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

ANNUAL FINANCIAL STATEMENTS

FOR THE YEAR ENDED

31 DECEMBER 2022

MALCOR MEDICAL AID SCHEME

ANNUAL FINANCIAL STATEMENTS
for the year ended 31 December 2022

MALCOR MEDICAL AID SCHEME

ANNUAL FINANCIAL STATEMENTS

for the year ended 31 December 2022

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 International Financial Reporting Standards (IFRS) and the requirements of the Medical Schemes Act of South Africa. In addition, the trustees are responsible for preparing the report of the board of trustees.

The trustees:-

- 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 15 - 19.

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 26 April 2023 and are signed on its behalf by:

A MARAIS	A LOWES	P DORFAN
Chairman	Trustee	Principal officer

MALCOR MEDICAL AID SCHEME

ANNUAL FINANCIAL STATEMENTS

for the year ended 31 December 2022

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

26 April 2023

MALCOR MEDICAL AID SCHEME

ANNUAL REPORT OF THE BOARD OF TRUSTEES
for the year ended 31 December 2022

The board of trustees ("the Board") hereby presents its report for the year ended 31 December 2022.

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 2022 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	5
L James	4	5
A Lowes	5	5
W Scott	5	5
C Van Zitters	5	5
R Verster (Deceased 28 January 2023)*	5	5
R Govender	5	5
R Govender (Alternate) (Appointed 1 February 2022)	5	5
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 chairperson received remuneration of R97,122 (2021: R96,371) for his services to the Scheme during the year.

*On 28 January 2023 Mr R Verster tragically passed away. Our deepest condolences to his family and friends.

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 R724,122 (2021: R677,981) 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

G Webb
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 2022 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	3	3
E Toerien (Resigned 31 March 2022)	1	1
M Lorgat	2	3
J Forson (Appointed 22 June 2022)	1	1
Trustee members:		
A Lowes	2	3
J Els	2	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 chairperson received remuneration of R47,672 (2021: R45,365) 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 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.

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

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 capitation fee. This is disclosed in the current annual financial statements and is the only risk transfer arrangement.

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 19.45% (2021: 19.22%) of the Scheme's funds available for investment in equities, 80.11% (2021: 76.57%) in cash or bonds and 0.44% (2021: 0.48%) 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 4.6% (2021: 6.7%).

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
R Verster (Deceased 28 January 2023)	2	2
P Dorfan (PO)	2	2
C Van Zitters (Appointed 22 June 2022)	1	1

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 2022

4. OPERATIONAL STATISTICS

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

	Plan A			Plan B			Plan C			Plan D			Total Scheme		
	2022	2021	%	2022	2021	%	2022	2021	%	2022	2021	%	2022	2021	%
Number of members at end of the year	610	669	-9%	3,046	3,000	2%	615	599	3%	137	139	-1%	4,408	4,407	0%
Number of beneficiaries at the end of the year	1,425	1,609	-11%	7,819	7,685	2%	1,097	1,089	1%	259	256	1%	10,600	10,639	0%
Average number of members per month	634	686	-8%	3,060	3,034	1%	611	598	2%	137	139	-2%	4,441	4,457	0%
Average number of beneficiaries per month	1,498	1,663	-10%	7,847	7,730	2%	1,092	1,082	1%	257	254	1%	10,693	10,729	0%
Average number of beneficiaries per member at year-end	2.34	2.41	-3%	2.57	2.56	0%	1.78	1.82	-2%	1.89	1.84	3%	2.40	2.41	0%
Dependant ratio to members at year-end	1.34	1.41	-5%	1.57	1.56	0%	0.78	0.82	-4%	0.89	0.84	6%	1.40	1.41	-1%
Average age of beneficiaries at the beginning of the year	45.6	43.4	5%	31.6	31.0	2%	31.8	31.1	2%	34.6	33.6	3%	33.6	33.1	2%
Pensioner ratio (beneficiaries >65 years)	19.9%	16.0%	25%	4.5%	4.0%	14%	7.0%	5.7%	23%	9.3%	10.4%	-11%	6.9%	6.2%	11%
Number of beneficiaries registered for chronic conditions at year end	746	798	-7%	2,219	2,067	7%	203	196	4%	4	27	-85%	3,172	3,087	3%
Average per month															
Risk contributions per member (R')	8,728	8,442	3%	5,740	5,460	5%	3,699	3,559	4%	2,090	1,961	7%	5,773	5,554	4%
Risk contributions per beneficiary (R')	3,694	3,482	6%	2,238	2,143	4%	2,070	1,967	5%	1,111	1,073	3%	2,398	2,307	4%
Relevant healthcare expenditure per member (R')	10,051	9,274	8%	5,707	5,054	13%	2,196	2,517	-13%	1,930	1,739	11%	5,728	5,260	9%
Relevant healthcare expenditure per beneficiary (R')	4,254	3,825	11%	2,225	1,984	12%	1,229	1,391	-12%	1,026	952	8%	2,379	2,185	9%
Non-healthcare expenditure per member (R')	331	309	7%	316	301	5%	307	289	6%	159	150	6%	312	296	5%
Non-healthcare expenditure per beneficiary (R')	140	127	10%	123	118	4%	172	160	7%	85	82	3%	129	123	5%
Accumulated funds per member at year-end (R')	n/a	n/a		n/a	n/a		n/a	n/a		n/a	n/a		33,336	33,225	0%
Relevant healthcare expenditure as % of risk contribution income	115.2%	109.9%	5%	99.4%	92.6%	7%	59.4%	70.7%	-16%	92.4%	88.7%	4%	99.2%	94.7%	5%
Managed care as % of risk contribution income	1.4%	1.4%	1%	2.1%	2.1%	0%	3.3%	3.3%	1%	-	-	-	2.1%	2.0%	1%
Administration expenditure as % of risk contribution income	2.6%	2.6%	2%	4.0%	4.0%	0%	6.1%	6.1%	1%	6.8%	6.9%	-1%	3.9%	3.9%	1%
Non-healthcare expenditure as % of risk contribution income	3.8%	3.7%	4%	5.5%	5.5%	0%	8.3%	8.1%	2%	7.6%	7.6%	-1%	5.4%	5.3%	1%

REPORT OF THE BOARD OF TRUSTEES
for the year ended 31 December 2022

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

	2022 R'000	2021 R'000
Amount paid to administrators		
- Administration fee (Note 10 to the annual financial statements)	11,986	11,450
- Managed care fee (Note 9 to the annual financial statements)	6,326	6,038
Total	18,313	17,489

5.3. Accumulated funds ratio

The accumulated funds ratio is calculated as follows:		
Total members' funds per statement of financial position	146,946	146,424
Less: Cumulative unrealised fair value gain on investments	(14,189)	(10,152)
Accumulated funds per Regulation 29	132,756	136,271
Risk contributions	307,699	297,072
Accumulated funds ratio	43.14%	45.87%
(accumulated funds/risk annual contribution income x 100)		

5.4. Reserve accounts

Movement in the reserve is set out in the statement of changes in funds and reserve.

5.5. Outstanding risk claims provision

The basis of calculation of the outstanding risk claims provision and the movement in the provision are set out in Note 5 to the annual financial statements. Other than noted in part 3.5 of this report relating to the provision for COVID-19 vaccinations, the basis of calculation is consistent with the prior year and there have been no unusual movements that the trustees believe should be brought to the attention of the members of the Scheme.

5.6. Other

It is evident from the operational statistics set out in note 4 to this report that, ignoring Plan D for which the operating responsibility is outsourced to National HealthCare Group (Pty) Ltd, the average net relevant healthcare expenditure per beneficiary per month reflects an increase of 11% for Plan A, an increase of 12% for Plan B and a decrease of 12% for Plan C. This is more than initially expected in view of the generally better tariffs that were negotiated for the Scheme by Discovery Health (Pty) Ltd for 2022.

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 detailed in paragraph 12(2) below, the Scheme did not hold shares in any related party or in companies whose employees are members of the Scheme.

7. RELATED PARTY TRANSACTIONS

Related party transactions are set out in Note 15 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 (2021: R25 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. Sustainability of benefit options

Nature and impact
In terms of section 33(2) of the Act, each benefit option shall be self-supporting in terms of membership and financial performance. At 31 December 2022 two of the four benefit options incurred deficits as set out in note 14 to the annual financial statements.

Causes of failure
Plan A and Plan B were deliberately costed to incur a deficit as the increase in contributions necessary to achieve a surplus would have been too onerous for members on these plans 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.

In addition, the Scheme continually provides the Registrar with updates on both the Scheme and individual benefit option performance through the monthly management accounts and quarterly monitoring meetings.

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

12.4. 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.

HDF

HARRIS DOWDEN & FONTAINE CHARTERED ACCOUNTANTS (SA)
IRBA Registration No. 943703

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E-Mail hdf@icon.co.za

R.T. Harris B.J. Dowden C.L.I. Fontaine

Independent Auditor's Report

To the Members of Malcor Medical Aid Scheme

Report on the audit of the Financial Statements
For the year ended 31 December 2022

Opinion

We have audited the financial statements of Malcor Medical Aid Scheme (the Scheme), set out on pages 20 to 57, which comprise the statement of financial position as at 31 December 2022 and the statement of comprehensive income, the statement of changes in members' funds and reserves and the statement of cash flows for the year then ended, and notes to the financial statements, including a summary of significant accounting policies.

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

Basis for Opinion

We conducted our audit in accordance with International Standards on Auditing (ISA's). Our responsibilities under those standards are further described in the Auditor's Responsibilities for the Audit of the Financial Statements section of our report. We believe that the audit evidence obtained is sufficient and appropriate to provide a basis for our opinion.

Independence

We are independent of the Scheme in accordance with the Independent Regulatory Board for Auditors Code of Professional Conduct for Registered Auditors (IRBA Code) and other independence requirements applicable to performing audits of financial statements in South Africa. We have fulfilled our other ethical responsibilities in accordance with the IRBA Code and in accordance with other ethical requirements applicable to performing audits in South Africa. The IRBA Code is consistent with the corresponding sections of the International Ethics Standards Board for Accountants Code of Ethics for Professional Accountants (including International Independence Standards). We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Key Audit Matters

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

1. Outstanding claims provision:

   International Financial Reporting Standards (IFRS) requires the Scheme to make provision for all future cash outflows for which a past event has occurred.

   As disclosed in Note 5 to the annual financial statements, the carrying amount of the Outstanding Claims Provision ("IBNR") at year end was R6,471,000. The determination of the IBNR requires the Scheme's Trustees to make assumptions and significant judgement in the valuation thereof, which is determined with reference to an estimation of the ultimate cost of settling all claims incurred but not yet reported at the Statement of Financial Position date.

   How the matter was addressed in the audit:

   In evaluating the valuation of the IBNR, we audited the calculations approved by the Board of Trustees and performed various procedures including the following:

   - Testing the Scheme's controls relating to the preparation of the IBNR calculation;
   - Testing the integrity of the information used in the calculation of the IBNR by performing substantive procedures, on a sample basis, on the completeness and accuracy of the claims data used in calculating the IBNR;
   - Performance of an independent estimate of the IBNR using substantive analytical procedures that involved historical claims data and trends and comparing the estimate to the Scheme's IBNR;
   - Performance of tests of details on the current year IBNR including testing actual claims experienced subsequent to year end and as close as possible to audit completion date; and
   - Performance of a retrospective review of the IBNR raised in the 2021 financial year based on actual claims paid in 2022 to verify the assumptions applied to determine the IBNR are reasonable.

   The assumptions applied in the IBNR are appropriate and we are satisfied that the movement of the IBNR in the Statement of Comprehensive Income and the related disclosure of the IBNR balance, in the Statement of Financial Position and assumptions are appropriate.

   We engage with management around the rationale for any adjustments or decisions over and above the numeric calculation.

2. Claims and contributions:

   Claims and contributions are significant classes of transactions in the annual financial statements of the Scheme. These are also subject to significant risk of fraud or material misstatement. The Scheme places significant reliance on the system of internal controls and various analytical and system based checks to ensure that all claims and contributions are valid and accurate.

   How the matter was addressed in the audit:

   During the audit the claims and contributions systems are subjected to various tests of controls and exception reports are reviewed.

3. Risk Transfer Arrangement:

   The Scheme has entered into a risk transfer arrangement for the duration of the year, which obliges the Capitator to compensate providers for costs incurred by members of the Scheme, in the case that an insured event occurred.

   How the matter was addressed in the audit:

   We tested the accuracy of the risk transfer arrangement fees expense, by agreeing the number of members and rates applied in the calculations, to member records and the service level agreement with the Capitator. No inconsistencies were noted.

Other Information

The Scheme's trustees are responsible for the other information. The other information comprises the Statement of Responsibility by the Board of Trustees, and the Report of the Board of Trustees. The other information does not include the financial statements and our auditor's report thereon.

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

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

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

Responsibilities of the Scheme's Trustees for the Financial Statements

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

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

Auditor's Responsibilities for the Audit of the Financial Statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an audit report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISA's will always detect a material misstatement when it exists.

Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

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

- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, design and perform audit procedures responsive to those risks, and obtain audit evidence that is sufficient and appropriate to provide a basis for our opinion. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control.

- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Scheme's internal control.

- Evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by the Scheme's trustees.

- Conclude on the appropriateness of the Scheme's trustees' use of the going concern basis of accounting and based on the audit evidence obtained, whether a material uncertainty exists in relation to events or conditions that may cast significant doubt on the Scheme's ability to continue as a going concern. If we conclude that a material uncertainty exists, we are required to draw attention in our audit report to the related disclosures in the financial statements or, if such disclosures are inadequate, to modify our opinion. Our conclusions are based on the audit evidence obtained up to the date of our auditor's report. However, future events or conditions may cause the Scheme to cease to continue as a going concern.

- Evaluate the overall presentation, structure and content of the financial statements, including the disclosures, and whether the financial statements represent the underlying transactions and events in a manner that achieves fair presentation.

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

We also provide the Scheme's Trustees with a statement that we have complied with relevant ethical requirements regarding independence, and to communicate with them all relationships and other matters that may reasonably be thought to bear on our independence, and where applicable, related safeguards.

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

Report on Other Legal and Regulatory Requirements

Non-compliance with the Medical Schemes Act of South Africa

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

Audit Tenure

In terms of the Independent Regulatory Board for Auditors (IRBA) Rule published in Government Gazette Number 39475 dated 04 December 2015, we report that we have been the auditor of Malcor Medical Aid Scheme for 16 years.

The engagement partner is Brian Dowden.

Harris Dowden & Fontaine

HARRIS DOWDEN & FONTAINE
Registered Auditors
Per: B.J. DOWDEN

Sandton
26 April 2023

MALCOR MEDICAL AID SCHEME

STATEMENT OF FINANCIAL POSITION

as at 31 December 2022

	Notes	2022 R'000	2021 R'000
ASSETS			
Non-current assets		113,872	109,975
Investments held at fair value through profit or loss	2	113,872	109,975
Current assets		65,171	62,971
Trade and other receivables	3	1,187	633
Cash and cash equivalents	4	63,984	62,338
Total assets		**179,043**	**172,946**
FUNDS AND LIABILITIES			
Members' funds		146,946	146,424
Current liabilities		32,097	26,522
Outstanding risk claims provision	5	6,471	5,750
Trade and other payables	6	25,626	20,772
Total funds and liabilities		**179,043**	**172,946**

MALCOR MEDICAL AID SCHEME

STATEMENT OF COMPREHENSIVE INCOME

for the year ended 31 December 2022

	Notes	2022 R'000	2021 R'000
Risk contribution income		**307,699**	**297,072**
Relevant healthcare expenditure		**(305,268)**	**(281,310)**
Net claims incurred		(299,377)	(275,352)
Risk claims incurred	7	(300,010)	(276,281)
Third party claim recoveries		633	929
Net income on risk transfer arrangements	8	435	80
Risk transfer arrangement fees paid		(3,169)	(2,901)
Recoveries from risk transfer arrangements		3,604	2,981
Managed care: management services	9	(6,326)	(6,038)
Gross healthcare result		**2,431**	**15,762**
Administration fees	10	(11,986)	(11,450)
Other administration expenses	11	(3,778)	(3,503)
Broker service fees		(885)	(796)
Net impairment gains/ (losses)	12	33	(64)
Net healthcare result		**(14,185)**	**(51)**
Other income		15,312	21,912
Investment income	13	7,488	16,367
Employer group reinsurance recoveries		7,793	5,519
Sundry income		31	26
Other expenditure		(605)	(551)
Asset management fees	2	(605)	(551)
Total net comprehensive income for the year		**522**	**21,310**

MALCOR MEDICAL AID SCHEME

STATEMENT OF CHANGES IN FUNDS AND RESERVES

for the year ended 31 December 2022

	Note	Total
		R'000
Balance as at 1 January 2021		**125,114**
Total net comprehensive income for the year		21,310
Balance as at 31 December 2021		**146,424**
Total net comprehensive income for the year		522
Balance as at 31 December 2022		**146,946**

MALCOR MEDICAL AID SCHEME

STATEMENT OF CASH FLOWS

for the year ended 31 December 2022

	Notes	2022 R'000	2021 R'000
CASH FLOWS FROM OPERATING ACTIVITIES			
Cash receipts from members and providers		312,950	295,968
• Cash receipts from members - contributions		311,366	296,076
• Cash receipts from members and providers – other		1,584	(108)
Cash paid to providers, employees and members		(322,499)	(298,097)
• Cash paid to providers and members – claims		(305,368)	(281,326)
• Cash paid to providers and employees – non-healthcare expenditure		(17,131)	(16,771)
Sundry income		7,823	5,545
NET CASH FLOWS FROM OPERATING ACTIVITIES		**(1,725)**	**3,416**
CASH FLOWS FROM INVESTING ACTIVITIES			
Purchase of investments	2	(77)	(100,219)
Proceeds on disposal of investments held at fair value through profit or loss	2	218	47,972
Investment income	13	3,231	5,286
NET CASH FLOWS FROM INVESTING ACTIVITIES		**3,372**	**(46,961)**
NET INCREASE/ (DECREASE) IN CASH AND CASH EQUIVALENTS		**1,647**	**(43,545)**
Cash and cash equivalents at the beginning of the year		62,338	105,883
CASH AND CASH EQUIVALENTS AT THE END OF THE YEAR		**63,984**	**62,338**

1. PRINCIPAL ACCOUNTING POLICIES

The following are the principal accounting policies applied in the preparation of these financial statements which are consistent with those of the previous year except for the adoption of the standards, amendments and interpretations in note 1.1.1.

1.1 Basis of preparation

The annual financial statements are prepared in South African Rands in accordance with International Financial Reporting Standards ("IFRS") and the requirements of the Medical Schemes Act 131 of 1998, as amended, on a going concern basis using the historical cost basis except as stated below.

The preparation of annual financial statements in conformity with IFRS requires the use of certain critical accounting estimates. It also requires management to exercise its judgement in the process of applying the Scheme's accounting policies. The notes to the annual financial statements set out those areas involving a high degree of judgement or complexity, or areas where assumptions and estimates are significant to the Scheme's financial statements.

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

Title	Effective date - financial year commencing on or after
Amendment to IAS 1 'Presentation of Financial Statements' on Classification of Liabilities as Current or Non-current - The amendment clarifies that liabilities are classified as either current or non-current, depending on the rights that exist at the end of the reporting period. Classification is unaffected by expectations of the entity or events after the reporting date.	1 January 2023
IFRS 17 - Insurance contracts - The Standard was issued in May 2017 and supersedes IFRS 4 'Insurance Contracts'. The Standard creates one accounting model for all insurance contracts and establishes principles for the recognition, measurement, presentation and disclosure of insurance contracts issued. The Standard requires insurance contracts to be measured using updated estimates and assumptions that reflect the timing of cash flows and takes into account any uncertainty relating to insurance contracts. **Insurance contracts -** The primary objective of the standard is to identify insurance contracts within the Scheme. The contracts issued by the Scheme are insurance contracts, indemnifying members and their dependants against the risk of loss arising as a result of a health event.	1 January 2023

1. PRINCIPAL ACCOUNTING POLICIES (continued)

1.1 Basis of preparation (continued)

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

Title	Effective date - financial year commencing on or after
IFRS 17 - Insurance contracts (continued) - Level of aggregation - Insurance contracts are aggregated into groups, or portfolios, of individual contracts when being measured and assessed as onerous on not. The level of aggregation has an impact on accounting for the insurance contracts, including the extent of offsetting and cross subsidisation to determine the appropriate level of aggregation in order to ultimately identify onerous contracts. A portfolio of insurance contracts comprises contracts subject to similar risks that are managed together. Once the portfolio of insurance contracts has been established, it becomes the unit of account to which the requirements of IFRS 17 are applied. All member contracts issued by the Scheme are subject to similar risks and are managed together, and therefore fall into the same portfolio, with no further disaggregation required. **Contract boundary -** The contracts issued by the Scheme are in line with its financial year and therefore no contracts will be issued for a financial year after the end of that specific financial year. In addition, as no contract will exceed 12 months, no discounting will be applied. Insurance contracts issued shall be recognized from the earliest of the following: (a) The beginning of the coverage period; (b) The date when the first payment from a policyholder becomes due; and (c) For onerous contracts, when the contracts become onerous. With the insurance contracts being included in a single portfolio, and the coverage period aligning with the reporting period (financial year), the insurance contracts will be recognised from 1 January or from inception of cover should the member join the Scheme after 1 January. An exception to this would be where the Scheme as a whole is priced for a deficit position. This would mean that all contracts would be onerous and the loss would need to be recognised when the contracts become onerous. As pricing for the Scheme is done in September for the following year, the onerous contract test would be assessed at this time, with the following year's loss being recognised in the current financial year. **Measurement -** The Standard further provides for a simplified approach, the "premium allocation approach", for the measurement of a group of insurance contracts under certain conditions. One of those conditions is that at the inception of the group of contracts, the entity reasonably expects that the simplification will produce measurement of the liability for remaining coverage that would not differ materially from that produced using the 'general measurement' model. Another condition is that the coverage period is one year or less. The Scheme has opted for the simplified "premium allocation approach".	1 January 2023

1. PRINCIPAL ACCOUNTING POLICIES (continued)

1.1 Basis of preparation (continued)

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

Title	Effective date - financial year commencing on or after
IFRS 17 - Insurance contracts - (continued) - Risk adjustment - The Standard requires an adjustment for non-financial risk. The Scheme shall adjust the estimate of the present value of the future cash flows in order to provide for the possible financial implications of the Scheme bearing the uncertainty of the amount and timing of cash flows that may arise from non-financial risk. The objective of the risk adjustment provision for non-financial risk is to reflect the Scheme's perception of the possible economic burden which may be the result of non-financial risks. IFRS 17 requires that the Standard is implemented retrospectively. This requires the identification, recognition and measurement of each group of insurance contracts as if the standard had always been applied. This also results in the derecognition of current balances that would not exist under IFRS 17, and the recognition of the resulting difference in Members' funds. **Financial impact - Onerous contracts -** With the requirement to implement the Standard retrospectively, the opening balances of 2021 and 2022 will be impacted by the budgeted deficits (onerous contracts) for the respective years. The 2021 budgeted deficit unwinds in 2022 with the 2022 budgeted deficit unwinding in 2023. The original budgets, with IFRS 17 adjustments, will be the starting point in calculating the onerous contract loss. **Risk margin on onerous contracts -** In addition to the "best estimate" onerous contract provision above, a risk margin amount reflecting potential adverse claims experience is required. It is required that a confidence interval approach is used. A confidence interval is a range of values into which one would expect an outcome to fall with a given chance. Historic variations from budget as a percentage of claims are used to calculate a 'standard error' deviation from budget, which is then used along with the Value at Risk (VaR) formula for claims variability in the Risk Based Solvency Assessment. The Value at Risk reflects a maximum financial loss which could be expected with a given probability i.e. a 90% VaR figure would be one that the scheme only has a 1 in 10 chance of performing worse than. This margin is expected to have a material impact on the onerous contract value. Management are confident that the Scheme will be fully prepared to apply IFRS 17 to the Annual Financial Statements for the financial year ending 31 December 2023, including the required comparative figures arising from the 2022 financial year end.	

1. PRINCIPAL ACCOUNTING POLICIES (continued)

1.2 Classification, recognition, presentation and derecognition of financial instruments

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

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

Offset
Where a legally enforceable right of offset exists for recognised financial assets and financial liabilities, and there is an intention to settle the liability and realise the asset simultaneously, or to settle on a net basis, all related financial assets and liabilities are offset.

Derecognition
Financial assets are derecognised when the rights to receive cash flows from them have expired or where they have been realised, and the Scheme has also transferred substantially all risks and rewards of ownership. The Scheme derecognises a financial liability when the contracted obligation is discharged or expires.

1.3 Financial assets

Investments at fair value through profit or loss
The Scheme recognises a financial asset at fair value through profit or loss when upon initial recognition the Scheme designated the asset as fair value through profit or loss. A group of financial assets is designated as at fair value through profit or loss if it is managed and its performance is evaluated on a fair value basis, in accordance with the Scheme's documented risk management strategy, and information about the group of assets is provided internally on that basis to the Scheme's key management personnel. Financial assets at fair value through profit or loss are initially recognised at fair value and the transaction costs are expensed in the profit or loss section of the Statement of Comprehensive Income. The fair value of the financial instruments traded in an active market is determined by using quoted market prices or dealer quotes. Gains or losses arising from subsequent changes in fair value are recognised under Other Income in the Statement of Comprehensive Income within the period in which they arise.

1. PRINCIPAL ACCOUNTING POLICIES (continued)

1.3 Financial assets (continued)

Trade and other receivables

Receivables are non-derivative financial assets with fixed or determinable payments that are not quoted in an active market, other than those the Scheme intends to sell in the short term. Receivables are initially recognised at fair value plus transaction costs. The Scheme holds its Insurance Receivables and Loans and Receivables with the objective to collect the contractual cash flows and therefore measures them subsequently at amortised cost using the effective interest method, less provision for impairment. Trade and other receivables comprise Insurance Receivables, arising from the Scheme's insurance contracts with its members and Loans and Receivables. As part of the implementation of IFRS 9: Financial Instruments, the classification between Insurance Receivables and Loans and Receivables was reassessed. Based on the reassessment, the balance relating to Forensic receivables, previously classified as Loans and Receivables as part of Sundry accounts receivables were reclassified to Insurance Receivables.

Cash and cash equivalents

Cash and cash equivalents comprise cash on hand, deposits held at call with banks, other short-term liquid investments that are readily convertible to a known amount of cash and are subject to an insignificant risk of change in value, and bank overdrafts. Cash and cash equivalents are carried at fair value.

1.4 Impairment of financial assets

Financial assets carried at amortised cost

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

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

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

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

1. PRINCIPAL ACCOUNTING POLICIES (continued)

1.4 Impairment of financial assets (continued)

Impairment of loans and receivables

The Scheme applies the IFRS 9 simplified approach to measure expected credit losses which uses a lifetime expected loss allowance for Loans and Receivables. To measure the expected credit losses, Loans and Receivables are grouped based on shared credit risk characteristics and days past due. For the year under review the Scheme does not expect any credit losses on these balances and no provision has been made.

1.5 Financial liabilities

Financial liabilities

Financial liabilities are initially measured at fair value, and are subsequently measured at amortised cost, using the effective interest rate method.

Insurance payables

Insurance payables are measured initially at fair value and subsequently measured at amortised cost, using the effective interest rate method.

Trade and other payables

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

1. PRINCIPAL ACCOUNTING POLICIES (continued)

1.6 Provisions

Provisions are recognised when the Scheme has a present legal or constructive obligation as a result of past events, for which it is probable that an outflow of economic benefits will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. Where the effect of discounting to present value is material, provisions are adjusted to reflect the time value of money.

Outstanding risk claims provision

The outstanding risk claims provision comprises a provision made for the estimated ultimate cost of settling all claims incurred but not yet reported at statement of financial position date. Outstanding risk claims are determined as accurately as possible based on a number of factors, which include previous experience in claims patterns, claims settlement patterns, changes in the nature and the number of members according to gender and age, trends in claims frequency, changes in the claims processing cycle, and variations in the nature and average cost incurred per claim.

The Scheme does not discount its provision for outstanding risk claims, as the effect of the time value of money is not considered material.

1.7 Risk contribution income

Contributions are received monthly in advance.

Contributions on member insurance contracts are accounted for monthly when their collection in terms of the insurance contract is reasonably certain. The earned portion of risk contributions received is recognised as revenue. Risk contributions are earned from the date of attached risk, over the indemnity period on a straight line basis. Risk contributions are shown before the deduction of broker service fees and other acquisition costs.

1.8 Relevant healthcare expenditure

Relevant healthcare expenditure consists of net claims incurred, net income/(expense) on risk transfer arrangements and managed care: management services.

Risk claims incurred

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

Risk claims incurred comprise the total of:

- claims submitted and accrued for services rendered during the year, net of recoveries from members for co-payments; and
- claims for services rendered during the previous year not included in the outstanding claims provision for that year, net of recoveries from members for co-payments.

1. PRINCIPAL ACCOUNTING POLICIES (continued)

1.8 Relevant healthcare expenditure (continued)

Net income on risk transfer arrangements

Contracts entered in to by the Scheme with third party service providers under which the Scheme is compensated for losses/claims (through the provision of services to members) on contracts that meet the classification requirements of insurance contracts are classified as risk transfer arrangements (reinsurance contracts). Risk transfer arrangements do not reduce the Scheme's primary obligations to its members, but are entered into to decrease the cost the Scheme may incur as a result of the carrying on of the business of a medical scheme.

Only contracts that give rise to a significant transfer of insurance risk are accounted for as risk transfer arrangements. Amounts recoverable under such contracts are recognised in the same year as the related claim.

Risk transfer premiums are recognised as an expense over the indemnity period on the straight line basis. If applicable, a portion of the risk transfer premiums are treated as a prepayment.

Risk transfer recoveries are presented in the statement of comprehensive income on a gross basis. They are calculated on the basis of what it would have cost the scheme had the arrangement been on a fee-for-service basis.

Claims paid in terms of the risk transfer arrangements are calculated based on estimated utilisation statistics.

Managed care: management services

Managed care: management services expenses 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. These are expensed as incurred.

1.9 Investment income

Investment income comprises interest and dividends on listed instruments, interest on money market instruments and current accounts and net gains or losses on investments at fair value through profit or loss.

Interest is recognised on a yield to maturity basis, taking account of the principal amount outstanding and the effective rate over the period to maturity, when it is determined that such income will accrue to the Scheme.

Dividends and interest are recognised when the right to receive payment is established.

1. PRINCIPAL ACCOUNTING POLICIES (continued)

1.10 Liabilities and related assets under the liability adequacy test

Liability adequacy tests are performed to ensure the adequacy of the member insurance contract liabilities as at the statement of financial position date.

The liability for insurance contracts is tested for adequacy by comparing current best estimates of future contractual cash flows with the carrying value of the liability net of any related assets. Where a shortfall is identified, an additional provision is made and charged to the statement of comprehensive income.

1.11 Impairment losses

The carrying amounts of the Scheme's assets are reviewed at each statement of financial position date to determine whether there is any indication of impairment. If any such indication exists, the asset's recoverable amount is estimated.

An impairment loss is recognised whenever the carrying amount of an asset exceeds its recoverable amount. Impairment losses are recognised in the statement of comprehensive income.

Calculation of recoverable amount

The Scheme's receivables are not discounted to the present value of their estimated future cash flows due to the short term nature of their recoverability.

Reversal of impairment

An impairment loss is reversed if there has been a change in the estimates used to determine the recoverable amount. An impairment loss is reversed only to the extent that the asset's carrying amount does not exceed the carrying amount that would have been determined, net of depreciation or amortisation, if no impairment loss had been recognised.

1.12 Medical insurance contracts

Contracts under which the Scheme accepts significant medical insurance risk from another party (the member) by agreeing to compensate the member if a specified uncertain future event (the insured event) adversely affects the member are classified as medical insurance contracts. The contracts issued compensate the Scheme's members for healthcare expenses incurred.

1.13 Broker fees

Brokers' fees are recognised as incurred.

1. PRINCIPAL ACCOUNTING POLICIES (continued)

1.14 Reimbursements 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.

1.15 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;
- The additional funding component

	2022 R'000	2021 R'000
2. INVESTMENTS AT FAIR VALUE THROUGH PROFIT OR LOSS		
Cost at the beginning of the year	98,738	49,173
Gain (loss) on adjustments to fair value	11,237	(2,682)
Fair value at the beginning of the year	109,975	46,491
Additions	77	100,219
Acquisitions	-	99,872
Reinvestment of investment income (Note 12)	77	347
Disposals	(218)	(47,972)
Disposals at cost	(605)	(45,555)
Realised gains/ (losses) on sale of investment (Note 12)	387	(2,417)
Gain on adjustments to fair value	4,037	11,237
Fair value at the end of the year	**113,872**	**109,975**
The investments included above represent investments in:		
Linked insurance policies	113,872	109,975
Fair value at the end of the year	**113,872**	**109,975**
The investments were managed by the following asset managers at year-end:		
Sygnia Asset Management (Pty) Ltd	113,872	109,975
	113,872	**109,975**

The investments are non-current and have no fixed maturity date. The fair values of the listed instruments are based on listed market prices and the unit price at the statement of financial position date.

Investments at fair value through profit or loss are classified as non-current assets, unless they are expected to be realised within twelve months of the statement of financial position date or unless they may need to be sold to raise operating capital.

The weighted average return for the year on investments at fair value through profit or loss was 4.6% (2021: 6.7%).

The asset management fees for the year comprised:		
• Asset management fees	605	518
• Investment advisor fees	-	33
	605	**551**

	2022 R'000	2021 R'000
3. TRADE AND OTHER RECEIVABLES		
Insurance receivables		
Contributions outstanding	190	8
Member receivables	68	105
Service provider receivables	761	608
	1,019	721
Less: Provision for impairment losses	(351)	(459)
Forensic debtors	70	143
Total insurance receivables	738	404
Financial receivables		
Interest receivable	449	229
Total financial receivables	449	229
Total trade and other receivables	**1,187**	**633**

The carrying amounts of trade and other receivables approximate their fair values due to the short term maturities of these assets.

Reconciliation of impairment losses		
Members' and service providers' portions that are not recoverable		
Balance at the beginning of the year	459	598
Amount recognised in the statement of comprehensive income for the year		
	(108)	(139)
Provisions made during the year	32	141
Over provisions reversed during the year	(140)	(280)
Balance at end of the year	**351**	**459**

	2022 R'000	2021 R'000
4. CASH AND CASH EQUIVALENTS		
Current accounts	14,756	17,127
Short term cash deposits	49,228	45,211
	63,984	**62,338**

The weighted average interest rate for the year on current accounts was 4.99% (2021: 3.29%).

The weighted average interest rate for the year on short term cash deposits was 5.65% (2021: 4.12%).

5. OUTSTANDING RISK CLAIMS PROVISION		
Outstanding risk claims provision	**6,471**	**5,750**
Analysis of movement in outstanding risk claims provision		
Balance at beginning of year	5,750	6,100
Payments in respect of prior year	(5,066)	(5,534)
Over provision in respect of prior year (Note 7)	684	566
Adjustment for the current year (Note 7)	5,787	5,184
Outstanding risk claims provision	**6,471**	**5,750**

There is no provision for outstanding claims covered by risk transfer arrangements as this is not considered to be material to the Scheme.

5. OUTSTANDING RISK CLAIMS PROVISION (continued)

Process used to determine the assumptions

In order to qualify for benefits any claim must, unless otherwise arranged, be submitted to the Scheme not later than the last day of the fourth month following the month in which the healthcare service was rendered.

Each notified claim is assessed on a separate, case by case basis with due regard to the claim circumstances, information available from managed care management services and historical evidence of the size of similar claims. The provisions are based on information currently available. However, the ultimate liabilities may vary as a result of subsequent developments. The percentage of the estimated gross claims paid in 2023 in respect of the 2022 financial year by 31 March 2023 (2021: 31 March 2022) was 88.90% (2021: 90.93%).

The cost of outstanding claims is estimated as follows:

- actual claims notified and assessed during the three months succeeding the financial year end of the Scheme and;

- an estimate of claims, using claims information, for the fourth and subsequent months succeeding the financial year end of the Scheme. Historical claims development information is used on the assumption that this pattern will occur again in the future.
- In addition to normal claims, the Scheme should also raise a provision for State COVID-19 vaccinations that were incurred until 31 December 2022. The Department of Health only started submitting claims for vaccinations carried out at the state facilities to medical schemes from December 2021.

There are reasons why this may not be the case, which, insofar as they can be identified, have been allowed for by modifying the method. Such reasons include:

- changes in the processes that affect the development/recording of claims paid and incurred (such as changes in claims reversing procedures);
- economic, legal, political and social trends (resulting in different than expected levels of inflation and/or minimum medical benefits to be provided);
- changes in composition of memberships; and
- random fluctuations, including the impact of large losses.

The trustees believe that the liability for claims reported in the statement of financial position is adequate and no additional provision is required in terms of a liability adequacy test.

5. OUTSTANDING RISK CLAIMS PROVISION (continued)

Changes in assumptions and sensitivities to changes in key variables

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

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

Impact on reported surplus due to changes in key variables:

	Change in variables	Variation in claims cost 2022 R'000	Variation in claims costs 2021 R'000
Hospitalisation	**5%**	135	91
Chronic medication	**5%**	13	10
Day-to-day benefits	**5%**	140	99

This analysis has been prepared for a variation in claims run-off factors with other variables remaining constant. An increase or decrease in the provision will result in an increase or decrease in the surplus as follows:

Increase in claims	2022 R'000	2021 R'000
Increase in outstanding risk claims provision	(288)	(200)
Decrease in net comprehensive income	288	200
Decrease in claims		
Decrease in outstanding risk claims provision	288	200
Increase in net comprehensive income	(288)	(200)

The sensitivity of the estimation process is reduced by the value of the risk claims paid subsequent to the year end relating to the period ended 31 December 2022.

6. TRADE AND OTHER PAYABLES

Insurance liabilities

Risk contributions received in advance	20,266	16,415
Reported claims not yet paid	3,225	2,344
Balance at the beginning of the year	2,344	2,086
Movements for the year	881	258
Total arising from insurance liabilities	23,491	18,759

Financial liabilities

Accrued expenses	4	3
Balances due to related parties -	1,696	1,596
Discovery Health (Pty) Ltd	1,509	1,444
Principal Officer	26	-
Total Medical Aid Administrators (Pty) Ltd	161	152
Provision for audit fees	435	414
Total arising from financial liabilities	2,135	2,013
Total trade and other payables	**25,626**	**20,772**

Reported risk claims not yet paid comprise risk claims that have been received and processed for payment. They have been accounted for in the relevant healthcare expenditure for the current year but will only be paid next year.

The carrying amounts of trade and other payables approximate their fair values due to the short-term maturities of these liabilities.

	2022 R'000	2021 R'000
7. RISK CLAIMS INCURRED		
Current year claims	293,539	270,531
Claims not covered by risk transfer arrangement	289,935	267,550
Claims covered by risk transfer arrangement	3,604	2,981
Movement in outstanding risk claims provision (Note 5)	6,471	5,750
Under provision in respect of prior year	684	216
Adjustment for current year	5,787	5,534
Risk claims incurred	**300,010**	**276,281**
8. NET INCOME ON RISK TRANSFER ARRANGEMENTS		
National HealthCare Group (Pty) Ltd		
Risk transfer arrangement fees paid	3,169	2,901
Recoveries under risk transfer arrangement	(3,604)	(2,981)
Net income on risk transfer arrangement	**(435)**	**(80)**

The Scheme has a capitation agreement with National HealthCare Group (Pty) Ltd. National HealthCare Group (Pty) Ltd bears the cost for all related individual claims less than R600,000 (2021: R600,000) for members on Plan D through their network of suppliers. Should National HealthCare Group (Pty) Ltd default on payment of these claims, the Scheme is held liable for the cost.

9. MANAGED CARE: MANAGEMENT SERVICES		
Disease management services	1,992	1,901
Hospital management services	2,010	1,918
Pharmaceutical benefit management services	628	600
Provider network management services	1,696	1,619
	6,326	**6,038**
Services provided by:		
Discovery Health (Pty) Ltd	6,287	6,000
Isimo Health (Pty) Ltd	39	38
	6,326	**6,038**

	2022 R'000	2021 R'000
10. ADMINISTRATION FEES		
Accredited services		
Customer services	3,987	3,808
Information management and data control	2,825	2,699
Claims management	1,020	974
Member record management	1,549	1,480
Contribution management	1,361	1,300
Financial management	41	39
Other services		
Forensic investigations and recoveries	414	395
Internal audit services	170	163
Actuarial services	156	149
Governance and compliance	34	32
Additional services		
Quality Management and Monitoring Services	160	154
Advanced Data Analytics	130	124
Digital Service Offering	48	46
Product Innovation	31	30
Enhanced Service Offering	26	25
Enterprise risk management services	26	25
Legal Services	8	7
	11,986	**11,450**

11. OTHER ADMINISTRATION EXPENSES		
Audit fees	435	414
Audit committee chairman fees	48	45
Bank charges	113	108
Advisory fees	2,031	1,858
Council for Medical Schemes levies	207	200
Other administration expenses	68	58
Principal officers' fees	724	678
Professional indemnity insurance	55	46
Trustee remuneration	97	96
	3,778	**3,503**

	2022 R'000	2021 R'000
12. NET IMPAIRMENT LOSSES		
Insurance receivables		
Members' and service providers' portions that are not recoverable	33	(64)
Movement in provision	109	139
Recoveries	(76)	(203)
	33	**(64)**
13. INVESTMENT INCOME		
Scheme		
Income from investment at fair value through profit or loss reinvested (Note 2)	2,229	2,134
Interest income	2,229	2,042
Money market instruments	2,151	1,787
Listed instruments	77	255
Dividend income	-	92
Realised gains on sale of investments	387	2,417
Fair value adjustment on investments at fair value through profit or loss	4,037	11,237
Interest on cash and cash equivalents	835	579
	7,488	**16,367**

14. (DEFICIT)/SURPLUS PER BENEFIT OPTION

2022	Notes	PLAN A R'000	PLAN B R'000	PLAN C R'000	PLAN D R'000	TOTAL R'000
Risk contribution income		66,390	210,764	27,114	3,431	307,699
Relevant healthcare expenditure		(76,457)	(209,541)	(16,101)	(3,169)	(305,268)
Net claims incurred	8	(75,526)	(205,042)	(15,204)	(3,604)	(299,376)
Risk claims incurred		(75,688)	(205,481)	(15,236)	(3,604)	(300,010)
Third party claim recoveries		162	439	33	-	634
Net income on risk transfer arrangements	9	-	-	-	435	435
Risk transfer arrangement fees paid		-	-	-	(3,169)	(3,169)
Recoveries from risk transfer arrangements		-	-	-	3,604	3,604
Managed care: management services	10	(931)	(4,498)	(897)	-	(6,326)
Gross healthcare result		(10,067)	1,223	11,013	262	2,431
Administration fees	10	(1,730)	(8,354)	(1,667)	(235)	(11,986)
Other adminstration expenses	11	(556)	(2,685)	(537)	-	(3,778)
Broker fees		(250)	(550)	(59)	(26)	(885)
Net impairment losses	12	17	1	15	-	33
Net healthcare result		(12,586)	(10,365)	8,765	1	(14,185)
Other income		4,553	10,016	658	85	15,312
Investment income	13	1,596	5,149	658	85	7,488
Employer group reinsurance recoveries		2,957	4,836	-	-	7,793
Sundry income		-	31	-	-	31
Asset management fees		(132)	(420)	(54)	-	(605)
Net (deficit)/surplus for the year		(8,165)	(769)	9,369	86	522
Number of members at year-end		610	3,046	615	137	4,408

Refer to note 1.14 for basis of allocation of certain income and expenses to Plan options

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

2021	Notes	PLAN A R'000	PLAN B R'000	PLAN C R'000	PLAN D R'000	TOTAL R'000
Risk contribution income		69,491	198,770	25,540	3,271	297,072
Relevant healthcare expenditure		(76,341)	(184,003)	(18,064)	(2,901)	(281,310)
Net claims incurred	8	(75,380)	(179,762)	(17,229)	(2,981)	(275,352)
Risk claims incurred		(75,637)	(180,376)	(17,287)	(2,981)	(276,281)
Third party claim recoveries		257	613	59	-	929
Net income on risk transfer arrangements	9	-	-	-	80	80
Risk transfer arrangement fees paid		-	-	-	(2,901)	(2,901)
Recoveries from risk transfer arrangements		-	-	-	2,981	2,981
Managed care: management services	10	(961)	(4,241)	(836)	-	(6,038)
Gross healthcare result		(6,850)	14,766	7,475	371	15,762
Administration fees	10	(1,784)	(7,886)	(1,554)	(227)	(11,450)
Other adminstration expenses	11	(557)	(2,461)	(485)	-	(3,503)
Broker fees		(225)	(494)	(53)	(24)	(796)
Net impairment losses	12	21	(104)	19	-	(64)
Net healthcare result		(9,394)	3,821	5,402	121	(51)
Other income		5,943	14,381	1,408	181	21,912
Investment income	13	3,828	10,950	1,408	181	16,367
Employer group reinsurance recoveries		2,115	3,404	-	-	5,519
Sundry income		-	26	-	-	26
Asset management fees		(122)	(384)	(45)	-	(551)
Net (deficit)/surplus for the year		(3,573)	17,818	6,764	300	21,310
Number of members at year-end		669	3,000	599	139	4,407

Refer to note 1.14 for basis of allocation of certain income and expenses to Plan options

15. 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.

	2022 R'000	2021 R'000
Transactions with key management personnel		
Statement of comprehensive income transactions		
Principal officers' fees	724	678
Principal officer and trustees:		
- Risk contributions received	837	879
- Risk claims incurred	655	621
Trustee remuneration	97	96
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.

	2022 R'000	2021 R'000
Discovery Health Proprietary Limited		
Statement of comprehensive income transactions		
Administration fees	11,986	11,450
Managed care: management fees	6,287	6,000
Statement of financial position		
Balance due at year end	1,509	1,444

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.

15. RELATED PARTY TRANSACTIONS (continued)

Transactions with related parties (continued)	2022 R'000	2021 R'000
Discovery Third Party Recovery Services Proprietary Limited		
Statement of comprehensive income transactions		
Road Accident Fund recoveries	583	727

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	1,951	1,858
Statement of financial position		
Balance due at year end	161	152
National HealthCare Group Proprietary Limited		
Statement of comprehensive income transactions		
Risk transfer arrangement fees paid	3,169	2,901
Employer Groups		
Statement of comprehensive income transactions		
Reinsurance recoveries	7,793	5,519

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.

16. 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 (2021: R25 million) to the Scheme.

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

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

In the process of applying the Scheme's accounting policies, the trustees are required to make critical assumptions regarding the future and accounting judgements. In the current and prior year the most significant estimates were considered to be the determination of:

- The outstanding risk claims provision (Refer note 5 to the financial statements); and
- The provision for impairment losses (Refer note 3 to the financial statements).

In the opinion of the Board of Trustees, these estimates and assumptions are not likely to create a significant risk of a material adjustment to the carrying values of assets and liabilities during the next financial year.

18. 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.

18. 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.

Age grouping (in years)	Average claims per beneficiary per year					
	2022			2021		
	Unlimited risk*	Limited risk**	Total	Unlimited risk*	Limited risk**	Total
	R	R	R	R	R	R
< 25	7,344	7,609	14,953	5,913	6,668	12,580
25 - 34	10,070	11,698	21,768	8,900	11,424	20,323
35 - 49	14,003	13,290	27,293	13,054	13,090	26,145
50 - 64	27,104	16,085	43,189	25,844	16,010	41,854
> 65	48,858	19,019	67,877	42,541	18,115	60,656

* 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.

18. 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 (2021: 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 1% movement in either direction in the cost of risk claims incurred with all other variables held constant would have either a negative or positive effect of R2,97 million (2021: R2,73 million) on the Scheme's risk claims incurred and net surplus for the year. The unlimited risk claim portion of this total amounts to R1,66 million (2021: R1,48 million).

19. 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 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
As at 31 December 2021					
Investments at fair value through profit or loss	109,975	-	-	-	109,975
Cash and cash equivalents	62,338	-	-	-	62,338
	172,313	-	-	-	172,313

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

19. 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 available-for-sale investments and 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	
	2022 R'000	2021 R'000	2022 R'000	2021 R'000
Carrying amount	190	8	829	713
Past due but not impaired - carrying amount	-	-	56	32
30 - 60 days	-	-	22	23
61 - 90 days	-	-	33	7
91 days +	-	-	1	2
Collectively impaired - carrying amount	-	-	351	460
Neither past due not impaired	190	8	422	221
	190	8	829	713

Past due but not impaired

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.

19. FINANCIAL RISK MANAGEMENT REPORT (continued)

Financial risk factors (continued)

Collectively impaired/allowance for impairment
Trade and other receivables are recoverable but, in exceptional circumstances small amounts may be irrecoverable. These irrecoverable amounts are written off as bad debts.

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 43.14% (2021: 45.87%) at 31 December 2022.

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 2022	**Up to 1 month R'000**	**1 - 3 months R'000**	**4 - 12 months R'000**	**Total R'000**
Outstanding risk claims provision	4,300	2,171	-	6,471
Trade and other payables	25,626	-	-	25,626
	29,926	2,171	-	32,097

As at 31 December 2021				
Outstanding risk claims provision	3,563	2,187	-	5,750
Trade and other payables	20,772	-	-	20,772
	24,335	2,337	-	26,671

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.

19. 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 R5,694 million (2021: R5,499 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).

Investments at fair value through profit or loss	**2022 R'000**	**2021 R'000**
Unit linked listed instruments	113,872	109,975
	113,872	109,975

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

19. 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:

	Investments at fair value through profit or loss	Financial assets	Insurance receivables and (payables)	Financial liabilities at amortised cost	Total carrying amount	Fair value amount
As at 31 December 2022	**R'000**	**R'000**	**R'000**	**R'000**	**R'000**	**R'000**
Investments						
Held at fair value through profit or loss	113,872	-	-	-	113,872	113,872
Cash and cash equivalents	-	63,984	-	-	63,984	63,984
Trade and other receivables	-	449	738	-	1,187	1,187
Trade and other payables	-	-	(23,491)	(2,135)	(25,626)	(25,626)
	113,872	64,433	(22,753)	(2,135)	153,417	153,417
As at 31 December 2021						
Investments						
Held at fair value through profit or loss	109,975	-	-	-	109,975	109,975
Cash and cash equivalents		62,338			62,338	62,338
Trade and other receivables	-	229	404	-	633	633
Trade and other payables	-	-	(18,759)	(2,013)	(20,772)	(20,772)
	109,975	62,567	(18,355)	(2,013)	152,174	152,174

20. NON COMPLIANCE WITH MEDICAL SCHEME LEGISLATION FOR THE YEAR UNDER REVIEW

20.1 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.

20.2 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.

20. NON COMPLIANCE WITH MEDICAL SCHEME LEGISLATION FOR THE YEAR UNDER REVIEW (continued)

20.3 Sustainability of benefit options

Nature and impact
In terms of section 33(2) of the Act, each benefit option shall be self-supporting in terms of membership and financial performance. At 31 December 2022 two of the four benefit options incurred deficits as set out in note 14 to the annual financial statements.

Causes of failure
Plan A and Plan B were deliberately costed to incur a deficit as the increase in contributions necessary to achieve a surplus would have been too onerous for members on these plans 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.

In addition, the Scheme continually provides the Registrar with updates on both the Scheme and individual benefit option performance through the monthly management accounts and quarterly monitoring meetings.

20. NON COMPLIANCE WITH MEDICAL SCHEME LEGISLATION FOR THE YEAR UNDER REVIEW (continued)

20.4 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 submitted 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.

21. EVENTS AFTER THE REPORTING DATE

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

22. CONTINGENT ASSETS

The Scheme has approximately R3 626 371 (2021: R3 366 105) in recoveries outstanding from the Road Accident Fund (RAF) for claims paid on behalf of members. The general likelihood of recovery of these amounts is uncertain, and the Trustees have elected not to recognise a debtor on the statement of financial position as any future recoveries are contingent on a multitude of factors. The Trustees consider, based on past experience and the current financial stability of the RAF, that the debtor, were it to be recognised would be impaired by R3 626 371 (2021: R3 366 105).