

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

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

15. INSURANCE RISK MANAGEMENT

Risk management objectives and policies for mitigating medical insurance risk

The primary medical activity carried out by the Scheme assumes the risk of loss from members and their dependants who are directly subject to medical insurance risk. These risks relate to the health of the Scheme members. As such the Scheme is exposed to the uncertainty surrounding the timing, severity of claims, changing epidemiology, and unexpected catastrophic events under each contract. The Scheme also has exposure to market risk such as changing member profiles and investment activities.

The Scheme uses several methods to assess and monitor medical insurance risk exposures both for individual types of risks insured and overall risks. The principal risk is that the frequency and severity of claims is greater than expected. Insurance events are, by their nature, random and the actual number and size of events during any one year may vary from those estimated using established statistical techniques.

Chronic medicine benefits cover the cost of medicines for conditions listed in the Chronic Disease List such as high blood pressure, cholesterol and asthma, as well as prescribed medicines for other specified conditions which are categorised as chronic, and are paid according to accepted protocols, and may be subject to limits.

As a result of regulations under the Medical Schemes Act, medical schemes are required to provide Prescribed Minimum Benefits, and the Scheme makes every effort to be compliant with this requirement. Such benefits are provided according to the regulated criteria and protocols.

Day to day benefits cover the cost (up to 100% of the Malcor rate for the appropriate year) of all out of hospital services, such as visits to medical practitioners and dentists, services rendered by auxiliaries and supplementary services, as well as prescribed non-chronic medicines.

Management information, including contribution income and claims ratios per plan is reviewed monthly.

Medical insurance risks facing the Scheme

The most significant medical insurance risk facing the Scheme is that risk contribution income will not be sufficient to cover risk claims expenditure and non-healthcare costs and will therefore not result in a surplus to enable the Scheme to achieve and maintain the required accumulated funds ratio.

Expected claims are determined on the basis of past claims experience, allowing for the effects of tariff and utilisation increases, and changes in benefit design. Prices are determined and managed according to changes in the National Health Reference Price List ("NHRPL") published by the Department of Health in 2006 and subsequently escalated by medical inflation annually, regulated fees such as dispensing fees, and negotiations with providers in certain major medical expense categories. Contributions are calculated so as to cover those claims, non-healthcare costs, and provide a surplus. There is always the risk that the past claims were overstated or understated, and/or that the calculations could be affected by changes in the membership profile or regulatory requirements, and that the contributions could consequently be calculated on the incorrect basis.

15. INSURANCE RISK MANAGEMENT (continued)

Medical insurance risks facing the Scheme (continued)

It is necessary, due to regulatory requirements for registering benefits and contributions in advance for the ensuing year, to estimate tariff increases and increases in benefit utilisation before negotiations with certain provider groups can be concluded. The extent of increases in the single exit prices for medicines also have to be estimated. All these factors constitute a risk that the results for the ensuing year will be affected by the use of the incorrect assumptions.

Changes in the membership profile as a result of plan selection, ageing of beneficiaries and demographics pose a risk to the Scheme, due to the effect they could have on claims experience, even though these factors are constantly monitored.

Concentration of medical insurance risks

The following table summarises the concentration of insurance risk per beneficiary, 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.

	Average claims per beneficiary per year					
	2023			2022		
Age grouping (in years)	Unlimited risk* R'000	Limited risk** R'000	Total R'000	Unlimited risk* R'000	Limited risk** R'000	Total R'000
< 25	7,127	7,613	14,739	7,344	7,609	14,953
25 - 34	10,847	11,934	22,781	10,070	11,698	21,768
35 - 49	14,385	13,930	28,315	14,003	13,290	27,293
50 - 64	29,495	16,168	45,663	27,104	16,085	43,189
> 65	49,822	19,102	68,925	48,858	19,019	67,877

* Unlimited risk claims comprise the cost to the Scheme of hospitalisation and related in-hospital treatment, Prescribed Minimum Benefits and chronic conditions for which there are no individual annual claim limits.

** Limited risk claims comprise the cost to the Scheme of all benefits for which there is an individual annual claim limit.

Management of forensic risk

The administrator provides a forensic service which analyses claims and investigates possible fraud and abuse of the benefits by providers and members, and institutes appropriate action.

15. INSURANCE RISK MANAGEMENT (continued)

Risk transfer arrangements

For a number of years the employer groups have elected to arrange stop-loss reinsurance cover outside the Scheme for hospital claims in excess of R300,000 per claim. The Scheme therefore has no requirement for reinsurance for its hospital claims. Nevertheless the employer groups have undertaken to contribute any reinsurance claim proceeds that they receive in terms of this cover to the Scheme by way of additional funding.

The Scheme has a capitation agreement with National HealthCare Group (Pty) Ltd which in return for a premium payable per member bears the risk for all individual claims less than R600,000 (2022: R600,000) per member in respect of all members of Plan D.

Sensitivity to insurance risk

A sensitivity analysis reflecting the impact on the Scheme's reported results for the year is as follows: A 10% movement in either direction in the provision for outstanding claims with all other variables held constant would have either a negative or positive effect of R0.8 million (2022: R0.6 million) on the Scheme's risk claims incurred and net surplus for the year.

Sensitivity of risk adjustment

	2023 R'000	2022 R'000
Risk adjustment with a 75% confidence level - as reported	258	190
Risk adjustment with a 85% confidence level	378	277

16. FINANCIAL RISK MANAGEMENT

Overview

The Scheme's activities expose it to a variety of financial risks, including the effects of changes in equity market prices, foreign currency exchange rates and interest rates. 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, which the Scheme holds to meet its obligations to its members.

Risk management and investment decisions are made by the trustees in consultation with the investment advisor.

Financial risk factors

Currency risk
The Scheme operates in South Africa and therefore its cash flows are denominated in South African Rand.

Interest rate risk
The investments of the Scheme, both long term and short term, comply with the regulations as set out in Regulation 30, annexure B, of the Medical Schemes Act.

Returns on interest bearing investments vary according to Reserve Bank monetary policy decisions.

The table below summarises the Scheme's exposure to interest rate risk. Included in the table are the Scheme's investments at carrying amounts. The investments that are subject to interest rate risks have been aged by the estimated period in which they could reasonably be liquidated.

	Up to 1 month R'000	1 - 3 months R'000	Greater than 4 months R'000	Non-interest bearing R'000	Total R'000
As at 31 December 2023					
Investments at fair value through profit or loss	123,951	-	-	-	123,951
Cash and cash equivalents	88,478	-	-	-	88,478
	212,429	-	-	-	212,429
As at 31 December 2022					
Investments at fair value through profit or loss	113,872	-	-	-	113,872
Cash and cash equivalents	63,984	-	-	-	63,984
	177,856	-	-	-	177,856

Non-interest bearing investments comprise investment in equity, commodities, property and preference shares.

16. FINANCIAL RISK MANAGEMENT (continued)

Financial risk factors (continued)

Credit risk

The Scheme's principal financial assets comprise investments held at fair value through profit or loss, trade and other receivables and cash and cash equivalents. The Scheme's credit risk is primarily attributable to its trade and other receivables. The amounts presented in the statement of financial position are net of allowances for impairment. An allowance for impairment is made where there is an identified loss event which, based on previous experience, is evidence of a reduction in the recoverability of the cash flows. Derivative counterparties (if applicable) and cash transactions are limited to high credit quality financial institutions.

With respect to cash and cash equivalents the Scheme limits its counterparty exposure by only dealing with financial institutions that have high external credit quality ratings. The Scheme has a policy of limiting the amount of credit exposure to any one financial institution in accordance with the limitation on asset requirements specified in the Regulations to the Medical Schemes Act.

Credit risk in respect of trade and other receivables is controlled through the application of credit monitoring procedures. Section 26(7) of the Medical Schemes Act requires all contributions to be paid to the Scheme within 3 days of becoming due. Whilst every effort is made to enforce this requirement the onus is on the member/employer group to ensure compliance. The rules of the Scheme provide for suspension and ultimately termination of membership after specified periods of non-compliance.

Exposure to credit risk

	Insurance receivables			
	Contribution receivables		Member and provider claim receivables	
	2023 R'000	2022 R'000	2023 R'000	2022 R'000
Carrying amount	-	190	1,090	829
Past due but no expected credit loss - carrying amount	-	-	313	56
30 - 60 days	-	-	92	22
61 - 90 days	-	-	213	33
91 days +	-	-	8	1
Expected credit loss - carrying amount	-	-	704	351
Not past due	-	190	73	422
	-	190	1,090	829

Past due but not expecting a credit loss

Contribution and member and provider receivable payments are past due but the Scheme believes that impairment is not appropriate on the basis of the stage of collection of amounts owed to the Scheme.

16. FINANCIAL RISK MANAGEMENT REPORT (continued)

Financial risk factors (continued)

Expected credit losses
Insurance assets are recoverable but, in exceptional circumstances small amounts may be irrecoverable. These irrecoverable amounts are written off.

Capital adequacy risk
The Scheme's objective when managing capital is to safeguard its ability to continue as a going concern in order to provide benefits for its stakeholders.

The principal risk is that the frequency and severity of claims is greater than expected and that there are insufficient reserves to provide for their settlement.

The Medical Schemes Act, 131 of 1998 requires a minimum accumulated funds (solvency) ratio, calculated as accumulated funds expressed as a percentage of registered contributions, of 25%. The Scheme's solvency ratio based on registered contributions was 44.72% (2022: 43.14%) at 31 December 2023.

Liquidity risk
Prudent liquidity risk management implies maintaining sufficient cash. The availability of funding through liquid holding cash positions with various financial institutions ensures that the Scheme has the ability to fund the day-to-day operations of the Scheme.

The table below summarises the Scheme's financial liabilities analysed by the expected maturity dates.

As at 31 December 2023	Up to 1 month R'000	1 - 12 months R'000	> 12 months R'000	Total R'000
Liability for incurred claims	30,163	3,370	-	33,533
Insurance liability for future members	-	-	179,439	179,439
Insurance and other payables	3,542	-	-	3,542
	33,705	3,370	179,439	216,514
As at 31 December 2022				
Liability for incurred claims	28,450	2,171	-	30,621
Insurance liability for future members	-	-	147,128	147,128
Insurance and other payables	25,626	-	-	25,626
	54,076	2,171	147,128	203,375

Market risk
Market risk is the risk that changes in market prices such as the interest rate, equity prices, foreign exchange rates and credit spreads will affect the Scheme's investment income or the value of its holdings of financial instruments. The objective of market risk management is to manage and control market risk exposure within acceptable parameters, while optimising the return on investments.

16. FINANCIAL RISK MANAGEMENT (continued)

Financial risk factors (continued)

Sensitivity risk

Listed and unit-linked investments

A 5% movement in the market value of investments in either direction would have had either a positive or negative effect of R6,198million (2022: R5,694 million) on the market value of the portfolio at year end.

Fair value estimation

IFRS 7 requires disclosure of fair value measurements of financial instruments by level in terms of the following fair value measurement hierarchy:

- Level 1 fair value measurements are those derived from quoted prices (unadjusted) in active markets for identical assets or liabilities
- Level 2 fair value measurements are those derived from inputs other than quoted prices included within Level 1 that are observable for the asset or liability, either directly (i.e. as prices) or indirectly (such as derived from prices).
- Level 3 fair value measurements are those derived from valuation techniques that include inputs for the asset or liability that are not based on observable market data (unobservable inputs).

	2023 R'000	2022 R'000
Investments at fair value through profit or loss		
Unit linked listed instruments	123,951	113,872
	123,951	113,872

The Scheme's investments are all valued on a level 2 basis.

16. FINANCIAL RISK MANAGEMENT (continued)

Breakdown of investments

The following table analyses the financial assets and financial liabilities of the Scheme per class of assets and liabilities:

As at 31 December 2023	Investments at fair value through profit or loss R'000	Financial assets at amortised cost R'000	Insurance contract liabilities R'000	Financial liabilities at amortised cost R'000	Total carrying amount R'000	Fair value amount R'000
Financial assets at fair value through profit or loss	123,951	-	-	-	123,951	123,951
Financial assets at amortised cost	-	1,269	-	-	1,269	1,269
Cash and cash equivalents	-	88,478	-	-	88,478	88,478
Insurance contract liabilities	-	-	(33,533)	-	(33,533)	(33,533)
Insurance liability for future members	-	-	(179,439)	-	(179,439)	(179,439)
Trade and other payables	-	-	-	(726)	(726)	(726)
	123,951	89,747	(212,972)	(726)	0	0
As at 31 December 2022						
Financial assets at fair value through profit or loss	113,871	-	-	-	113,871	113,871
Financial assets at amortised cost	-	519	-	-	519	519
Cash and cash equivalents	-	63,984	-	-	63,984	63,984
Insurance contract liabilities	-	-	(30,621)	-	(30,621)	(30,621)
Insurance liability for future members	-	-	(147,127)	-	(147,127)	(147,127)
Trade and other payables	-	-	-	(626)	(626)	(626)
	113,871	64,503	(177,748)	(626)	0	0

17. AREAS OF NON COMPLIANCE WITH MEDICAL SCHEME LEGISLATION FOR THE YEAR UNDER REVIEW

Although they may not be material in amount or effect, the trustees are required by the Council for Medical Schemes to report on all matters of non-compliance with the Act irrespective of whether or not the external auditors consider the non-compliance as material. In accordance with this requirement, the trustees note:

17.1 Late payment of 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. In terms of the Scheme rules, contributions are required to be received no later than three days after their due date. During the financial year certain contributions were identified that were not paid to the Scheme within this deadline period.

Causes of failure

The failure was mainly caused due to administrative delays by certain participating employers in paying over their respective contributions to the Scheme.

Corrective action

Whilst every effort is made through credit control procedures to enforce this requirement, the onus is on the member/employer group to ensure compliance. The loss of interest to the Scheme from this delay is minimal.

17.2 Investments in participating employers and medical scheme administrators

Nature and impact

Section 35(8)(a), (c) and (d) of the Act states that a medical scheme shall not invest any of its assets in participating employers, medical scheme administrators or persons associated with these organisations. During the year the Scheme did have investments in certain of these organisations.

Causes of failure

The Scheme invests in investment vehicles which allow investment managers discretion to invest in organisations of their choice. Certain of these choices have resulted in the Scheme having investments in organisations which are in conflict with this Section of the Act.

Corrective action

The Scheme has received exemption from the provisions of this Section from Council on the grounds that the investments are made, without reference to the Scheme, by the asset managers in the portfolios in which the Scheme invests. These investment choices are therefore not influenced by the Scheme.

17. AREAS OF NON COMPLIANCE WITH MEDICAL SCHEME LEGISLATION FOR THE YEAR UNDER REVIEW (continued

17.3 Late payment of claims

Nature and impact

Section 59(2) of the Act requires that medical schemes shall pay a member or a supplier of service, any benefit owing to that member or supplier of service within 30 days after the day on which the claim in respect of such benefit was received by the medical scheme.

Causes of failure

Late payment of claims usually resulted from members or providers submitting claims without the necessary details for these payments to be made timeously. These are isolated cases and thus do not have a material effect on the Scheme.

Corrective action

The necessary assistance is provided to the identified members and healthcare providers to ensure that these types of isolated cases are minimised.

17.4 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 and be financially sound. At 31 December 2023 Plan A incurred a net insurance service deficit of R3.0 million (2022: deficit of R11.3 million).

Causes of failure

Plan A was deliberately costed to incur a deficit as the increase in contributions necessary to achieve a surplus would have been too onerous for members on this plan and might lead to members changing to other plans to the detriment of the Scheme as a whole.

Corrective action

The Trustees are expecting this trend for Plan A to continue in future. The performance of all benefit options is monitored on a continuous basis with a view to improving their financial outcomes, and the Scheme continually evaluates different strategies to address the deficit in these benefit options.

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

18. (DEFICIT)/SURPLUS PER BENEFIT OPTION

2023	PLAN A R'000	PLAN B R'000	PLAN C R'000	PLAN D R'000	TOTAL R'000
Insurance revenue	70,857	242,191	29,862	3,529	346,439
Insurance service expense	(73,881)	(221,707)	(25,721)	(2,779)	(324,088)
Net claims incurred	(71,136)	(208,442)	(22,959)	(2,528)	(305,065)
Third party claim recoveries	105	526	117	25	773
Other directly attributable expenses					
Accredited administration services	(1,574)	(8,172)	(1,752)	(237)	(11,735)
Accredited managed healthcare services	(924)	(4,805)	(1,030)	-	(6,759)
Broker services	(352)	(814)	(97)	(39)	(1,302)
Net expense on risk transfer arrangements	(10)	(49)	(5)	(721)	(785)
Risk transfer arrangement fees paid	(40)	(191)	(21)	(3,336)	(3,588)
Recoveries from risk transfer arrangements	30	142	16	2,615	2,803
Insurance service result	(3,034)	20,435	4,136	29	21,566
Net investment income	3,346	11,471	1,422	167	16,406
Net insurance and investment result	**312**	**31,906**	**5,558**	**196**	**37,972**
Employer group reinsurance recoveries	-	65	-	-	65
Sundry income	-	44	-	-	44
Asset management fees	(131)	(446)	(55)	-	(632)
Other operating expenses	(700)	(3,643)	(778)	(17)	(5,138)
Net result	**(519)**	**27,926**	**4,725**	**179**	**32,311**
Number of members at year-end	578	3,081	708	139	4,506

Refer to note 1.14 for basis of allocation of income and expenses to benefit options.

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

2022	PLAN A R'000	PLAN B R'000	PLAN C R'000	PLAN D R'000	TOTAL R'000
Insurance revenue	66,390	210,764	27,114	3,431	307,699
Insurance service expense	(77,672)	(216,007)	(17,623)	(3,962)	(315,264)
Net claims incurred	(75,114)	(203,968)	(15,217)	(3,604)	(297,903)
Third party claim recoveries	162	438	33	-	633
Other directly attributable expenses					
Accredited administration services	(1,539)	(7,429)	(1,483)	(332)	(10,783)
Accredited managed healthcare services	(931)	(4,498)	(897)	-	(6,326)
Net impairment losses				-	
Broker services	(250)	(550)	(59)	(26)	(885)
Net income on risk transfer arrangements	-	-	-	435	435
Risk transfer arrangement fees paid	-	-	-	(3,169)	(3,169)
Recoveries from risk transfer arrangements	-	-	-	3,604	3,604
Insurance service result	(11,282)	(5,243)	9,491	(96)	(7,130)
Net investment income	1,596	5,149	658	85	7,488
Net insurance and investment result	**(9,686)**	**(94)**	**10,149**	**(11)**	**358**
Employer group reinsurance recoveries	2,957	4,836	-	-	7,793
Sundry income	-	31	-	-	31
Asset management fees	(132)	(419)	(54)	-	(605)
Other operating expenses	(726)	(3,296)	(1,037)	78	(4,981)
Net result	**(7,587)**	**1,058**	**9,058**	**67**	**2,596**
Number of members at year-end	610	3,046	615	137	4,408

Refer to note 1.14 for basis of allocation of income and expenses to benefit options.