ANGLOVAAL
GROUP MEDICAL SCHEME

NOTICE OF THE ANNUAL GENERAL MEETING

TO BE HELD ON 24 MAY 2023 AT 10H00 AT

THE OFFICES OF AVI LTD,

2 HARRIES ROAD, ILLOVO, SANDTON

ANGLOVAAL
GROUP MEDICAL SCHEME

NOTICE OF THE ANNUAL GENERAL MEETING OF THE ANGLOVAAL GROUP MEDICAL SCHEME

The 26th Annual General Meeting of the members of the Anglovaal Group Medical Scheme will take place at 10H00 on 24 May 2023 at the offices of AVI Ltd, 2 Harries Road, Illovo, Sandton.

A quorum for the meeting will be fifteen members of the Scheme, present in person.

Attached please find your copy of the Agenda, Annual Financial Statements (incorporating the Auditors' Report and the Trustees' Annual Report), and a Proxy Form. AVI reserves the right to refuse entry to any person or to ask any person to leave the premises.

Notice of any motions to be placed before the Annual General Meeting must reach the Principal Officer by no later than 12h00 on 17 May 2023. Such motions must be lodged with or posted to:

The Principal Officer c/o Alastair Rogers
Anglovaal Group Medical Scheme,
AGM Motions,
P O Box 652509, Benmore, 2010 or
1 Discovery Place, Sandton or
fax to (011) 539-1018 or
email to avgmsagm@discovery.co.za

Please note that you will be required to produce your membership card when registering for the AGM.

AGENDA

Annual General Meeting of the Anglovaal Group Medical Scheme to be held on 24 May 2023 at 10h00 at the offices of AVI Ltd, 2 Harries Road, Illovo, Sandton.

1. Welcome and additions to the Agenda
2. Apologies
3. Minutes of the previous meeting
4. Report of the Board of Trustees
5. Annual Financial Statements
6. Appointment of the auditors
7. Submitted motions
8. General
9. Close

MINUTES OF THE ANNUAL GENERAL MEETING OF THE MEMBERS OF THE ANGLOVAAL GROUP MEDICAL SCHEME HELD ON 27 MAY 2022 AT 10H00 AT THE OFFICES OF AVI LIMITED, 2 HARRIES ROAD, ILLOVO

PRESENT

M Koursaris	(Chairman, Trustee and member)
V Crystal	(Principal Officer and member)
I Masike	(Trustee and member)
G Bergman	(Trustee)
V Lazarus	(Trustee and member)
D Erskine	(Trustee and member)
A Mills	(Trustee and member)
W Germanus	(Member)
L Swartz	(Member)
J Cranke	(Member)
M Wright	(Member)
J O'Meara	(Member)
T Vadi	(Member)
C Coetzee	(Member)
P Pillay	(Member)
S Chibambo	(Member)
S Scheepers	(Member)
S Singh	(Member)

IN ATTENDANCE

A Rogers	(Discovery Health)
M Jacobs	(Discovery Health)
M Buckingham	(Discovery Health)
Thandiwe Baloyi-Motaung	(CMS)

APOLOGIES

None

1. WELCOME

Mr Koursaris introduced himself as the Chairman of the Board of Trustees and welcomed all present to the 25th Annual General Meeting.

Before commencement, all those present were made aware of the COVID-19 protocols applicable to the venue. These were displayed on the entrance doors to the boardroom as well as included in the meeting packs which were distributed prior to the meeting. Visitors were required to ensure face masks were worn at all times.

With proper notice having been given and a quorum of at least 15 members in

person being present, the meeting was declared properly constituted.

2. APOLOGIES

There were no apologies.

3. MINUTES OF THE PREVIOUS MEETING

The Chairman took the members through the minutes of the Annual General Meeting held on 26th of May 2021, and the minutes were approved without changes.

4. REPORT OF THE BOARD OF TRUSTEES

The Chairman took the members through the report of the Board of Trustees included in the Annual Financial Statements.

He reported that the Scheme's solvency ratio remained stable at 81.74%, against the legislated requirement of 25%.

The members were referred to pages 21 and 31 regarding the 2020 restatement of cash flows which was explained in note 4 on page 57. The statement of cash flows for 2021 was aligned to the format prescribed by the Council for Medical Schemes in Circular 52 of 2021. He also drew attention to pages 55, 56 and 57 of the report where the non-compliance matters were outlined and stated that, as advised in previous years, none of these issues were material to the continued operations of the Scheme or its sustainability and arose largely as a result of the highly regulated environment in which the Scheme operates.

The Chairman confirmed that the Trustees were satisfied with the results of the year-end audit. The report of the Board of Trustees, included in the Annual Financial Statements for the period ending 31 December 2021, was approved.

5. ANNUAL FINANICAL STATEMENTS

The Chairman referred to the Annual Financial Statements for the period under review and advised that the Scheme's financial administrator was present to answer questions from the floor. Copies of the audited Annual Financial Statements were also made available at the meeting.

The Annual Financial Statements for the period ending 31 December 2021 were approved.

6. APPOINTMENT OF TRUSTEES

In terms of the rules of the Scheme, trustees are appointed at annual general meetings to serve terms of office for two years and the retiring trustees are eligible for re-election. Mr. B Jales, Ms. V Lazarus, Ms. H de Groot and Mr. G Bergman were re-appointed by the company for a further two-year term. At the beginning of April

2022, the company called for nominations for member elected trustees and no new nominations were received. The current member elected trustees made themselves available for re-election and therefore, in the absence of any new nominations, Mr. M Koursaris, Mr. I Masike, Mr. A Mills and Mr. D Erskine were re-elected as member elected trustees for a further two-year term.

7. APPOINTMENT OF THE AUDITORS

The recommendation from the Board of Trustees to reappoint PwC as the Scheme's external auditor was approved. The Chairman thanked PwC for their services over the past year.

8. SUBMITTED MOTIONS

No motions were submitted.

9. GENERAL

9.1 Complaints or disputes

The Chairman advised that in accordance with the requirements of the Council for Medical Schemes, the Scheme was obliged to inform members that any member complaints or disputes may be lodged with the Scheme in writing. Should the complaint not be resolved to the member's satisfaction, the Principal Officer would appoint a Disputes Committee and convene a meeting of this Committee to hear and resolve the complaint. The Disputes Committee would consist of three Scheme members, who were not Board members, employees of Discovery Health, or officers of the Scheme. One of the three members would be a person with legal expertise. Members had the right to appeal the decisions of the Disputes Committee to the Council for Medical Schemes.

10. CLOSING

In conclusion the Chairman thanked everyone present for their attendance and time. He also extended thanks to the Board of Trustees, the Principal Officer, the members of the Audit and Investment Committee, the administrator (Discovery Health), as well as the independent service providers, Insight Actuaries and Consultants, for their services during this period.

There being no further matters to discuss, the meeting was closed.

Minutes accepted

_____ _____

M. Koursaris DATE

CHAIRMAN

ANGLOVAAL GROUP MEDICAL SCHEME

FINANCIAL STATEMENTS

FOR THE YEAR ENDED

31 DECEMBER 2022

ANGLOVAAL GROUP MEDICAL SCHEME
(Registration no. 1571)

FINANCIAL STATEMENTS
for the year ended 31 December 2022

TRUSTEES	Mr M Koursaris Mr I Masike Ms H de Groot Mr B Jales Mr O Bergman Ms V Lazarus Mr A Mills Mr D Erskine
PRINCIPAL OFFICER	Ms V Crystal
AUDITOR	PricewaterhouseCoopers Inc.
ADMINISTRATOR	Discovery Health (Pty) Ltd 1 Discovery Place Sandton 2146
REGISTERED OFFICE	2 Harries Road Illovo 2196

CONTENTS **Pages**

ANGLOVAAL GROUP MEDICAL SCHEME
(Registration no. 1571)

FINANCIAL STATEMENTS
for the year ended 31 December 2022

TRUSTEES' RESPONSIBILITY AND APPROVAL

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

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

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

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

Approval of the financial statements

The financial statements of Anglovaal Group Medical Scheme, as identified in the first paragraph, were approved by the Trustees on 26 April 2023 and are signed on their behalf by:

CHAIRMAN | TRUSTEE | PRINCIPAL OFFICER

ANGLOVAAL GROUP MEDICAL SCHEME
(Registration no. 1571)

FINANCIAL STATEMENTS
for the year ended 31 December 2022

STATEMENT OF CORPORATE GOVERNANCE BY THE BOARD OF TRUSTEES

The Anglovaal Group Medical Scheme is committed to the principles and practice of fairness, openness, integrity and accountability in all dealings with its stakeholders. The Trustees are either appointed by the respective employers or elected by the members of the Scheme. The Scheme adopts good corporate governance practices in all aspects.

THE BOARD OF TRUSTEES

The Trustees meet regularly and monitor the performance of the Administrator and other service providers. They address a range of key issues and ensure that discussion of items of policy, strategy and performance is critical, informed and constructive.

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

INTERNAL CONTROL

The Administrator of the Scheme maintains 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 Trustees that indicates any material breakdown in the functioning of the key internal controls and systems during the year under review.

CHAIRMAN | TRUSTEE | PRINCIPAL OFFICER

26 April 2023

Independent Auditor's Report

To the Members of Anglovaal Group Medical Scheme

Report on the financial statements

Opinion

We have audited the financial statements of *Anglovaal Group Medical Scheme* (the Scheme), set out on pages 10 to 50, which comprise *the statement of financial position* as at 31 December 2022, and *the statement of comprehensive income*, *the statement of changes in members' funds and the statement of cash flows* for the *year* then ended, and notes to the financial statements, including a summary of significant accounting policies.

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

Basis for Opinion

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

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

Independence

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

Key Audit Matters

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

Key audit matter	How our audit addressed the key audit matter
Outstanding claims provision The *outstanding claims provision* of R7,916,139 at *year*-end as described in Note 5 to the financial statements, is a provision recognised for the estimated cost of healthcare benefits that have been incurred prior to *year*-end but that were only reported to the Scheme after *year*-end. The outstanding claims provision is calculated by the Scheme's *actuaries* which is reviewed by management and the Audit Committee and recommended to the Board of Trustees for approval. The Scheme's *actuaries* use *an actuarial* model, based on the Scheme's actual claim development patterns throughout the *year*, to project the *year* end provision. This model applies the *Basic Chain Ladder ("BCL").* The claim service date, processing date and amount are used to derive claim development patterns. These historical patterns are then used to estimate the outstanding claims provision. We identified this to be a matter of most significance to the audit because of the uncertainty in the projected claims pattern. A change in the projected claims pattern could cause a material change to the amount of the provision.	We obtained an understanding from the Scheme's *actuaries* regarding the process followed in calculating the outstanding claims provision, which included the design and implementation of controls within the process. The *actuarial* method applied by the Scheme is one that is generally applied within the medical scheme industry. We obtained the actual claims data from the member administration system covering the *year* ended 31 December 2022. The actual claims data reflects the most recent claims patterns, including the impact of COVID-19, and is taken into account in calculating the outstanding claims provision. We assessed the completeness of the claims data on the member administration system by understanding management's controls and selecting claim transactions from the claim source and agreeing these to the member administration system. No material inconsistencies were noted. We substantively tested a sample of claims received by the Scheme in the 31 December 2022 financial *year*, selected from the member administration system, and confirmed the accuracy of the service and process dates and the validity of the claim against the relevant Scheme rules. No material inconsistencies were noted. We assessed the completeness of the claims data in the Scheme's actuarial model by understanding management's controls and testing the reconciliation between the claims data per the member administration system and the claims data per the actuarial model. No material inconsistencies were noted. To assess the reasonableness of the Scheme *actuaries'* estimation process, we compared the actual claim results in the current *year* to the prior *year* provision. We noted no matters for further consideration with respect to the estimation process.

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

Other Information

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

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

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

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

Responsibilities of the Scheme's Trustees for the Financial Statements

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

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

Auditor's Responsibilities for the Audit of the Financial Statements

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

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

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

- Evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by the Scheme's trustees.
- Conclude on the appropriateness of the Scheme's trustees' use of the going concern basis of accounting and based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the Scheme's ability to continue as a going concern. If we conclude that a material uncertainty exists, we are required to draw attention in our auditor's report to the related disclosures in the financial statements or, if such disclosures are inadequate, to modify our opinion. Our conclusions are based on the audit evidence obtained up to the date of our auditor's report. However, future events or conditions may cause the Scheme to cease to continue as a going concern.
- Evaluate the overall presentation, structure and content of the financial statements, including the disclosures, and whether the financial statements represent the underlying transactions and events in a manner that achieves fair presentation.

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

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

Report on Other Legal and Regulatory Requirements

Non-compliance with the Medical Schemes Act of South Africa

As required by the Council for Medical Schemes, we report the following 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:

- **Non-compliance with Section 33(2) – Option self sufficiency**
  The benefit option is not self-supporting in terms of financial performance.

Audit Tenure

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

The engagement partner, Lumko Sihiya, has been responsible for Anglovaal Group Medical Scheme's audit for *three* years.

PricewaterhouseCoopers Inc.

PricewaterhouseCoopers Inc.
Director: Lumko Sihiya
Registered Auditor
Johannesburg, South-Africa
2 May 2023

ANGLOVAAL GROUP MEDICAL SCHEME
(Registration no. 1571)

STATEMENT OF FINANCIAL POSITION

at 31 December 2022

	Notes	2022 R	2021 R
ASSETS			
Non-current assets		**176,326,519**	**182,748,119**
Financial assets at fair value through profit or loss	2	176,326,519	182,748,119
Current assets		**28,436,969**	**20,477,983**
Trade and other receivables	3	2,141,863	1,298,861
Cash and cash equivalents	4	26,295,106	19,179,122
Total assets		**204,763,488**	**203,226,102**
FUNDS AND LIABILITIES			
Members' funds		**171,387,625**	**173,009,463**
Accumulated funds		171,387,625	173,009,463
Current liabilities		**33,375,863**	**30,216,639**
Outstanding risk claims provision	5	7,916,139	4,100,000
Personal medical savings account liability	6	21,775,232	23,031,819
Trade and other payables	7	3,684,492	3,084,820
Total funds and liabilities		**204,763,488**	**203,226,102**

ANGLOVAAL GROUP MEDICAL SCHEME
(Registration no. 1571)

STATEMENT OF COMPREHENSIVE INCOME
for the year ended 31 December 2022

	Notes	2022 R	2021 R
Risk contribution income	8	**116,605,181**	**118,605,718**
Relevant healthcare expenditure		**(123,325,481)**	**(113,506,990)**
Risk claims incurred	9	(121,696,432)	(111,698,381)
Claims recoveries from third parties		608,826	483,772
Managed care: management services	11	(2,237,725)	(2,235,246)
Net expense on risk transfer arrangements		(150)	(57,135)
Risk transfer arrangement fees	10	(1,569,733)	(1,747,707)
Recoveries from risk transfer arrangements	10	1,569,583	1,690,572
Gross healthcare results		**(6,720,300)**	**5,098,728**
Administration expenditure	12	(8,155,519)	(8,146,445)
Other operating expenses	13	(1,238,699)	(1,092,155)
Impairment (gains) / reversal on healthcare receivables	14	(165,362)	98,444
Net healthcare results		**(16,279,880)**	**(4,041,428)**
Other income		**16,274,001**	**34,459,875**
Investment income	15	16,274,001	34,459,875
Other expenditure		**(1,615,959)**	**(1,353,685)**
Expenses for asset management services rendered		(1,881,364)	(1,128,129)
Sundry income / (expense)	16	265,405	(225,556)
Total comprehensive (loss) / income for the year		**(1,621,838)**	**29,064,762**

ANGLOVAAL GROUP MEDICAL SCHEME
(Registration no. 1571)

STATEMENT OF CHANGES IN FUNDS AND RESERVES
for the year ended 31 December 2022

	Members' funds
	R
Balance as at 31 December 2020	**143,944,701**
Total comprehensive income for the year	29,064,762
Balance at 31 December 2021	**173,009,463**
Total comprehensive loss for the year	(1,621,838)
Balance as at 31 December 2022	**171,387,625**

ANGLOVAAL GROUP MEDICAL SCHEME
(Registration no. 1571)

STATEMENT OF CASH FLOWS
for the year ended 31 December 2022

	Notes	2022	2021
		R	R
Cash flows from operating activities			
Cash receipts from members and providers		146,276,330	148,404,998
Cash receipts from members – gross contributions		145,951,812	147,525,041
Cash receipts from members and providers – other		324,518	879,957
Cash paid to providers, employees and members		(159,878,954)	(154,181,309)
Cash paid to providers and members – claims		(149,077,279)	(142,948,017)
Cash paid to providers – non-healthcare expenditure		(9,018,935)	(9,469,881)
Cash paid to members – savings plan refunds		(1,782,740)	(1,763,411)
Net cash (used in) / from operating activities		(13,602,624)	(5,776,311)
Cash generated from operations			
Interest received		718,608	703,091
Net cash (used in) / from operations		(12,884,014)	(5,073,220)
Cash flows from investing activities			
Proceeds on disposal of investments		20,000,000	-
Net cash from/(used in) investing activities		20,000,000	-
Cash and cash equivalents at beginning of period			
- As previously reported		19,179,122	24,252,342
Cash and cash equivalents at end of year		**26,295,106**	**19,179,122**

NOTES TO THE FINANCIAL STATEMENTS
for the year ended 31 December 2022

1 PRINCIPAL ACCOUNTING POLICIES

The principal accounting policies applied in the preparation of these financial statements are set out below, and are consistent with prior year unless otherwise stated, except for the adoption of new accounting standards as explained in note 1.2.

1.1 Basis of preparation

The financial statements have been prepared in accordance with International Financial Reporting Standards (IFRS) and the Medical Schemes Act of South Africa (the Act)

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

- Financial instruments at fair value through profit or loss.

The preparation of financial statements in conformity with IFRS requires the use of certain critical accounting estimates. It also requires management to exercise its judgement in the process of applying the accounting policies. The notes to the 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 (note 21).

These financial statements are presented in Rand, which is the Scheme's functional currency.

1.2 Implementation of new standards

Title	Effective date - financial year commencing on
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. This standard has no material impact in the Scheme.	01 January 2024

NOTES TO THE FINANCIAL STATEMENTS
for the year ended 31 December 2022

1 PRINCIPAL ACCOUNTING POLICIES (continued)

1.2 Implementation of new standards (continued)

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

Title	Effective date - financial year commencing on
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. Certain of these contracts contain a Personal Medical Savings Account which were previously accounted for as financial instruments. Under IFRS 17 these will be accounted for as part of the insurance contracts. **Level of aggregation** - Insurance contracts are aggregated into groups, or portfolios, of individual contracts when being measured and assessed as onerous on not. The level of aggregation has an impact on accounting for the insurance contracts, including the extent of offsetting and cross subsidisation to determine the appropriate level of aggregation in order to ultimately identify onerous contracts. A portfolio of insurance contracts comprises contracts subject to similar risks that are managed together. Once the portfolio of insurance contracts has been established, it becomes the unit of account to which the requirements of IFRS 17 are applied. All member contracts issued by the Scheme are subject to similar risks and are managed together, and therefore fall into the same portfolio, with no further disaggregation required. **Contract boundary** - The contracts issued by the Scheme are in line with its financial year and therefore no contracts will be issued for a financial year after the end of that specific financial year. In addition, as no contract will exceed 12 months, no discounting will be applied.Insurance contracts issued shall be recognized from the earliest of the following:(a) The beginning of the coverage period;(b) The date when the first payment from a policyholder becomes due; and(c) For onerous contracts, when the contracts become onerous.With the insurance contracts being included in a single portfolio, and the coverage period aligning with the reporting period (financial year), the insurance contracts will be recognised from 1 January or from inception of cover should the member join the Scheme after 1 January. An exception to this would be where the Scheme as a whole is priced for a deficit position. This would mean that all contracts would be onerous and the loss would need to be recognised when the contracts become onerous. As pricing for the Scheme is done in September for the following year, the onerous contract test would be assessed at this time, with the following year's loss being recognised in the current financial year.	01 January 2023

1 PRINCIPAL ACCOUNTING POLICIES (continued)

1.2 Implementation of new standards (continued)

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

Title	Effective date - financial year commencing on
Measurement - The Standard further provides for a simplified approach, the "premium allocation approach", for the measurement of a group of insurance contracts under certain conditions. One of those conditions is that at the inception of the group of contracts, the entity reasonably expects that the simplification will produce measurement of the liability for remaining coverage that would not differ materially from that produced using the 'general measurement' model. Another condition is that the coverage period is one year or less. The Scheme has opted for the simplified "premium allocation approach". **Risk adjustment -** The Standard requires an adjustment for non-financial risk. The Scheme shall adjust the estimate of the present value of the future cash flows in order to provide for the possible financial implications of the Scheme bearing the uncertainty of the amount and timing of cash flows that may arise from non-financial risk. The objective of the risk adjustment provision for non-financial risk is to reflect the Scheme's perception of the possible economic burden which may be the result of non-financial risks.IFRS 17 requires that the Standard is implemented retrospectively. This requires the identification, recognition and measurement of each group of insurance contracts as if the standard had always been applied. This also results in the derecognition of current balances that would not exist under IFRS 17, and the recognition of the resulting difference in Members' funds. **Financial impact - Onerous contracts -** With the requirement to implement the Standard retrospectively, the opening balances of 2021 and 2022 will be impacted by the budgeted deficits (onerous contracts) for the respective years. The 2021 budgeted deficit unwinds in 2021 with the 2022 budgeted deficit unwinding in 2022. The original budgets, with IFRS17 adjustments, will be the starting point in calculating the onerous contract loss. **Financial Impact 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.	01 January 2023

The Scheme has not yet applied the above and will adopt these standards on its effective date. The impact of the adoption in future financial reporting periods is being assessed.

NOTES TO THE FINANCIAL STATEMENTS
for the year ended 31 December 2022

1 PRINCIPAL ACCOUNTING POLICIES (continued)

1.3 Financial instruments

Financial instruments are recognised when and only when, the Scheme becomes a party to the contractual provisions of the particular instrument.

The Scheme de-recognises a financial asset when and only when:
- The contractual rights to the cash flows arising from the financial asset have expired or been forfeited by the Scheme; or
- It transfers the financial asset including substantially all the risk and rewards of ownership of the asset; or
- It transfers the financial asset, neither retaining nor transferring substantially all the risks and rewards of ownership of the asset, but no longer retains control of the asset.

A financial liability is de-recognised when and only when the liability is extinguished, that is, when the obligation specified in the contract is discharged, cancelled or has expired.

All purchases and sales of financial assets that require delivery within the time frame established by regulation or market convention ("regular way" purchases and sales) are recognised at trade date.

Measurement
Financial instruments are initially measured at fair value plus, in the case of a financial asset or financial liability not measured at fair value through profit or loss, transaction costs that are directly attributable to acquisition or issue of the financial asset or liability. Subsequent to initial recognition, these instruments are measured as set out below.

1 PRINCIPAL ACCOUNTING POLICIES (continued)

1.3 Financial instruments

Business model assessment

The Scheme makes an assessment of the objective of a business model in which an asset is held at a portfolio level because this best reflects the way the business is managed and information is provided to management. The information considered includes:

- the stated policies and objectives for the portfolio and the operation of those policies in practice. In particular, whether management focuses on earning contractual interest revenue, maintaining a particular interest rate profile, matching the duration of the financial assets to the duration of the liabilities that are funding those assets or realising cash flows through the sale of the assets;
- how the performance of the portfolio is evaluated and reported to the Scheme's management;
- the risks that affect the performance of the business model (and the financial assets held within that business model) and its strategy for how those risks are managed;
- how managers of the business are compensated (e.g. whether compensation is based on the fair value of the assets managed or the contractual cash flows collected; and
- the frequency, volume and timing of sales in prior periods, the reasons for such sales and its expectations about future sales activity. However, information about sales activity is not consideration in isolation, but as part of an overall assessment of how the Scheme's stated objective for managing the financial assets is achieved and how cash flows are realised.

Financial assets that are held for trading or managed and whose performance is evaluated on a fair value basis are measured at fair value through profit or loss because they are neither held to collect contractual cash flows nor held both to collect contractual cash flows and to sell financial assets.

Assessment whether contractual cash flows are solely payments of principal and interest (SPPI)

For the purposes of this assessment, "principal" is defined as the fair value of the financial asset on initial recognition. "Interest" is defined as consideration for the time value of money and for the credit risk associated with the principal amount outstanding during a particular period of time and for other basic lending risks and costs (e.g. liquidity risk and administrative costs), as well as profit margin.

In assessing whether the contractual cash flows are SPPI, the Scheme considers the contractual terms of the instrument. This includes assessing whether the financial asset contains a contractual term that could change the timing or amount of contractual cash flows such that it would not meet this condition. In making the assessment, the Scheme considers:

- contingent events that would change the amount and timing of the cash flows;
- leverage features;
- prepayment and extension terms;
- features that modify consideration of the time value of money (e.g. periodical reset of interest rates).

The business model applied by the Scheme for its investments is achieved through combination of collection of contractual cash flows, selling of financial assets and realisation of gains through sale of financial assets.

Financial assets through profit or loss

Subsequent to initial recognition, financial assets are carried at fair value through profit or loss. Gains or losses arising from changes in the fair value of the financial assets are recognised in other income through profit or loss.

1 PRINCIPAL ACCOUNTING POLICIES (continued)

1.4 Trade and other receivables

Trade and other receivables are non-derivative financial assets with fixed or determinable payments that are not quoted in an active market. They are included in current assets, except for maturities greater than 12 months after the reporting date. These are classified as non-current assets.

Trade and other receivables comprise insurance receivables, arising from the Scheme's insurance contracts with its members and loans and receivables.

Subsequent to initial recognition, trade and other receivables are carried at amortised cost using the effective interest method, less accumulated impairment losses.

Impairment of insurance receivables

The Scheme assesses at each reporting date whether there is objective evidence that an insurance receivable is impaired. An insurance receivable, or group of insurance receivables 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 insurance receivable (a "loss event") and that loss event (or events) has an adverse impact on the estimated future cash flows of the insurance receivable that can be reliably estimated.

Objective evidence that an insurance receivable or group of insurance receivables is impaired includes observable data that comes to the attention of the Scheme regarding the following loss events:

- Significant financial difficulty of service provider or member debtors.
- Breach of contract, such as non-payment of member contributions when due, and if these remain unpaid for extended periods.
- Default or delinquency in payments due by service providers and other debtors.
- Adverse changes in the payment status of members of the Scheme.
- National or local economic conditions that correlate with non-payment of debtor contributions.

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

If there is objective evidence that an impairment loss on an insurance receivable has been incurred, the amount of the loss is measured as the difference between the carrying amount and the present value of estimated future cash flows. The carrying amount of the receivable is reduced and the amount of the loss is recognised in the Statement of Comprehensive Income.

When a receivable is uncollectable, it is written off against the related provision for impairment. Such receivables are written off after all the necessary collection procedures have been completed and the amount of the loss has been determined. Where a provision for impairment has not been raised, the receivable is written off directly to the Statement of Comprehensive Income. Subsequent recoveries of amounts previously written off decrease the amount of the provision for impairment in the Statement of Comprehensive Income.

1 PRINCIPAL ACCOUNTING POLICIES (continued)

1.4 Trade and other receivables (continued)

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 the Statement of Comprehensive Income.

Impairment of loans and receivables

The Scheme applied the IFRS 9 simplified approach to measure expected credit losses which uses a lifetime expected loss allowance for loans and receivables. To measure the expected credit losses, loans and receivables are grouped based on shared credit risk characteristics and days past due.

1.5 Cash and cash equivalents

In the statement of cash flows, cash and cash equivalents comprise:

- Money market instruments; and
- Balances with banks.

Cash and cash equivalents include items held for the purpose of meeting short-term cash commitments and money market instruments. Cash and cash equivalents have a maturity of less than three months and an insignificant risk of changes in fair value. Subsequently, cash and cash equivalents are measured at amortised cost which approximates fair value.

1.6 Financial liabilities

A financial liability is any liability that is a contractual obligation to deliver cash or another financial asset to another entity. Financial liabilities include trade payables. The Scheme is not permitted to borrow in terms of Section 35(6)(c) of the Medical Schemes Act of South Africa. The Scheme therefore has no long-term financial liabilities.

Trade and other payables

Trade and other payables are measured initially at fair value plus directly attributable transaction costs and subsequently measured at amortised cost using the effective interest method.

Insurance payables

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

Members' medical savings accounts: monies managed by the Scheme

The members’ medical savings account, which constitutes a portion of the members’ monthly contributions allocated for the exclusive benefit of a member and his/her dependants, represents savings contributions (which are a deposit component of the insurance contracts) and accrued interest thereon, net of any savings claims paid on behalf of members in terms of the Scheme’s registered rules.

1 PRINCIPAL ACCOUNTING POLICIES (continued)

1.6 Financial liabilities (continued)

The deposit component of the insurance contracts has been unbundled, since the Scheme can measure the deposit component separately. The insurance component is recognised as an insurance liability.

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

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

1.7 Outstanding risk claims provision

Risk claims outstanding comprise provisions for the Scheme's estimate of the ultimate cost of settling all risk claims incurred but not yet reported (IBNR) at the reporting date. Risk claims outstanding 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 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.

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

Estimated co-payments and payments from medical savings accounts (MSA) are deducted in calculating the outstanding risk claims provision.

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

1.8 Personal Medical Savings Account

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

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

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

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

No interest accrues to members on positive PMSA balances.

1 PRINCIPAL ACCOUNTING POLICIES (continued)

1.9 Member insurance contracts

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

The contracts issued compensate the Scheme's members for healthcare expenses incurred and are detailed in note 19.

1.10 Risk contribution income

Gross contributions comprise of risk contributions and medical personal savings account (MSA) contributions.

Risk contributions on member insurance contracts are accounted for monthly when their collection in terms of the insurance contract is reasonably assured. Risk contributions represent gross contributions after the deduction of Personal Medical Savings Account contributions. Risk contributions are earned from the date of attachment of risk, over the indemnity period on a straight-line basis. The earned portion of risk contributions received is recognised as revenue.

1.11 Relevant healthcare expenditure

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

1.11.1 Risk claims incurred

Gross risk 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 the year.

Risk claims incurred (net of claims from members' medical savings accounts, recoveries from members for co-payments, recoveries from third parties (e.g. Road Accident Fund and fraud recoveries) and discounts received from service providers) comprise:

- Claims submitted and accrued for services rendered during the year;
- Payments under provider contracts (managed care) for services rendered to members;
- Over or under provisions relating to prior year claims;
- Claims incurred but not yet reported; and
- Claims settled in terms of risk transfer arrangements net of claims from members' Personal Medical Savings Accounts, recoveries from members for co-payments, recoveries from third parties and discount received from service providers.

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

1 PRINCIPAL ACCOUNTING POLICIES (continued)

1.11.2 Risk transfer arrangements

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

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

Risk transfer claims and benefits reimbursed are presented in profit or loss and in the statement of financial position on a gross basis. Only contracts that give rise to a significant transfer of insurance risk are accounted for as an insurance contract (reinsurance contract). Amounts recoverable under such contracts are recognised in the same year as the related claim. Anticipated recoveries under risk transfer arrangements are disclosed separately as assets and are assessed in a manner similar to the assessment of the outstanding claims provision and claims reported not yet paid.

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

Amounts recoverable under risk transfer arrangements are assessed for impairment at each reporting date. These assets are deemed impaired if there is objective evidence, as a result of an event that occurred after its initial recognition, that the Scheme may not recover all amounts due. The Scheme gathers the objective evidence that a risk transfer arrangement asset is impaired using the same process adopted for financial assets held at amortised cost. These processes are described in note 1.4.

1.11.3 Managed care: management services fees

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

1.12 Liability adequacy test

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

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

NOTES TO THE FINANCIAL STATEMENTS
for the year ended 31 December 2022

1 PRINCIPAL ACCOUNTING POLICIES (continued)

1.13 Investment income

Investment income comprises dividends, interest income and fair value gains or losses on investments.

Interest income is recognised using the effective interest method.

Dividend income from investments is recognised when the right to receive payment is established.

1.14 Unallocated funds

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

Unallocated funds older than three years have legally prescribed and are included under other income in profit or loss.

1.15 Income tax

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

	2022 R	2021 R
2. FINANCIAL ASSETS AT FAIR VALUE THROUGH PROFIT OR LOSS		
Fair value at the beginning of the year	182,748,119	150,139,469
Disposals	(20,000,000)	-
Fair value adjustment on financial assets at fair value through profit or loss	9,149,264	33,484,161
Realised gain on disposal of financial assets at fair value through profit or loss	6,310,500	252,618
Asset management service fees	(1,881,364)	(1,128,129)
Fair value at the end of the year	176,326,519	182,748,119
Non-current	176,326,519	182,748,119
	176,326,519	**182,748,119**
The investments included above represent investments in:		
Linked insurance policies	176,326,519	182,748,119
	176,326,519	**182,748,119**

The Scheme's investment strategy is achieved through the combination of instruments held to collect contractual cash flows, selling of assets and a documented strategy for realisation of cash flows through the sale of assets.

The performance of the various portfolios is assessed based on the marked to market valuation (fair values) and the asset managers are remunerated based on the market value of their assets under management.

Investments held 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 reporting date or unless they will need to be realised to raise operating capital.

3. TRADE AND OTHER RECEIVABLES		
Insurance receivables		
Contributions receivable	400,132	746,539
Amounts recoverable from members and suppliers	1,385,657	292,643
Amounts due	2,344,915	1,107,134
Impairment losses	(959,258)	(814,491)
Forensic receivable	51,963	40,513
Total insurance receivables	**1,837,752**	**1,079,695**
Loans and other receivables		
Interest receivable	155,135	59,506
Sundry accounts receivable	148,976	159,660
Total loans and other receivables	**304,111**	**219,166**
Total trade and other receivables	**2,141,863**	**1,298,861**

At 31 December 2022 the carrying amounts of trade and other receivables approximate their fair values due to the short-term maturities of these assets.

		2022 R	2021 R
4.	**CASH AND CASH EQUIVALENTS**		
	CURRENT AND MONEY MARKET ACCOUNTS		
	Current accounts	1,933,506	1,831,798
	Money market instruments	24,361,600	17,347,324
		26,295,106	**19,179,122**

The weighted average interest rate on cash and cash equivalents was 4.99% (2021: 3.84%).

5.	**OUTSTANDING RISK CLAIMS PROVISION**		
	Outstanding risk claims provision - not covered by risk transfer arrangements	7,916,139	4,100,000
	Analysis of movement in outstanding risk claims		
	Balance at beginning of year	4,100,000	4,900,000
	Payments in respect of prior year	(3,812,612)	(4,790,780)
	Over provision in respect of prior year	287,388	109,220
	Adjustment for current year	7,628,751	3,990,780
	Balance at end of year	**7,916,139**	**4,100,000**
	Analysis of outstanding risk claims provision		
	Estimated gross claims	18,693,165	4,321,060
	Estimated recoveries from savings plan accounts (note 6)	(10,777,026)	(221,060)
	Balance at end of year	**7,916,139**	**4,100,000**

The Scheme's rules provide that risk claims must be submitted to the Scheme not later than the last day of the fourth month following the month in which the service was rendered.

5. OUTSTANDING RISK CLAIMS PROVISION (continued)

The outstanding risk claims provision is an estimate of the proportion of the risk claims liability incurred in the current financial year that is expected to be reported and paid only after the reporting date.

The risk claims incurred by service date estimates are based on the Scheme's actual demographic structure and risk claims. Due to differences in claiming patterns, risk claims are grouped into in-hospital, chronic and out-of-hospital claim categories, and the claims incurred are assessed separately for each category. Results from the assessment are regularly reconciled with actual paid claims and adjustments made where necessary to ensure that these results remain accurate.

The outstanding risk claims provision is determined by the Scheme's appointed actuary in consultation with the Administrator.

Process used to determine the assumptions

The process used to determine the assumptions is intended to result in neutral estimates of the most likely or expected outcomes. The sources of data used as inputs for the assumptions are internal, using detailed studies that are carried out annually. There is more emphasis on current trends, and where in early years there is insufficient information to make a reliable best estimate of claims development, prudent assumptions are used.

This process is done on a monthly basis and regularly reconciled with the actual experience.

Assumptions

The assumptions that have the greatest effect on the measurement of the outstanding risk claims provision are the expected claims ratios for the most recent benefit years for the in-hospital, chronic and out-of-hospital categories of claims. These are used for assessing the outstanding claims provisions for the 2022 and 2021 benefit years.

The assumptions used in estimating the risk claims incurred for the Scheme are as follows:

Membership

The actual demographics of the Scheme were used, incorporating all membership movements for the period January to December. Membership is analysed on a beneficiary level, age, gender, area, type of dependant and chronic status of a dependant.

Utilisation

The Scheme's actual risk claims experience is used by the Scheme's actuary to project the risk claims incurred during the last part of 2022.

The provision for outstanding risk claims is calculated as the difference between the estimate of risk claims incurred in 2022 and actual claims paid in 2023 for services in 2022.

Reasonability checks

This estimation was tested against estimations produced by the following calculations:
- Actual risk claims paid in 2023 for 2022; and
- Traditional "chain ladder" methods, using risk claims development patterns derived from 2021 and 2022, as well as an analysis of the development patterns of December 2022 in isolation.

	2022 R	2021 R
6. PERSONAL MEDICAL SAVINGS ACCOUNT LIABILITY		
Balance on savings account liability at the beginning of the year	23,031,819	23,075,508
Add:		
- Savings account contributions (note 8)	29,000,228	29,418,197
- Transfers	203,943	381,302
	52,235,990	52,875,007
Less:		
- Claims paid to or on behalf of members (note 9)	(28,678,018)	(28,079,776)
- Refunds on death or resignation	(1,782,740)	(1,763,411)
Balance on savings account liability at the end of the year	**21,775,232**	**23,031,819**

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

It is estimated that claims to be paid out of medical savings accounts in respect of claims incurred in 2022 but not reported amount to R189 269 (2021: R221 060) (note 5).

The carrying amount of the medical savings accounts approximates their fair values, since it is payable on demand. The amounts were not discounted due to the demand feature.

7. TRADE AND OTHER PAYABLES		
Insurance liabilities		
Contribution received in advance	23,952	-
Reported claims not yet paid	2,146,354	1,945,915
Amounts due to members	700,612	749,505
Amounts due to suppliers	1,445,742	1,196,410
Total liabilities arising from insurance contracts	2,170,306	1,945,915
Other liabilities		
Amounts owing to Administrator (note 19)	865,263	853,463
Unallocated receipts	206,471	83,401
Accruals	442,452	202,038
Total	1,514,186	1,138,902
Total trade and other payables	**3,684,492**	**3,084,820**

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

NOTES TO THE FINANCIAL STATEMENTS
for the year ended 31 December 2022

	2022 R	2021 R
8. RISK CONTRIBUTION INCOME		
Gross contributions per registered rules	145,605,409	148,023,915
Less: Savings contributions received*	(29,000,228)	(29,418,197)
Net contribution income	116,605,181	118,605,718

* The savings contributions are received by the Scheme in terms of Regulation 10(1) and the Scheme's registered rules. Refer to note 6 to the financial statements for more detail on how these monies were utilised.

9. RISK CLAIMS INCURRED		
Current year claims	146,558,311	140,578,157
Claims not covered by risk transfer arrangements	144,988,728	138,887,585
Claims covered by risk transfer arrangements	1,569,583	1,690,572
Movement in outstanding claims provision	3,816,139	(800,000)
Over provision in prior year (note 5)	(287,388)	(109,220)
Adjustment for current year	4,103,527	(690,780)
	150,374,450	139,778,157
Less: Claims paid from members' savings accounts *	(28,678,018)	(28,079,776)
Risk claims incurred	121,696,432	111,698,381

* Claims are paid from members' personal medical savings accounts in terms of Regulation 10(3) and the Scheme's registered benefits. Refer to note 6 to the financial statements for a breakdown of the movement in these balances.

10. NET EXPENSE ON RISK TRANSFER ARRANGEMENTS		
The Scheme had the following risk transfer arrangement transactions during the year:		
Risk transfer arrangement fees	(1,569,733)	(1,747,707)
Recoveries from risk transfer arrangements	1,569,583	1,690,572
	(150)	(57,135)

During 2022 the Scheme had one risk transfer arrangement in place. The methodology used to determine the claims covered by this arrangement is set out below.

10. NET EXPENSE ON RISK TRANSFER ARRANGEMENTS (continued)

Centre for Diabetics and Endocrinology (CDE)

CDE covers treatment for members diagnosed with diabetes. As no underlying fee-for-service data is available from CDE, the cost of providing the capitated services was estimated as follows:

- Members have a choice of using CDE for their diabetes related treatments;
- The claims experience of the non-CDE members was used to estimate the CDE members' fee-for-service cost;
- Per life per month estimates for the non-CDE members were calculated for consultations, procedures, medication and hospital admissions to the extent that these services were covered under the CDE capitation agreement;
- The costs were split based on whether the member was a Type I or Type II diabetic; and
- The expected fee-for-service cost was calculated by multiplying the calculated per life per month costs by the number of CDE members exposed for the period.

	2022 R	2021 R
11. MANAGED CARE: MANAGEMENT SERVICES		
Pharmaceutical benefit management	224,024	223,728
Specialist, hospital referrals and pre-authorisations	693,831	693,005
Disease management	715,871	715,116
Network management	603,999	603,397
	2,237,725	2,235,246
12. ADMINISTRATION EXPENDITURE		
Accredited services		
Member record management	780,901	779,994
Contribution management	686,601	685,732
Claims management	717,290	862,619
Financial management	27,899	27,930
Information management and data control	1,400,543	1,398,811
Customer services	3,814,110	3,810,072
Other services		
Internal audit services	116,061	115,792
Forensic investigations and recoveries	291,268	144,885
Governance and compliance	22,877	22,984
Additional services		
Quality management and monitoring services	109,226	109,100
Advanced data analytics	91,458	91,353
Digital service offering	33,787	33,748
Enhanced service offering	18,059	18,038
Enterprise risk management services	18,059	18,038
Legal services	5,534	5,528
Product innovation	21,846	21,821
	8,155,519	8,146,445

NOTES TO THE FINANCIAL STATEMENTS
for the year ended 31 December 2022

		2022 R	2021 R
13.	**OTHER OPERATING EXPENSES**		
	Association fees	5,973	5,923
	Audit fees	448,962	396,948
	Audit services - current year	416,795	402,774
	Audit services - prior year (over) / under provision	32,167	(5,826)
	Bank charges	72,228	69,492
	Consulting fees	307,879	293,564
	Council for Medical Schemes	107,844	108,683
	Fidelity guarantee and professional indemnity insurance premium	51,722	49,258
	Legal fees	714	-
	Professional fees	230,000	-
	Sundry expenses	13,377	168,287
		1,238,699	1,092,155
14.	**IMPAIRMENT ON HEALTHCARE RECEIVABLES**		
	Insurance receivables		
	Members' and service providers' portions not recoverable	165,362	(98,444)
	Increase / (Decrease) in impairment	144,768	(161,429)
	Written off / (reversal)	20,594	62,985
		165,362	(98,444)
15.	**INVESTMENT INCOME**		
	Income from investments		
	Interest on cash and cash equivalents	814,237	723,096
	Fair value adjustment on financial assets at fair value through profit or loss	9,149,264	33,484,161
	Realised gains on disposal of financial assets at fair value through profit or loss	6,310,500	252,618
		16,274,001	34,459,875
16.	**SUNDRY EXPENSES**		
	Prescribed debt reversal / (written-off)	265,405	(225,556)
		265,405	(225,556)

17. COMMITMENTS AND OTHER CONTINGENT LIABILITIES

The Scheme does not have any commitments or contingent liabilities outstanding at 31 December 2022.

18. EVENTS AFTER THE REPORTING DATE

There have been no events that occurred subsequent to the end of the accounting period that affect the statements and that the Trustees consider should be reported.

19. RELATED PARTY TRANSACTIONS

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

Parties with significant influence over the Scheme:

Administrator and managed care organisation

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

Discovery Third Party Recovery Services Proprietary Limited

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

Specialist Pharmaceutical Services

The Scheme paid claims for specialist pharmaceutical services to Southern RX Pharmacy, a wholly owned subsidiary of Discovery Health (Pty) Ltd.

Consultants

Mr Andre Bellingham - Consulting Actuary have significant influence over the Scheme as he participates in the Scheme's financial and operating policy decisions, but does not control the Scheme.

19. RELATED PARTY TRANSACTIONS (continued)

Parties with significant influence over the Scheme (continues):

Key management personnel

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

Close family members include family members of the Board of Trustees and Principal Officer.

Transactions with key management personnel

The following table provides the total amount of transactions, which have been entered into with related parties for the relevant financial year.

	2022 R	2021 R
Key management personnel		
Contributions and claims (Trustees and their beneficiaries)		
- Statement of comprehensive income		
Gross contributions received	483,840	499,884
Gross claims incurred	(280,960)	(417,132)
- Statement of financial position		
Medical savings account balances	11,208	55,726

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

Transaction	Nature of transactions and terms and conditions thereof
Contributions received	This constitutes the contributions paid by the related parties as members of the Scheme in their individual capacity. All contributions were on the same terms as those applicable to other members.
Claims incurred	This constitutes amounts claimed by the related parties in their individual capacity as members of the Scheme. All claims were paid out in terms of the rules of the Scheme, as applicable to other members.
Medical savings account balances	The amounts owing to the related parties relate to medical savings account balances to which the parties have a right. The amounts are all current, and would need to be payable on demand should an appropriate claim be issued, or should the member resign from the Scheme.

19. RELATED PARTY TRANSACTIONS (continued)

	2022 R	2021 R
Transactions with parties that have significant influence over the Scheme		
Discovery Health (Pty) Ltd - administrator		
Statement of comprehensive income		
Administration fees	(8,155,519)	(8,146,445)
Discovery Health (Pty) Ltd - managed care organisation		
Statement of comprehensive income		
Managed care fees	(2,237,725)	(2,235,246)
Statement of financial position		
Balance due to Discovery Health (Pty) Ltd (note 7)	865,263	853,463

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

Administration and managed care management service agreements

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

Discovery Third Party Recovery Services Proprietary Limited		
Statement of comprehensive income		
Road Accident Fund Recoveries	100,143	-
Southern RX Distributors (Pty) Ltd		
Statement of comprehensive income		
Claims paid from the Scheme	(413,784)	(154,468)
Insight Actuaries and Consultants - Mr Andre Bellingham		
Statement of comprehensive income		
Consulting fees	(307,879)	(293,564)
Statement of financial position		
Balance due to Insight Actuaries and Consultants	25,657	24,552

20. INSURANCE RISK MANAGEMENT REPORT

Nature and extent of risks arising from insurance contracts

The primary insurance activity carried out by the Scheme indemnifies covered members and their dependants against the risk of loss arising as a result of the occurrence of a health event (i.e. an event relating to the health of the Scheme member and his or her registered dependants). As such, the Scheme is exposed to the uncertainty surrounding the timing and severity of claims under the contract. Insurance events are, by nature, random and the actual number and size of events during any one year may vary.

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

Insurance risk

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

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

Risk management objectives and policies for mitigating insurance risk

The Scheme’s annual budget is prepared under strict actuarial supervision which determines the contributions against claims projections, taking the statutory solvency requirements into account. The performance against the budget is closely monitored by the Board of Trustees and appointed sub-committees. Should any deviations occur, they are investigated with the necessary interventions implemented.

The methods employed by the Scheme to monitor and manage its insurance risk, inherent in the medical scheme environment, include the following:

- A Committee of Management which monitors and reviews all financial and operational performance on a monthly basis;
- All claims and demographic movements are monitored on a monthly basis via a multi-simulation actuarial model;
- Actuarial projections of the Scheme's year-end financial position are done monthly;
- The Scheme also applies a number of managed care programmes to monitor and manage the appropriateness, cost and quality of the healthcare services provided to the beneficiaries of the Scheme; and
- The need for re-insurance is considered on an ongoing basis within the existing regulatory environment.

20. INSURANCE RISK MANAGEMENT REPORT (continued)

Insurance risk - description of benefit option

The Scheme offers members one benefit option. The types of benefits offered by the Scheme in return for monthly contributions are indicated below:

Prescribed Minimum Benefits (PMBs)

This benefit covers the benefits contemplated in section 29(1)(o) of the Act and consists of the provision of the diagnosis, treatment and care costs of the diagnosis and treatment pairs listed in Annexure A of the Regulations, subject to any limitations specified therein and any emergency medical condition.

The Scheme applies guidelines and protocols for appropriate clinical management under Designated Service Provider (DSP) agreements.

Major Medical Expenses (insured benefits)

Hospital Benefit

The hospital benefit covers medical expenses incurred if members are admitted to hospital and the Scheme has authorised the treatment.

Clinical protocols and provider contracting are applied to pre-authorisations and the management of the benefit.

The Administrator negotiates hospital tariffs annually on behalf of the Scheme to allow for benefit of scale.

Chronic Illness Benefit (CIB)

The chronic illness benefit covers approved medication for up to 48 listed conditions. These are the 27 Prescribed Minimum Benefit chronic conditions and other non-prescribed chronic conditions.

This benefit and approval are managed by an appointed accredited Managed Care Organisation for drug utilisation, medicine management and adherence to compliance with regard to the Prescribed Minimum Benefit conditions.

Other services (insured procedure benefits)

These services provide cover for non-hospital expenses, subject to prior approval from the Scheme, which is managed and monitored by an appointed clinical committee.

Personal Medical Savings Account

This benefit provides cover for out-of-hospital healthcare services, such as visits to a general practitioner. The savings plan facility assists members in managing cash flows for costs to be borne by them during the year.

20. INSURANCE RISK MANAGEMENT REPORT (continued)

Hospital benefit risk

Frequency and severity of claims

The frequency and severity of claims can be affected by several factors. The most significant factor is the admission rate which has a direct impact on the cost of claims.

A 2% increase or decrease in the admission rate is estimated to increase or decrease the Scheme's loss ratio by 1.60%. The introduction of new hospital technologies could also increase variability of claims. In some instances, the new technology has a beneficial impact on costs, whether in-hospital or consequent costs. In other instances the new technologies will increase costs.

The change in the admission rate is shown in the following table.

Plan type	2022 Admission rate	2021 Admission rate	% Increase/ (decrease)
Anglovaal Group Medical Scheme	29.1%	24.9%	17.01%

Other factors that impact on hospital claims are shown below.

Key indicators	2022	2021	% Increase/ (decrease)
Average length of stay	4.49 days	4.69 days	-4.26%
Average cost per event *	R 42,030	R 41,432	1.44%
Hospital cost per life per month *	R 1,021	R 860	18.70%

* After adjusting for IBNR, case mix and excluding the cost of professionals attending in-hospital.

Initiatives used by the Scheme to manage the risk associated with admission rate include:
- The development of protocols around admissions, including funding protocols for various treatments and procedures;
- The “See Your Doctor First” initiative which requires members to see their doctor prior to an elective admission; and
- The amendment to the pre-authorisation length of stay benchmarks.

Chronic Illness Benefit (CIB) risk

Frequency and severity of claims

The main factors impacting the frequency and / or severity of chronic claims are the number of claimants and the cost per claimant. An increase in the number of claimants results in an increase in the frequency and / or severity of claims. Higher increases in claimants can be attributed to increases in the number of claimants at older ages. Increases in the number of items per claimant drives up the cost of chronic claims per claimant.

20. INSURANCE RISK MANAGEMENT REPORT (continued)

The mix between the various chronic conditions impacts the frequency and severity of claims. The following table shows the change in the chronic prevalence for key measures.

Measures	2022	2021	% Increase/ (decrease)
Cost per claimant	R 4,469	R 4,526	-1.26%
Claimants per 1000 lives	25.85	25.89	-0.14%
Per life per member (PLPM) cost	R 116	R 117	-1.40%

Day-to-day benefit risk

Frequency and severity of claims

The risk to the Scheme is limited up to an annual limit per benefit per family via individualised medical savings accounts, as prescribed by the rules of the Scheme.

Concentration of insurance risk

The following table summarises the concentration of insurance risk, with reference to the carrying amount of the insurance claims incurred (net of adjustments per beneficiary) for service years 2022 and 2021, by age group and in relation to the type of risk cover/benefits provided.

Claims incurred for 2022 service year per beneficiary

Age grouping (in years)	Avg number of beneficiaries	In-hospital R	Chronic R	Day-to-day R	Total R
< 26	1,474	5,019	88	1,023	6,130
26 – 35	569	8,214	205	1,779	10,198
36 – 50	1,088	12,367	896	2,225	15,488
> 50	1,520	44,500	3,451	9,127	57,078

Claims incurred for 2021 service year per beneficiary

Age grouping (in years)	Avg number of beneficiaries	In-hospital R	Chronic R	Day-to-day R	Total R
< 26	1,489	4,293	133	962	5,388
26 – 35	626	9,202	252	2,398	11,852
36 – 50	1,086	11,972	956	3,261	16,189
> 50	1,598	34,439	3,350	9,237	47,026

Contracts with providers are negotiated by the Administrator on behalf of the Scheme to benefit from scale and ultimately the rates. Such contracts are reviewed annually.

20. INSURANCE RISK MANAGEMENT REPORT (continued)

Risk transfer arrangements

The Scheme has a capitation agreement to cover specific risks. The Scheme has contracted with the Centre for Diabetics and Endocrinology (CDE) for the disease management of registered diabetic patients.

Risk in terms of risk transfer arrangements

According to the terms of the capitation agreement, the provider provides certain benefits to Scheme members, as and when required by the members. The Scheme does however remain liable to its members if the supplier should fail to meet its obligations.

Claims development

Claims development tables are not presented as the uncertainty regarding the amount and timing of claim payments is typically resolved within one year and in the majority of cases within four months. At year end, a provision is made for those claims outstanding that are not yet reported at that date. Details regarding the subsequent development in respect thereof have been disclosed in note 5.

Outstanding risk claims provision

There are some sources of uncertainty that need to be considered in the estimate of the liability that the Scheme will ultimately pay for claims made under insurance contracts.

Process used to determine the assumptions

Refer to note 5.

Changes in assumptions and sensitivities to changes in key variables

The table on page 38 outlines the sensitivity of insured liability estimates to particular movements in assumptions used in the estimation process. It should be noted that this is a deterministic approach with no correlations between the key variables. For each sensitivity illustrated, all other assumptions have been left unchanged.

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 the sensitivities around various scenarios for the general medical insurance business provides an indication of the adequacy of the Scheme's estimation process. The Scheme believes that the liability for claims reported in the statement of financial position is adequate. However, it recognises that the process of estimation is based upon certain variables and assumptions which could differ when claims arise.

20. INSURANCE RISK MANAGEMENT REPORT (continued)

The impact on the liability and reported profits caused by changes in key variables are as follows:

	Change in variable %	Increase in liability 2022 R	Increase in liability 2021 R
Risk claims incurred	10% increase in claims cost	791,614	410,000

The Scheme is most vulnerable to changes in membership distribution and changes in the underlying rate of inflation which drives a number of assumptions.

Sensitivity of the Scheme's profit or loss and reserves to changes in variables that have a material effect on them

The Scheme's profitability, reserves and therefore solvency are most sensitive to changes in claims development patterns. Another relevant assumption is medical inflation. Other assumptions that are considered include assumptions regarding utilisation trends, the impact of new technology and the expected demographic profile of the Scheme membership.

21. FINANCIAL RISK MANAGEMENT REPORT

Overview

The Scheme is exposed to financial risk through its financial assets, financial liabilities and insurance liabilities. In particular, the key financial risk is that the proceeds from its financial assets may not be sufficient to fund the obligations arising from its insurance contracts. The most important components of this financial risk are market risk, credit risk and liquidity risk. The Scheme's overall risk management programme focuses on the unpredictability of financial markets and seeks to minimise potential adverse effects on the Scheme's statutory solvency requirement.

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

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

An Audit and Investment Committee has been established by the Board of Trustees to assist in the implementation and monitoring of these risk management processes.

Market risk

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

Currency risk

All of the Scheme's benefits are Rand-denominated and therefore the Scheme does not have significant net currency risk.

Price risk

The Scheme is exposed to equity security price risk because of investments held by the Scheme which are classified as financial assets through profit or loss. To manage its price risk arising from investments in equity securities, the Scheme diversifies its portfolio. Diversification of the portfolio is done by the relevant asset manager in accordance with the mandate set by the Scheme.

The Scheme continues to pursue a strategy that maximizes returns on a long-term basis at an acceptable risk.

21. FINANCIAL RISK MANAGEMENT REPORT (continued)

Interest rate risk

The Scheme is exposed to interest rate risk as it places funds at both fixed and floating interest rates. The risk is managed by maintaining an appropriate mix between fixed and floating rate investments within the Scheme's money market investment portfolio.

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

As at 31 December 2022	Up to 1 month R	1 to 3 months R	3 and more months R	Total R
Financial assets at fair value through profit or loss *	-	-	176,326,519	176,326,519
Cash and cash equivalents	1,933,506	24,361,600	-	26,295,106
Total	**1,933,506**	**24,361,600**	**176,326,519**	**202,621,625**

As at 31 December 2021	Up to 1 month R	1 to 3 months R	3 and more months R	Total R
Financial assets at fair value through profit or loss *	-	-	182,748,119	182,748,119
Cash and cash equivalents	1,831,798	17,347,324	-	19,179,122
Total	**1,831,798**	**17,347,324**	**182,748,119**	**201,927,241**

* Non-interest-bearing

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

	2022	2021
Cash and cash equivalents	4.99%	3.28%

Sensitivity analysis for variable rate instruments

Due to the short-term duration of these instruments, a reasonably possible change in interest rates is 100 basis points. At the reporting date, the effect of this change on the Scheme's accumulated funds and deficit is shown below. This analysis assumes that all other variables remain constant. The analysis was performed on the same basis for 2022.

	Surplus or deficit		Accumulated funds	
As at 31 December 2022	100bp Increase R	100bp Decrease R	100bp Increase R	100bp Decrease R
Cash and cash equivalents	262,951	(262,951)	262,951	(262,951)
Sensitivity (net)	**262,951**	**(262,951)**	**262,951**	**(262,951)**

	Surplus or deficit		Accumulated funds	
As at 31 December 2021	100bp Increase R	100bp Decrease R	100bp Increase R	100bp Decrease R
Cash and cash equivalents	191,791	(191,791)	191,791	(191,791)
Sensitivity (net)	**191,791**	**(191,791)**	**191,791**	**(191,791)**

21. FINANCIAL RISK MANAGEMENT REPORT (continued)

Credit risk

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

The Scheme's principal financial assets are cash and cash equivalents, trade and other receivables and investments. The Scheme's credit risk is primarily attributable to its trade and other receivables.

Trade and other receivables

Trade and other receivables comprises insurance receivables and other receivables. The main components of insurance receivables are in respect of:

- Receivables for contributions due from members; and
- Receivables for amounts recoverable from service providers and members in respect of claims debt.

The Scheme manages credit risk by:

- Actively pursuing all contributions after 3 days of becoming due, as required by S26(7) of the Medical Schemes Act, of South Africa;
- Suspending benefits on members' accounts whose contributions have not been received for 30 days;
- Terminating benefits on members' accounts whose contributions have not been received for 60 days; and
- Ageing and pursuing unpaid accounts on a monthly basis.

The Scheme establishes an allowance for impairment that represents its estimate of incurred losses in respect of trade and other receivables. The main components of this allowance are a specific loss component that relates to individually significant exposures, and a collective loss component established for groups of similar assets in respect of losses that have been incurred but not yet identified. The collective loss allowance is determined based on historical data of payment statistics for similar financial assets. The carrying amount of financial assets represents the maximum credit exposure.

Details of the process to estimate the impairment provision are included in note 1.4.

Cash and cash equivalents

The Scheme has no significant concentration of credit risk. Cash transactions are limited to financial institutions with a high credit rating. The Scheme has a policy of limiting the amount of credit exposure to any one financial institution.

21. FINANCIAL RISK MANAGEMENT REPORT (continued)

Exposure to credit risk

The carrying amount of financial assets represents the maximum credit exposure.

Impairment

The ageing of insurance receivables at year end was:

	2022		2021	
	Gross	Impairment	Gross	Impairment
	R	R	R	R
Not past due	1,232,939		824,461	
Past due, not impaired	464,063	-	127,495	-
Past due, impaired	1,048,046	(959,258)	901,717	(814,491)
	2,745,048	(959,258)	1,853,673	(814,491)

The movement in the allowance for impairment during the year was as follows:

	2022	2021
	R	R
Balance at the beginning of the year	814,491	975,921
Increase / (Decrease) in impairment	124,173	(224,415)
Amounts reversed / (written off) during the period	20,594	62,985
Balance at the end of the year	959,258	814,491

Based on past experience, the Scheme believes that no allowance is necessary in respect of insurance receivables that are past due and outstanding for less than 60 days.

Investments

The Scheme limits its exposure to credit risk by investing in liquid securities and only with counterparties that have high credit ratings. The Trustees do not expect any counterparty to fail to meet its obligations. Annexure B to Regulation 30 to the Medical Schemes Act of South Africa, prescribes the credit limits per institution which reduces the individual risk per institution. The utilisation of these limits are regularly monitored.

The table below shows the credit limit and balances of cash and cash equivalents and money market instruments held at five major counterparties at year end which is in compliance with Annexure B of the Regulations. The statutory credit limit is calculated as 35% of the aggregate fair value of liabilities and accumulated funds.

Counterparty	2022		2021	
	Credit limit	Balance	Credit limit	Balance
	R	R	R	R
Firstrand Bank Limited	70,917,569	7,101,715	70,674,535	5,344,759
ABSA Bank Limited	70,917,569	11,402,328	70,674,535	2,306,739
Standard Bank Limited	70,917,569	21,771,624	70,674,535	11,798,128
Nedbank Limited	70,917,569	15,000,284	70,674,535	4,753,353
Investec Bank Limited	70,917,569	2,263,712	70,674,535	11,649,815

No credit limits were exceeded during the reporting period and the Trustees do not expect any losses from non-performance of these counterparties.

21. FINANCIAL RISK MANAGEMENT REPORT (continued)

Credit quality of financial assets

The credit quality of financial assets that are neither past due nor impaired can be assessed by reference to external credit ratings (if available) or to historical information about counterparty default rates:

	2022 R	2021 R
Insurance receivables		
Counterparties without external credit ratings		
Contribution debtors	400,132	746,539
Member claims debtors	1,508,862	450,248
Provider claims debtors	836,054	656,886
	2,745,048	1,853,673

Contribution debtors

On analysing the credit quality of contribution debtors, the Scheme collected 148.03% of these amounts in January 2022. This indicates a high credit quality rating of these debtors.

Active member claims debtors

These debtors are members of the Scheme and therefore are expected to have a similar credit quality to the contribution debtors.

Counterparties with external credit ratings (Moody's)

Cash and cash equivalents			
Current accounts	Baa3	1,933,506	1,831,798
Stanlib Money Market	Baa3	-	5,000,000
Nedbank Money Market	Baa3	24,361,600	12,347,324
		26,295,106	19,179,122
Financial assets at fair value through profit or loss			
Allan Gray Life Domestic Equity Portfolio Fund	Not rated	104,441,483	98,217,537
Allan Gray Life Stable Medical Scheme Portfolio Fund	Not rated	71,885,037	84,530,582
		176,326,520	182,748,119

21. FINANCIAL RISK MANAGEMENT REPORT (continued)

Liquidity risk

Liquidity risk is the risk that the Scheme will not be able to meet its financial obligations as they fall due. The Scheme's approach to managing liquidity is to ensure, as far as possible, that it will always have sufficient liquidity to meet its liabilities when due, under both normal and stressed conditions, without incurring unacceptable losses or risking damage to the Scheme's reputation.

Approximately 99% of the Scheme's insurance liabilities are settled within four months after the claim was incurred and the remaining liability is settled within eight months.

A maturity analysis for financial liabilities, excluding insurance liabilities is provided below:

As at 31 December 2022	**Less than 1 year**	**Total**
Outstanding risk claims provision (note 5)	7,916,139	7,916,139
Members' savings accounts (note 6)	21,775,232	21,775,232
Trade and other payables (note 7)	3,684,492	3,684,492

As at 31 December 2021	**Less than 1 year**	**Total**
Outstanding risk claims provision (note 5)	4,100,000	4,100,000
Members' savings accounts (note 6)	23,031,819	23,031,819
Trade and other payables (note 7)	3,084,820	3,084,820

Legal risk

Legal risk is the risk that the Scheme will be exposed to contractual obligations which have not been provided for. At 31 December 2022, the Scheme did not consider there to be any significant concentration of legal risk that had not been provided for.

Capital management

The Scheme is subject to the capital requirement imposed by Regulation 29(2) to the Medical Schemes Act of South Africa, which requires a minimum solvency ratio of accumulated funds expressed as a percentage of gross contributions to be at least 25%.

The Scheme's objectives when managing capital are to maintain the requirements of the Medical Schemes Act of South Africa, and to safeguard the Scheme's ability to continue as a going concern in order to provide benefits for its stakeholders.

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

	2022 **R**	**2021** **R**
Total members' funds per statement of financial position	171,387,625	173,009,463
Less: Fair value adjustment on financial assets at fair value through profit or loss	(61,160,472)	(52,011,208)
Accumulated funds per Regulation 29	110,227,153	120,998,254
Annualised gross contributions (note 8)	145,605,409	148,023,915
Solvency margin = Accumulated funds/annualised gross contribution income x 100	75.70%	81.74%

21. FINANCIAL RISK MANAGEMENT REPORT (continued)

Investment risk

The Scheme's Audit and Investment Committee invests excess funds in line with the Medical Schemes Act of South Africa.

The Scheme's investment objectives are to maximise the return on its investments on a long-term basis at acceptable risk, subject to any constraints imposed by legislation or the Trustees. The Scheme continues to diversify its investment portfolio by investing in money market instruments and equity portfolios managed by various asset managers.

Continuous monitoring takes place to ensure that appropriate assets are held where the Scheme's liabilities are dependent upon the performance of the investment portfolio and that a suitable match of assets exists for all liabilities.

Breakdown of Financial Assets at Fair Value through profit and loss

The assets of the portfolio must be invested in accordance with Annexure B of Regulation 30 to the Medical Schemes Act of South Africa.

The investments for the purposes of the financial statements comprise of financial assets at fair value through profit and loss or cash and cash equivalents.

	2022 R	2021 R
Financial assets at fair value through are made up of the following:		
Investments in linked insurance policies	176,326,519	182,748,119
	176,326,519	182,748,119
Cash and cash equivalents are made up of the following:		
Current accounts	1,933,506	1,831,798
Money market instruments	24,361,600	17,347,324
	26,295,106	19,179,122

21. FINANCIAL RISK MANAGEMENT REPORT (continued)

Fair value estimation

The face values less any estimated credit adjustments for financial assets and liabilities with a maturity of less than one year are assumed to approximate their fair values.

Analysis of carrying amounts of financial assets and financial liabilities per category

The following table compares the fair value and carrying amounts of financial assets and liabilities per class of financial asset and financial liability. The carrying amount approximates the fair value.

	Financial assets at fair value through profit or loss	Trade and other receivables/ (other financial liabilities)	Insurance receivables and (payables)	Total carrying amount
	R	R	R	R
31 December 2022				
Cash and cash equivalents	-	26,295,106	-	**26,295,106**
Trade and other receivables	-	304,111	1,837,752	**2,141,863**
Trade and other payables	-	(1,514,186)	(2,170,306)	**(3,684,492)**
Financial assets at fair value through profit or loss	176,326,519	-	-	**176,326,519**
Members' savings account liability	-	(21,775,232)	-	**(21,775,232)**
	176,326,519	3,309,797	(332,554)	**179,303,764**
31 December 2021				
Cash and cash equivalents	-	19,179,122	-	**19,179,122**
Trade and other receivables	-	219,166	1,079,695	**1,298,861**
Trade and other payables	-	(1,138,903)	(1,945,917)	**(3,084,820)**
Financial assets at fair value through profit or loss	182,748,119	-	-	**182,748,119**
Members' savings account liability	-	(23,031,819)	-	**(23,031,819)**
	182,748,119	(4,772,434)	(866,222)	**177,109,463**

22. CRITICAL ACCOUNTING ESTIMATES AND JUDGEMENTS

Critical accounting estimates and assumptions

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

Outstanding risk claims provision

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

Other risk transfer arrangements

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

Impairment of financial assets

The critical estimates and judgements relating to the impairment of assets are set out under note 1.4.

22. CRITICAL ACCOUNTING ESTIMATES AND JUDGEMENTS (continued)

Valuation of financial instruments

The Scheme's accounting policy on fair value measurements is discussed in accounting policy 1.3.

The Scheme measures fair values using the following fair value hierarchy that reflects the significance of the inputs used in making the measurements:

- Level 1: Quoted market price (unadjusted) in an active market for an identical instrument.
- Level 2: Valuation techniques based on observable inputs, either directly (i.e. prices) or indirectly (i.e. derived from prices). This category includes instruments valued using quoted market prices in active markets for similar instruments; quoted prices for identical or similar instruments in markets that are considered less than active; or other valuation techniques where all significant inputs are directly or indirectly observable from market data.
- Level 3: Valuation techniques using significant unobservable inputs. This category includes all instruments where the valuation technique includes inputs based on observable data and the unobservable inputs have a significant effect on the instrument's valuation. This category includes instruments that are valued based on quoted prices for similar instruments where significant unobservable adjustments or assumptions are required to reflect differences between the instruments.

  All the Scheme's financial instruments at fair value through profit or loss are categorised as level 2.

23. NON-COMPLIANCE MATTERS

23.1 Contributions not received within three days of them becoming due

In terms of Section 26(7) of the Medical Schemes Act of South Africa (the Act), all subscriptions or contributions shall be paid directly to a medical scheme not later than three days after payment thereof becoming due.

Although the majority of contribution payments were made within the stipulated payment deadlines, there were a small number of instances where the Scheme received contributions after three days of becoming due. These contributions equate to less than 0.27% of the gross contributions billed and were received within the month of them becoming due. Such arrear payments are outside the agreed contribution collection agreements with paying parties and are actively addressed as and when they occur.

The procedures that the Scheme follows for collection of these arrear contributions are aligned with its credit risk management policies in note 21.

23.2 Payment of claims within 30 days

In terms of Section 59(2) of the Medical Schemes Act of South Africa, a medical scheme shall, in the case where an account has been rendered, subject to the provisions of this Act and the rules of the medical scheme concerned, pay to 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.

Management have implemented a process to monitor claims made by members and providers on a monthly payment cycle and ensure that payment is performed within 30 days.

23. NON-COMPLIANCE MATTERS (continued)

23.3 Investment in participating employer

As at 31 December 2022, the Scheme indirectly through its holdings in the Allan Gray portfolios held shares in AVI Ltd, a participating employer of the Scheme, amounting to R1 384 908 (2021: R1 297 445) and R766 765 (2021: R812 091) in African Rainbow Minerals Ltd.

Ordinarily this would be in contravention of Section 35(8) of the Act, which, inter alia, prohibits a medical scheme from investing any of its assets in an employer that participates in that scheme. However, as funds in these specific portfolios are structured at the sole discretion of the asset manager in a manner that maximizes the return on investment, and neither the Scheme nor these employers provide input into the structuring of the portfolio, the Scheme has received exemption from the Council for Medical Schemes for compliance with this Section of the Act.

23.4 Sustainability of benefit option

In terms of Section 33(2) of the Medical Schemes Act, No 131 of 1998, as amended, each option shall be self-supporting in terms of membership and financial performance and be financially sound. The Anglovaal Group Medical Scheme only has one option.

At 31 December 2022, the Scheme reported a net healthcare deficit amounting to R16 279 880. After taking into account investment income and fair value adjustments on investments, the Scheme reported a total comprehensive loss of R1 621 838 for the year ended 31 December 2022.

The Trustees continuously monitor the overall performance of the Scheme. On a monthly basis, the management accounts are scrutinised; the investment returns are analysed in line with the overall market performance; and claims patterns are analysed by the actuaries and administrator against what the expected claims should be, given the demographics and claiming behaviour of the Scheme members. In addition, the Scheme's investment policy is reviewed annually against expected returns. The solvency level at 31 December 2022 is 75.70% against the legislated requirement of 25%. The Trustees do not believe in making short term decisions based on limited information, but to rather take a well thought out, well considered, long term view in order to ensure the sustainability of the Scheme. This prudent approach allows the Scheme to be managed through any short term adverse claims experience, whilst minimizing the potentially negative impact on the members. The solvency level at 31 December 2022 of 75.70% allows the Trustees the leeway to take a medium to long term view whilst protecting the members' interests in the short term. The Trustees are of the opinion that increasing member contributions to address what could be a short term anomaly, while having a high solvency level, is not in the interests of the members. Finally, the Scheme undergoes an independent, annual actuarial review to determine the appropriate level of contributions given the benefits provided, which allows the Trustees the opportunity to review the sustainability of the Scheme and to adjust the contributions for the following year accordingly.

The Trustees are comfortable that the Scheme is financially sound and sustainable.

ANGLOVAAL GROUP MEDICAL SCHEME
(Registration no. 1571)

REPORT OF THE BOARD OF TRUSTEES

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

1 DESCRIPTION OF THE SCHEME

1.1 Terms of registration

The Anglovaal Group Medical Scheme is a not-for-profit restricted membership Scheme registered in terms of the Medical Schemes Act of South Africa ("the Act").

1.2 Benefit options within the Anglovaal Group Medical Scheme

The Scheme offers one (1) benefit option.

1.3 Savings plan

To provide a facility for Scheme members to set funds aside to meet day-to-day and other healthcare costs not covered by the 'risk' benefits in the option, the Trustees have made a personal medical savings account available.

Contributions to the personal medical savings accounts (MSA) are set and the total available amount is based on family size and the member's income level. The amounts contributed to the personal MSA do not exceed 20% (twenty percent) of the member’s total medical scheme contribution.

The liability to the members in respect of the savings plan is reflected as a current liability in the Scheme’s financial statements, repayable in terms of Regulation 10.

In terms of the rules of the Scheme, the savings plan is underwritten by the Scheme.

REPORT OF THE BOARD OF TRUSTEES (continued)

2 MANAGEMENT

2.1 Board of Trustees in office during the year and at the date of this report was:

M Koursaris		Chairman - Member Elected Trustee
I Masike		Member Elected Trustee
V Lazarus		Employer Appointed Trustee
H de Groot		Employer Appointed Trustee
B Jales		Employer Appointed Trustee
O Bergman		Employer Appointed Trustee
A Mills	- appointed 13 Oct 2021	Member Elected Trustee
D Erskine	- appointed 14 December 2021	Member Elected Trustee

2.2 Principal Officer

V Crystal

2.3 Registered office address and postal address

2 Harries Road	PO Box 1897
Illovo	Saxonwold
2196	2132

2.4 Scheme administrator during the year

Discovery Health (Pty) Limited

1 Discovery Place	PO Box 786722
Sandton	Sandton
2146	2146

REPORT OF THE BOARD OF TRUSTEES (continued)

2.5 Investment managers during the year

The Scheme made use of the services of the following asset managers:

• Allan Gray Proprietary Limited

2.6 Actuaries

Mr André Bellingan	Insight Actuaries and Consultants
2nd Floor Gateway West 22 Magwa Crescent Waterval City Midrand 2066	Private Bag X17 Halfway House 1685

3 INVESTMENT AND FIXED ASSET POLICY OF THE SCHEME

The Trustees continue to invest funds in line with the requirements of the Act. The Scheme continues to pursue a strategy that maximizes returns on a long-term basis at an acceptable risk.

REPORT OF THE BOARD OF TRUSTEES (continued)

4 REVIEW OF THE ACCOUNTING PERIOD'S ACTIVITIES

4.1 Operational statistics

	2022	2021
Number of members at the end of the accounting period	2,309	2,389
Number of beneficiaries at the end of the accounting period	4,591	4,740
Average number of members for the accounting period	2,334	2,426
Average age of beneficiaries for the accounting period	40.61	40.71
Pensioner ratio (beneficiaries > 65 years)	20.85%	21.08%
Average net contributions per member per month	R 4,163.28	R 4,073.70
Average net contributions per beneficiary per month	R 2,116.55	R 2,085.19
Average claims incurred per member per month	R 4,403.22	R 3,898.57
Average claims incurred per beneficiary per month	R 2,238.54	R 1,995.55
Average administration costs per member per month	R 335.41	R 317.31
Average administration costs per beneficiary per month	R 170.52	R 162.42
Accumulated funds per member at 31 December	R 74,225.91	R 72,419.20
Beneficiary ratio at 31 December	1.99	1.98
Net claims as a percentage of net contributions	105.76%	95.70%
Managed care: Management services as a percentage of gross contributions	1.54%	1.51%
Administration expenses as a percentage of gross contributions	6.57%	6.17%

4.2 Results of operations

The results of the Scheme are set out in the financial statements and the Trustees believe that no further clarification is required.

4.3 Accumulated funds ratio

	2022 R	2021 R
The accumulated funds ratio is calculated on the following basis:		
Total members' funds per statement of financial position	171,387,625	173,009,462
- Less fair value adjustment on investments held at fair value profit or loss	(61,160,472)	(52,011,208)
Accumulated funds per Regulation 29	110,227,153	120,998,254
Annualised gross contributions	145,605,409	148,023,915
Accumulated funds ratio = Accumulated funds/annualised gross contribution income x 100	75.70%	81.74%

REPORT OF THE BOARD OF TRUSTEES (continued)

4.3 Accumulated funds ratio (continued)

** Cumulative net gains on re-measurement to fair value are calculated as follows:

	2022 R	2021 R
Net cumulative gain at the beginning of the period	(52,011,208)	(18,530,723)
Fair value adjustment on financial assets at fair value through profit or loss	(2,838,764)	(33,227,867)
Realised gains on derecognition of financial assets at fair value through profit or loss	(6,310,500)	(252,618)
Cumulative net gain on remeasurement to fair value of financial assets at fair value through profit or loss in accumulated funds	**(61,160,472)**	**(52,011,208)**

4.4 Reserve accounts

Movements in the reserves are set out in the statement of changes in funds and reserves. There have been no unusual movements that the Trustees believe should be brought to the attention of the members of the Scheme.

4.5 Outstanding risk claims

Movements on the outstanding risk claims provision are set out in note 5 to the financial statements. There have been no unusual movements that the Trustees believe should be brought to the attention of the members of the Scheme.

5 ACTUARIAL SERVICES

The Scheme's actuaries have been consulted in the determination of the contribution and benefit levels. The Scheme's actuaries also calculate the annual budget and monthly actuarial reports of the Scheme, including the monthly incurred but not yet reported (IBNR) claims provision.

6 EVENTS AFTER THE REPORTING DATE

There have been no events that occurred subsequent to the end of the accounting period that affect the statements and that the Trustees consider should be reported.

REPORT OF THE BOARD OF TRUSTEES (continued)

7 INVESTMENTS IN AND LOANS TO PARTICIPATING EMPLOYERS OF MEMBERS OF THE SCHEME AND TO OTHER RELATED PARTIES

The Scheme had invested in various portfolios, which in turn held shares in African Rainbow Minerals Ltd and AVI Ltd, participating employers of the Scheme.

Discovery Health (Pty) Ltd is the administrator of the Scheme.

Payments are made in terms of the administration and managed care agreements, reviewed for 2022 at the end of 2021, with Discovery Health (Pty) Ltd. Fees were paid as follows:

	2022 R	2021 R
Discovery Health (Pty) Ltd	10,393,244	10,381,691
Administration fees	8,155,519	8,146,445
Managed care: management services fees	2,237,725	2,235,246

The Scheme appointed consultants to the Scheme and their fees were paid as follows:

Consultation fees		
Insight Actuaries and Consultants	307,879	293,564

8 AUDIT AND INVESTMENT COMMITTEE

An audit and investment committee (the Committee) was established in accordance with the provisions of the Act. The Committee is mandated by the Board of Trustees by means of written terms of reference as to its membership, authority and duties. The Committee consists of five members of which two are members of the Board of Trustees. The Committee met on three occasions during the course of the year as follows:

- 8 April 2022
- 13 September 2022
- 23 November 2022

The Principal Officer, Chairman of the Board of Trustees and the Administrator attend all Committee meetings and have unrestricted access to the Chairman of the Committee. The external auditors of the Scheme attend meetings on invitation only.

In accordance with the provisions of the Act, the primary responsibility of the Committee is to assist the Board of Trustees in carrying out its duties relating to the Scheme's accounting policies, internal control systems and financial reporting practices. The external auditors formally report to the Committee on critical findings arising from audit activities.

This Committee also acts as an investment committee.

The Committee presently comprises: J O'Meara; M Koursaris, S Chatrooghoon, J Fourie and I Masike.

9 NON-COMPLIANCE MATTERS

9.1 Contributions not received within three days of them becoming due

In terms of Section 26(7) of the Medical Schemes Act of South Africa (the Act), all subscriptions or contributions shall be paid directly to a medical scheme not later than three days after payment thereof becoming due.

Although the majority of contribution payments were made within the stipulated payment deadlines, there were a small number of instances where the Scheme received contributions after three days of becoming due. These contributions equate to less than 0.27% of the gross contributions billed and were received within the month of them becoming due. Such arrear payments are outside the agreed contribution collection agreements with paying parties and are actively addressed as and when they occur.

The procedures that the Scheme follows for collection of these arrear contributions are aligned with its credit risk management policies in note 21.

9.2 Payment of claims within 30 days

In terms of Section 59(2) of the Medical Schemes Act of South Africa, a medical scheme shall, in the case where an account has been rendered, subject to the provisions of this Act and the rules of the medical scheme concerned, pay to 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.

Management have implemented a process to monitor claims made by members and providers on a monthly payment cycle and ensure that payment is performed within 30 days.

9.3 Investment in participating employer

As at 31 December 2022, the Scheme indirectly through its holdings in the Allan Gray portfolios held shares in AVI Ltd, a participating employer of the Scheme, amounting to R1 384 908 (2021: R1 297 445) and R766 765 (2021: R812 091) in African Rainbow Minerals Ltd.

Ordinarily this would be in contravention of Section 35(8) of the Act, which, inter alia, prohibits a medical scheme from investing any of its assets in an employer that participates in that scheme. However, as funds in these specific portfolios are structured at the sole discretion of the asset manager in a manner that maximizes the return on investment, and neither the Scheme nor these employers provide input into the structuring of the portfolio, the Scheme has received exemption from the Council for Medical Schemes for compliance with this Section of the Act.

9.4 Investment in Medical Administrators and Other Medical Schemes

At 31 December 2022, the Scheme indirectly through its holdings in the Allan Gray portfolios held shares in Liberty Holdings Ltd R789 682 (2021: R789 682)

Ordinarily this would be in contravention of Section 35(8) of the Act which, inter alia, prohibits medical schemes from holding shares in any other medical scheme, any administrator and any person associated with any of these. However, as funds in these portfolios are structured at the sole discretion of the asset manager in a manner that maximises returns and the Scheme provides no input into the structuring of the portfolios, the Scheme has received exemption from the Council for Medical Schemes for compliance with this Section of the Act.

9 NON-COMPLIANCE MATTERS (continued)

9.5 Sustainability of benefit option

In terms of Section 33(2) of the Medical Schemes Act, No 131 of 1998, as amended, each option shall be self-supporting in terms of membership and financial performance and be financially sound. The Anglovaal Group Medical Scheme only has one option.

At 31 December 2022, the Scheme reported a net healthcare deficit amounting to R16 279 880. After taking into account investment income and fair value adjustments on investments, the Scheme reported a total comprehensive loss of R1 621 838 for the year ended 31 December 2022.

The Trustees continuously monitor the overall performance of the Scheme. On a monthly basis, the management accounts are scrutinised; the investment returns are analysed in line with the overall market performance; and claims patterns are analysed by the actuaries and administrator against what the expected claims should be, given the demographics and claiming behaviour of the Scheme members. In addition, the Scheme's investment policy is reviewed annually against expected returns. The solvency level at 31 December 2022 is 75.70% against the legislated requirement of 25%. The Trustees do not believe in making short term decisions based on limited information, but to rather take a well thought out, well considered, long term view in order to ensure the sustainability of the Scheme. This prudent approach allows the Scheme to be managed through any short term adverse claims experience, whilst minimizing the potentially negative impact on the members. The solvency level at 31 December 2022 of 75.70% allows the Trustees the leeway to take a medium to long term view whilst protecting the members' interests in the short term. The Trustees are of the opinion that increasing member contributions to address what could be a short term anomaly, while having a high solvency level, is not in the interests of the members. Finally, the Scheme undergoes an independent, annual actuarial review to determine the appropriate level of contributions given the benefits provided, which allows the Trustees the opportunity to review the sustainability of the Scheme and to adjust the contributions for the following year accordingly.

REPORT OF THE BOARD OF TRUSTEES (continued)

10 MEETING ATTENDANCE

The following schedules set out Board of Trustee meeting attendances and attendances by members of Sub-Committees:

Board of Trustees meetings	Number of meetings
Number of meetings for the year	**4**
M Koursaris	4
I Masike	4
H de Groot	4
B Jales	3
O Bergman	4
A Mills	4
V Lazarus	3
D Erskine	4
Attendees:	
V Crystal	4

Audit and Investment Committee meetings	Number of meetings
Number of meetings for the year	**3**
J O'Meara (Chairperson)	2
M Koursaris	3
J Fourie	3
S Chatrooghoon	3
I Masike	3
Attendees:	
V Crystal	3

Committee of Management meetings	Number of meetings
Number of meetings for the year	**3**
M Koursaris (Chairperson)	2
V Crystal	3

CHAIRMAN TRUSTEE PRINCIPAL OFFICER

26 April 2023

Anglovaal Group Medical Scheme
Proxy Form for the Annual General Meeting
24 May 2023

Membership Number ……

I (Name in block letters)……

Of Address: ……

Being a principal member of Anglovaal Group Medical Scheme, hereby appoint:

1. ……,with member number……; or failing him/her

2. ……,with member number……; or failing him/her

3. The Principal Officer of the Scheme; or failing him/her

4. The Chairman of the Annual General Meeting;

as my proxy to vote for me on my behalf at the Annual General Meeting of the Scheme to be held on 24 May 2023 at 10h00.

Signed at …… on this …… day of …… 2023

Signature: ……..

NOTES

- The person whose name is listed first on the Proxy Form and who is present at the Annual General Meeting will be entitled to act as proxy to the exclusion of those whose names follow.
- The completion and lodging of this Proxy Form will not preclude the relevant member from attending the Annual General Meeting and speaking and voting in person thereat to the exclusion of any proxy appointed in terms hereof, should such members wish to do so.
- Proxy Forms must be lodged at, or posted to the Principal Officer c/o Alastair Rogers, Anglovaal Group Medical Scheme, AGM Motions, P O Box 652509, Benmore, 2010, faxed to (011) 539-1018, or emailed to avgmsagm@discovery.co.za. Proxies to be received no later than 12h00 on 22 May 2023.