BONITAS MEDICAL FUND

ANNUAL REPORT '18

REGISTRATION NUMBER 1512

AFFORDABLE, QUALITY HEALTHCARE FOR ALL SOUTH AFRICANS

Bonitas

CONTENTS

THIS REPRESENTS OUR BOARD OF TRUSTEES REPORT.

The Board of Trustees ("Board") and executive management of Bonitas Medical Fund ("Bonitas" or "the Scheme") are pleased to share the Report of the Board for the financial year ended 31 December 2018 with its partners and valued members. This report details the Scheme's strategy to ensure the delivery of affordable and quality healthcare to members, its performance against this strategy, an overview of the Scheme's financial performance, challenges faced by the Scheme and the manner in which the Board has exercised and discharged its responsibility for governance.

Approved on 15 April 2019 by:

Mr G van Emmenis
Principal Officer

Mr O Komane
Chairman of the Board

ABOUT BONITAS

WHAT WE DO

Terms of registration

The Scheme is an open medical scheme registered in terms of the Medical Schemes Act of South Africa, No 131 of 1998, as amended ("the Act" or "MSA") under registration number 1512. The Scheme is incorporated and domiciled in the Republic of South Africa. Bonitas is one of the top three medical schemes registered in South Africa and one of the top two open medical schemes in the country. The Scheme is administered by Medscheme Holdings Proprietary Limited.

About us

We have been around for 37 years – long enough to have developed a rich heritage and a solid understanding of the private healthcare industry in South Africa. Our team of experts is always looking for innovative ways to reduce rising costs, whether it is keeping our fingers on the pulse of technology, managing your care to ensure lifestyle diseases are identified before they become chronic, or negotiating better rates for you. If you are one of our 710 206 beneficiaries, then you will know we are always on your side – negotiating better rates and sourcing reputable service providers to help keep you healthy and limit rising healthcare costs.

We do not believe in one-size-fits-all; our wide range of benefit options ensures that you and your family will find a snug fit for your particular needs. We also believe there is beauty in simplicity and have made our benefit options user-friendly while helping to stretch your benefits as far as possible. Whether you are a go-getting entrepreneur, a chief executive officer, newlyweds, a couple with a new family, someone nearing retirement, or a minimum wage earner who needs peace of mind when it comes to healthcare, Bonitas is there for you.

Benefit options

We offered the following benefit options to employers and members of the public during the year:

BENEFIT OPTIONS[1]	
BonComprehensive	A first-class savings plan offering ample savings, an above-threshold benefit and extensive hospital cover
BonClassic	A generous savings option offering a wide range of medical benefits, in and out of hospital
BonComplete	A savings option offering generous savings, an above-threshold benefit and rich hospital cover
BonSave	A savings option offering savings to use as members choose for medical expenses and extensive hospital cover
BonFit	A savings plan offering basic cover for day-to-day medical needs and essential hospital cover
Standard	A traditional option offering rich day-to-day benefits and comprehensive hospital cover
Standard Select (efficiency discounted option)	A traditional option using a quality provider network to offer rich day-to-day benefits and hospital cover
Primary	A traditional option offering simple day-to-day benefits and hospital cover
Hospital Plus[2]	A hospital plan offering comprehensive hospital benefits with some value-added out-of-hospital benefits
Hospital Standard	A hospital plan offering extensive hospital benefits with some value-added benefits
BonEssential	A hospital plan offering rich hospital benefits with some value-added benefits
BonCap	An income-based entry-level plan offering basic day-to-day benefits and hospital cover using a network of doctors, providers and hospitals

[1] *Two new efficiency discounted options ("EDOs"), Primary Select and BonEssential Select, were launched effective 1 January 2019.*

[2] *The Hospital Plus benefit option was discontinued on 31 December 2018 as it was unsustainable. Members were offered a planned transfer to other options and 97% accepted the offer.*

ABOUT BONITAS CONTINUED

Personal medical savings options

Personal medical savings options are available for members to set aside funds to meet healthcare costs that are not covered in the benefit options.

PERSONAL MEDICAL SAVINGS OPTIONS	
BonComprehensive **BonClassic** **BonComplete** **BonSave** **BonFit**	These options enable members to pay an agreed sum into a personal medical savings account ("PMSA") to help pay their portion of healthcare costs up to a prescribed limit. Unused savings amounts are accumulated for the long-term benefit of the member. Interest is allocated monthly on the cumulative balances. Members' liability for the personal medical savings option is reflected as a financial liability in the financial statements[3]. The average interest earned on these funds in 2018 was 7.7% (2017: 8.1%). Credit balances of savings contributions are refunded to members if they enrol in another benefit option or another medical scheme without a PMSA, or if they do not enrol in another medical scheme. These refunds comply with the Scheme Rules. Since June 2017, medical schemes have been entitled to treat all funds paid by members as assets. This means that medical schemes can retain the interest, and if a medical scheme is liquidated, the money in a member's medical savings account will not be protected from creditors. Bonitas members continue earning a return on cumulative positive savings balances.

[3] *Repayable in terms of Regulation 10 of the Act.*

For further information on changes in the PMSA, refer to note 11 in the annual financial statements.

THE WORLD OF HEALTHCARE

EXTERNAL INFLUENCES

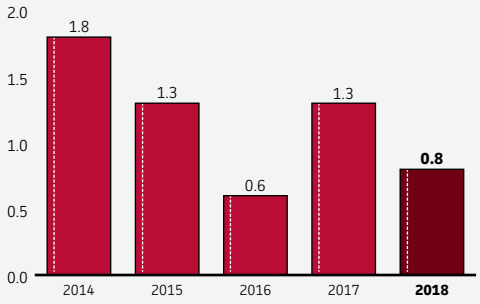
General overview of the Board

Our operating environment directly impacts our ability to create and sustain value. The healthcare industry is affected by several factors. By understanding the challenges and opportunities in our operating environment, we can respond to them with our risk and opportunity management process.

WHAT IS THE IMPACT ON BONITAS

ECONOMIC AND POLITICAL ENVIRONMENT

South African gross domestic product ("GDP") growth (%)



Source: StatsSA

- Stagnant economic growth impacts the affordability of medical aid for members, resulting in the transfer of some existing members to less expensive options and limited entry of new members. Increased job losses also reduce membership numbers
- Sustained economic weakness impacts investment markets, reducing the return on our investment income
- Policy uncertainty, governance failures at state-owned entities and pre-election posturing limit South Africa's growth prospects.

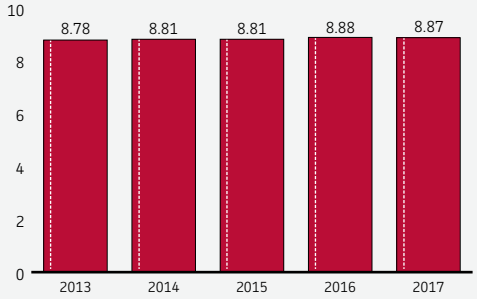
SOCIAL ENVIRONMENT

Source: Forensic report Medscheme

- Rising healthcare costs are driven by higher utilisation of healthcare services largely as a result of ageing medical aid membership profiles and increased deaths related to non-communicable diseases ("NCDs"). The rise in NCDs – most prominently cancer, heart disease and diabetes – is fuelled by urbanisation, sedentary lifestyles, changing diets and rising obesity levels, according to a recent global healthcare study[4]
- Increased supply of healthcare service providers, including new hospitals, results in an oversupply of hospital beds in urban areas, which creates further potential to increase utilisation
- Large-scale fraud, waste and abuse of members' benefits has an adverse impact on the financial position of medical aids, which may translate to higher costs for members.

COMPETITIVE ENVIRONMENT

Number of beneficiaries (consolidated schemes) (millions)



Source: CMS Annual Report 2017/2018

- Bonitas is currently the second largest medical aid scheme in a market in which the largest open scheme has a 55% market share. Sizeable market share enables the negotiation of preferential hospital tariffs
- Increasing competition for members in an environment of marginal membership growth over the past decade increases the pressure on medical aids to invest in the retention and growth of their memberships.

[4] *Deloitte 2019 Global Health Care Outlook. https://www2.deloitte.com/global/en/pages/life-sciences-and-healthcare/articles/global-healthcare-sector-outlook.html.*

THE WORLD OF HEALTHCARE CONTINUED

REGULATORY ENVIRONMENT

"Bonitas is premised on making quality healthcare more affordable and accessible. We therefore welcome the efforts of the NHI to improve access to healthcare. However, our key concerns are around quality and preventing duplication of services."

Bonitas Principal Officer

- Removing tax credit for private healthcare signifies government's commitment to the National Health Insurance ("NHI"), but there are considerable obstacles to its implementation. This creates uncertainty about the future of the private medical aid industry and places additional pressure on membership growth.

TECHNOLOGY ADVANCES

Health technology sector is expected to reach an estimated R4 trillion by 2021, at a **compound annual growth rate ("CAGR") of 15.9%** between 2016 and 2021.[5]

- Technology advances are enabling the healthcare industry to be more innovative and efficient, which should improve affordability over time
- Digital advances enable more cost-effective member engagement and increase accessibility to younger members
- Technology facilitates cyber crime and places the integrity of our systems and members' information at risk. It may also facilitate competitive disruption.

MANAGEMENT OF INSURANCE RISKS

The business of Bonitas is to manage the healthcare risk exposure of our members and their dependants. This risk is directly linked to the health of our beneficiaries. As such, uncertainty exists on the timing and severity of claims members may submit.

Assessing insurance risk exposure

We use several methods to assess and monitor insurance risk exposure, both for individual types of risks and overall risks. These methods include internal risk measurement models, sensitivity analyses, scenario analyses and stress testing.

The theory of probability is applied to the pricing and provisioning for a portfolio of insurance contracts. The principal risk is that the frequency and severity of claims are greater than what we expect.

Managing insurance risk

Bonitas manages insurance risk through various methods, including benefit limits and sub-limits, approval procedures for transactions that involve pricing guidelines, pre-authorisation and case management, service provider profiling, monitoring of emerging issues and the centralised management of risk transfer arrangements. Refer to note 21 of the annual financial statements for more information.

Risk transfer arrangements

Bonitas has entered into risk transfer arrangements with the following service providers:

Service provider	Risk transfer arrangements and options affected
Dental Information Systems Proprietary Limited ("DENIS")	Dental benefits, including dental-related hospitalisation **Standard, BonSave, Primary, BonClassic, BonComplete and Standard Select**
ER24 EMS Proprietary Limited ("ER24")	Emergency and evacuation services and emergency medical care **All options**
Iso Leso Optics Limited ("ISO LESO") Service provider terminated on 31 December 2018	Optical benefits **Standard, Primary, BonCap and BonClassic**
Bryte Insurance Company Limited ("Bryte")	International travel benefits **All options**

[5] *Deloitte 2019 Global Health Care Outlook. https://www2.deloitte.com/global/en/pages/life-sciences-and-healthcare/articles/global-healthcare-sector-outlook.html.*

Risk transfer arrangements continued

In 2018, Bonitas re-visited the accounting disclosure relevant to its risk transfer arrangements. Large net expenses or losses, particularly relating to DENIS, have been reported in previous years in the Scheme's financial statements pertaining to its risk transfer arrangements. Hence it was critical to ensure that these arrangements are disclosed in accordance with the relevant accounting standard IFRS 4 Insurance Contracts. Bonitas also benchmarked against other schemes' disclosures with similar risk transfer arrangements.

Although these disclosures do not impact the bottom line of the Scheme's reported surplus, it is important that the Scheme reports the correct net expense or income on the risk transfer arrangements to prevent any misconceptions surrounding the commercial business rationale for transferring the risk on these insured benefits to third parties.

Following an investigation into the appropriate disclosures, the Scheme determined that the recoveries reported on the three major risk transfer arrangements, being DENIS, ISO LESO and ER24, were previously understated as they were calculated at the cost incurred by the third party. In terms of IFRS 4, the Scheme should rather report the recoveries at the **cost the Scheme would have incurred** had it not entered into the contract with the insurer.

Bonitas therefore requested DENIS, ISO LESO and ER24 and the Scheme's actuaries to re-calculate the recoveries relating to the three major risk transfer arrangements in accordance with IFRS 4. Recoveries relating to the CDE risk transfer arrangement have not been re-stated in the figures below due to the fact that the net expense comprised less than 5% of the total reported "net expense on risk transfer arrangements" and therefore considered immaterial.

Bonitas therefore revised its disclosure in the annual financial statements and re-stated the 2017 comparative figures accordingly.

The impact of the re-statement on the 2014 to 2017 financial statement disclosure is as follows:

	2017 R'000	2016 R'000	2015 R'000	2014 R'000
Net income/(expense) on risk transfer arrangements				
– As reported on previously	(154 034)	(160 450)	(115 304)	(111 799)
Net income/(expense) on risk transfer arrangements				
– Revised in accordance with IFRS 4	74 268	24 728	92 836	40 296
Difference	228 302	185 178	208 139	152 095

Bonitas is confident that the revised disclosure now accurately reflects the commercial reality of the risk transfer arrangements.

Bonitas will continue utilising risk transfer arrangements where beneficial to members to reduce the impact of rising healthcare costs and downstream costs such as hospital admissions. It is not always in the interest of members for Bonitas to manage certain healthcare risks in-house as the costs of procurement, infrastructure and intellectual property would be disproportionate. For more information on the risk transfer arrangements, refer to note 14 in the annual financial statements.

RISK AND OPPORTUNITY MANAGEMENT AT BONITAS

Risk and opportunity management is an integral part of decision-making and routine management at Bonitas and is integrated in our day-to-day processes. Bonitas has an established risk management framework to ensure compliance with the MSA.

The framework provides guidance on how to implement a consistent, efficient and effective approach to identifying, evaluating and responding to key risks that may impact our ability to achieve our strategy. The framework is based on the principles of the COSO Framework of the Treadway Commission, the International Guideline on Risk Management (ISO 31000) and the King Report on Corporate Governance™ for South Africa, 2016 ("King IV™")[6] governance outcomes.

[6] *Copyright and trademarks are owned by the Institute of Directors in Southern Africa NPC and all of its rights are reserved..*

THE WORLD OF HEALTHCARE CONTINUED

Our top-of-mind risks, as presented to the Audit and Risk Committee and Board, are illustrated below:

Description	Context	Link to strategic response
Information technology ("IT") environment	A robust IT governance framework and effective service level agreements ("SLAs") with service providers are critical to protect members' information which is highly sensitive, enable an integrated medical value chain and advance a digital strategy. This is coupled with the increased exposures with regard to cyber threats and vulnerabilities within the IT environment. Member records and data are used for member administration, claims and medical research. It is critical to ensure that there is no unauthorised access to personal information and that technology systems are regularly evaluated for vulnerabilities to ensure compliance with relevant security laws and the Protection of Personal Information Act ("POPIA").	
Inability to achieve Scheme growth	The health industry has experienced marginal growth over the past decade. Bonitas must retain existing members and grow the Scheme to ensure relevance in this competitive market.	
Political and economic conditions	Adverse political and economic impacts (refer to page 3) lead to a loss in membership, downscaling of benefit options, and lack of sustainability of options. This is coupled with the negative impact on investment performance.	
Third-party delivery against service level agreements	The quality of third-party service delivery has a direct impact on our member experience. Poor delivery can negatively impact member experience, resulting in reputational loss and, in a worst-case scenario, non-compliance with policies, the MSA and Scheme Rules.	
Claims paid outside approved benefits and limits	It is important that the integration in the value chain between Bonitas and the administrator is seamless and member queries are resolved timeously. Delayed payments or non-payment of valid claims can potentially lead to a contravention of the MSA, underprovisioning for claims, reputational damage and membership loss.	
Council of Medical Schemes ("CMS") inspection and related loss of stakeholder confidence	Brand and reputational damage can affect Bonitas including stakeholder relationships due to negative media publicity surrounding the inspection by the CMS and the negative market perception it might create.	
Related party transactions not at arm's length	The Scheme could suffer reputational or financial loss if related party transactions are not transacted at arm's length and may present non-compliance with the Ethics Policy and Code of Conduct.	
Impact of NHI on Bonitas	Uncertainty due to the lack of defined NHI implementation timelines impacts Bonitas's ability to be positioned as a role player that is complementary to the NHI and to ensure that benefit options remain relevant.	

 **Strategic purchasing**

 **Business development**

 **Connecting with the customer**

 **Integration of value chain**

 **Create value through innovation**

 **Optimise investment returns**

THE BONITAS STRATEGY

Over the past three years, Bonitas has implemented a five-year strategy to achieve its core objective of providing quality and affordable healthcare. The strategy was revised in early 2018 to allow Bonitas to achieve the next level with the defined pillars. The strategy is therefore implemented through the pillars of strategic purchasing, business development, connecting with the customer, value chain integration, value innovation and optimising investment returns.

Bonitas aims to… be a strategic purchaser

Hospital and specialist service provider negotiations

Over the past two decades, healthcare costs have outpaced inflation. The trend of rising healthcare costs is a key concern of the medical aid industry, exacerbated by the non-regulation of some costs.

Bonitas addresses this risk by continually exploring and acting on opportunities to reduce supplier costs, minimise wastage and improve the efficiency of healthcare services. Key initiatives include:

- Strategic purchasing arrangements with defined hospital networks. In 2017, the Scheme entered into three-year partnerships with two large hospital groups in South Africa to reduce the burden of escalating healthcare costs on its members. As the second largest open medical scheme in South Africa, Bonitas uses its market share to negotiate preferential tariffs with carefully selected hospitals to ensure members continue receiving quality care at facilities close to them at the lowest possible tariffs. Inefficient hospital partners are offered the opportunity to improve their performance to avoid being removed from the hospital networks
- Negotiating arrangements with specialist service provider networks to reduce the length of hospital stays and improve the cost-efficiency of treatment, while ensuring quality care for members and appropriate reimbursement for service providers.

Strategic purchasing yielded savings of R290 million in 2018 (2017: R243 million), bringing the total savings over the two-year period to R532 million. It is projected that further cost savings in 2019 will continue benefiting members.

Fraud, waste and abuse management

The industry and Bonitas experience high levels of waste and abuse of members' benefits by certain healthcare professionals. There is also a high incidence of fraudulent claims as a result of collusion between healthcare professionals and, in some instances, members. This behaviour undermines the financial sustainability of Bonitas and, as such, has a negative impact on all members.

Bonitas minimises the impact of this risk by adopting a zero-tolerance approach to fraud, waste and abuse. Since 2016, the Scheme has applied deterrent measures to curb unethical behaviour and reinforce the principles of ethical billing and claims behaviour during the provision of services to medical aid members.

The deterrent measures include:

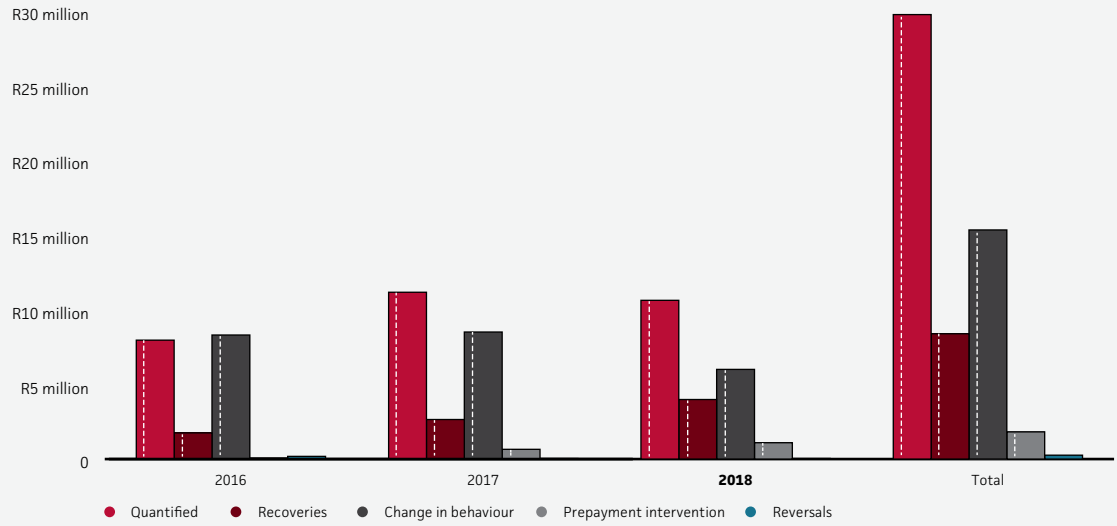
- Raising awareness about fraud, waste and abuse
- Applying abuse prevention tactics
- Using analytical software to identify outlier behaviour
- Employing forensic resources to engage with outliers, conduct investigations if necessary, and manage fraud cases.

Over the past three years, Bonitas has achieved the following successes in its Fraud, Waste and Abuse Prevention Programme:

7 convictions of healthcare practitioners	**28** active criminal cases involving false claims	**54** active cases reported to Health Professions Council of South Africa ("HPCSA")	**762** hotline reports on fraud, waste and abuse
R297 million quantified in fraud, waste and abuse since 2016	**R84 million** recovered thus far	**R153 million** savings from positive change in claiming behaviour	Total savings of **R174 million** realised

THE WORLD OF HEALTHCARE CONTINUED

The following graph demonstrates the amounts quantified, recovered and saved as a result of the Fraud, Waste and Abuse Prevention Programme:



	2016	2017	**2018**	Total
Quantified	R79 559 459	R111 612 302	**R106 207 514**	R297 379 275
Recoveries	R17 528 625	R26 469 445	**R39 846 850**	R83 844 920
Change in behaviour	R83 000 000	R85 000 000	**R60 000 000**	R228 000 000
Prepayment intervention	R729 009	R6 521 052	**R10 941 765**	R18 191 826
Reversals	R1 804 266	R370 557	**R424 133**	R2 598 956

In addition to the R40 million recovered in 2018 by Medscheme Forensics, R3.5 million was recovered on behalf of Bonitas by Qhubeka Forensics Services.

Bonitas aims to… boost business development

Growth of the membership base is critical to our sustainability. While this was achieved through amalgamation with other schemes in the past, the primary focus is now on defining and understanding our target market to retain the existing membership base and attract new members, with an emphasis on younger members.

Key initiatives to achieve the business development strategy are:

- Actively build more distribution channels
- Identify complementary products to be sold
- Build the Bonitas brand
- Re-align the options of the Scheme to address the specific needs of different target groups.

New efficiency discounted options ("EDOs")

Two new EDOs were introduced to meet the evolving needs of members in specific target groups. Following the launch of the BonFit option for younger members in 2017, the Primary Select and BonEssential Select options were launched with effect from 1 January 2019 to provide a more cost-effective alternative to members. Bonitas also introduced benefits for mammograms, prostate screening antigen tests, childhood immunisation and a full suite of care for families.

Broadening the distribution channel

The introduction of Sanlam and Liberty to the Bonitas distribution channel enhanced the existing direct channel and secured new members. This initiative is expected to gain more traction in 2019.

Through collaboration with brokers and other financial services businesses, Bonitas negotiates discounted rates for members on a range of products, including insurance for medical gap cover, life, funeral, income protection and disability.

Repositioning the Bonitas brand

A new branding and marketing strategy to position Bonitas for future growth will be implemented during 2019.

Bonitas started increasing its brand exposure in 2018 as part of a broader communication strategy, taking into account member-focused initiatives where the return is more effective across an economically active population, through social media platforms such as Twitter and Facebook. We aim to promote the brand through electronic marketing campaigns.

Where we have identified specific target groups, we will take a more direct approach to creating brand awareness and we will also increase general brand awareness through our website and member magazine.

Bonitas aims to… connect with the customer

Bonitas focuses on providing quality and affordable healthcare that meets members' evolving needs. Communication is key to engaging with members and ensuring that they get full value for the medical aid cover they have purchased.

The main focus of the strategy to connect with the customer is to:

- Implement a comprehensive customer relationship management programme
- Educate and engage patients to take responsibility for their health and conditions and to manage their medical care in partnership with Bonitas and their healthcare practitioners
- Ensure alignment of broker and Bonitas processes in the engagement of members
- Actively promote openness and approachability.

Quality and affordability

Bonitas offers a range of options to meet a broad spectrum of members' requirements. We assess and adapt our options to changing needs and have implemented an affordable, market-related single-digit contribution increase for 2019.

An electronic health record is used to improve quality and coordination of care through the sharing of information between provider, member and managed care organisations.

Digital engagement

In July 2018, Bonitas implemented a digital plan to improve its engagement with customers who favour the convenience, immediacy and cost-effectiveness of online communication. Improved digital offerings include an upgraded Bonitas app, a chatbot that operates during business hours, a new multi-insurer platform with exclusive deals and offers for Bonitas members, and enhancements to the broker website that allow for self-help functionality.

Broker portal	Chatbot	Member portal	Lead forms
1 237 broker registrations	**319 681** interactions with potential members	**3 984** member activations from web	**40 143** forms completed

Managed care programmes

As the leading causes of death and disability globally, chronic conditions place a significant and increasing burden on most healthcare systems. Prevention and early intervention contribute to the goal of healthier people through better lifestyles and compliance with recommended care regimens.

Diabetes is a key contributor to the rising prevalence of chronic diseases. To manage the disease burden and curtail costs, Bonitas operates an integrated holistic programme to empower diabetic patients to manage their health. The programme manages each member's unique mix of lifestyle factors and chronic conditions associated with diabetes, such as hypertension, high cholesterol, heart disease and depression. By addressing all factors that increase diabetic patients' risk of complication, Bonitas improves the effectiveness of diabetes management. From the programme's inception in 2017 to the end of 2018, Bonitas increased the number of actively managed diabetic patients by 26% to 14 888.

THE WORLD OF HEALTHCARE CONTINUED

Continuous improvement in the health of actively managed diabetic patients reduced hospital admissions of all diabetic patients by 22% between May 2017 and March 2018.

In addition, there has been an intense focus on high-risk diabetics identified by predictive modelling during an integrated chronic care network pilot. This intervention was conducted in collaboration with contracted doctors using an electronic health record and supported by an alternative reimbursement model. A 40% reduction in hospital admissions was achieved during this pilot and we are currently exploring the potential for taking the intervention to scale.

Mental health is a rapidly growing chronic condition in South Africa and is exacerbated by the stresses associated with socioeconomic challenges unique to the country. Mental health features in the top five of Bonitas hospital admissions, and the associated cost increase has necessitated introducing managed care approach to the condition.

Bonitas continues to focus on registering more patients in its range of managed care programmes to enable these members to benefit from the dedicated care offered. Substantial savings have been realised as a result of these programmes and Bonitas continues to explore other opportunities to reduce healthcare costs.

169 008	beneficiaries registered to receive chronic medicine
34 096	beneficiaries on the HIV/AIDS Programme
9 563	beneficiaries on the Cancer Programme
14 888	beneficiaries on the Diabetes Programme
1 816	beneficiaries completed the Back and Neck Programme in 2018

* *31 December 2018.*

Bonitas aims to… integrate the value chain

Bonitas has built partnerships and relationships with many service providers over several years. This has created the opportunity to increase value for customers and optimise the efficiency of our value chain to the mutual benefit of Bonitas and our network of healthcare partners and other service providers.

The key areas we are focusing on to achieve value chain integration are:

- Actively shifting the nature of our partnerships from a client and service provider relationship to partnerships based on investment in a shared future
- Defining and implementing common goals that will enable us to optimise efficiency and create value
- Consolidating our position as the second largest open medical scheme in South Africa.

Bonitas aims to… create value through innovation

Technology is central to the development and continuous improvement of processes that enable members to take responsibility for the management of their healthcare and that of their dependants. As such, technology will be an increasingly important determinant of competitive advantage.

We are responding to this opportunity by:

- Strengthening our alignment with partners in our value chain to ensure we make the most effective use of technology to eliminate waste and deliver seamless processes that improve the experience of our customers
- Leveraging technology to balance affordability, quality and cost-efficiency
- Supporting disruptive strategies to make healthcare technology more easily available to more people
- Actively positioning Bonitas as a key participant in South Africa's future healthcare market.

Bonitas aims to… optimise investment returns

Bonitas optimises the return on investments within its risk appetite. Our investment strategy considers regulations and the constraints imposed by the Board.

The investment portfolio is appropriately diversified, in line with the Bonitas investment policy statement. Asset allocation is managed by taking our asset liability matching into account to ensure sufficient liquid funds exist to meet claims and other liabilities as they fall due. Due to the short-term nature of our liabilities, a significant portion of the investment portfolio is invested in cash instruments.

Sustained weakness in the South African economy and underperformance in domestic equity and property investment markets heavily impacted Bonitas's investment portfolio, resulting in many asset classes recording returns below the targeted return of CPI +4%. Refer to page 16 for further financial commentary.

We responded proactively to regain sound investment returns by appointing a new asset management consultant, who, together with the Investment Committee, held an investment workshop in October 2018 to develop a revised investment strategy for approval by the Board early in 2019. The investment policy statement will be updated in line with the revised strategy and will target a real return of CPI +3.5%.

The market value of Bonitas's investment portfolio at 31 December 2018 was R4.2 billion (2017: R3.9 billion), excluding cash and cash equivalents and investment properties.

REPORT OF THE PRINCIPAL OFFICER

Our members are the cornerstone of our business and we are committed to acting in their best interest at all times.

Mr G van Emmenis
Principal Officer

SCHEME PERFORMANCE

REPORT OF THE PRINCIPAL OFFICER

Performance overview

In 2018, Bonitas focused on consolidating and investing in its future growth. We implemented new initiatives in support of our strategy to provide quality and affordable healthcare, and to position our business as a reliable and sustainable participant in a rapidly evolving healthcare environment.

Bonitas reported a surplus of R164.8 million (2017: R730.2 million) in difficult operating conditions but underperformed relative to our expectations. This was primarily due to disappointing returns on our investment portfolio and higher-than-anticipated claims. Furthermore, our current performance was hindered by an underprovision of the 2017 outstanding claims reserve which was understated by R100.8 million primarily due to slower run-off periods as a result of slower hospital submissions and the implementation of a new claims adjudication system by the administrator. These impacts were mitigated by disciplined management of our healthcare and non-healthcare costs and effective implementation of our strategy.

Notably, our hospital negotiations initiative yielded further savings of R290 million, bringing the total saved over the past two years to R532 million. Robust management of fraud, waste and abuse of our members' benefits resulted in the gross recovery of R39.9 million, part of a total of R68 million in third-party recoveries returned to our risk contribution income for the benefit of our members. Our managed healthcare programmes identified members at risk of chronic diseases and enabled them to manage their healthcare proactively, reducing hospital admissions of diabetes patients and contributing to cost containment in the management of other chronic conditions.

Rising healthcare costs were also mitigated by transferring healthcare risk to third-party partners through risk transfer arrangements. We re-visited the disclosure relating to our risk transfer arrangements in 2018. The Scheme determined that the recoveries reported on the risk transfer arrangements were previously understated as they were calculated at the cost incurred by the third party which is incomplete. In terms of IFRS 4, the Scheme should rather report the recoveries at the cost the Scheme would have incurred had it not entered into the contract with the insurer. The Scheme corrected these disclosures in the annual financial statements and we are pleased to report that, on aggregate, these arrangements are now reported as a net income to the Scheme as opposed to a net expense as previously disclosed. Comparatives were also re-stated but did not impact the surplus reported in 2017.

Effective implementation of the Bonitas strategy

These initiatives were introduced to address significant challenges to the healthcare industry. An increasing trend in the use of healthcare services, largely driven by a higher prevalence of lifestyle diseases such as diabetes and hypertension, and an increase in hospital admissions for mental health and cancer patients contributes to increasing healthcare costs. Ageing membership profiles also increase utilisation, while an oversupply of private healthcare facilities in South Africa's urban areas – in stark contrast to underserved rural areas – exacerbates the trend.

The management of utilisation is one of the main levers that can be used to contain spiralling healthcare costs and make medical aid cover more affordable. Therefore, we use our size in the market to create partnerships with defined networks of hospitals and specialist service providers who can help us limit utilisation and contain costs, without compromising members' access to quality healthcare. It also explains why we emphasise our managed care programmes: by early intervention and ensuring compliance with recommended care regimes, we can prevent or delay the onset of costly chronic diseases, such as diabetes, hypertension, HIV/AIDS, cancer, and back and neck injuries. In 2018, we implemented a managed care programme for mental health, which is one of the fastest growing chronic conditions and one of the top five contributors to hospital admissions in South Africa.

The growing incidence of fraud, wasteful expenditure and abuse of members' benefits is another factor that impacts the cost of medical aid. In partnership with our administrator, we have been meticulous in our zero-tolerance response to these unethical practices, deploying forensic software and other resources to identify and address wrongdoing. Over the past three years, our deterrent measures have yielded savings of R174 million. Significantly, R153 million of this amount is attributable to a positive change in the claiming behaviour of wrongdoers after they were investigated and sanctioned. The Scheme actively engages with its healthcare stakeholders to manage the complexity of forensic monitoring and investigation. Bearing in mind that only about 5% of healthcare providers behave unethically and the balance renders professional services, we involve our doctor and specialist networks in seeking solutions that serve the interests of our members.

Repositioning Bonitas for future growth

During the past two years, Bonitas has consolidated its financial and market position, growing income to R15.7 billion in 2018, exceeding the required solvency ratio of 25% and shoring up reserves of R4.1 billion, while continually responding to the evolving needs of its members. This has created a sound foundation for Bonitas to be repositioned for future growth; however, it will not be an easy task. In an environment of sustained economic weakness and policy uncertainty, most medical aid schemes are impacted by diminishing customer affordability, job losses and a lack of clarity about the impact of the NHI on the private healthcare industry. This has resulted in marginal growth in the number of lives covered by our industry.

With a proven track record of effective implementation of our strategy to manage cost inflation, we have embarked on a range of new initiatives to retain existing members and attract new members, by improving our distribution and communication channels and enhancing benefit options for target member groups, while continuing to curtail healthcare costs. A key focus is the mitigation of the impact of chronic conditions and an ageing membership profile on the Scheme's longer-term sustainability by attracting younger, healthier members.

Technology is central to these initiatives and is likely to be a key determinant of future competitiveness in the healthcare sector, particularly regarding ideas, regulation of patent rights and intellectual property. Technologically driven disruption will play a role in the development of new inventions to improve quality of life and reduce healthcare costs over time. More importantly, it will make these inventions accessible to more people, improving the prospect of achieving integrated healthcare that serves the rich and the poor.

Technology is changing the way we interact with our members, particularly younger members, and real-time access to information and service is fast becoming the norm.

To ensure we adequately respond to the opportunities presented by this changing environment, Bonitas has implemented a digital plan with enhanced platforms to transform the way we connect with our members. This forms part of a broader brand repositioning and marketing strategy that Bonitas will implement during 2019 to position us for future growth. While these developments will improve the experience of many of our members, we recognise that some still favour personal interaction and we will maintain our open-door approach to communication.

In partnership with our administrator, we have also applied measures to manage risks associated with digital transformation, such as cyber crime and breaches of data integrity. Protection of our systems and the personal information of our members is included in the SLAs of service providers and we are in the process of formulating an IT governance framework.

Bonitas is favourably positioned with a broad range of benefit options that appeal to South Africans. We assess our options annually, restructuring them where necessary to ensure they remain responsive to our members' evolving needs. Following the introduction of the BonFit option for younger members in 2017, the Board approved the new Primary Select and BonEssential Select options, which were launched with effect from 1 January 2019 to provide a cost-effective alternative to members. The Scheme also introduced a range of new benefits across its options. One unsustainable option was terminated and members were transferred to other options in a carefully managed process.

Our members are the cornerstone of our business and we are committed to acting in their best interest at all times. Finding innovative ways to connect with our customers to ensure we better service them is critical to achieving this aim. We therefore continue to improve our servicing model, call centre and digital platforms on an ongoing basis.

Revisions to our broker distribution model have broadened our distribution channel, resulting in some growth in membership numbers early in 2019. We expect the impact of introducing Sanlam and Liberty brokers into our distribution channel to improve as their relationships with existing and potential new members mature.

Acknowledgement

Our membership base is an asset of great value and our primary function is to serve our members to the best of our ability. In doing so, we depend on a range of partners and service providers to achieve our strategy of providing quality and affordable healthcare. This requires constant engagement and negotiation to ensure we act in the best interests of our members, while ensuring that our partners and the Bonitas business remain sustainable in the long term.

I wish to thank my Executive Management team and employees, the Board and our partners for their support in achieving sound performance in challenging conditions. I am confident that Bonitas has the necessary financial and human capacity to implement our new strategic initiatives, while continuing to create value from our cost containment and managed care programmes in 2019.

Mr G van Emmenis
Principal Officer

15 April 2019

FINANCIAL RESULTS

Financial commentary

Key financial statistics – 31 December 2018

Net surplus (R'million)	Solvency ratio (%)	Administrative expense as % gross contributions	Claims loss ratio (%)	Loss-making options
164.8	**25.2**	**7.1**	**91.1**	**9**
(2017: 730.1)	(2017: 24.5)	(2017: 7.4)	(2017: 88.0)	(2017: 7)

The Scheme's financial performance for the year was below expectations. This was largely due to the deterioration in gross healthcare results as a consequence of:

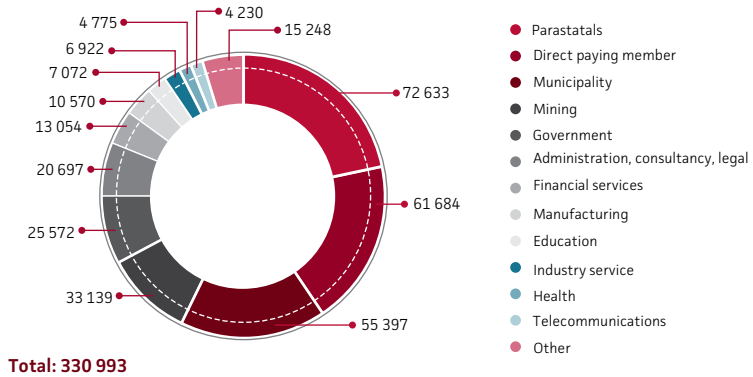
- Membership losses, which restricted the growth of risk contribution income to 5%
- An 8.9% increase in net claims incurred
- The 1% increase in VAT from 1 April 2018, which resulted in an increase in service providers' fees that the Scheme absorbed
- A disappointing 55% decline in investment performance.

Risk contribution income increases marginally

The Scheme experienced a 2.3% decline in membership to 330 993 at 31 December 2018. This was marginally lower than the 2.7% decline in the prior year. However, this reduced the number of lives covered by 2.6% and restricted growth of the risk contribution income, resulting in a marginal 5% increase in risk contribution income to R15.7 billion (2017: R14.9 billion).

Of the Scheme's beneficiaries (total lives covered), 9.45% are 65 years and older. This is a 1.24 percentage point increase since December 2017. Bonitas has implemented strategic interventions to attract and retain younger members.

Bonitas membership – 31 December 2018 (number)



Total: 330 993

Net claims loss ratio increases

Net claims increased by R1.1 billion (8.9%) to R13.9 billion (2017: R12.8 billion). Rising healthcare costs, which typically exceed inflation, are largely driven by tariff increases and higher utilisation of healthcare services. Higher utilisation mainly occurs as a result of higher prevalence of lifestyle diseases (such as diabetes and hypertension) and an increase in the disease burden (notably in-hospital mental health admissions and rising oncology prevalence). The impact of an ageing membership profile also leads to higher utilisation. Of the risk contributions, 91.1% (2017: 88.0%) were used to fund healthcare expenditure.

Positively, the net claims included an amount of R68 million (2017: R51 million) recovered from third parties.

SCHEME PERFORMANCE CONTINUED

Accredited managed care service cost increases

Bonitas offers the following managed care services through its managed care service providers:

- Active risk disease management
- HIV/AIDS management
- Chronic benefits management
- Diabetes management
- Hospital benefits management
- Mental health management (since 1 March 2018).

Costs incurred by managed care services increased by 7.1% in 2018 as part of Bonitas's strategic investment in long-term prevention. We are confident that the managed care expenses will not only result in retention and growth in membership, but also deliver savings in benefit utilisation in the longer term.

Administration expenses increased by 1.1%

Administration expenses comprise operational expenses and the fee paid to the administrator. Administration fees increased by 3.8%, from R778.9 million to R808.6 million which was below the average reported Consumer Price Index ("CPI") for the same period. Other fees such as forensic, marketing and wellness decreased over the financial period which also contributed to the low increase in administration expenditure over the 2018 period.

Dedicated non-healthcare and cost-saving initiatives realised savings in excess of R50 million, largely as a result of a reduction in marketing and other Scheme overheads. Membership-related cost reductions were attributable to lower-than-anticipated membership numbers; and AfroCentric provided Bonitas with a R5.0 million discount on administration and managed care fees.

Administration fees accounted for 5.0% of gross contributions (2017: 5.0%).

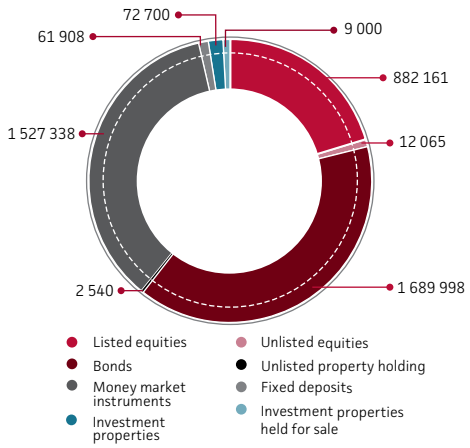
Investment market value of R4.3 billion despite weak returns

Sustained weakness in the South African economy and underperformance in domestic equity and property investment markets heavily impacted the Scheme's investment portfolio, resulting in many asset classes recording returns below the targeted return of CPI +4%.

The JSE All Bond Composite Index returned 7.7% (2017: 10.2%), the Cash STeFi Composite Index returned 7.3% (2017: 6.9%), and the FTSE/JSE All Share Index returned -8.5% (2017: 21.0%). This underperformance resulted in a net fair value loss of R111.9 million compared to a profit of R129.7 million in the prior year. Investment income declined by 55.0% to R197.4 million (2017: R394.3 million).

The market value of the Scheme's investment portfolio at 31 December 2018 was R4.2 billion (2017: R3.9 billion), excluding cash and cash equivalents and investment properties.

Market value (R'000)



Total: R4 257 710

Reported surplus of R164.8 million

Bonitas reported a surplus of R164.8 million for the year (2017: R730.2 million). In difficult operating conditions, this financial performance was achieved mainly as a result of cost-saving initiatives implemented during the year and strategic purchasing. Fraud, waste and abuse interventions are encouraging behaviour change. Disciplined management of relevant healthcare costs, which account for 91.1% of risk contributions, resulted in a saving of R309 million due to the strategic purchasing plan and other partner interventions.

Solvency ratio achieved

Bonitas improved its solvency ratio from 24.5% in 2017 to 25.2% in 2018. In doing so Bonitas achieved the regulatory target two years ahead of schedule which is testament to our commitment to meeting the required solvency level. Strategic initiatives to improve member experience by enhancing benefit options and reducing healthcare costs contributed to the strengthening of the solvency ratio over the past two years.

	2018 R'000	2017 R'000
Members' funds per the statements of financial position	**4 134 028**	3 969 191
Adjusted for:		
Regulation 29 exclusion of unrealised gains on investments	**(23 397)**	(156 341)
Cumulative net gains on re-measurement to fair value of investment properties included in the accumulated funds*	**(15 474)**	(21 774)
Accumulated funds per Regulation 29	**4 095 157**	3 791 076
Gross contributions	**16 276 305**	15 497 049
Solvency ratio (%)	**25.2**	24.5
* *Cumulative net gains/(losses) on re-measurement to fair value of investment properties included in the accumulated funds are calculated as follows:*		
At beginning of the year	***21 774***	*20 374*
Movement in unrealised gains/(losses) on re-measurement to fair value of investment properties included in accumulated funds	***(6 300)***	*1 400*
At end of the year	***15 474***	*21 774*

Reserves of R4.1 billion

Members' funds and reserves increased from R4.0 billion in the prior year to R4.1 billion.

Outstanding claims provision

Bonitas reported an underprovision of R100.8 million relating to the 2017 December incurred but not reported ("IBNR") provision, which negatively impacted the 2018 financial results.

The underprovision was as a result of slower run-off speeds observed for 2017 treatments, notably for November and December 2017, compared to prior year trends and assumptions. This mainly impacted hospitals and specialists.

Bonitas investigated the underprovision that revealed the following major contributing factors:

- The administrator implemented a new claims adjudication module in November 2017, resulting in numerous claims being rejected erroneously. The administrator rectified the system issues early in 2018, but providers and hospitals had to re-submit claims in 2018, which resulted in a slower-than-expected run-off of claims
- Certain hospital groups centralised their billing departments in 2017, resulting in large inefficiencies in claims administration. Claims updates and other outstanding information required from the hospitals were not provided timeously, which contributed to the longer and slower run-off periods. Special task teams were formed by the administrator and the relevant hospital groups to finalise these long-outstanding claims.

Bonitas is confident that these anomalies have been adequately addressed by both the administrator and the hospital groups and that claim run-off periods have stabilised.

Further details regarding the data, methodology and assumptions relating to the outstanding claims provision are provided in note 10 in the annual financial statements.

Actuarial valuation

The actuary reports monthly to Bonitas on the risk status and performs an annual actuarial evaluation. Contributions and benefit levels are re-designed based on the actuary's recommendations. Note 21.4 in the annual financial statements sets a sensitivity analysis to major insurance risk and the effects on the solvency ratio and expected claims.

Did you know?

A difference of 0.5 years in the average age of a Bonitas member can have as much as a **R62 MILLION** effect on total hospital claims in a year. Similarly, if general hospital tariff increases are only 1% higher than expected, the effort can be as high as **R60 MILLION** on total hospital claims.

SCHEME PERFORMANCE CONTINUED

2 Operational statistics

Bonitas Medical Fund 2018	THE BONITAS FAMILY			
	Consolidated total	**Standard**	**BonSave**	**Primary**
Average number of members during the year (n)	**331 955**	**122 028**	**35 282**	**74 323**
Number of members at 31 December (n)	**330 993**	**119 945**	**35 257**	**74 475**
Average number of beneficiaries during the year (n)	**713 190**	**274 668**	**81 882**	**176 714**
Number of beneficiaries at 31 December (n)	**710 206**	**269 831**	**82 115**	**177 390**
Proportion of dependants at end of the year (n)	**1.15**	**1.25**	**1.33**	**1.38**
Risk contributions per average member per month (R)	**3 932**	**5 223**	**3 141**	**3 354**
Risk contributions per average beneficiary per month (R)	**1 830**	**2 320**	**1 353**	**1 411**
Healthcare expenditure per average beneficiary per month (R)	**1 667**	**2 050**	**1 189**	**1 219**
Non-healthcare expenditure per average beneficiary per month (R)	**171**	**177**	**170**	**168**
Relevant healthcare expenditure as a percentage of gross contributions (%)	**87.7**	**88.4**	**74.0**	**86.4**
Relevant healthcare expenditure as a percentage of risk contributions (%)	**91.1**	**88.4**	**87.9**	**86.4**
Non-healthcare expenditure as a percentage of gross contributions (%)	**9.0**	**7.6**	**10.6**	**11.9**
Average beneficiary age (n)	**35**	**36**	**31**	**30**
Pensioner ratio at 31 December (%)	**9.5**	**10.4**	**5.8**	**4.0**
Chronic profile at 31 December (%)	**17.6**	**23.1**	**11.4**	**9.6**

Bonitas Medical Fund 2017	THE BONITAS FAMILY			
	Consolidated total	Standard	BonSave	Primary
Average number of members during the year (n)	339 003	128 299	35 661	72 687
Number of members at 31 December (n)	338 649	127 332	35 364	72 529
Average number of beneficiaries during the year (n)	731 494	292 199	82 144	172 948
Number of beneficiaries at 31 December (n)	728 943	289 391	81 908	172 796
Proportion of dependants at end of the year (n)	1.15	1.27	1.32	1.38
Risk contributions per average member per month (R)	3 664	4 835	2 894	3 117
Risk contributions per average beneficiary per month (R)	1 698	2 123	1 256	1 310
Healthcare expenditure per average beneficiary per month (R)	1 495	1 840	1 037	1 076
Non-healthcare expenditure per average beneficiary per month (R)	164	170	164	161
Relevant healthcare expenditure as a percentage of gross contributions (%)	84.7	86.7	69.4	82.2
Relevant healthcare expenditure as a percentage of risk contributions (%)	88.0	86.7	82.5	82.2
Non-healthcare expenditure as a percentage of gross contributions (%)	9.3	8.0	11.0	12.3
Average beneficiary age (n)	33	35	29	28
Pensioner ratio at 31 December (%)	8.3	8.5	4.8	3.5
Chronic profile at 31 December (%)	16.7	21.7	10.5	8.8

* *Option discontinued as at 31 December 2018.*

THE BONITAS FAMILY

BonCap	BonClassic	BonComp	BonEssential	Standard Select	BonFit	Hospital Standard*	Hospital Plus	Bon-Complete
43 844	**11 035**	**6 604**	**7 877**	**4 875**	**4 092**	**6 749**	**3 534**	**11 712**
45 857	**10 788**	**6 449**	**7 848**	**4 870**	**4 252**	**6 502**	**3 409**	**11 341**
67 091	**20 525**	**12 102**	**17 283**	**10 709**	**8 355**	**12 895**	**6 575**	**24 391**
70 286	**19 980**	**11 768**	**17 255**	**10 672**	**8 723**	**12 407**	**6 261**	**23 518**
0.53	**0.85**	**0.82**	**1.20**	**1.19**	**1.05**	**0.91**	**0.84**	**1.07**
1 447	**5 132**	**7 499**	**2 685**	**4 546**	**2 442**	**3 097**	**4 790**	**4 228**
946	**2 759**	**4 092**	**1 224**	**2 069**	**1 196**	**1 621**	**3 179**	**2 030**
1 045	**2 750**	**4 421**	**1 066**	**2 126**	**891**	**1 509**	**2 680**	**7 236**
115	**199**	**213**	**170**	**184**	**187**	**199**	**213**	**193**
110.5	**85.6**	**92.7**	**87.1**	**102.7**	**63.5**	**93.1**	**104.1**	**81.9**
110.5	**99.7**	**114.0**	**87.1**	**102.7**	**74.5**	**93.1**	**104.1**	**96.1**
12.1	**6.2**	**4.5**	**13.9**	**8.9**	**13.4**	**12.3**	**8.3**	**8.1**
33	**50**	**52**	**36**	**37**	**30**	**46**	**55**	**41**
7.6	**28.7**	**35.7**	**10.9**	**13.4**	**5.2**	**22.3**	**39.6**	**15.7**
9.2	**42.5**	**46.1**	**10.2**	**29.5**	**8.0**	**17.0**	**25.9**	**24.4**

THE BONITAS FAMILY

BonCap	BonClassic	BonComp	BonEssential	Standard Select	BonFit	Hospital Standard*	Hospital Plus	Bon-Complete
42 942	11 704	6 928	8 229	4 045	3 440	7 718	4 049	13 301
45 233	11 522	7 123	8 269	4 038	3 550	7 216	3 836	12 637
64 707	22 118	13 097	17 890	8 846	6 812	14 780	7 744	28 210
68 496	21 649	13 239	17 944	8 782	7 040	13 825	7 279	26 594
0.51	0.88	0.86	1.17	1.17	0.98	0.92	0.90	1.10
1 321	4 697	6 586	2 401	4 122	2 156	2 788	4 455	3 866
877	2 485	3 484	1 104	1 885	1 088	1 456	2 330	1 823
883	2 457	3 909	837	2 000	734	1 324	2 286	1 667
106	188	195	163	178	183	188	195	179
100.7	84.9	91.2	75.8	106.1	57.3	91.0	98.1	77.9
100.7	98.9	112.2	75.8	106.1	67.4	91.0	98.1	91.4
12.1	6.5	4.5	14.8	9.4	14.3	12.9	8.4	8.4
32	48	50	34	37	29	43	52	39
6.6	25.2	31.3	8.9	11.7	5.0	18.9	34.1	13.4
8.4	40.3	43.2	8.7	27.2	6.3	15.0	24.8	22.1

GOVERNANCE

GOVERNANCE STRUCTURE AND FRAMEWORK

The Board is accountable for the governance and oversight of the business of Bonitas. The Board is ultimately responsible for the decision-making and management of the Scheme as well as oversight of strategy implementation. In executing its accountabilities, the Board has developed a governance framework that includes structures in line with the requirements of the MSA, Scheme Rules and good corporate governance practices. The Board is driven by the objective of ensuring that Bonitas acts in the best interests of members while ensuring long-term sustainability of the Scheme. The Board is therefore committed to conducting all its duties in an effective, transparent and ethical manner within a recognised governance system.

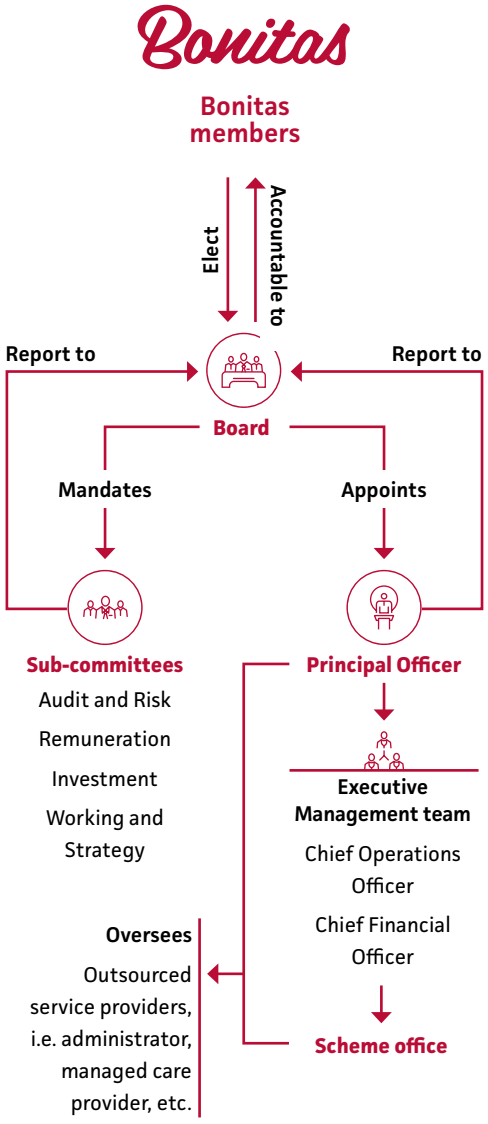
Governing legislation and regulation

The Act and regulations (including proposed Amendment Bill) – all medical schemes in South Africa are governed by the Act.

Scheme Rules – developed and maintained in accordance with the Act and approved by the CMS.

Corporate governance principles – although voluntary for medical schemes, Bonitas is committed to subscribing to King IV™ for additional governance guidance and leading practice on good governance.

Common law – relevant common law principles such as Fit and Proper, Public Funds, Position of Trust, etc.



Board

- Scheme governed by an independent Board
- Trustees duly elected by members of the scheme for a five-year term, as stipulated in the Scheme Rules
- Fit and Proper
- Accountable to Bonitas members.

Sub-committees

- Board supported by four sub-committees to effectively fulfil its duties and responsibilities
- Consist of both Trustees and independent members
- Mandated through defined terms of reference/charters.

Principal Officer

- Board appointed
- Accountable for implementing strategy and any other decisions made by the Board
- Responsible for the day-to-day management of Bonitas
- Fit and Proper
- Supported by an Executive Management team.

GOVERNANCE CONTINUED

BOARD AND GOVERNANCE STRUCTURE

S Claassen (52) *Chairperson*
Mr Claassen has more than 21 years' successful proven experience in the pharmaceutical and medical industry and extensive knowledge of the total healthcare industry, including medical aids. He is skilled in strategic growth and business development and is highly competent in corporate governance and financial management.

0000 1 September 2012 and re-elected on 1 September 2017. Appointed 4 April 2017 as acting Chairperson and 27 May 2017 as Chairperson. **Resigned with effect from 1 March 2019**

O Komane (53) *Vice-Chairperson*
Mr Komane holds an MSc in Engineering Business Management from the University of Warwick. He is the founder and chairman of Bambatha Engineers and Mining Services. Prior to this, he served as the Deputy General Secretary of the National Union of Mineworkers. He brings experience in strategic corporate management and negotiations, has served on numerous boards in various capacities and acquired extensive knowledge as a non-executive director and Trustee.

0000 2 January 2016. Appointed as Vice-Chairperson with effect from 1 October 2017. **Appointed as Chairperson with effect from 11 March 2019**

R Cowlin (64)
Mr Cowlin has 23 years' experience in the medical aid industry and has been involved in several aspects of the industry, including administration, marketing, product design and managed care. He has held various top management positions within Medscheme and was the Managing Director of Aid for AIDS for 10 years.

0000 2 January 2016. **Appointed Vice-Chairperson with effect from 11 March 2019**

HE Nematswerani (52)
Dr Nematswerani is a medical practitioner and has a wealth of experience in the healthcare industry. He holds an MBChB from the University of Natal, a master's in Medical Science (Sports Medicine) and postgraduate diplomas in Occupational Health, Tropical Medicine and Hygiene.

0000 15 October 2016 (previous Trustee of LMS. Appointed to the Bonitas Board pursuant to the amalgamation with LMS). Term ended with effect from 31 March 2019

J Bagg (66)
Mr Bagg is a qualified actuary with 41 years' actuarial, financial management and consulting experience. He has served as Statutory Actuary for numerous life insurance companies and is a Trustee of various retirement funds. In addition, he holds directorships at life insurance and re-insurance companies.

0000 15 October 2016 (previous Trustee of LMS. Appointed to the Bonitas Board pursuant to the amalgamation with LMS). Re-appointed with effect from 1 April 2019

L Koch (54)
Adv Koch holds a BLC and LLB. She is an admitted Advocate of the High Court and is currently employed as a senior at the Specialised Commercial Crimes Unit where she has worked since 2001.

0000 1 October 2017

MG Netshisaulu (42)
Mr Netshisaulu holds an MCom in Taxation. He is a registered tax practitioner with the South African Institute of Taxation Professionals and a member of the Compliance Institute of South Africa. He is currently employed as a Financial Strategic Analyst at the University of South Africa and is studying towards an LLB.

0000 1 September 2017

M Lesunyane (66)
Ms Lesunyane holds a BA from the University of South Africa. She is the founder of Lesunyane Enterprises. She worked at RAF until 2017.

0000 1 September 2012 and re-elected on 1 September 2017

J Usher (59)
Ms Usher is a qualified Chartered Accountant with 25 years' senior executive board experience across various industries, including medical schemes, fast goods, industrial manufacturing, conservation tourism and emerging economic empowerment. She is skilled in corporate governance, financial management, commerce, strategic growth and skills development. She is Chief Financial Officer of Great Plans Conservation Limited.

0000 7 July 2015 and re-elected on 1 September 2017

0000 Trustee appointment/election date

The Board believes that Bonitas has the appropriate mix of skills and experience and will aim to improve its gender diversity in future years.

AUDIT AND RISK COMMITTEE

INVESTMENT COMMITTEE

REMUNERATION COMMITTEE

WORKING AND STRATEGY COMMITTEE

EXECUTIVE MANAGEMENT

G van Emmenis (56) *Principal Officer*
Mr van Emmenis has an MCom from the University of Pretoria and a Diploma in Healthcare Management from the University of Luton. He has extensive experience in the healthcare industry, human resources management, client services and managed care administration. He was Principal Officer of two other medical schemes before joining Bonitas.

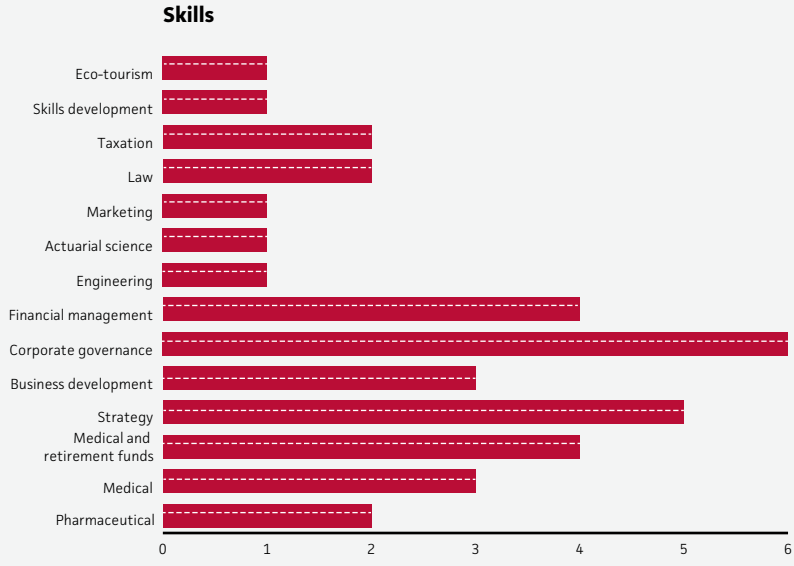
1 July 2017. Resigned with effect from 30 April 2019

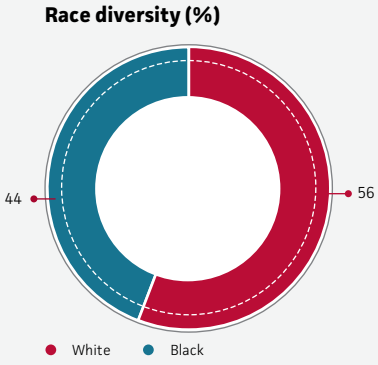
K Marion (49) *Chief Operations Officer*
Mr Marion joined Bonitas in July 2014 as the General Manager responsible for operations. Prior to this, he served as the Bonitas Senior Fund Manager responsible for administrative management. He has managed numerous closed schemes and has a total of 19 years' experience in medical scheme operational management.

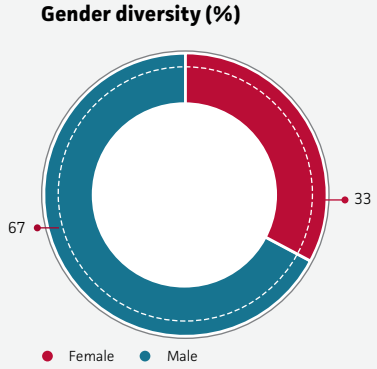
1 August 2017

GC Sanqela (37) *Chief Financial Officer*
Ms Sanqela is a qualified Chartered Accountant, registered with the South African Institute of Chartered Accountants ("SAICA"), and holds a Senior Management Development Programme certificate from Stellenbosch University. She is enrolled for an MCom in Accounting and has experience in financial services and wealth management.

1 January 2017. Resigned with effect from 28 February 2019







Key Board activities performed during 2018

BUSINESS DEVELOPMENT	STRATEGIC PURCHASING	CONNECTING WITH THE CUSTOMER	VALUE CHAIN INTEGRATION	OPTIMISING RETURNS
• We continued to seek and pursue inorganic growth by identifying and pursuing amalgamation partners • We monitored the performance of the benefit options closely and the impact these had on our overall performance. Executive Management was urged to address the loss-making options and provide strategies to improve performance • Member retention was an area of concern that required our attention.	• We oversaw the fraud, waste and abuse initiative • We focused on cost-saving initiatives. Executive Management was urged to identify additional areas to reduce costs and derive additional savings to enable Bonitas to achieve a healthy surplus.	• We considered the value our members derived from our managed care interventions, i.e. Diabetes Management Programme. We also considered ways of improving and strengthening the interventions to reach and impact additional Bonitas beneficiaries • The digital strategy was reviewed, and a budget approved to implement the digital strategy.	• The administrator was engaged on service-related failures and penalised where applicable in line with agreed SLAs • Key healthcare contracts with DENIS were renewed and ER24 was re-appointed following a request-for-proposal ("RFP") process.	• We considered and approved the appointment of the new asset management consultant. The contract of the previous asset management consultant was terminated as a result of service delivery not achieving the Scheme's requirements • We commissioned a revision of the investment strategy • We continued providing oversight through the Investment Committee on the Scheme's investment performance.

Other activities

- The implementation of the strategy was monitored, and the progress and impact reviewed during the year
- The annual budget and financial statements were approved, as per customary annual practice, after a rigorous review process
- Oversight of the key risks facing the Scheme including reviewing and monitoring the effectiveness of the risk management process
- Efforts were made to finalise the CMS inspection through engagements with either the inspector and/or regulator. We are confident that the matter will be resolved
- Policies are considered and approved based on recommendations provided by the sub-committees (the order in which policies are considered depends on matters such as urgency, change in legislation, etc.)
- Sub-committee charters and terms of reference documents are regularly reviewed. New documents were approved for the Remuneration Committee and the Investment Committee
- The updating of member data was a key issue addressed by the Audit and Risk Committee
- The effectiveness of the sub-committees was evaluated and Trustee training was identified as an improvement opportunity for committee members. This matter will be monitored
- The following registers are regularly considered and monitored at ordinary meetings: register of legal matters, contracts register and policy register
- The Board made regular disclosures related to potential conflicts or gifts received as dictated by good governance practice.

BOARD SUB-COMMITTEES

The members reviewed their performance in terms of each sub-committee's mandate and were satisfied that they had performed their responsibilities in accordance with the terms of reference.

The schedule below summarises the attendance by members of the Board, and members of the Audit and Risk, Remuneration, Investment, and Working and Strategy Committees at mandatory Board and committee meetings held during 2018. This includes special meetings and attendance by invitation.

Trustee and/or independent member	Board	Audit and Risk Committee	Remuneration Committee	Investment Committee	Working and Strategy Committee
	Actual number of meetings attended/total number of meetings members could have attended during their period in office				
S Claassen	9/9	5/6	3/4	6/9	8/8
J Bagg	8/9	–	–	8/9	–
R Cowlin	9/9	–	–	9/9	8/8
L Koch	9/9	–	–	1[4]	–
O Komane	8/9	1[2]	2/4	4/9	8/8
M Lesunyane	9/9	–	3/4	–	–
H Nematswerani	9/9	–	–	–	–
M Netshisaulu	9/9	6/6	–	1[4]	1[5]
J Usher	9/9	6/6	–	1[4]	8/8
KG Mbonambi	2[1]	6/6	–	–	–
J Prinsloo	–	6/6	–	–	–
J Ferreira	–	6/6	–	–	–
P Kekana	–	–	7/7[3]	–	–
W Kirima	–	–	–	9/9	–
C van Zyl	–	–	6/7[3]	6/9	–

[1] *Ms KG Mbonambi attended two Board meetings (one scheduled and one special) as the Chairperson of the Audit and Risk Committee.*

[2] *Mr O Komane attended one Audit and Risk Committee meeting on behalf of the Chairperson of the Board.*

[3] *Three additional special meetings were conducted for the Remuneration Committee. All these special meetings were only attended by Ms P Kekane and Mr C van Zyl (independent members) including Executive Management to re-assess the Trustee Remuneration Policy.*

[4] *Ms L Koch, Mr M Netshisaulu and Ms J Usher attended the annual investment day.*

[5] *Mr M Netshisaulu attended one Working and Strategy Committee meeting by invitation.*

AUDIT AND RISK COMMITTEE

MANDATE

In terms of the section 36 of the Act, the Scheme is obliged to have an Audit and Risk Committee, which it has, and which is duly constituted and functional. The Audit and Risk Committee comprises a majority of independent members whose mandate is to assist the Board in discharging its duties relating to the safeguarding of assets; the operation of adequate and effective systems, internal controls and processes; the preparation of financial statements that fairly represent the financial position of the Scheme; oversight of the external and internal audit appointments and functions; oversight of the policies and processes for identifying and assessing business risks of the Scheme; oversight of the risk management processes; oversight of the governance, risk and compliance functions; and to advise on any matter referred to the Committee by the Board.

Committee meetings for the year:

6

OUR KEY ACTIVITIES DURING 2018

- Reviewed the **audited annual financial statements** and **related disclosures** (including the report of the Board) and recommended the annual financial statements to the Board for approval
- Monitored the **quality and effectiveness of the external audit process**, overall performance and independence of the external auditors and considered the audit findings reported in the external audit annual report. Reviewed and approved the external auditor's annual plan including related scope of work and proposed fees
- Monitored the **quality and the effectiveness of the Scheme's outsourced internal audit function**, overall performance including the independence and objectivity of the internal auditors, approved the internal audit risk-based plan including fees and monitored the coverage and execution of the plan. Considered the reports issued by internal audit and monitored and debated the actions taken by management of the Scheme and the administrator with regard to "critical" and "significant" internal audit findings. In addition, considered and challenged the internal audit reports issued by the internal audit function of the administrator
- Monitored the adequacy, efficiency and appropriateness of the **Scheme's risk management processes** and **governance structures**. Participated in a **risk identification workshop** towards the end of the year
- Monitored the adequacy, efficiency and appropriateness of the processes in place for ensuring that the **Scheme complies with relevant legislation and regulatory requirements**, coupled with **policies** reviewed and recommended to the Board for approval
- Continued consideration of the **Scheme's major contracts** (i.e. administration, managed care, etc.) and the management processes in place to **monitor performance against service levels**. This included oversight over the **performance outcomes of the risk transfer arrangements**
- Continued consideration of the **Scheme's fraud, waste and abuse initiatives** including **pending legal** and **criminal matters**.

Members as at 31 December 2018	Capacity	Member since
M Mbonambi	Independent member (Chairperson)	1 September 2014; appointed Chairperson 1 May 2017; resigned 27 January 2019
J Prinsloo	Independent member	1 January 2012; appointed Chairperson 1 February 2019
J Ferreira	Independent member	1 August 2015
J Usher	Trustee member	1 January 2012 Ms J Usher was an independent member of the Audit and Risk Committee for the period 1 January 2012 to 7 July 2015. Following her appointment as a Trustee she became a member of the Audit and Risk Committee in her capacity as a Trustee.
M Netshisaulu	Trustee member	1 October 2017

REMUNERATION COMMITTEE

MANDATE

The purpose of the Remuneration Committee is to assist the Board with oversight of the Bonitas remuneration strategy and related policies while ensuring compliance with these policies. The Remuneration Committee oversees the remuneration of Trustees, independent members and employees.

Committee meetings for the year:

4

OUR KEY ACTIVITIES DURING 2018

- Recommendation of the Committee's **terms of reference** to the Board for approval
- Reviewed the **Trustee Remuneration Policy**, which will be recommended to the Board for consideration and tabled at the next **annual general meeting for approval and adoption**. The independent member Remuneration Policy is handled as a separate policy from the Trustee Remuneration Policy
- Took the decision to implement an **automated human resources system** for the Scheme office
- Undertook a **salary benchmarking** exercise to ensure employees are fairly and competitively remunerated
- Recommendation of the following **human resources policies** for approval by the Board: Probation Policy, Remuneration Policy for Employees, Performance Management Policy, Grievance Policy, Leave Policy and Disciplinary Policy
- Took the decision to replace the **retirement fund consultant**
- Considered and held discussions around the implementation of a proposed **Long-Term Incentive Policy**
- **Performance management ratings** versus **incentives** were reconsidered based on the Board's discretion (i.e. employee rated 3 not awarded an incentive).

STATEMENTS BY THE REMUNERATION COMMITTEE

- Bonitas did not deviate from its remuneration policies for employees, Trustees or independent members, in implementing its remuneration practices during 2018
- It is the view of the Remuneration Committee that the remuneration policies achieved the stated objectives
- We believe the remuneration disclosures in the annual financial statements are sufficient to be considered an implementation report as envisaged by King IV™.

Members as at 31 December 2018	Capacity	Member since
P Kekana	Independent member	2 January 2016; appointed Chairperson 1 October 2017
C van Zyl	Independent member	1 March 2018
O Komane	Trustee member (Board Vice-Chairperson)	1 July 2016
M Lesunyane	Trustee member	1 October 2017

INVESTMENT COMMITTEE

MANDATE

The Investment Committee is responsible for assisting the Board in managing the investment portfolio in line with the investment strategy and policy of Bonitas and ensures compliance with the regulations of the MSA. The Committee advises the Board on strategic matters relating to investment of reserves, ensuring investments are made in the best interests of members.

Committee meetings for the year:

9

OUR KEY ACTIVITIES DURING 2018

- Reviewed the **investment policy statement** and recommended it to the Board for approval
- **Engaged** with the contracted **asset management consultant** to ensure asset allocations achieve agreed targeted returns
- Provided oversight on the **appointment** of a new asset management consultant for approval by the Board
- Recommended that **PMSA assets** would need to have a separate target and benchmark
- Interrogated **investment reports** and identified solutions to improve the investment performance in line with regulatory requirements
- Monitored the **performance of asset managers**.

Members as at 31 December 2018	Capacity	Member since
R Cowlin	Trustee member (Chairperson)	30 June 2016
W Kirima	Independent member	1 June 2014
C van Zyl	Independent member	1 July 2016
J Bagg	Trustee member	15 October 2016

WORKING AND STRATEGY COMMITTEE

MANDATE

The Working and Strategy Committee assists the Board in directing and monitoring the implementation of the strategy, and is responsible for managing procurement and contract management processes and recommending the budget to the Board for its consideration and approval.

Committee meetings for the year:

8

OUR KEY ACTIVITIES DURING 2018

- Reviewed and recommended the proposed **budget** for approval by the Board
- Oversight of the **financial performance** of Bonitas (including **membership movements**)
- Reviewed the **Delegation of Authority** and **Scheme Rules**
- Monitored the progress of the **section 44 inspection** by CMS
- Monitored **progress on key strategic initiatives**, e.g. cost-saving initiatives, hospital partnerships, and fraud, waste and abuse initiatives
- Monitored **progress on sub-committee evaluation** development areas previously identified
- Considered potential **amalgamations**
- Involvement in key **contract management** matters relating to renewals of major contracts, requests for proposals, service delivery issues and the **Procurement Policy**
- Took on the oversight role in the implementation and advancement of the **Scheme's IT governance framework** and **IT strategy** and ensured the alignment of administrator and Bonitas processes.

Members as at 31 December 2018	Capacity	Member since
S Claassen	Chairperson – Board Chairperson	Trustee member since the Committee was established in 2014; appointed Chairperson 23 December 2016
O Komane	Trustee member	1 October 2017
J Usher	Trustee member	28 November 2015
R Cowlin	Trustee member	1 October 2017
G van Emmenis	Principal Officer	Executive member since the Committee was established in 2014. In capacity as Principal Officer, member since 1 July 2017
K Marion	Chief Operations Officer	1 August 2017
C Sanqela	Chief Financial Officer	1 January 2017

OTHER GOVERNANCE MATTERS

Claim for recovery of ceded policies

As previously reported, Bonitas instituted a claim to recover R44 million arising from historic policies ceded to Louis Pasteur Hospital Holdings ("Louis Pasteur"), related to shareholder funding requirements. Subsequent to a 2016 Court judgment in favour of Bonitas, for the full amount plus interest, and an unsuccessful appeal against the judgment by Louis Pasteur in the Supreme Court of Appeal, Louis Pasteur was placed into business rescue. We are now engaging with the business rescue practitioner to pursue our rights as a creditor of Louis Pasteur.

CMS inspection

Bonitas received a notice from the registrar of Medical Schemes in 2014 indicating an intention to inspect certain issues that arose primarily while Bonitas was under curatorship. Bonitas was unsuccessful in its legal challenge of this inspection and agreed to co-operate with the inspector.

Bonitas was informed late in 2018 that the inspector's mandate was terminated and subsequently received an interim final report in January 2019. Bonitas has queried a number of fundamental inaccuracies in the interim final report and was informed in March 2019 that the registrar intends appointing another inspector to finalise the inspection. Bonitas hopes that the inspection will soon be concluded. The inspection does not impact members directly but may result in the Scheme incurring costs for legal remedies where appropriate.

Resignation of Principal Officer

The current Principal Officer of the Scheme, Mr GJ van Emmenis, resigned from this position with effect from 30 April 2019. The Scheme has appointed a new Principal Officer, Mr LR Callakoppen with effect from 1 May 2019.

NON-COMPLIANCE WITH THE MSA

The following areas of non-compliance with the MSA were identified during the course of the financial year (refer to note 26 of the annual financial statements for more details):

Which part of the Act?	Section 33(2)	Section 26(7)
What does it say?	The registrar may withdraw the approval of such benefit options that in his opinion are not financially sound.	Requires that all subscriptions and contributions be paid directly to a medical scheme not later than three days after payment becomes due.
Nature and cause	For the year ended 31 December 2018, the Scheme reported a net healthcare deficit on nine (2017: seven) of its benefit options:	Bonitas has aged debtors of up to 120 days for both group and direct-paying members and is thus in breach of the three-day rule.
Possible impact	Loss-making benefit options erode the solvency margin of the Scheme. However, due to historical member reserves coupled with an efficient return on investments, Bonitas is able to absorb these losses.	During 2018, Bonitas incurred bad debt write-offs of R17.4 million (2017: R20.9 million), which equals 0.11% (2017: 0.14%) of risk contribution income. Significant members' debt could affect the liquidity of Bonitas and its ability to service members and potential non-recoverability of such debtors.
Corrective course of action	Bonitas experienced positive performance on its largest options. In 2018, Standard and Primary reported a net healthcare surplus of R304.6 million and R52.4 million respectively. Much of the positive performance is attributed to successful hospital negotiations, benefit design and the re-alignment of membership into the correct options. Bonitas continues to monitor the performance of the nine benefit options monthly. There are also quarterly operational meetings with the regulator to advise on the performance of these options. Bonitas has adopted a long-term strategy to correct the loss-making options in future, particularly the BonCap and BonComprehensive options. Bonitas has also appointed a task team to drive initiatives that will reduce both healthcare and non-healthcare costs over the next 12 months. These cost-saving measures should have a positive impact on all options.	It is not possible to receive all contributions within three days of the due date, as there may be reasons that prevent payments. In such instances members are notified of the breach. In addition, Bonitas applies mitigating controls to address non-payment of contributions. These include the enforcement of the Scheme's Credit Control Policy. Other interventions include direct management engagement with affected groups to resolve such concerns.

	2018 R'000	2017 R'000
Standard Select	**30 830**	31 049
BonCap	**172 651**	87 216
BonClassic	**46 570**	42 483
BonComp	**109 992**	97 405
BonEssential	**2 396**	–
BonComplete	**33 266**	7 764
BonSave	**6 052**	–
Hospital Standard	**13 548**	10 028
Hospital Plus	**25 116**	14 030

	Section 26(11)	Section 35(8)	Section 59(2)
	Retirement funding of any sort is not considered to be the business of a medical scheme and is prohibited.	A medical scheme may not invest any of its assets in the business of or grant loans to: • An employer group that participates in the medical scheme or any administrator or any arrangement associated with the medical scheme • Any other medical scheme • Any administrator • Any person associated with any of the above.	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 for such benefit was received by the medical scheme.
	As a result of the amalgamation of Bonitas and Protector Health on 1 January 2006, a post-retirement health obligation arose with reference to the provisions stipulated in Protector Health's prior amalgamation agreement with Vaalmed. This resulted in an unavoidable contravention.	Bonitas invested in various entities associated with its administrator and the Scheme's employer groups during the financial year.	Exceptions were found at the beginning of the financial year when claims were put on hold, to ensure that the approved tariff and benefit limits were loaded correctly on the administration platform. This process resulted in a delay in the processing of payments due to the backlog in claims, but only for a few days. Other exceptions included situations where claims were delayed where providers exceeded their monthly limit. These providers are first screened by the forensic team, prior to the limit being lifted, resulting in claims being paid after 30 days.
	There is a limited negative impact on members as Bonitas is currently honouring its obligation to the three members affected by these amalgamations.	The Scheme has invested with various entities associated with its administrator and the Scheme's employer groups during the financial year.	Bonitas is not compliant with the Act and/or its rules. Valid claims could be rejected or amounts due on valid claims could be short-paid. No fraud risks were identified.
	Bonitas obtained an exemption notice on 1 June 2010 in terms of section 8(h) of the Act from the CMS, in respect of this non-compliance.	Bonitas obtained an exemption from the CMS in respect of this non-compliance.	This is not considered to be significant due to the members and providers conforming to the annual practice. The practice above ensures accurate claims processing for the new benefit year and is a risk management measure. The administrator will introduce a special claims run and increase payment runs to reduce these claims being paid after 30 days.

STATEMENT OF RESPONSIBILITY OF THE BOARD OF TRUSTEES

FOR THE YEAR ENDED 31 DECEMBER 2018

Annual financial statements

The Board is responsible for ensuring that Bonitas Medical Fund ("the Scheme") maintains accurate accounting records; the preparation, integrity and fair presentation of the annual financial statements of the Scheme. The annual financial statements comprise the statement of financial position as at 31 December 2018, the statements of comprehensive income, changes in funds and reserves and cash flows for the period ended; and the notes to the financial statements which include a summary of significant accounting policies and other explanatory notes. The annual financial statements presented on pages 41 to 103 have been prepared in accordance with International Financial Reporting Standards ("IFRS") and in a manner required by the Medical Schemes Act of South Africa, No 131 of 1998, as amended.

In the preparation of the annual financial statements, the Board considers that the most appropriate accounting policies have been used, consistently applied and supported by reasonable and prudent judgements and estimates in line with IFRS. The Board is satisfied that the information contained in the annual financial statements fairly represents the results of operations for the year and the financial position of the Scheme as at year-end. The Board also prepares other information included in the annual report and is responsible for its accuracy and consistency with the annual financial statements.

Significant matter

The Trustees re-visited the disclosure relating to the risk transfer arrangements in 2018. The Trustees determined that the recoveries reported in previous financial periods were not calculated and disclosed in line with IFRS 4 Insurance Contracts. Previously, the Scheme reported claim recoveries as the actual claims cost paid by the risk insurer/capitation house. **However, IFRS 4 requires the Scheme to disclose the recoveries as the cost the Scheme would have incurred had it not entered into the capitation agreement.** The cost that the Scheme would have incurred to deliver the specified benefits represents the Scheme's recovery in kind from the managed healthcare provider.

The Scheme accordingly utilised IFRS 4 in its 2018 financial statements, and ensured that the 2017 calculations in respect of the risk transfer arrangements were done so that proper comparisons are made in these financial statements. The Trustees are of the view that utilising IFRS 4, which is used in the industry, will ensure that comparative analyses of risk transfer arrangements between schemes will be properly contextualised, and that the Bonitas risk transfer arrangements are properly benchmarked against that of its peers.

Accounting records and control environment

The Board is responsible for the Scheme's system of internal controls which includes risk management and internal control procedures that are designed to provide reasonable, but not absolute assurance that assets are safeguarded and the risks facing the business are being monitored and controlled. Furthermore, the internal controls are designed to enable the preparation of annual financial statements that are free from material misstatement, whether due to fraud or error, and maintaining adequate accounting records and an effective system of risk management. To the best of its knowledge and belief, based on the above, the Board is satisfied that no material breakdown in the operation of the systems of internal control and procedures has occurred during the year under review.

Going concern

The going concern basis has been adopted in preparing these annual financial statements. The Board has no reason to believe that the Scheme will not be a going concern in the foreseeable future, based on the current financial position and available cash resources. The Scheme's forecasts support the long-term viability of the Scheme.

External auditor's responsibility

The external auditor, Deloitte & Touche, is responsible for reporting on whether the annual financial statements fairly represent the financial position of the Scheme in accordance with the applicable financial reporting framework, and their unqualified audit report is presented on pages 38 to 40. Deloitte & Touche had unrestricted access to all financial records and related data. The Board believes that all representations made to the external auditor during their audit were accurate and appropriate.

Approval of the annual financial statements

The annual financial statements of the Scheme were approved by the Board on 15 April 2019.

Mr O Komane
Chairperson of the Board

15 April 2019

Mr G van Emmenis
Principal Officer

15 April 2019

STATEMENT OF CORPORATE GOVERNANCE

FOR THE YEAR ENDED 31 DECEMBER 2018

Board

The Scheme is committed to the principles and practices of fairness, transparency, responsibility and accountability in all dealings and engagements with its stakeholders. The Trustees are nominated and elected by the members of the Scheme in terms of the Rules of the Scheme and in accordance with the Medical Scheme Act of South Africa, No. 131 of 1998, as amended ("the Act"). The Trustees are required to act with due care, diligence and good faith in the best interests of the Scheme and its members. In pursuit of this, the Trustees conduct themselves in accordance with the Rules of the Scheme, the Act and terms of reference of the Board. Although voluntary for medical schemes, Bonitas is committed to subscribing to King IV™ for additional guidance and leading practice on good governance.

The Board meets regularly and monitors the performance of the Scheme, the administrator and other third-party service providers. The Trustees address a range of key issues and ensure that engagements, review and assessment of policy, governance, strategy and performance are critical, informed and constructive.

The Board further monitors its performance and that of the Board sub-committees against an agreed charter and performance targets.

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

Risk management and internal controls

The Board, through the Audit and Risk Committee, remains ultimately responsible for oversight and approval of risk management within the Scheme. The governance, risk and compliance function is responsible for co-ordinating, facilitating, monitoring and reporting risk within the Scheme. These roles are executed based on an established risk management framework.

The Board is responsible for overseeing the establishment of effective systems of internal controls in order to provide reasonable assurance as to the integrity and reliability of the annual financial statements and to adequately safeguard the Scheme's assets, mainly through an outsourced model (i.e. administrator). The Scheme's internal controls are based on established policies and procedures and are implemented and exercised by trained personnel with the appropriate segregation of duties.

PricewaterhouseCoopers provides an outsourced internal audit function to the Scheme with a direct functional reporting line to the Audit and Risk Committee of the Scheme. In addition, an in-house internal audit function exists within the administrator with regular reporting to executive management including the Audit and Risk Committee of the Scheme.

Mr O Komane
Chairperson of the Board

15 April 2019

Mr G van Emmenis
Principal Officer

15 April 2019

OTHER INFORMATION

OUR CONTACT DETAILS

Officers of the Scheme

Principal Officer *Resigned with effect from 30 April 2019*	Principal Officer *Appointed with effect from 1 May 2019*	Chief Financial Officer *Resigned with effect from 28 February 2019*	Chief Operations Officer
Mr GJ van Emmenis	**Mr LR Callakoppen**	**Ms CM Sanqela**	**Mr K Marion**
Physical address 2nd Floor 34 Melrose Boulevard Melrose Arch Johannesburg 2076	**Physical address** 2nd Floor 34 Melrose Boulevard Melrose Arch Johannesburg 2076	**Physical address** 2nd Floor 34 Melrose Boulevard Melrose Arch Johannesburg 2076	**Physical address** 2nd Floor 34 Melrose Boulevard Melrose Arch Johannesburg 2076
Postal address PO Box 3496 Cramerview 2060	**Postal address** PO Box 3496 Cramerview 2060	**Postal address** PO Box 3496 Cramerview 2060	**Postal address** PO Box 3496 Cramerview 2060

Registered office and postal address of the Scheme	Administrator Medscheme Holdings Proprietary Limited ("Medscheme")	Managed care provider Health Risk Solutions, a division of Medscheme Accreditation number MCO53
Physical address 2nd Floor 34 Melrose Boulevard Melrose Arch Johannesburg 2076	**Physical address** 37 Conrad Drive Florida North 1709	**Physical address** The Boulevard Building F Searle Street Woodstock 7925
Postal address PO Box 3496 Cramerview 2060	**Postal address** PO Box 1101 Florida Glen 1708	**Postal address** PO Box 38632 Pinelands 7430

Investment managers		
Investec Asset Management Proprietary Limited Financial service provider number: 587	**Physical address** 100 Grayston Drive Sandton 2196	**Postal address** PO Box 785700 Sandton 2146
Taquanta Asset Management Proprietary Limited Financial service provider number: 618	**Physical address** 7th Floor Newlands Terrace Boundary Road Newlands Cape Town 7735	**Postal address** PO Box 23450 Claremont 7700
Argon Asset Management Proprietary Limited Financial service provider number: 835 *Service provider was terminated with effect from 1 February 2018.*	**Physical address** 1st Floor Colinton House The Oval 1 Oakdale Road Newlands 8000	**Postal address** PO Box 23254 Claremont 7735

Investment managers

STANLIB Asset Management Limited Financial service provider number: 719 *Service provider was terminated with effect from 30 September 2017. Final proceeds were received in November 2018.*	**Physical address** 17 Melrose Arch Boulevard Melrose Arch 2196	**Postal address** PO Box 220 Melrose Arch 2076
Prescient Investment Management Proprietary Limited Financial service provider number: 612	**Physical address** Prescient House Westlake Business Park Otto Close Westlake 7945	**Postal address** PO Box 31142 Tokai 7966
Prudential Investment Managers (South Africa) Proprietary Limited Financial service provider number: 45199	**Physical address** 5th Floor Protea Place 40 Dreyer Street Claremont Cape Town 7700	**Postal address** PO Box 44813 Claremont 7735
Sanlam Investment Management Proprietary Limited Financial service provider number: 579	**Physical address** 55 Willie van Schoor Avenue Bellville Cape Town 7530	**Postal address** Private Bag X8 Tyger Valley 7536

Investment consultants

Alexander Forbes Financial Services Proprietary Limited Financial service provider number: 1177 *The investment advisory service provider was terminated with effect from 31 July 2018.*	**Physical address** 115 West Street Sandown Sandton 2196	**Postal address** PO Box 787240 Sandton 2146
RisCura Solutions Proprietary Limited Financial service provider number: 46638 *The investment advisory service provider was appointed with effect from 1 August 2018.*	**Physical address** 5th Floor, Montclare Place cnr Campground and Main Roads Claremont Cape Town 7708	**Postal address** PO Box 23983 Claremont 7735

OTHER INFORMATION CONTINUED

Actuaries

Health Risk Solutions, a division of Medscheme Accreditation number MCO53	NMG Consultants and Actuaries Proprietary Limited Financial service provider number: 12968
Physical address The Boulevard Building F Searle Street Woodstock 7925 **Postal address** PO Box 38632 Pinelands 7430	**Physical address** NMG House 411 Main Avenue Randburg 2125 **Postal address** PO Box 3075 Randburg 2125

External auditor	Internal auditor
Deloitte & Touche	**PricewaterhouseCoopers Inc. ("PwC")**
Physical address Building 3 Deloitte Place The Woodlands Woodlands Drive Woodmead 2128 **Postal address** Private Bag x6 Gallo Manor 2052	**Physical address** 4 Lisbon Lane Waterfall City Jukskei View 2090 **Postal address** Private Bag x36 Sunninghill 2157

Deloitte.

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Gallo Manor 2052
South Africa

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INDEPENDENT AUDITOR'S REPORT

TO THE MEMBERS OF BONITAS MEDICAL FUND

Report on the Audit of the Financial Statements

Opinion

We have audited the financial statements of Bonitas Medical Fund (the Scheme), set out on pages 41 to 103, which comprise the statement of financial position as at 31 December 2018 and the statement of profit or loss and other 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, the financial statements present fairly, in all material respects, the financial position of Bonitas Medical Fund as at 31 December 2018, 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 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 *Code of Ethics for Professional Accountants* (Parts A and B). We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Key audit matters

Key audit matters are those matters that, in our professional judgement, were of most significance in our audit of the financial statements of the current period.

This matter was 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 this matter.

INDEPENDENT AUDITOR'S REPORT CONTINUED

TO THE MEMBERS OF BONITAS MEDICAL FUND

The key audit matter	How the matter was addressed in our audit
Outstanding claims provision: As disclosed in Note 10, the carrying amount of the Outstanding Claims Provision ("IBNR") at year end was R813.8 million (2017: R690.3 million). The determination of the IBNR requires the Scheme's Trustees to make assumptions in the valuation thereof, which is determined with reference to an estimation of the ultimate cost of settling all claims incurred but not yet reported at the Statement of Financial Position date. The IBNR calculation is 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; • Variations in the nature and average cost per claim; and • Other factors such as expectations of future events that are believed to be reasonable to be taken into account in the valuation of the IBNR at year end. Certain of the above mentioned factors require judgement and assumptions to be made by the Schemes Trustees and therefore accordingly, for the purposes of our audit, we identified the valuation of the IBNR as representing a key audit matter.	In evaluating the valuation of the IBNR, we audited the calculations approved by the Board of Trustees and performed various procedures including the following: • Testing the Scheme's controls relating to the preparation of the IBNR calculation; • Testing the integrity of the information used in the calculation of the IBNR by performing substantive procedures; • With the assistance of our internal actuarial specialist will perform an independent calculation of the estimate of the provision using historical claims data and trends, and using this estimate as a basis of assessing the reasonableness of the trustee's estimate of the provision; • Performing a retrospective review of the IBNR raised in the 2017 financial year based on actual claims paid in 2018 to verify the assumptions applied to determine the IBNR is reasonable; • Performing tests of detail on the current year IBNR including testing actual claims experienced subsequent to year end and to as close as possible to audit completion date; and • Assessing the presentation and disclosure in respect of the IBNR and consider whether the disclosures reflect the risks inherent in the accounting for the IBNR. The assumptions applied in the IBNR are appropriate and we are satisfied that the movement of the IBNR in the Statement of Comprehensive Income and the related disclosure of the IBNR balance and assumptions are appropriate.

Other information

The Scheme's Trustees are responsible for the other information. The other information comprises the Statement of responsibility by the Board of Trustees, the Statement of corporate governance by the Board of Trustees and the Report of the Board of Trustees as required by Medical Schemes Act of South Africa which we obtained prior to the date of this report. 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.

INDEPENDENT AUDITOR'S REPORT CONTINUED
TO THE MEMBERS OF BONITAS MEDICAL FUND

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.

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

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

Report on other legal and regulatory requirements

Non-compliance with the Medical Schemes Act of South Africa

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

Deloitte & Touche
Registered Auditor

Per: Penny Binnie
Partner

15 April 2019

STATEMENT OF FINANCIAL POSITION

AT 31 DECEMBER 2018

	Notes	**2018 R'000**	2017 R'000
ASSETS			
Property and equipment	4	**5 439**	6 019
Investment properties	5	**72 700**	70 000
Financial assets held at fair value through profit or loss	7	**2 467 694**	2 192 102
Non-current assets		**2 545 833**	2 268 121
Investment property held for sale	6	**9 000**	18 000
Financial assets held at fair value through profit or loss	7	**1 708 316**	1 662 616
Insurance, trade and other receivables	8	**688 016**	761 665
Cash and cash equivalents		**1 230 818**	1 306 002
Scheme cash and cash equivalents	9	**1 230 818**	714 712
Personal medical savings account investment	11.2	**–**	591 290
Current assets		**3 636 150**	3 748 283
Total assets		**6 181 983**	6 016 404
MEMBERS' FUNDS AND LIABILITIES			
Accumulated funds		**4 134 028**	3 969 191
Members' funds		**4 134 028**	3 969 191
Outstanding risk claims provision	10	**813 831**	690 319
Personal medical savings accounts liability	11.1	**592 504**	603 812
Insurance, trade and other payables	12	**641 620**	753 082
Current liabilities		**2 047 955**	2 047 213
Total members' funds and liabilities		**6 181 983**	6 016 404

STATEMENT OF PROFIT OR LOSS AND OTHER COMPREHENSIVE INCOME

FOR THE YEAR ENDED 31 DECEMBER 2018

	Notes	2018 R'000	Restated 2017 R'000
Risk contribution income	13	**15 661 125**	14 906 405
Relevant healthcare expenditure	14	**(14 270 896)**	(13 124 594)
Net claims incurred	14	**(13 892 297)**	(12 751 091)
Risk claims incurred		**(13 960 337)**	(12 802 103)
Third-party claim recoveries		**68 040**	51 012
Accredited managed healthcare services	14	**(479 375)**	(447 771)
Net income on risk transfer arrangements	14	**100 776**	74 268
Risk transfer arrangement fees/premiums paid		**(776 019)**	(780 249)
Recoveries from risk transfer arrangements		**876 795**	854 517
Gross healthcare result		**1 390 229**	1 781 811
Broker service fees		**(295 629)**	(281 235)
Administrative expenditure	15	**(1 151 945)**	(1 139 228)
Net impairment losses on healthcare receivables	16	**(14 316)**	(15 493)
Net healthcare result		**(71 661)**	345 855
Other income		**293 213**	443 650
Investment income – Scheme	17	**197 382**	394 323
Investment income – personal medical savings account	17	**–**	42 365
Change in fair value of investment property	17	**(6 300)**	1 400
Sundry income	18	**102 131**	5 562
Other expenditure		**(56 715)**	(59 345)
Asset management fees		**(15 695)**	(11 326)
Interest expense	11	**(35 161)**	(42 365)
Operating expenses on rental of investment property		**(5 859)**	(5 654)
Surplus for the year		**164 837**	730 160
Total comprehensive income for the year		**164 837**	730 160

STATEMENT OF CHANGES IN MEMBERS' FUNDS AND RESERVES

FOR THE YEAR ENDED 31 DECEMBER 2018

	Accumulated funds R'000	Available-for-sale fair value reserve R'000	Total R'000
Balance as at 31 December 2016	3 137 771	97 229	3 235 000
Total comprehensive income/(loss)	831 420	(97 229)	734 191
Surplus for the year	730 160	–	730 160
IFRS 9 expected credit loss model – opening balance adjustment	4 031	–	4 031
Transfer of available-for-sale reserve to accumulated funds	97 229	(97 229)	–
Balance as at 31 December 2017	3 969 191	–	3 969 191
Total comprehensive income	**164 837**	**–**	**164 837**
Surplus for the year	**164 837**	**–**	**164 837**
Balance as at 31 December 2018	**4 134 028**	**–**	**4 134 028**

STATEMENT OF CASH FLOWS

FOR THE YEAR ENDED 31 DECEMBER 2018

	Notes	**2018 R'000**	2017 R'000
Cash flows from operating activities			
Cash generated by operations before working capital changes	20.1	**69 698**	519 562
Working capital changes			
Decrease/(increase) in insurance, trade and other receivables	20.2.1	**66 878**	(150 520)
(Decrease)/increase in insurance, trade and other payables	20.2.2	**(111 844)**	84 030
Increase in personal medical savings account liability	20.2.3	**75 914**	66 172
Cash generated by operating activities		**100 646**	519 244
Interest paid	11	**(35 161)**	(42 365)
Interest received	17	**6 056**	49 641
Net cash inflow from operating activities		**71 541**	526 520
Cash flows from investing activities			
Acquisition of property and equipment	4	**(1 225)**	(5 162)
Proceeds on disposal of property and equipment		**10**	16
Acquisition of financial assets held at fair value through profit or loss	7	**(13 540 225)**	(9 623 750)
Disposal of financial assets held at fair value through profit or loss	7	**13 322 609**	9 221 532
Interest received	20.3.1	**229 272**	153 814
Dividends received	20.3.2	**45 215**	25 563
Asset management fees	20.3.3	**(15 317)**	(11 095)
Rentals received	20.3.4	**7 820**	7 745
Net cash inflow/(outflow) from investing activities		**48 159**	(231 337)
Net increase in cash and cash equivalents		**119 700**	295 183
Cash and cash equivalents at beginning of the year		**1 111 118**	1 010 819
Analysed as follows:			
Cash and cash equivalents at beginning of the year		**1 306 002**	1 010 819
Transfer of personal medical savings account to investments		**(194 884)**	–
Cash and cash equivalents at end of the year		**1 230 818**	1 306 002
Analysed as follows:			
Scheme cash and cash equivalents	9	**1 230 818**	714 712
Personal medical savings account investment	11.2	**–**	591 290
		1 230 818	1 306 002

NOTES TO THE ANNUAL FINANCIAL STATEMENTS

FOR THE YEAR ENDED 31 DECEMBER 2018

1. GENERAL INFORMATION

The Scheme is a registered non-profit, open medical scheme in terms of the Act and is domiciled in the Republic of South Africa. The Scheme is administered by Medscheme Holdings Proprietary Limited.

2. SIGNIFICANT ACCOUNTING POLICIES

The significant accounting policies applied in the preparation of the annual financial statements are set out below. These policies have been consistently applied to all the years presented, unless otherwise stated.

2.1 Basis of preparation

2.1.1 Statement of compliance

The annual financial statements are prepared in accordance with IFRS and interpretations issued by IFRS Interpretations Committees, as applicable in South Africa, and in the manner required by the Act.

2.1.2 Basis of measurement

These annual financial statements have been prepared on the going concern principle and using the historical cost basis except for fair value through profit or loss financial assets and investment properties that are held at fair value.

Historical cost is generally based on the fair value of the consideration given in exchange for goods and services.

Fair value is the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date, regardless of whether that price is directly observable or estimated using another valuation technique.

In estimating the fair value of an asset or liability, the Scheme takes into account the characteristics of the asset or liability if market participants would take these characteristics into account when pricing the asset or liability at the measurement date. Fair value for measurement and/or disclosure purposes in these financial statements is determined on such a basis.

2. SIGNIFICANT ACCOUNTING POLICIES continued

2.1 Basis of preparation continued

2.1.3 Functional and presentation currency

The annual financial statements are prepared in rand which is the Scheme's functional and presentation currency. All financial information presented has been rounded to the nearest thousand, unless otherwise stated.

2.1.4 New standards, amendments to published standards and interpretations

The following standards, amendments and interpretations are effective for the current financial year. The Scheme has complied with the new standards and interpretations from the various effective dates:

Standard	Details of amendment	Effective date Periods beginning on or after
IFRS 16 Leases	After 10 years of joint drafting by the IASB and FASB, they decided that lessees should be required to recognise assets and liabilities arising from all leases (with limited exceptions) on the statement of financial position. Lessor accounting has not substantially changed in the new standard. The model reflects that, at the start of a lease, the lessee obtains the right to use an asset for a period of time and has an obligation to pay for that right. A lessee measures lease liabilities at the present value of future lease payments. A lessee measures lease assets, initially at the same amount as lease liabilities, and also includes costs directly related to entering into the lease. Lease assets are amortised in a similar way to other assets such as property, plant and equipment. This approach will result in a more faithful representation of a lessee's assets and liabilities and, together with enhanced disclosures, will provide greater transparency of a lessee's financial leverage and capital employed. The Scheme leases its head office building through an operating lease agreement. The Scheme will be required to reflect the lease asset and liability as per the standard above on the statement of financial position. Refer below for the estimated impact on the statement of financial position and statement of comprehensive income at 31 December 2019.	1 January 2019

	R'000
Statement of financial position as at 1 January 2019	
Non-current assets	
Right-of-use asset – head office lease	**9 352**
Non-current liabilities	
Lease liability – head office lease	**(9 352)**
Statement of comprehensive income for the period ended 31 December 2019	
Other expenditure	
Interest expense	**(613)**
Depreciation	**(2 338)**
Statement of financial position as at 31 December 2019	
Non-current assets	
Right-of-use asset – head office lease	**7 014**
Non-current liabilities	
Lease liability – head office lease	**(7 363)**

NOTES TO THE ANNUAL FINANCIAL STATEMENTS CONTINUED

FOR THE YEAR ENDED 31 DECEMBER 2018

2. SIGNIFICANT ACCOUNTING POLICIES continued

2.1 Basis of preparation continued

Standard	Details of amendment	Effective date Periods beginning on or after
IFRS 17 Insurance Contracts	The IASB issued IFRS 17 Insurance contracts and thereby started a new epoch of accounting for insurers. Whereas the current standard, IFRS 4, allows insurers to use their local GAAP, IFRS 17 defines clear and consistent rules that will significantly increase the comparability of financial statements. For insurers, the transition to IFRS 17 will have an impact on financial statements and on key performance indicators. Under IFRS 17, the general model requires entities to measure an insurance contract at initial recognition at the total of the fulfilment cash flows (comprising the estimated future cash flows, an adjustment to reflect the time value of money and an explicit risk adjustment for non-financial risk) and the contractual service margin. The fulfilment cash flows are re-measured on a current basis each reporting period. The unearned profit (contractual service margin) is recognised over the coverage period. Aside from this general model, the standard provides, as a simplification, the premium allocation approach. This simplified approach is applicable for certain types of contracts, including those with a coverage period of one year or less. The Scheme is in the process of assessing the impact of the new standard.	1 January 2021

2.2 Events after reporting date

Recognised amounts in the annual financial statements are adjusted to reflect events arising after reporting date that provide evidence of conditions that existed at the reporting date. Events arising after the reporting date that are indicative of conditions that arose after the reporting date are dealt with by way of a note disclosure.

2.3 Property and equipment

Property and equipment is measured at historical cost less accumulated depreciation and accumulated impairment losses.

Costs include expenditure that is directly attributable to the acquisition of the asset.

Depreciation is calculated using the straight-line method to allocate the cost of items of property and equipment to their residual values over their estimated useful lives.

The depreciation rates applicable to each category of property and equipment for the current and comparative periods are as follows:

- Motor vehicles – five years
- Leasehold improvements – five years
- Computer equipment – one to five years
- Office equipment – one to five years
- Furniture and fittings – one to five years.

Depreciation methods, residual values and useful lives are reviewed at each reporting date and adjusted where appropriate. If the carrying amount of the asset is greater than its estimated recoverable amount, the carrying amount is written down immediately to its recoverable amount.

Subsequent costs are included in an asset's carrying amount or recognised as a separate asset, as appropriate, only when it is probable that future economic benefits associated with the item will flow to the Scheme and the cost of the item can be measured reliably. All other repairs and maintenance costs are recognised in profit or loss during the financial period in which they are incurred.

Gains and losses on disposals are determined by comparing the proceeds from the disposal with the carrying amount of the relevant asset and these are recognised in profit or loss during the financial period.

2. SIGNIFICANT ACCOUNTING POLICIES continued

2.4 Investment properties

Investment properties are initially measured at cost and subsequently measured using the fair value model.

Land and buildings that constitute investment properties are not depreciated. The fair value of investment properties is determined annually by independent external professional valuators using the comparable sales and income capitalisation approaches. The fair value movement is recognised in profit or loss during the financial period.

Any gain or loss on disposal of investment property (calculated as the difference between the net proceeds from disposal and the carrying amount of the item) is recognised in profit or loss.

2.5 Investment property held for sale

Assets are classified as held for sale if the carrying amount will be recovered principally through a sale transaction, not through continuing use. The condition is regarded as met only when the sale is highly probable and the asset is available for immediate sale in its present condition. Upon initial classification as held for sale, current assets are recognised at the lower of carrying amount and fair value less costs to sell.

2.6 Impairment of non-financial assets

The carrying amounts of the Scheme's property and equipment are reviewed at each reporting date to determine whether there are events or changes in circumstances that indicate that the carrying amount may not be recoverable. If any such indication exists, then the affected asset's recoverable amount is estimated.

The recoverable amount of an asset is the higher of its value in use and its fair value less costs to sell. In assessing value in use, the estimated future cash flows are discounted to their present value using a pre-tax discount rate that reflects current market assessments of the time value of money and the risks specific to the asset.

An impairment loss is recognised if the carrying amount of an asset exceeds its estimated recoverable amount. Impairment losses are recognised in profit or loss.

Impairment losses recognised in prior periods are assessed at each reporting date for any indications that the loss has decreased or no longer exists. An impairment loss is reversed if there has been a change in the estimates used to determine the recoverable amount. An impairment loss is reversed only to the extent that the asset's carrying amount does not exceed the carrying amount that would have been determined, net of depreciation, if no impairment loss had been recognised.

2.7 Financial instruments

2.7.1 Classification, recognition and measurement

The Scheme has the following financial instrument categories: Fair value through profit or loss; loans and receivables; and financial liabilities. The Scheme has classified its financial instruments into the following classes:

- Financial assets held at fair value through profit or loss
- Insurance, trade and other receivables
- Cash and cash equivalents
- Insurance, trade and other payables
- Personal member savings accounts liability.

The classification depends on the purpose for which the financial instruments are acquired. Management determines the classification of financial instruments at initial recognition and re-evaluates this at every reporting date.

Financial instruments are initially measured at fair value plus 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.

Regular-way purchases and sales of financial assets and liabilities are recognised on trade date, being the date that the Scheme becomes a party to the contractual rights or obligations of the instrument.

NOTES TO THE ANNUAL FINANCIAL STATEMENTS CONTINUED

FOR THE YEAR ENDED 31 DECEMBER 2018

2. SIGNIFICANT ACCOUNTING POLICIES continued

2.7 Financial instruments continued

2.7.1 Classification, recognition and measurement continued

i) Financial assets held at fair value through profit or loss

These financial assets are initially recorded at fair value excluding transaction costs, which are immediately expensed.

These financial assets are subsequently measured at fair value. The fair value adjustments are recognised in the statement of profit or loss during the financial period.

ii) Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments that are not quoted in an active market other than those that the Scheme intends to sell in the short term. Insurance receivables are classified in this category and are reviewed for impairment as part of the impairment review of loans and receivables. They are included in current assets, except for maturities greater than 12 months after the end of the reporting period. These are classified as non-current assets.

Loans and receivables comprise "insurance, trade and other receivables" (excluding prepayment) and "cash and cash equivalents".

Loans and receivables are subsequently measured at amortised cost using the effective interest method, less impairment losses.

a) Insurance, trade and other receivables

Insurance, trade and other receivables with members (insurance receivables) and these balances are reviewed for impairment as part of the impairment review conducted on loans and receivables.

b) Cash and cash equivalents

Cash and cash equivalents comprise cash on hand, deposits held at call with banks, other short-term liquid investments that are readily convertible to a known amount of cash and are subject to an insignificant risk of change in value, and have an original maturity of 90 days or less.

iii) Financial liabilities

A financial liability is a liability that is a contractual obligation to deliver cash or another financial asset to another entity or to exchange financial assets or financial liabilities with another entity under conditions that are potentially unfavourable to the entity. They are included in current liabilities, except for maturities greater than 12 months after the end of the reporting period. These are classified as non-current liabilities.

Financial liabilities comprise "insurance, trade and other payables" (excluding contributions received in advance and VAT) and "personal member savings accounts liability".

Financial liabilities are recognised initially at fair value less any directly attributable transaction costs. Subsequent to initial recognition, financial liabilities are measured at amortised cost using the effective interest method.

a) Insurance, trade and other payables

Insurance, trade and other payables include payables relating to healthcare insurance contracts.

2.7.2 Impairment of financial assets

i) Loans and receivables

The Scheme's loans and receivables do not contain a significant financing component and therefore the loss allowance is measured at initial recognition as the expected the credit losses ("ECLs")that result from all possible default events over the expected life of a financial instrument in accordance with IFRS 9. As a practical expedient, IFRS 9 allows a provision matrix to be used to estimate ECL for these financial instruments.

The provision matrix is based on historical observed default rates, adjusted for forward looking estimates. At every reporting date, the historical observed rates are updated. Objective evidence that a financial asset or group of assets is impaired includes observable data that comes to the attention of the Scheme about the following events:

- The Scheme is unable to collect all amounts due according to the original terms of the receivables
- Significant financial difficulty of the issuer or debtor
- A breach of contract, such as a default or delinquency in payments by the debtor
- The disappearance of an active market for that financial asset because of financial difficulties
- National or local economic conditions that correlate with defaults on the assets in the Scheme.

2. SIGNIFICANT ACCOUNTING POLICIES continued

2.7 Financial instruments continued

2.7.2 Impairment of financial assets continued

i) Loans and receivables continued

It is in respect of contributions receivable, member and service provider debit balances and advances from savings plan accounts recoverable by management. The Scheme utilises readily available economic information such as consumer price index, healthcare inflation, national credit rating and unemployment indicators as a basis for determining the future expectations of the observable data.

If it is determined that a possible impairment loss will be incurred on loans and receivables measured at amortised cost, the amount of the loss is measured as the difference between the present value of the cash flows due under the contract and the present value of the cash flows that the entity expects to receive. These losses are recognised at initial recognition in profit or loss and reflected in an allowance account.

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 (such as improved credit rating), the previously recognised impairment loss is reversed directly to profit or loss.

2.7.3 Derecognition of financial instruments

Financial assets are derecognised when the rights to receive cash flows from the assets have expired, the right to receive cash flows has been retained but an obligation to pay them in full without material delay has been assumed or the right to receive cash flows has been transferred together with substantially all the risks and rewards of ownership.

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

Where the Scheme neither transfers nor retains substantially all the risks and rewards of ownership of the financial asset, the Scheme determines whether it has retained control of the financial asset. If the Scheme has not retained control, it derecognises the financial asset and recognises separately as assets or liabilities any rights and obligations created or retained in the transfer; and if the Scheme has retained control, it continues to recognise the financial asset to the extent of its continuing involvement in the financial asset.

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

2.7.4 Offset

Financial assets and liabilities are offset and the net amount reported in the statement of financial position only when there is a legally enforceable right to offset the recognised amounts and there is an intention to settle on a net basis, or to realise the asset and settle the liability simultaneously.

2.8 Insurance contracts

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

2.9 Outstanding claims provision

Outstanding claims comprise provisions for the Scheme's estimate of the ultimate cost of settling all claims incurred but not yet reported ("IBNR") at the reporting date. Outstanding claims are actuarially 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
- Variations in the nature and average cost incurred per claim.

Estimated co-payments and payments from savings plan accounts are deducted in calculating the outstanding claims provision. The Scheme does not discount its provision for outstanding claims, since the effect of the time value of money is not considered material. The estimation of claims to be paid by the Scheme is up to four months after reporting date.

NOTES TO THE ANNUAL FINANCIAL STATEMENTS CONTINUED
FOR THE YEAR ENDED 31 DECEMBER 2018

2. SIGNIFICANT ACCOUNTING POLICIES continued

2.10 Liabilities and related assets under liability adequacy test

The liability for insurance contracts is tested for adequacy by discounting current estimates of all future contractual cash flows, including related cash flows, and comparing this amount to the carrying value of the liability. Where a shortfall is identified, an additional provision is made and the Scheme recognises the deficiency in profit or loss for the year.

2.11 Personal medical savings account ("PMSA") liability

The PMSA liability is managed by the Scheme on behalf of its members. It represents PMSA contributions, which are a deposit component of the medical insurance contracts and accrued interest thereon, net of any PMSA claims paid on behalf of members in terms of the Scheme's rules. The deposit component has been unbundled since the Scheme can measure the deposit component separately and its accounting policies do not otherwise require it to recognise all obligations and rights arising from the deposit component. The medical insurance component is recognised in accordance with IFRS 4 Insurance Contracts.

Members' unused savings at year-end are retained in the members' PMSAs. In terms of the Act, balances standing to the credit of members are refundable in accordance with the Scheme Rules.

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

The PMSA liability, i.e. deposit component, is recognised in accordance with IFRS 9 and is initially measured at fair value (i.e. the amount payable on demand) because it has a demand feature and subsequently measured at amortised cost.

PMSA contributions are credited on the deposit basis and withdrawals on a cash basis, i.e. no provision is made for outstanding claims at year-end.

2.12 Risk contribution income

Contributions on member insurance contracts are accounted for monthly when their collection in terms of the insurance contract is reasonably certain. Risk contributions represent the gross contributions per the registered rules after the unbundling of savings contributions. The earned portion of risk contributions received is recognised as revenue. Risk contributions are earned from the date of attachment of risk, over the indemnity period on a straight-line basis. Risk contributions are shown before the deduction of broker service fees.

2.13 Relevant healthcare expenditure

Relevant healthcare expenditure consists of net claims incurred and net income or expenses from risk transfer arrangements and accredited managed care services as per Circular 56 of 2015.

2.13.1 Risk claims incurred

Risk claims incurred comprise the total estimated cost of all claims arising from healthcare events that have occurred in the year and for which the Scheme is responsible in terms of its registered rules, whether or not reported by the end of the year. Net risk claims incurred represent claims incurred net of discounts received, recoveries from members for co-payments, PMSA and recoveries from third parties.

2.13.2 Risk transfer arrangements

The risk transfer arrangements comprise the provision of medical services that are outsourced to third parties of the Scheme. A risk transfer arrangement is defined by IFRS 4 as an insurance contract issued by one insurer ("the re-insurer") to compensate another insurer ("the cedant") for losses on one or more contracts issued by the cedant. The cost the Scheme would have incurred to deliver the specified benefits had it not entered into the capitation agreement, represents the Scheme's exposure to its members, as the capitation agreement cannot absolve the Scheme from its responsibility towards its members. Only contracts that give rise to a significant transfer of insurance risk are accounted for as risk transfer arrangements. Risk transfer fees are recognised as an expense over the indemnity period on a straight-line basis. Where applicable, a portion of risk transfer fees is treated as pre-payments.

Capitation fees relating to risk transfer arrangements are calculated on a per member per month basis.

Risk transfer claims and benefits reimbursed are presented in profit or loss and the statement of financial position on a gross basis. Amounts recoverable under such contracts are recognised in the same year as the related claim.

Claims recoveries relating to risk transfer arrangements represent a recovery in kind of the amount that the Scheme would have incurred in claims, had the risk transfer arrangement not been in place.

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. Such 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 and that the event has a reliably measurable impact on the amounts that the Scheme will receive under the risk transfer arrangement.

2. SIGNIFICANT ACCOUNTING POLICIES continued

2.14 Employee benefits

2.14.1 Defined contribution plans

A defined contribution plan is a post-employment benefit plan under which an entity pays fixed contributions into a separate entity and will have no legal or constructive obligation to pay further amounts. Obligations for contributions to defined contribution pension plans are recognised as an employee benefit expense in profit or loss when they are due. Prepaid contributions are recognised as an asset to the extent that a cash refund or a reduction in future payments is available.

2.14.2 Short-term benefits

Short-term employee benefit obligations are measured on an undiscounted basis and are expensed in profit or loss during the period in which the employee renders the related service.

A liability is recognised for the amount expected to be paid under short-term cash bonus plans if the Scheme has a present legal or constructive obligation to pay this amount as a result of past service provided by the employee and the obligation can be estimated reliably.

2.15 Operating leases

The Scheme leases property. Under the leasing agreements where all the risks and rewards of ownership are effectively retained by the lessor, the agreements are classified as operating leases. Payments made under operating leases are recognised in profit or loss on a straight-line basis over the period of the lease.

2.16 Investment income

Investment income comprises: interest on call accounts, current accounts, bonds and money market instruments; dividend income; rental income from investment properties; net fair value gains on financial assets at fair value through profit or loss; changes in the fair value of investment property; and gains/losses on disposal of investment properties.

2.16.1 Interest income

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

2.16.2 Dividend income

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

2.16.3 Rental income

Assets leased to third parties are included in investment property in the statement of financial position. Lease income from operating leases is recognised in profit or loss on a straight-line basis over the lease term.

2.17 Allocation of income and expenses to benefit options

The following items are directly allocated to benefit options:

- Risk contribution income
- Net claims incurred
- Net expenses on risk transfer arrangements
- Net impairment losses
- Administration fees
- Managed care: management services
- Broker service fees
- Interest on savings plan liability.

The remaining non-healthcare costs are apportioned based on the number of members per option divisible by total membership on the Scheme for the financial period:

- Other administrative expenditure
- Net impairment losses
- Investment income
- Sundry income
- Asset management fees.

NOTES TO THE ANNUAL FINANCIAL STATEMENTS CONTINUED

FOR THE YEAR ENDED 31 DECEMBER 2018

3. USE OF ESTIMATES AND JUDGEMENTS

The preparation of the annual financial statements in conformity with IFRS requires management to make judgements, estimates and assumptions that affect the application of the accounting policies and the reported amounts of assets, liabilities, income and expenses. The areas involving a higher degree of judgement or complexity, or areas where assumptions and estimates are significant to the annual financial statements, are disclosed below.

Estimates and underlying assumptions are continually evaluated and reviewed on an ongoing basis and are based on historical experience and other factors, including expectations of future events that are believed to be reasonable under the circumstances. Revisions to accounting estimates are recognised in the period in which the estimates are revised and in any future periods affected.

The Scheme makes estimates and assumptions concerning the future. The resulting accounting estimates will seldom equal the related actual results. The estimates and assumptions that have a risk of causing a significant adjustment to the carrying amount of assets and liabilities within the next financial year are discussed below.

3.1 Determination of outstanding claims provision

The provision for outstanding risk claims has been calculated using an actuarial valuation. The method used by the actuary, including information about significant areas of estimation, uncertainty and critical judgements applied, is discussed in note 10 outstanding risk claims provision.

3.2 Determination of fair values

Investment properties, available-for-sale financial instruments and fair value through profit or loss financial instruments are measured at fair value. Fair values have been determined for measurement and/or disclosure purposes based on the methods listed below. Where applicable, further information about the assumptions made in determining fair values is disclosed in the notes specific to that asset or liability.

3.2.1 Investment properties

An independent valuation company, having appropriate recognised professional qualifications and recent experience in the location and category of property being valued, values the Scheme's investment property portfolio annually.

Valuations reflect, when appropriate, the type of tenants actually in occupation or responsible for meeting lease commitments or likely to be in occupation after letting vacant accommodation, and the market's general perception of their creditworthiness; the allocation of maintenance and insurance responsibilities between the Scheme and the lessee; and the remaining economic life of the property.

3.2.2 Fair value through profit or loss financial assets

Financial assets classified as level 2 are valued using a discounted cash flow method. For unlisted equity financial assets, fair value was determined by the Board using the net asset value valuation approach.

The unlisted property holding is valued based on the fair value of the underlying property. The property is valued using the net income of the property and applying a capitalisation rate to the net income. The capitalisation rate applied is based on an assumed average commercial property yield simulating the risk characteristics of a similar investment. The majority of investments held within the portfolio are subject to various assumptions based on valuation techniques not supported by observable market data.

3.3 Discount rates

The discount rates used are the appropriate pre-tax rates that reflect the current market assessment of the time value of money and the risks specific to the assets and liabilities being measured for which the future cash flow estimates have not been adjusted.

3.4 Unconsolidated investment structures

The Scheme has involvement with investment funds in which it invests but it does not consolidate. The investment funds meet the definition of structured entities because:

- The voting rights in the funds are not dominant rights in deciding who controls them because they relate to administrative tasks only
- Each fund's activities are restricted by prospectus
- The funds have narrow and well-defined objectives to provide investment opportunities.

3.5 Investment in associate

The investment of 26% in Louis Pasteur Hospital Holding Proprietary Limited has not been accounted for as an investment in associate as the Scheme is not actively involved and does not have significant influence over the entity. The investment has been accounted for as an unlisted investment and classified as a financial asset held at fair value through profit or loss.

4. PROPERTY AND EQUIPMENT

	Motor vehicles R'000	Leasehold improvements R'000	Computer equipment R'000	Office equipment R'000	Furniture and fittings R'000	Total R'000
Cost						
Balance at 31 December 2016	–	1 954	4 368	69	3 938	10 329
Additions	359	3 783	377	19	624	5 162
Disposals/scrappings	–	(1 954)	(91)	–	(15)	(2 060)
Balance at 31 December 2017	359	3 783	4 654	88	4 547	13 431
Additions	**–**	**507**	**601**	**17**	**100**	**1 225**
Disposals/scrappings	**–**	**–**	**(33)**	**–**	**(89)**	**(122)**
Balance at 31 December 2018	**359**	**4 290**	**5 222**	**105**	**4 558**	**14 534**
Accumulated depreciation						
Balance at 31 December 2016	–	1 647	3 890	48	2 447	8 032
Disposals/scrappings	–	(1 954)	(75)	–	(15)	(2 044)
Depreciation for the period	72	430	318	14	590	1 424
Balance at 31 December 2017	72	123	4 133	62	3 022	7 412
Disposals/scrappings	**–**	**–**	**(33)**	**–**	**(89)**	**(122)**
Depreciation for the period	**72**	**858**	**398**	**12**	**465**	**1 805**
Balance at 31 December 2018	**144**	**981**	**4 498**	**74**	**3 398**	**9 095**
Carrying amount						
Balance at 31 December 2017	287	3 660	521	26	1 525	6 019
Balance at 31 December 2018	**215**	**3 309**	**724**	**31**	**1 160**	**5 439**

Details of the property and equipment are recorded in an asset register which may be inspected at the registered office of the Scheme. No assets have been pledged as security.

NOTES TO THE ANNUAL FINANCIAL STATEMENTS CONTINUED

FOR THE YEAR ENDED 31 DECEMBER 2018

	2018 R'000	2017 R'000
5. INVESTMENT PROPERTIES		
Balance at beginning of the year	**70 000**	87 600
Transfer to investment property held for sale (note 6)	**–**	(19 000)
Fair value increase in investment property	**2 700**	1 400
Balance at end of the year	**72 700**	70 000
Direct operating expenses incurred in the generation of rental income applicable to investment properties	**5 859**	5 654

Investment properties comprise commercial properties that are leased to third parties. The properties are leased for various periods. Subsequent renewals are negotiated with the lessee. No contingent rents are charged. Refer to note 23 of the financial statements for minimum future lease rental receivables from lessees. Lease rentals amounting to R7.7 million (2017: R8.0 million) relating to the lease of investment properties are included in profit or loss (refer to note 17). The vacant property comprising land was re-classified as investment property held for sale following a resolution of the Board to dispose of the vacant land (refer to note 6).

The estimated open market value for developed commercial property leased to third parties was determined by independent property valuators DDP Valuations & Advisory Services Proprietary Limited using an income capitalisation approach. The capitalisation rate used in determining the open market value was 9% (2017: 9%).

	2018 R'000	2017 R'000
6. INVESTMENT PROPERTY HELD FOR SALE		
Balance at beginning of the year	**18 000**	–
Transfer from investment property at fair value	**–**	19 000
Provision for selling costs	**–**	(1 000)
Fair value decrease in investment property held for sale	**(9 000)**	–
Balance at end of the year	**9 000**	18 000

Investment property held for sale comprises the Bryanston Commercial Property.

The estimated open market value for the vacant property was determined by independent property valuators DDP Valuations & Advisory Services Proprietary Limited using a comparable sales approach.

On 14 March 2019, the Scheme received an offer following public auction of the property. The Board approved the sale of the property and accepted the offer in April 2019.

The fair value of R9 million represents the net selling price of the property after taking into account all costs associated with the sale of the property.

		2018 R'000	2017 R'000
7.	**FINANCIAL ASSETS HELD AT FAIR VALUE THROUGH PROFIT OR LOSS**		
	Balance at beginning of the year	**3 854 718**	304 917
	Transfer from available-for-sale investments	**–**	2 948 129
	Additions/re-investments	**13 540 225**	9 623 750
	Withdrawals	**(13 322 609)**	(9 221 532)
	Transfer from personal medical savings account (note 11.2)	**194 884**	–
	Interest income re-invested	**20 574**	69 139
	Dividend income re-invested	**471**	853
	Asset managers' fees capitalised in investments	**(378)**	(231)
	Net fair value (losses)/gains on fair value assets through profit or loss (note 17)	**(111 875)**	129 693
	Balance at end of the year	**4 176 010**	3 854 718
	Non-current	**2 467 694**	2 192 102
	Current	**1 708 316**	1 662 616
		4 176 010	3 854 718
	Comprises:		
	Listed equities	**882 161**	1 131 816
	Unlisted equities	**12 065**	12 065
	Bonds	**1 689 998**	1 380 822
	Money market instruments	**1 527 338**	1 327 704
	Unlisted property holding	**2 540**	2 311
	Fixed deposits	**61 908**	–
		4 176 010	3 854 718

NOTES TO THE ANNUAL FINANCIAL STATEMENTS CONTINUED

FOR THE YEAR ENDED 31 DECEMBER 2018

		2018 R'000	2017 R'000
8.	**INSURANCE, TRADE AND OTHER RECEIVABLES**		
8.1	**Insurance receivables**		
	Contributions outstanding	**626 122**	706 374
	Recoveries due from members for co-payments	**8 693**	6 969
	Service provider receivables	**4 304**	2 551
	Receivables under risk transfer arrangements	**48 823**	36 505
	Savings plan account advances (note 11)	**5 407**	6 291
	Allowance for impairment losses	**(12 103)**	(10 327)
	Balance at 1 January	**(10 327)**	(13 280)
	IFRS 9 opening balance adjustment	**–**	4 031
	Increase in provision charged to profit or loss	**(1 776)**	(1 078)
	Total insurance receivables	**681 246**	748 363
8.2	**Trade and other receivables**		
	Prepaid expenses	**3 452**	3 716
	Amount owing from Helios IT Solutions Proprietary Limited	**–**	5 896
	Other receivables	**3 318**	3 690
	Interest receivables	**22**	710
	Rent receivables	**234**	202
	Rent deposit	**1 533**	1 516
	Sundry receivables	**1 529**	1 262
	Total trade and other receivables	**6 770**	13 302
	Total insurance, trade and other receivables	**688 016**	761 665
	The carrying amounts of receivables approximate their fair values due to the short-term maturities of these assets.		
9.	**CASH AND CASH EQUIVALENTS**		
	Cash with investment managers	**902 941**	121 865
	Call accounts	**64 459**	202 106
	Current accounts	**263 418**	390 741
	Total cash and cash equivalents	**1 230 818**	714 712
10.	**OUTSTANDING RISK CLAIMS PROVISION**		
	Covered by risk transfer arrangements	**48 823**	36 505
	Not covered by risk transfer arrangements	**765 008**	653 814
	Outstanding risk claims provision incurred but not yet reported (IBNR)	**813 831**	690 319

	Covered by risk transfer arrangements R'000	Not covered by risk transfer arrangements R'000
10. OUTSTANDING RISK CLAIMS PROVISION continued		
2018		
Analysis of movements in outstanding risk claims		
Balance at 1 January	**36 505**	**653 814**
Payments in respect of prior year claims	**(36 505)**	**(754 564)**
Underprovision in prior year*	**–**	**(100 750)**
Adjustment for current period	**48 823**	**865 758**
Balance at 31 December	**48 823**	**765 008**
Net exposure in respect of outstanding risk claims		
Gross outstanding risk claims		**813 831**
Less: Estimated risk transfer arrangements recoveries		**(48 823)**
Net outstanding risk claims		**765 008**
2017		
Analysis of movements in outstanding risk claims		
Balance at 1 January	30 271	504 491
Payments in respect of prior year claims	(30 271)	(552 281)
Underprovision in prior year	–	(47 790)
Adjustment for current period	36 505	701 604
Balance at 31 December	36 505	653 814
Net exposure in respect of outstanding risk claims		
Gross outstanding risk claims		690 319
Less: Estimated risk transfer arrangements recoveries		(36 505)
Net outstanding risk claims		653 814

* *The underprovision of R100.8 million in the prior year (2017) was as a result of slower run-off speeds observed for 2017 treatments, notably for November and December 2017, compared to prior year trends and assumptions used. This mainly impacted hospitals and specialists and can be illustrated as follows:*

	Hospitals		Specialists	
Month	Actual run-off observed in 2017 %	Assumed run-off %	Actual run-off observed in 2017 %	Assumed run-off %
0	27	30	48	48
1	79	81	85	87
2	91	93	91	93
3	95	96	94	96
4	97	99	96	98
5	98	99	97	99
6	99	100	98	99
7	99	100	98	99
8	99	100	99	100
9+	99	100	99	100

NOTES TO THE ANNUAL FINANCIAL STATEMENTS CONTINUED
FOR THE YEAR ENDED 31 DECEMBER 2018

10. OUTSTANDING RISK CLAIMS PROVISION continued

Data, methodology and assumptions

10.1 Data

The primary source of data used in this exercise was the Medscheme data warehouse. This contained the necessary contributions, risk claims and other data of the Scheme. The data used included all claim payments and membership movements up to the end of February 2019.

Data was compared to the Scheme's December 2018 management accounts and found to be consistent after adjusting for manually paid claims.

10.2 Process used to determine the assumptions

The process used to determine the assumptions is intended to result in estimates of the most likely or expected outcome. The sources of data used as inputs for the assumptions are generated internally, using detailed studies that are carried out regularly (at least annually).

The general methodology involves increasing the claims paid so as to estimate the total claim amounts expected for treatments occurring up to 31 December 2018. The difference between the total expected risk claims and the paid risk claims is the outstanding risk claims provision.

The provisions are based on information currently available; however, the ultimate liabilities may vary as a result of subsequent developments. The impact of many of the items affecting the ultimate costs of the risk claims is difficult to estimate. The provision estimation difficulties also differ by category of risk claims (i.e. in-hospital, chronic and above-threshold benefits) due to differences in the underlying medical insurance contract, claim complexity, the volume of risk claims, the individual severity of risk claims, determining the occurrence date of a claim and reporting lags.

Run-off factors are most reliable as a predictive tool where outstanding claims are relatively small and the payment pattern is stable over time. Actuarial run-off triangle techniques are applied to estimate the total expected claims. In particular, run-off factors (development factors) are used to calculate the remaining outstanding claims with respect to a particular treatment month, as it takes several months for all claims to be paid, due to delays in receiving or processing claims. Members must submit all claims for payment within four months of seeking medical treatment. However, some claims do take significantly longer than four months to settle. One would expect the most recent month to have a significant proportion of claims still to be paid. This proportion would decrease each preceding month, with all claims assumed to have been fully paid about nine months after treatment. These run-off factors are calculated by considering the Scheme's recent experience on the pattern of when claims occur and when they are paid. It is assumed that payments will emerge in a similar way in each treatment month. In determining run-off factors, claims are categorised into groups for which one can expect a homogeneous run-off pattern to emerge.

The above method uses historical risk claims development information and assumes that the historical risk claims development pattern will occur again in the future. There are reasons why this may not be the case, which, insofar as they can be identified, have been allowed for by modifying the methods. Such reasons include:

- Changes in processes that affect the development/recording of risk claims paid and incurred (such as changes in claim reserving procedures)
- Economic, political and social trends
- Changes in composition of members and their dependants
- Random fluctuations, including the impact of large losses.

10. OUTSTANDING RISK CLAIMS PROVISION continued

Data, methodology and assumptions continued

10.2 Process used to determine the assumptions continued

The calculations are based on treatment dates rather than payment dates. Treatment dates are the dates on which treatment of the member actually occurs, while payment date refers to the date on which the health practitioner was actually paid.

10.3 Assumptions

The assumptions that have the greatest effect on the measurement of the outstanding risk claims provision are the run-off factors for the 2017 and 2018 benefit years.

Changes in assumptions and sensitivities to changes in key variables

The table below outlines the sensitivity of the outstanding risk claims provision to reasonable possible movements in assumptions used in the estimation process. It should be noted that this is a deterministic approach with no correlations between the key variables.

Where variables are considered to be immaterial, no impact has been assessed for insignificant changes to these variables. Particular variables may not be considered material at present. However, should the materiality level of an individual variable change, an assessment of and reasonable changes to that variable in the future may be required.

An analysis of sensitivity around various scenarios for the general medical insurance business provides an indication of the adequacy of the Scheme's estimation process. Information from the managed healthcare provider, Medscheme Health Risk Solutions, on pre-authorised but unpaid hospital accounts was used as an independent source of information to assess the reasonability of the projected hospital claims and to modify the estimate where necessary. Hospital claims are the largest claims category by value and are also one of the slowest categories of claims to be paid. Thus, an independent estimate of the expected hospital cost is particularly valuable in estimating the total expected claims costs for the Scheme.

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 on certain variables and assumptions which could differ when claims arise.

The change in the outstanding risk claims provision also represents the absolute change in net surplus/(deficit) for the year. It should be noted that increases in provisions will result in decreases in surplus and vice versa. These reasonable possible changes in key assumptions do not result in any changes directly in reserves.

Impact on surplus reported caused by reasonable possible changes in key variables

	Total expected claims R'million	Outstanding risk claims provision# R'million	Change in outstanding risk claims provision R'million
2018			
As at 31 December	**12 956**	**765**	**–**
Run-off factors 20% faster than assumed	**12 930**	**649**	**(116)**
Run-off factors 20% slower than assumed	**12 982**	**884**	**119**
2017			
As at 31 December	11 871	654	–
Run-off factors 20% faster than assumed	11 761	1 198	(110)
Run-off factors 20% slower than assumed	11 983	1 420	112

Not covered by risk transfer arrangements.

NOTES TO THE ANNUAL FINANCIAL STATEMENTS CONTINUED

FOR THE YEAR ENDED 31 DECEMBER 2018

	2018 R'000	2017 R'000
11. PERSONAL MEDICAL SAVINGS ACCOUNT MONIES MANAGED BY THE SCHEME ON BEHALF OF ITS MEMBERS		
11.1 Personal medical savings account liability		
Balance of personal medical savings account liability at 1 January	**603 812**	537 640
Less: Personal medical savings plan advances	**(6 291)**	(5 548)
Balance of personal medical savings account liability at 1 January	**597 521**	532 092
Add: Savings account contributions received	**615 180**	590 644
Savings plan liabilities transferred to the Scheme from other schemes in terms of Regulation 10(4)	**11 628**	9 011
Net interest paid on savings plan account	**35 161**	42 365
Interest paid	**36 228**	43 139
Investment expenses/fees	**(1 067)**	(774)
Less: Claims paid on behalf of members	**(535 414)**	(524 357)
Refunds on death or resignation in terms of Regulation 10(5)	**(49 757)**	(52 234)
Personal medical savings plan advances (note 8)	**5 407**	6 291
Unclaimed personal medical savings account written off to Scheme funds	**(87 222)**	–
Balances due to members on personal medical savings accounts held at 31 December	**592 504**	603 812

The BonSave, BonClassic, BonComprehensive, BonComplete and BonFit benefit options allow members the facility to pay a percentage of their gross contributions into a savings account, to assist members in managing their healthcare costs to their own requirements. The percentage per option varies from 14.1% on BonClassic, 15.0% on BonFit, 15.0% on BonComplete, 16.0% on BonSave, and 18.9% on BonComprehensive. Savings are capped at a maximum of 25.0% of the gross contributions.

The personal medical savings account ("PMSA") liability contains a demand feature in terms of Regulation 10 of the Act that any credit balance on a member's PMSA must be taken as a cash benefit when the member terminates his or her membership of the Scheme or benefit option, and then enrols in another benefit option or medical scheme without a PMSA, or does not enrol in another medical scheme.

It is estimated that the claims to be paid out of members' PMSAs in respect of claims incurred in 2018 but not reported will amount to R10.7 million (2017: R9.0 million). Advances paid on PMSAs are funded by the Scheme and are included in trade and other receivables (refer to note 8).

Council for Medical Schemes Circular 38 of 2011 required medical schemes to ringfence personal members' savings accounts, such that these monies are managed and reported separately from other cash and investments held by the Scheme.

A Constitutional Court judgment on 6 June 2017 found that PMSA funds enter the Scheme's bank account without being impressed by a trust or fiduciary relationship. There is no statutory requirement for assets arising from any unspent PMSA allocation to be invested separately. The judgment found that as PMSAs are not trust assets, medical schemes may keep interest accruing from PMSAs in its bank account. The Scheme Rules shall determine whether PMSA assets are invested in separate bank or investment accounts and whether interest will be allocated to members with positive PMSA balances.

The Scheme amended the Scheme Rules to align to the court judgment on 1 January 2018. The Board resolved the following with the effective date 1 January 2018:

- The funds should no longer be ringfenced
- Interest would still be paid to members on PMSA monies at the rate achieved by the funds' cash portfolio, net of administration costs. An effective 0.125% return achieved for a particular month (1.5% annual) is deducted for investment expenses from the return allocated to the PMSA, relating to administration costs associated with managing the members' PMSA
- Interest would be applied to members' accumulated fund balances. Net interest is not allocated to current savings balances.

11. PERSONAL MEDICAL SAVINGS ACCOUNT MONIES MANAGED BY THE SCHEME ON BEHALF OF ITS MEMBERS continued

11.1 Personal medical savings account liability continued

The effective interest rate earned was 7.7% (2017: 8.1%) and 6.2% was allocated to the PMSA balances.

The effect of the change on the annual financial statements is summarised as follows:

- **Statement of financial position:** PMSA funds have been reclassified as "cash and cash equivalents" or "financial assets held at fair value through profit and loss" depending on the nature and maturity of the instruments as these are no longer deemed trust monies but rather assets of the medical scheme.
- **Statement of comprehensive income:** An amount of R8.3 million relating to the 1.5% administration fee is included in sundry income.
- **Statement of comprehensive income:** An amount of R87.2 million was written back to the statement of comprehensive income and included under "sundry income" which related to prescribed unclaimed PMSA savings credits.
- **Cash flow statement:** Cash and cash equivalents' opening balance has been adjusted in 2018 to accurately reflect a re-classification of R195 million from cash and cash equivalents to "financial assets held at fair value through profit and loss". The R195 million related to instruments previously classified as PMSA that are now treated as financial assets held at fair value through profit and loss in line with the Scheme's accounting policy.

	2018 R'000	2017 R'000
11.2 Personal medical savings account investment		
Cash and cash equivalents		
Money market instruments	**–**	591 290
Total personal medical savings account monies invested	**–**	591 290

In line with the Constitutional Court ruling detailed in note 11.1, the PMSA investment has been re-classified between cash and cash equivalents and financial assets held at fair value through profit or loss depending on the nature and maturity of the investments, in line with the Scheme Rules and accounting policies.

The difference of R12.5 million in the prior year between the PMSA liability (R603.8 million) and the PMSA investment (R591.3 million) was due to the timing difference created by accrual accounting. This difference was reconciled and transferred after the 2017 year-end.

NOTES TO THE ANNUAL FINANCIAL STATEMENTS CONTINUED

FOR THE YEAR ENDED 31 DECEMBER 2018

		2018 R'000	2017 R'000
12.	**INSURANCE, TRADE AND OTHER PAYABLES**		
12.1	**Insurance payables**		
	Contributions received in advance	**503 318**	596 156
	Dorbyl contributions received in advance	**156**	234
	Reported claims not yet paid (note 12.3)	**79 698**	112 218
	Credit balances due to members – overpayments	**10 473**	11 090
	Total insurance payables	**593 645**	719 698
12.2	**Trade and other payables**		
	Provision for external audit fees	**2 325**	2 233
	Provision for internal audit fees	**1 349**	1 764
	Amounts owing to administrator and related entities (excluding marketing costs)	**23 729**	7 534
	South African Revenue Service	**203**	191
	Accrual for advertising and marketing expenses	**9 612**	11 880
	Sundry payables	**10 757**	9 782
	Total trade and other payables	**47 975**	33 384
	Total insurance, trade and other payables	**641 620**	753 082

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

		2018 R'000	2017 R'000
12.3	**Reported claims not yet paid**		
	Balance at 1 January	**112 218**	130 637
	Net movement – members and providers	**(32 520)**	(18 419)
	Claims received	**12 916 794**	11 645 084
	Claims paid	**(12 949 314)**	(11 663 503)
	Reported claims not yet paid	**79 698**	112 218

Reported claims not yet paid comprise claims that have been received and processed for payment. These claims have been accounted for in the claims cost expense for the current financial year. Payment of these claims will only occur during the next financial year.

		2018 R'000	2017 R'000
13.	**RISK CONTRIBUTION INCOME**		
	Gross contributions per registered rules	**16 276 305**	15 497 049
	Less: Personal medical savings account contributions received*	**(615 180)**	(590 644)
	Risk contribution income	**15 661 125**	14 906 405

* *The savings contributions are received by the Scheme in terms of Regulation 10(1) and the Scheme Rules. Refer to note 11 of the financial statements for details of how these funds were applied.*

		2018 R'000	2017 R'000
14.	**RELEVANT HEALTHCARE EXPENDITURE**		
	Net risk claims (note 14.1)	**13 892 297**	12 751 091
	Accredited managed healthcare services (note 14.2)	**479 375**	447 771
	Net income on risk transfer arrangements (note 14.3)	**(100 776)**	(74 268)
	Total relevant healthcare expenditure	**14 270 896**	13 124 594
14.1	**Net claims incurred**		
	Claims incurred excluding claims incurred in respect of risk transfer arrangements	**13 083 543**	11 947 586
	Current year claims per registered rules	**13 507 763**	12 322 620
	Movement in outstanding claims provision	**111 194**	149 323
	Provision in prior year	**(653 814)**	(504 491)
	Provision for the current year	**765 008**	653 814
	Claims paid from personal medical savings account**	**(535 414)**	(524 357)
	Claims incurred in respect of risk transfer arrangements	**876 794**	854 517
	Current year claims incurred in respect of risk transfer arrangements	**827 971**	818 012
	Movement in outstanding claims provision (note 10)	**48 823**	36 505
	Third-party claims recoveries	**(68 040)**	(51 012)
	Net claims incurred	**13 892 297**	12 751 091
14.2	**Accredited managed healthcare services**		
	Hospital benefit management	**205 133**	196 490
	Medicine benefit management	**80 626**	77 362
	Disease management*	**90 660**	77 493
	HIV/AIDS management	**47 085**	43 012
	Provider network management	**55 871**	53 414
	Accredited managed healthcare services	**479 375**	447 771

* *The Bonitas Diabetes Management Programme previously managed by CDE in the form of a risk transfer arrangement is now incorporated into the Managed Care Programme and disclosed as disease management, part of accredited managed healthcare services.*

** *Claims are paid on behalf of the members from their PMSA in terms of Regulation 10(3) and the Scheme's registered benefits. Refer to note 11 to the financial statements for a breakdown of the movement in these balances.*

NOTES TO THE ANNUAL FINANCIAL STATEMENTS CONTINUED

FOR THE YEAR ENDED 31 DECEMBER 2018

	2018 R'000	2017 R'000
14. RELEVANT HEALTHCARE EXPENDITURE continued		
14.3 Risk transfer arrangements		
Premiums/fees paid	**776 019**	780 249
CDE Holdings Proprietary Limited ("CDE")*	**–**	22 968
Dental Information Systems Proprietary Limited ("DENIS")	**462 812**	452 429
ISO LESO Optics Proprietary Limited ("ISO LESO")	**196 941**	195 456
ER24 EMS Proprietary Limited ("ER24")	**109 490**	109 396
Bryte Insurance Company Limited ("Bryte")	**6 776**	–
Recoveries received	**(876 795)**	(854 517)
Claims recoveries	**(876 795)**	(854 517)
Net income on risk transfer arrangements	**(100 776)**	(74 268)

The net income of the risk transfer arrangements for the current financial year per third-party service provider is as follows:

	2018 R'000	2017 R'000
CDE*	**–**	6 608
DENIS	**(49 983)**	(38 165)
ER24	**(24 024)**	(11 610)
ISO LESO	**(26 114)**	(31 101)
Bryte	**(655)**	–
Net income on risk transfer arrangements	**(100 776)**	(74 268)

* *The Bonitas Diabetes Management Programme previously managed by CDE in the form of a risk transfer arrangement is now incorporated into the Managed Care Programme and disclosed as diabetes management, part of accredited managed healthcare services.*

In 2018, the Scheme re-visited the disclosure requirements relevant to risk transfer arrangements.

The Scheme determined that the recoveries reported in previous financial periods were not calculated and disclosed in line with the IFRS 4 accounting standard (Insurance Contracts).

Previously, the Scheme reported claims recoveries as the actual claims cost paid by the risk insurer/capitation house. However, IFRS 4 requires the Scheme to disclose the recoveries as the cost the Scheme would have incurred had it not entered into the capitation agreement. The cost that the Scheme would have incurred to deliver the specified benefits represents the Scheme's recovery in kind from the managed healthcare provider.

Taking the above into account, the Scheme re-calculated the recoveries for DENIS, ER24 and ISO LESO. As a result, the recoveries increased significantly. See note 28 for further detail regarding the re-classification and re-statement of 2017 figures.

Recoveries relating to the CDE risk transfer arrangement have not been re-stated for 2017 due to the fact that the net expense comprised 4% of the total reported "net expense on risk transfer arrangement" and is therefore considered immaterial.

14. RELEVANT HEALTHCARE EXPENDITURE continued

14.3 Risk transfer arrangements continued

Risk transfer arrangements are entered into in respect of the provision of medical services that are outsourced to third parties by the Scheme. These services comprise:

- Dental benefits provided by DENIS
- Ambulance and emergency services provided by ER24
- International travel benefits provided by Bryte
- Optical benefit management provided by ISO LESO.

The service providers noted above have a national footprint across South Africa, providing access to all members.

Refer to note 21 to the financial statements for nature, terms and conditions of the risk transfer arrangements.

The methodologies used to determine the costs of the claims covered by these arrangements are set out below.

DENIS

The Scheme has appointed DENIS to attend to all aspects of dental claim administration, including payments of all claims and to provide the SMILE Programme. The Scheme pays DENIS a fixed fee on a monthly basis for members on the Standard, BonSave, Primary, BonComprehensive and BonClassic options. Refer to note 21 for further details on other aspects of the services provided.

ISO LESO

Fee income for ISO LESO comprises the net effect of capitation fees received less mandated claims paid, incidental costs and screening fees and any surplus or loss in terms of the contract with the Scheme. Capitation fees are the fee per beneficiary for providing the optometric services in terms of the Scheme's benefit option, payable by the Scheme to ISO LESO on a monthly basis. ISO LESO provides optometric services to the beneficiaries on behalf of the Scheme and accepts liability for the payment of all valid claims received from participating and non-participating providers in respect of optometric services for the duration of the agreement. Claims in respect of optometric services rendered during the duration of the agreement may be submitted for processing and payment by ISO LESO up to four months after the date on which the services were rendered. The contract with ISO LESO has been terminated effective 31 December 2018.

ER24

In 2018, after following a tender process, the Scheme re-appointed ER24 to render emergency medical services whereby it will maintain a 24 hours a day professionally staffed contact centre to provide general medical advice, appropriate rapid response vehicle services with the necessary life saving support equipment and care, as well as medical transportation to the most appropriate medical facility for providing adequate care.

Bryte

The Scheme has entered into a risk transfer arrangement with Bryte for the provision of international travel benefits for members who travel overseas for a period of not more than 90 days.

Third-party claim recoveries of R68.0 million (2017: R51.0 million) are included in net claims incurred. Included in this is third-party recoveries for motor vehicle accident ("MVA") and injury on duty ("IOD") claims of R29.2 million (2017: R30.0 million). These claims are currently being administered by Gildenhuys Malatji Attorneys. The net claims recoveries in the current year include R27.9 million (2017: R16.5 million) in relation to forensic recoveries pertaining to the fraud waste and abuse services provided by the administrator, R2.6 million (2017: R0.2 million) in relation to diabetes clawbacks and R8.1 million (2017: R3.4 million) in recoveries from Mediclinic and Life Healthcare related to settlement discounts.

NOTES TO THE ANNUAL FINANCIAL STATEMENTS CONTINUED

FOR THE YEAR ENDED 31 DECEMBER 2018

	2018 R'000	2017 R'000
15. ADMINISTRATIVE EXPENDITURE		
Administrator's fees	**808 572**	778 940
Administration fees	**627 743**	595 482
Administration fees – software licensing	**180 829**	183 458
Actuarial services	**3 934**	3 705
Annual general meeting costs	**3 547**	1 772
Amalgamation expenses	**–**	312
Audit fees – external	**2 610**	1 971
Current year	**2 324**	2 275
Prior year under/(over)provision	**286**	(304)
Audit fees – internal	**3 866**	1 928
Current year	**4 014**	2 526
Prior year overprovision	**(148)**	(598)
Bank charges	**3 427**	3 675
Benefit management services	**35 692**	34 428
Communication expenses	**280**	220
Consulting fees	**2 300**	2 723
Council for Medical Schemes levies	**12 134**	11 238
Committee fees – independent members	**1 667**	1 503
Audit and Risk Committee fees	**804**	811
Investment Committee fees	**544**	470
Remuneration Committee fees	**319**	222
Computer maintenance	**3 605**	3 974
Depreciation	**1 805**	1 424
Fidelity, professional indemnity and other insurance premiums	**424**	387
Forensic fees	**11 131**	17 141
Hire of equipment	**163**	386
Human resourcing and payroll management fees	**1 418**	1 478
IOD administration expense	**48**	574
Legal fees	**5 126**	5 456
Marketing and advertising expenses	**166 336**	166 048
Meeting venue and catering costs	**292**	201
Office expenses	**282**	137
Postage and courier service	**2 740**	3 936
Principal Officer short-term employee benefits	**5 271**	5 124
Principal Officer remuneration	**3 788**	4 009
Performance bonus	**1 024**	724
Defined contribution benefits	**301**	261
Other disbursements	**158**	130

		2018 R'000	2017 R'000
15.	**ADMINISTRATIVE EXPENDITURE** continued		
	Printing and stationery	**4 784**	5 862
	Professional services	**3 310**	2 724
	Road Accident Fund administration expense	**13 762**	15 260
	Rental costs	**5 127**	3 830
	Repairs and maintenance	**6**	25
	Staff short-term employees' benefits	**17 807**	14 323
	Employees' remuneration	**14 278**	12 189
	Performance bonus	**1 718**	977
	Defined contribution benefits	**962**	628
	Other disbursements	**849**	529
	Subscription fees	**745**	4 211
	Sundry expenses	**752**	2 902
	Travel, accommodation and conferences	**577**	306
	Trustee elections	**–**	9 385
	Trustees' remuneration and other disbursements	**4 079**	4 495
	Trustees' remuneration	**3 591**	3 922
	Other disbursements	**488**	573
	Wellness expenses	**24 326**	27 224
		1 151 945	1 139 228

15. ADMINISTRATIVE EXPENDITURE continued

15.1 Trustees' remuneration and considerations

2018

R	Fees for meeting attendance[1]	Fees for holding of office[2]	Fees for other meeting attendance[3]	Total remuneration	Accommo-dation, travel and meals	Conference fees	Training and annual subscription fees	Total
SE Claassen	**319 710**	**253 217**	**110 388**	**683 315**	**22 344**	**–**	**3 675**	**709 334**
O Komane	**164 811**	**207 651**	**112 062**	**484 524**	**37 915**	**16 115**	**3 675**	**542 229**
L Koch	**69 580**	**182 976**	**7 583**	**260 139**	**11 364**	**–**	**3 675**	**275 178**
HE Nematswerani	**69 580**	**182 976**	**38 915**	**291 471**	**16 241**	**16 115**	**3 675**	**327 502**
J Bagg	**124 328**	**182 976**	**54 414**	**361 718**	**22 578**	**16 115**	**3 675**	**404 086**
MG Netshisaulu	**115 744**	**182 976**	**23 082**	**321 802**	**21 368**	**16 115**	**3 675**	**362 960**
R Cowlin	**244 044**	**182 976**	**62 168**	**489 188**	**195 649**	**16 115**	**3 675**	**704 627**
F Martin	**–**	**14 974**	**–**	**14 974**	**1 593**	**–**	**–**	**16 567**
J Usher	**170 492**	**182 976**	**46 831**	**400 299**	**7 633**	**–**	**3 675**	**411 607**
MP Lesunyane	**100 578**	**182 976**	**–**	**283 554**	**21 538**	**16 115**	**3 675**	**324 882**
	1 378 867	**1 756 674**	**455 443**	**3 590 984**	**358 223**	**96 690**	**33 075**	**4 078 972**

2017

R	Fees for meeting attendance[1]	Fees for holding of office[2]	Fees for other meeting attendance[3]	Total remuneration	Accommo-dation, travel and meals	Conference fees	Training and annual subscription fees	Total
SE Claassen	309 827	238 001	126 365	674 193	28 044	10 666	77	712 980
O Komane	140 442	175 869	74 724	391 035	27 924	11 387	7 277	437 623
L Koch	7 583	44 921	–	52 504	1 401	–	–	53 905
HE Nematswerani	68 245	175 869	52 284	296 398	27 560	11 387	77	335 422
MJ Rampedi	7 100	47 443	4 891	59 434	–	–	–	59 434
J Bagg	121 325	175 869	38 008	335 202	24 634	11 387	77	371 300
MG Netshisaulu	22 748	59 894	8 879	91 521	15 244	1 392	77	108 234
O Pretorius	88 751	130 949	99 268	318 968	29 138	10 666	77	358 849
R Cowlin	173 870	175 869	74 140	423 879	130 271	11 387	77	565 614
F Martin	113 742	175 869	34 199	323 810	80 785	11 387	77	416 059
J Usher	166 822	175 869	45 139	387 830	24 833	11 387	77	424 127
MP Lesunyane	98 576	175 869	32 589	307 034	14 876	11 387	77	333 374
Y Mbuli	83 411	130 949	46 218	260 578	47 437	9 995	–	318 010
	1 402 442	1 883 240	636 704	3 922 386	452 147	112 428	7 970	4 494 931

[1] *Fees for meeting attendance refer to remuneration payable to Trustees for attending meetings of Board and sub-committees of the Board.*
[2] *Fees for holding office refer to remuneration payable to individuals to act in their capacity as Trustee, including carrying out their fiduciary duty.*
[3] *Fees for other meeting attendance refer to remuneration payable to Trustees for attendance of other meetings at which their attendance is required to act in the interest of the Scheme.*

	2018 R'000	2017 R'000
16. IMPAIRMENT LOSSES ON INSURANCE, TRADE AND OTHER RECEIVABLES		
Increase in provision for healthcare receivables (note 8)	**1 776**	1 078
Bad debts written off	**17 161**	20 856
Contributions	**9 996**	12 210
Members' portion	**7 088**	8 646
Other receivables	**77**	–
Previous impairment losses recovered	**(4 621)**	(6 441)
	14 316	15 493
17. INVESTMENT INCOME		
Cash and cash equivalents interest income	**6 056**	7 276
Financial assets held at fair value through profit or loss	**295 532**	249 369
Interest income	**249 846**	222 953
Dividend income	**45 686**	26 416
Net fair value (losses)/gains on financial assets held at fair value through profit or loss	**(111 875)**	129 693
Rentals received	**7 669**	7 985
Contractual rental	**7 852**	7 137
Straight-lining of lease accrual	**(183)**	848
Investment income – Scheme	**197 382**	394 323
Investment income – Personal medical savings account investment	**–**	42 365
Change in fair value of investment properties	**(6 300)**	1 400
	191 082	438 088
18. SUNDRY INCOME		
Profit on sale of property and equipment	**10**	–
Forensic recoveries	**3 459**	4 874
Sundry income	**98 662**	688
Unclaimed personal medical savings account write backs (note 11.1)	**87 222**	–
Recovery of personal medical savings account investment and administration expense	**8 266**	–
Other income	**3 174**	688
	102 131	5 562

Forensic recoveries comprise financial recoveries from members and healthcare providers who defrauded the Scheme by the submission of fictitious claims. These members and healthcare providers were thoroughly investigated and were either legally prosecuted by the Scheme, or have signed an acknowledgement of debt thereby committing to pay back the Scheme the amounts claimed fraudulently. See note 14.1, third-party claims recoveries, which includes recoveries as a result of fraud, waste and abuse services provided by the administrator.

19. SURPLUS/(DEFICIT) PER BENEFIT OPTION

19.1 Surplus/(deficit) per benefit option 2018

The features of the benefit options are disclosed in the Board of Trustees' report.
For management purposes the traditional scheme is organised into the following 12 benefit options:

R'000	Standard	Standard Select	BonSave	Primary	BonCap	BonFit	BonClassic	Bon Comp	Bon Essential	Bon Complete	Hospital Standard	Hospital Plus	Scheme total
2018													
Gross contribution income	7 647 736	265 941	1 579 772	2 991 738	761 383	140 649	791 050	692 866	253 831	697 371	250 857	203 111	16 276 305
Less: Savings contributions	–	–	(249 953)	–	–	(20 750)	(111 473)	(129 894)	–	(103 110)	–	–	(615 180)
Risk contribution income	7 647 736	265 941	1 329 819	2 991 738	761 383	119 899	679 577	562 972	253 831	594 261	250 857	203 111	15 661 125
Relevant healthcare expenditure	(6 758 084)	(273 155)	(1 168 490)	(2 584 011)	(841 555)	(89 337)	(677 246)	(642 025)	(221 021)	(570 956)	(233 561)	(211 455)	(14 270 896)
Net claims incurred	(6 621 952)	(268 584)	(1 113 130)	(2 502 594)	(791 570)	(84 967)	(668 513)	(635 474)	(210 170)	(562 936)	(224 743)	(207 664)	(13 892 297)
Claims incurred	(6 646 924)	(269 584)	(1 120 366)	(2 517 841)	(800 598)	(85 810)	(670 770)	(636 825)	(211 784)	(565 329)	(226 121)	(208 385)	(13 960 337)
Third-party recoveries	24 972	1 000	7 236	15 247	9 028	843	2 257	1 351	1 614	2 393	1 378	721	68 040
Managed healthcare services	(203 410)	(6 598)	(47 264)	(104 791)	(49 352)	(5 318)	(14 782)	(8 683)	(9 958)	(16 360)	(8 428)	(4 431)	(479 375)
Net (expense) on risk transfer arrangements	67 279	2 027	(8 095)	23 373	(633)	948	6 049	2 132	(893)	8 341	(390)	638	100 776
Risk transfer arrangement fees/premiums paid	(417 293)	(15 981)	(76 540)	(167 146)	(28 259)	(4 231)	(32 734)	(2 704)	(2 792)	(24 700)	(2 387)	(1 252)	(776 019)
Recoveries from risk transfer arrangements	484 572	18 008	68 445	190 519	27 626	5 179	38 783	4 836	1 899	33 041	1 997	1 890	876 795
Gross healthcare result	889 652	(7 214)	161 329	407 727	(80 172)	30 562	2 331	(79 053)	32 810	23 305	17 296	(8 344)	1 390 229
Broker service fees	(117 980)	(5 020)	(34 648)	(70 988)	(22 118)	(3 419)	(6 982)	(6 184)	(6 089)	(12 587)	(5 899)	(3 715)	(295 629)
Administrative expenditure	(461 790)	(18 386)	(131 211)	(281 178)	(68 467)	(15 183)	(41 443)	(24 470)	(28 777)	(43 479)	(24 654)	(12 907)	(1 151 945)
Net impairment losses on healthcare receivables	(5 261)	(210)	(1 522)	(3 205)	(1 894)	(177)	(476)	(285)	(340)	(505)	(291)	(150)	(14 316)
Net healthcare result	304 621	(30 830)	(6 052)	52 356	(172 651)	11 783	(46 570)	(109 992)	(2 396)	(33 266)	(13 548)	(25 116)	(71 661)
Other income	94 878	3 795	39 937	57 785	34 048	3 609	19 479	9 399	6 130	16 159	5 249	2 745	293 213
Investment income – Scheme	59 745	2 385	29 749	36 288	21 309	2 418	16 303	7 498	3 856	12 798	3 311	1 722	197 382
Sundry income	37 419	1 502	10 859	22 914	13 612	1 272	3 381	2 023	2 423	3 577	2 061	1 088	102 131
Change in fair value of investment property	(2 286)	(92)	(671)	(1 417)	(873)	(81)	(205)	(122)	(149)	(216)	(123)	(65)	(6 300)
Other expenditure	(7 922)	(317)	(14 804)	(4 826)	(2 847)	(688)	(11 619)	(4 694)	(511)	(7 819)	(438)	(230)	(56 715)
Interest on savings plan liability – PMSA	–	–	(12 513)	–	–	(423)	(10 902)	(4 265)	–	(7 058)	–	–	(35 161)
Asset management fees	(5 769)	(231)	(1 668)	(3 514)	(2 073)	(193)	(522)	(312)	(372)	(554)	(319)	(168)	(15 695)
Operating expenses on investment property	(2 153)	(86)	(623)	(1 312)	(774)	(72)	(195)	(117)	(139)	(207)	(119)	(62)	(5 859)
Net surplus/(deficit) for the year	391 577	(27 352)	19 081	105 315	(141 450)	14 704	(38 710)	(105 287)	3 223	(24 926)	(8 737)	(22 601)	164 837
Number of members (n)	119 945	4 870	35 257	74 475	45 857	4 252	10 788	6 449	7 848	11 341	6 502	3 409	330 993

19. SURPLUS/(DEFICIT) PER BENEFIT OPTION

19.2 Surplus/(deficit) per benefit option 2017

The features of the benefit options are disclosed in the Board of Trustees' report.

For management purposes the traditional scheme is organised into the following 12 benefit options:

R'000	Standard	Standard Select	BonSave	Primary	BonCap	BonFit	BonClassic	Bon Comp	Bon Essential	Bon Complete	Hospital Standard	Hospital Plus	Scheme total
2017													
Gross contribution income	7 443 316	200 112	1 471 857	2 718 750	680 689	104 682	767 931	673 748	237 089	724 229	258 173	216 473	15 497 049
Less: Savings contributions	191	–	(233 482)	–	–	(15 713)	(108 309)	(126 246)	–	(107 085)	–	–	(590 644)
Risk contribution income	7 443 507	200 112	1 238 375	2 718 750	680 689	88 969	659 622	547 502	237 089	617 144	258 173	216 473	14 906 405
Relevant healthcare expenditure	(6 452 805)	(212 311)	(1 022 149)	(2 233 928)	(685 611)	(60 001)	(652 212)	(614 274)	(179 687)	(564 284)	(234 905)	(212 427)	(13 124 594)
Net claims incurred	(6 315 337)	(209 462)	(972 541)	(2 153 260)	(637 553)	(55 301)	(644 464)	(606 362)	(168 767)	(555 087)	(225 293)	(207 664)	(12 751 091)
Claims incurred	(6 334 634)	(210 071)	(977 903)	(2 164 196)	(644 046)	(55 819)	(646 223)	(607 409)	(170 005)	(557 078)	(226 448)	(208 271)	(12 802 103)
Third-party recoveries	19 297	609	5 362	10 936	6 493	518	1 759	1 047	1 238	1 991	1 155	607	51 012
Managed healthcare services	(193 184)	(5 025)	(44 159)	(94 534)	(44 182)	(4 127)	(14 246)	(8 076)	(9 650)	(16 968)	(8 935)	(4 685)	(447 771)
Net (expense) on risk transfer arrangements	55 716	2 176	(5 449)	13 866	(3 876)	(573)	6 498	164	(1 270)	7 771	(677)	(78)	74 268
Risk transfer arrangement fees/premiums paid	(438 410)	(12 719)	(73 232)	(157 339)	(26 273)	(1 333)	(34 238)	(3 379)	(2 805)	(26 775)	(2 458)	(1 288)	(780 249)
Recoveries from risk transfer arrangements	494 126	14 895	67 783	171 205	22 397	760	40 736	3 543	1 535	34 546	1 781	1 210	854 517
Gross healthcare result	990 702	(12 199)	216 226	484 822	(4 922)	28 968	7 410	(66 772)	57 402	52 860	23 268	4 046	1 781 811
Broker service fees	(118 915)	(3 921)	(32 053)	(63 965)	(20 041)	(2 457)	(6 801)	(5 885)	(5 592)	(12 289)	(5 728)	(3 588)	(281 235)
Administrative expenditure	(471 967)	(14 745)	(128 378)	(266 200)	(60 255)	(12 345)	(42 560)	(24 426)	(29 092)	(47 734)	(27 221)	(14 305)	(1 139 228)
Net impairment losses on healthcare receivables	(5 853)	(184)	(1 624)	(3 314)	(1 998)	(159)	(532)	(322)	(376)	(601)	(347)	(183)	(15 493)
Net healthcare result	393 967	(31 049)	54 171	151 343	(87 216)	14 007	(42 483)	(97 405)	22 342	(7 764)	(10 028)	(14 030)	345 855
Other income	151 793	4 785	55 235	85 981	51 117	4 471	25 556	12 354	9 740	28 748	9 094	4 776	443 650
Investment income – Scheme	149 148	4 703	41 434	84 490	50 260	4 004	13 595	8 087	9 572	15 410	8 929	4 691	394 323
Investment income – PMSA investment		–	13 066	–	–	397	11 718	4 127	–	13 057	–	–	42 365
Sundry income	2 118	66	589	1 193	669	54	195	111	134	229	135	69	5 562
Change in fair value of investment property	527	16	146	299	188	15	48	29	34	52	30	16	1 400
Other expenditure	(6 427)	(202)	(14 852)	(3 641)	(2 157)	(569)	(12 303)	(4 474)	(412)	(13 721)	(385)	(202)	(59 345)
Interest on savings plan liability – PMSA		–	(13 066)	–	–	(397)	(11 718)	(4 127)	–	(13 057)	–	–	(42 365)
Asset management fees	(4 283)	(135)	(1 191)	(2 430)	(1 445)	(115)	(390)	(232)	(275)	(441)	(255)	(134)	(11 326)
Operating expenses on investment property	(2 144)	(67)	(595)	(1 211)	(712)	(57)	(195)	(115)	(137)	(223)	(130)	(68)	(5 654)
Net surplus/(deficit) for the year	539 333	(26 466)	94 554	233 684	(38 256)	17 908	(29 230)	(89 525)	31 670	7 263	(1 319)	(9 456)	730 160
Number of members (n)	127 332	4 038	35 364	72 529	45 233	3 550	11 522	7 123	8 269	12 637	7 216	3 836	338 649

NOTES TO THE ANNUAL FINANCIAL STATEMENTS CONTINUED

FOR THE YEAR ENDED 31 DECEMBER 2018

		2018 R'000	2017 R'000
20.	**CASH FLOW NOTES**		
20.1	**Cash generated by operations before working capital changes**		
	Surplus for the year	**164 837**	730 160
	Adjusted for:		
	Investment income – Scheme (note 17)	**(197 382)**	(394 323)
	Investment income – personal medical savings account (note 11)	**–**	(42 365)
	Change in fair value of investment properties (note 5)	**(2 700)**	(1 400)
	Change in fair value of investment properties held for sale (note 6)	**9 000**	–
	Bad debts written off (note 16)	**17 161**	20 857
	Increase in provision for doubtful debts (note 8)	**1 776**	1 078
	Interest on savings plan liability	**35 161**	42 365
	Depreciation	**1 805**	1 424
	Profit on sale of property and equipment	**(10)**	–
	Asset management fees	**15 695**	11 326
	Provision for property selling costs	**–**	1 000
	Straight-lining of lease expenses	**382**	117
	Unclaimed personal medical savings account write backs	**(87 222)**	–
	Increase in outstanding claims provision not covered by risk transfer agreements	**111 195**	149 323
		69 698	519 562
20.2	**Cash flow movements in working capital**		
20.2.1	***Insurance, trade and other receivables***		
	Movement per statement of financial position	**73 649**	(139 090)
	Adjusted for non-cash movements:		
	Receivables under risk transfer arrangements	**12 318**	6 234
	Rent receivables	**32**	(608)
	Allowance for impairment losses	**(18 938)**	(17 904)
	Straight-lining of lease receivables	**(183)**	848
		66 878	(150 520)
20.2.2	***Insurance, trade and other payables***		
	Movement per statement of financial position	**(111 462)**	84 147
	Adjusted for non-cash movements:		
	Straight-lining of lease payables	**(382)**	(117)
		(111 844)	84 030
20.2.3	***Personal medical savings account liability***		
	Movement per statement of financial position	**(11 308)**	66 172
	Adjusted for non-cash movements:		
	Unclaimed personal medical savings account write backs	**87 222**	–
		75 914	66 172

20. CASH FLOW NOTES continued

20.3 Returns on available-for-sale investments and financial assets at fair value through profit or loss

The bulk of investment income on investments is immediately re-invested by the fund managers into financial instruments and is not held as cash and cash equivalents.

		2018 R'000	2017 R'000
20.3.1	***Interest received***		
	Finance income (note 17)	**249 846**	222 953
	Interest capitalised in investments	**(20 574)**	(69 139)
		229 272	153 814
20.3.2	***Dividends received***		
	Dividend income (note 17)	**45 686**	26 416
	Dividends capitalised in investments	**(471)**	(853)
		45 215	25 563
20.3.3	***Asset management fees***		
	Asset management fees per statement of comprehensive income	**(15 695)**	(11 326)
	Fees capitalised in investments	**378**	231
		(15 317)	(11 095)
20.3.4	***Rentals received***		
	Rentals received (note 17)	**7 669**	7 985
	Straight-lining of lease receivables	**183**	(848)
	(Increase)/decrease in rent receivables (note 20.2.1)	**(32)**	608
		7 820	7 745

NOTES TO THE ANNUAL FINANCIAL STATEMENTS CONTINUED

FOR THE YEAR ENDED 31 DECEMBER 2018

21. INSURANCE RISK MANAGEMENT

21.1 Risk management objectives, policies and strategies to mitigate insurance risk

The primary insurance activity carried out by the Scheme assumes the risk of loss from members and their dependants that are directly subject to the risk. This risk relates to the health of the Scheme members. As such, the Scheme is exposed to the uncertainty surrounding the timing and severity of claims under the contract.

The Scheme manages its insurance risk through benefit limits and sub-limits, approval procedures for transactions that involve pricing guidelines, pre-authorisation and case management, service provider profiling, centralised management of risk transfer arrangements and the monitoring of emerging issues. Certain risks are mitigated by entering into risk transfer arrangements.

The Scheme uses several methods to assess and monitor insurance risk exposures both for individual types of risks insured and overall risks. These methods include internal risk measurement models, sensitivity analyses, scenario analyses and stress testing. The theory of probability is applied to the pricing and provisioning for a portfolio of insurance contracts. The principal risk is that the frequency and severity of claims are greater than expected. Insurance events are, by their nature, random, and the actual number and size of events during any one year may vary from those estimated using established statistical techniques.

This variation could be due to adverse experience due to, for example, an unexpected epidemic, unanticipated demographic movements e.g. a substantial number of young members leaving the Scheme, changes in the health profile of the membership, unexpected price increases and the cost of new technologies or drugs.

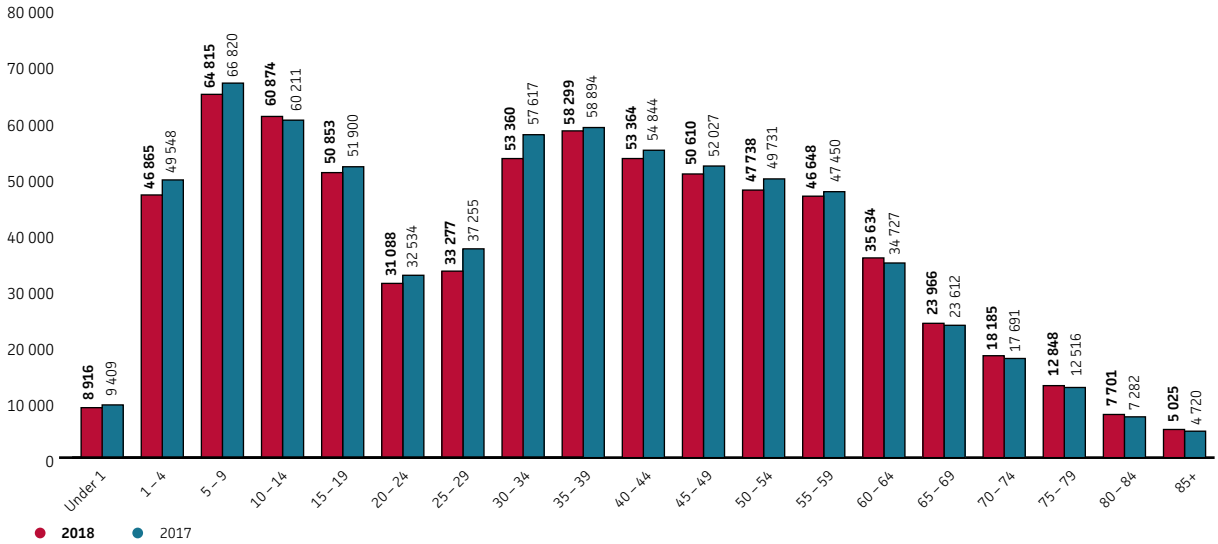
A major risk affecting the future sustainability of the Scheme is the possibility of deterioration in the risk profile of members. Schemes with a better member risk profile can offer the same benefits at a lower contribution rate than other schemes, as their members will be claiming less.

If a scheme charges higher contribution rates than the market, it is at risk of losing members and not replacing them. It is typically easier for younger, healthier members to move to another scheme. Should this happen, the member risk profile would deteriorate, resulting in even higher contribution rates being required.

One of the Scheme's key objectives, therefore, is to keep contribution rates as competitive and affordable as possible given the increases in claims costs. It is important that the Scheme maintains or improves its member risk profile by attracting lower risk members and retaining healthy members in the Scheme.

The chart below provides an overview of the Scheme's beneficiary demographic profile:

Beneficiary demographic profile (age)



21. INSURANCE RISK MANAGEMENT continued

21.1 Risk management objectives, policies and strategies to mitigate insurance risk continued

The Scheme's strategy seeks diversity to ensure a balanced portfolio approach. The balanced portfolio approach is based on having a large portfolio of similar risks over a number of years, which is believed to reduce the variability of the outcome.

The strategy is set out in the annual business plan, and specifies the benefits to be provided by each option, the expected number of members per option and their expected demographic profile.

All the benefit option contracts are annual in nature and the Scheme has the right to change the terms and conditions of the contracts at renewal. Management information including contribution income, claims ratios, target market and demographic split profile per option is reviewed periodically. There is also an underwriting review programme that reviews a sample of contracts periodically to ensure adherence to the Scheme's objectives.

It is important to note that the Scheme's insurance risk management strategy focuses primarily on the management of systematic risk factors, which are risks within the control of the Scheme. Conversely limited focus is placed on the management of unsystematic risk factors as these factors are uncontrollable in nature and are inherent to the medical industry as a whole.

The Scheme has noted the steady migration of insurance risk pertaining to Prescribed Minimum Benefits ("PMBs"), from systematic to unsystematic risk over the past three years. This is mainly attributable to change in legislation associated with PMBs, which requires the Scheme to pay for PMBs at full invoice price and no longer at set benefit limits and sub-limits.

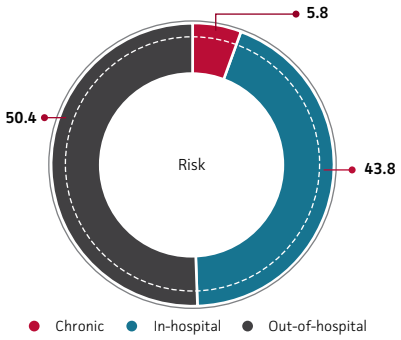
21.2 Concentrations of insurance risk

The Scheme's concentrations of insurance risk can be split into the following three benefit categories:

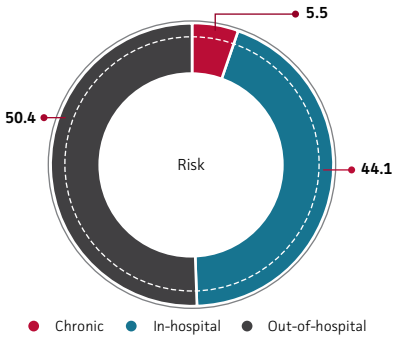
- **Out-of-hospital benefits**
  The out-of-hospital benefits include both the PMSA and an insurance risk element dependent on the elected benefit option. These benefits cover the cost of out-of-hospital healthcare services, such as visits to general practitioners and dentists as well as prescribed acute medicines.
- **In-hospital benefits**
  The hospital benefit covers medical expenses incurred due to admission to hospital.
- **Chronic illness benefit**
  The chronic illness benefit ("CIB") covers approved medication for listed conditions, including the 27 PMB chronic conditions.

The following charts summarise the concentrations of insurance risk in relation to the type of risk covered/benefits provided:

Concentration of insurance risk: 2017 (%)



Concentration of insurance risk: 2018 (%)



NOTES TO THE ANNUAL FINANCIAL STATEMENTS CONTINUED

FOR THE YEAR ENDED 31 DECEMBER 2018

21. INSURANCE RISK MANAGEMENT continued

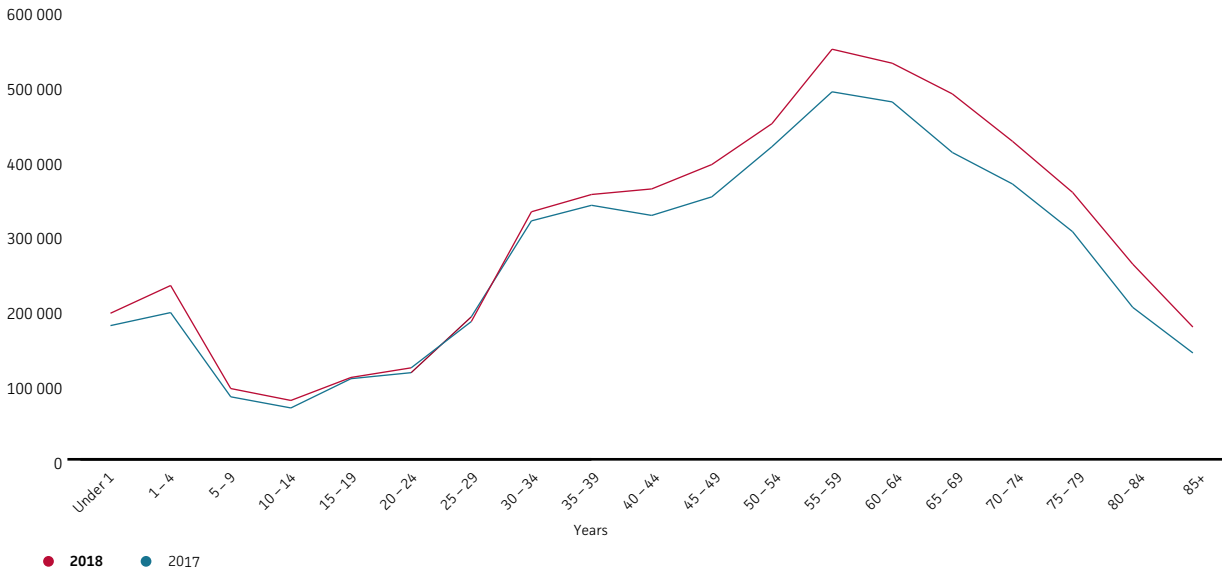
21.2 Concentrations of insurance risk continued

The following graph summarises the concentrations of insurance risk, with reference to the carrying amount of the insurance claims incurred (before risk transfer arrangements), by age, scheme and in relation to the benefit category.

The health status of the membership is a primary determinant of demand for health services which subsequently affects total cost of care. Therefore mitigation strategies are focused on positively influencing the utilisation and price of such services to ensure overall systemwide cost containment of quality care. The strategies for each benefit category are also summarised below.

21.2.1 In-hospital risk

Concentration of insurance risk: In-hospital risk (R'000)



Hospital and major medical expenses make up a significant part of overall expenditure and require close management. Therefore there is a strong focus on ensuring appropriate treatment during the hospital stay (including level of care and length of stay) as well as post-discharge, which improves patient outcomes and reduces the likelihood of re-admission for high-risk admissions.

Initiatives used by the Scheme include:

- Hospital Benefit Management Programme – focusing on patient care co-ordination from pre-admission to six weeks post-discharge, in order to ensure best and appropriate care
- Reviewing and updating of clinical funding protocols as well as criteria for recognising specific healthcare professionals as being able to perform certain procedures
- Health technology assessments ("HTA") on existing and new technologies entering the market, within a framework of clinical validity and economic appropriateness of the healthcare intervention, based on a systematic review of the evidence base and costing considerations
- Specialised case management – providing a dedicated focus on psychiatric cases, neonates, high-cost cases and cases involving alternatives to hospitalisation (e.g. step down facilities)
- "Call-me-back" functionality to promote treating doctor to medical adviser engagement in answering questions and offering choice in terms of funding alternatives.

21. INSURANCE RISK MANAGEMENT continued

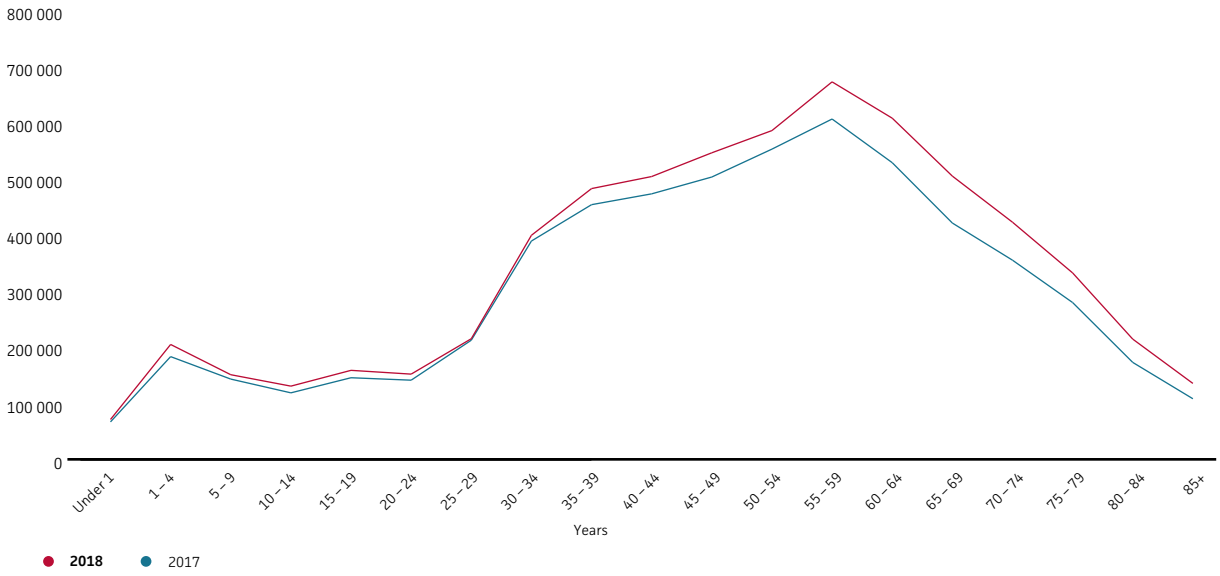
21.2 Concentrations of insurance risk continued

21.2.1 In-hospital risk continued

- Monitoring compliance to care pathways to reduce the risk of re-admission. This involves a follow-up process where, in the case of non-compliance, support is provided to assist the beneficiary to return to the care pathway
- Innovative reimbursement models with hospitals/hospital groups to ensure the most appropriate level of risk is transferred through reimbursement such as:
  - Efficiency gain share
  - Claims increase protection
  - Rewarding providers for efficiency and quality care
- Entering into risk-based contracting with specialists where specific risks within the member population can be addressed, e.g. arthroplasty (global fee)
- Contracting of a specialist network at agreed reimbursement rates
- Clinical audit and re-pricing of claims to ensure that claims are paid against the contracted hospital rates and the pre-authorised level of care.

21.2.2 Out-of-hospital risk

Concentration of insurance risk: Out-of-hospital risk (R'000)



Managing claims expenditure is not only about negotiating lower rates but also about curtailing preventable hospital utilisation and cost. Initiatives focused on co-ordinating care for segments of the population that are likely to present for medical care with associated high claim costs, have been implemented. Such initiatives include:

- Active Disease Risk Management Programme – an integrated care co-ordination programme enabling high and emerging risk beneficiaries to improve their health and quality of life by empowering the beneficiary through information sharing and counselling to take responsibility for his or her own health and wellness
- Back Rehabilitation Programme – an evidence-based physiotherapy and active rehabilitation programme that concentrates primarily on back and neck ailments, thus reducing the need for surgical intervention

NOTES TO THE ANNUAL FINANCIAL STATEMENTS CONTINUED

FOR THE YEAR ENDED 31 DECEMBER 2018

21. INSURANCE RISK MANAGEMENT continued

21.2 Concentrations of insurance risk continued

21.2.2 Out-of-hospital risk continued

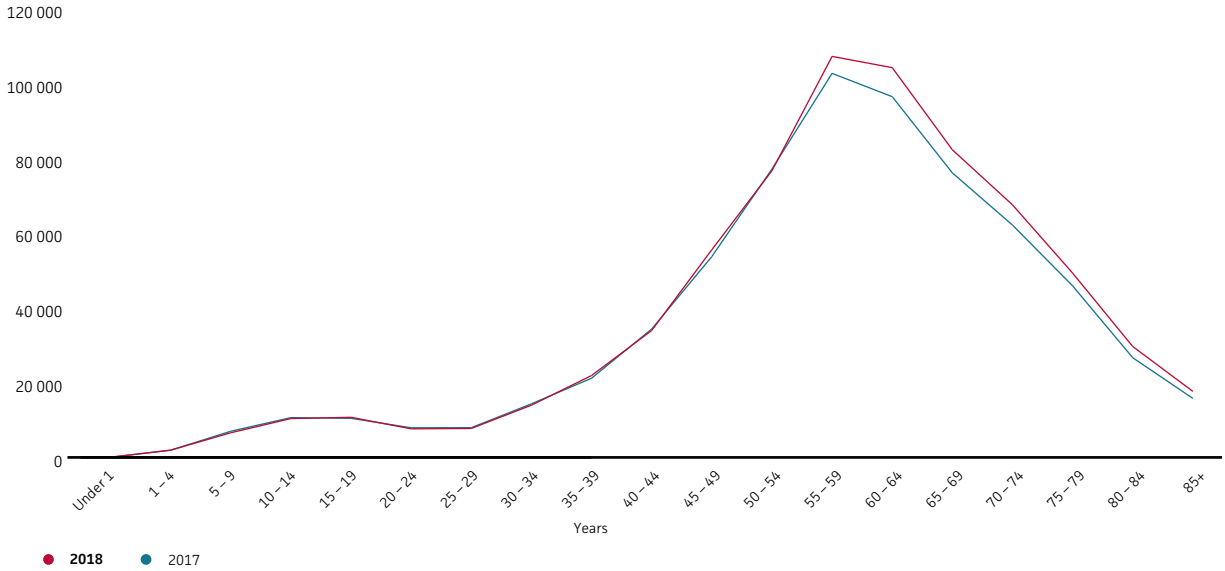
- High-Risk Maternity Case Management – pregnant mothers with potentially high-risk pregnancies are supported and additional benefits are provided where this is deemed necessary to reduce the risk of high-cost hospitalisation and premature deliveries
- Oncology Disease Management – complex or unusual patient-specific requirements are managed on a case-by-case basis ensuring that beneficiaries access funding for appropriate and cost-effective oncology therapy before, during and after active treatment.

Other initiatives include:

- Pathology Programme – application of clinical protocols and utilisation rules to prevent wasteful utilisation of pathology benefits
- Contracting of a general practitioner network at agreed reimbursement rates.

21.2.3 Chronic illness risk

Concentration of insurance risk: Chronic illness risk (R'000)



Chronic risk may, if not managed appropriately, have a significant impact on both out-of-hospital and in-hospital risks.

Initiatives in this regard include:

- Diabetes Management Programme – the programme is made up of a combination of care co-ordination including risk stratification, adherence and pathology management and health coaching. The programme also includes family practitioner upskilling and payment for prolonged consultations for diabetic patients through enhanced care plans. There is also an arrangement for acute diabetic hospitalisations where the diabetic beneficiaries are registered on chronic programmes.
- A chronic medicine pre-authorisation process which ensures access to appropriate treatment and the management of the chronic medicine benefit through a formal drug utilisation review
- Generic reference pricing and formularies incentivise cost-effectiveness
- Medicine exclusions eliminate products with no clinical benefit or which may be harmful
- Real-time drug utilisation evaluation to alert against potential contraindications and drug interactions as well as excessive utilisation
- Processing of claims in real-time against all Scheme Rules and benefit limits
- Sophisticated analytical capabilities to identify medicine trends and potential fraud.

21. INSURANCE RISK MANAGEMENT continued

21.3 Risk transfer arrangements

The Scheme makes use of risk transfer arrangements as an alternative insurance risk management strategy to mitigate specified risks associated with the provision of certain in-hospital and out-of-hospital benefits. Currently risk transfer arrangements approximate 6.3% of the Scheme's relevant healthcare expenditure.

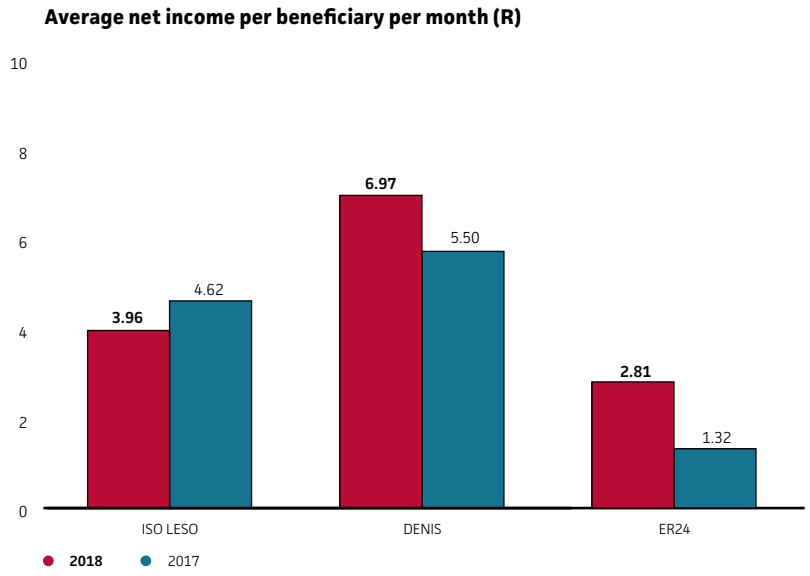
The Scheme entered into capitation agreements directly with DENIS, ER24, Bryte and ISO LESO. The capitation agreements involve a transfer of risk, however, the Scheme remains ultimately liable to its members with respect to ceded risks if any supplier fails to meet the obligations it assumes.

These risk transfer arrangements spread the insurance risk and minimise the effect of losses. The amount of each risk retained depends on the Scheme's evaluation of the specific risk, subject in certain circumstances to maximum limits on the basis of characteristics of coverage. According to the terms of the capitation agreements, the suppliers provide certain minimum benefits to all Scheme members, as and when required by the members.

When selecting a supplier, the Scheme considers its relative security and ability to deliver the relevant service.

Management re-negotiates the agreed fees and benefits of the capitation agreements annually.

The graph below outlines the net income (i.e. capitation premiums less cost recoveries) incurred per beneficiary relevant to services provided in accordance with the capitation agreements:



21.3.1 ISO LESO

The Scheme contracts ISO LESO to provide members of the Scheme with access to the optometric network and to manage the claims submitted by the network service providers. ISO LESO is also responsible for the training of network providers in respect of procedures and initiatives so as to maximise the cost-effectiveness of the service. They also provide call centre services where members may direct any query relating to optometric and related services or any accounting or financial enquiries related to optometric services.

NOTES TO THE ANNUAL FINANCIAL STATEMENTS CONTINUED

FOR THE YEAR ENDED 31 DECEMBER 2018

21. INSURANCE RISK MANAGEMENT continued

21.3 Risk transfer arrangements continued

21.3.1 ISO LESO continued

The Scheme pays ISO LESO a fixed fee of R36.33 (2017: R35.27) per beneficiary for members on the Standard option, R21.93 (2017: R21.29) per beneficiary on the Primary option, R43.67 (2017: R42.40) per beneficiary for members on the BonClassic option and R16.65 (2017: R16.16) per beneficiary on the BonCap option.

The contract with ISO LESO has been terminated effective 31 December 2018.

21.3.2 DENIS

The Scheme contracts DENIS to manage all aspects of dental claims administration, including the payment of all approved claims from service providers. Services rendered by DENIS are limited to all aspects of dental benefits including related hospitals, clinic and anaesthetist cost, and any claim administration related to such dental and related services excluding services, benefits and claims classified under PMB as defined by the Medical Scheme Act, or amendments of the Act applicable to PMBs. DENIS also provides the Scheme with monthly financial reports reflecting all transactions related to fees paid by the Scheme and services rendered by DENIS.

The Scheme pays DENIS a monthly fixed fee in advance of R77.02 (2017: R72.03) for members on the Standard and Standard Select options, R66.00 (2017: R61.72) for members on the BonSave option, R45.27 (2017: R42.34) for members on the Primary option, R73.04 (2017: R68.29) for members on the BonClassic option, and R70.17 (2017: R65.62) for members on the BonComplete option.

The current contract took effect from 1 January 2016 for a period of five years. Fees and benefits have been approved for the 2019 benefit year.

21.3.3 Bryte

The Scheme has entered into a risk transfer arrangement with Bryte for the provision of international travel benefits for members who travel overseas for a period of not more than 90 days at a fee of R1.96 per member per month. This contract applies to all members of the Scheme except for those on the BonCap option.

The duration of the contract is three years, with the option to renew the contract annually after the initial three years. Fees and benefits have been agreed for the 2019 financial year.

21.3.4 ER24

The Scheme contracted ER24 for the provision of emergency medical and international travel services. ER24 conducts its business as an emergency response, assistance and transportation company. ER24 ensures that all telephonic requests for medical assistance received from members are dealt with in accordance with the contract. ER24 maintains and updates its database to continuously reflect the most recently available data and information relating to the provision of services.

The Scheme pays ER24 a standard fee of R29.86 (2017: R28.19) per member per month.

The contract terminated on 31 December 2018. Through an RFP, ER24 was re-appointed as the provider for emergency medical evacuation services for a period of three (3) years effective from 1 January 2019.

21.3.5 CDE

This contract has been terminated and replaced by the Bonitas Diabetes Management Programme which is a new managed care initiative of the Scheme. The costs related to this programme are included in the managed care fees paid to Medscheme Health Risk Solutions.

21. INSURANCE RISK MANAGEMENT continued

21.4 Claims sensitivity analysis

The table below outlines the sensitivity of claims and solvency to the major insurance risks, i.e. tariff inflation, ageing and utilisation being higher than expected. Each change in the criteria is quantified in the form of an expected claims and solvency impact on the Trustee-approved 2019 budget.

Claims category	Change in variable	Estimated impact on expected 2019 claims R'000	Estimated impact on expected 2019 solvency %
Inflation assumptions			
Represents the increase in the price of service units rendered			
In-hospital claims (ward/theatre/consumables)	Tariff inflation 1% higher	60 038	(0.34)
Chronic claims	Tariff inflation 1% higher	7 632	(0.04)
Ageing assumptions			
Represents the expected claims increase due to members getting older on average			
In-hospital claims (ward/theatre/consumables)	Average member age 0.5 years higher	62 004	(0.35)
Acute medicine claims	Average member age 0.5 years higher	5 850	(0.03)
Chronic claims	Average member age 0.5 years higher	7 814	(0.04)
Utilisation assumptions			
Represents expected claims increases over and above what is explained by inflation, ageing and benefit changes			
In-hospital claims (ward/theatre/consumables)	Utilisation rate 1% higher	60 927	(0.34)
Chronic claims	Utilisation rate 1% higher	7 678	(0.04)
Specialist costs	Utilisation rate 1% higher	17 847	(0.10)

NOTES TO THE ANNUAL FINANCIAL STATEMENTS CONTINUED

FOR THE YEAR ENDED 31 DECEMBER 2018

22. FINANCIAL RISK MANAGEMENT

22.1 Financial risk management principles

The Scheme's activities expose it to the following financial risks:

- Credit risk
- Liquidity risk
- Market risk from equity market prices (price risk) and interest rate risk.

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

Financial risk management and investment decisions are made under the guidance and policies approved by the Board together with the Scheme's Executive Management who have overall responsibility for the establishment and oversight of the Scheme's financial and non-financial risk management framework.

The Investment Committee is responsible for assisting the Board to manage the investment portfolio in accordance with the agreed policies of the Scheme and ensure compliance with the regulations of the Act. Refer to section 4 of the Board of Trustees' report for further details on the Scheme's investment strategy.

22.2 Credit risk

Credit risk is the risk that the Scheme will suffer a financial loss if a customer (insurance or trade receivable) or other counterparty to a financial instrument fails to meet their current obligations to the Scheme. Credit risk arises principally from the Scheme's investment securities (excluding the equity instruments), cash and cash equivalents, insurance, and trade and other receivables.

22.2.1 Exposure to credit risk

The carrying amounts of financial assets represents the maximum credit exposure. The maximum exposure to credit risk at the reporting date was:

	2018 R'000	2017 R'000
Investments (current and non-current)	**4 185 010**	3 872 718
Insurance, trade and other receivables (excluding prepayments)	**684 564**	757 949
Cash and cash equivalents (risk and personal medical savings account)	**–**	1 306 002
Cash and cash equivalents	**1 230 818**	–
	6 100 392	5 936 669

22. FINANCIAL RISK MANAGEMENT continued

22.2 Credit risk continued

22.2.2 Investments

The credit risk is managed by limiting exposure as well as the quality of instruments that the Scheme's assets can be invested in, limiting the impact of a default on the overall portfolio. The following guidelines provide the current limits on each instrument:

Domestic equity investments

- Domestic equity investments shall be restricted to securities that are actively traded on the Johannesburg Stock Exchange ("JSE") and readily marketable
- Not more than 5% of the total share portfolio may be invested in the share of any one company at the time of purchase
- For investee companies that have a market capitalisation of below R5 billion, no more than 2.5% of the total Scheme investment portfolio may be invested in the share instrument of any one investee company
- In cases of investments into a pooled fund, the Scheme may invest in accordance with Regulation 30 requirements, in which case the Scheme may waive strict adherence to the guidelines above.

Domestic fixed income and cash investments

- At the time of purchase, debt instruments should have a minimum quality rating of BBB- or equivalent as rated by Moody's and Standard & Poor's. Split-rated issues will be governed by the lower quality designation
- Debt instruments which are downgraded for which the asset manager believes it should continue to hold the instrument, a report providing reasons should be provided in one month
- Instruments that are rated AA- and above are limited to 10% per issuer. Those instruments rated below AA- but not lower than BBB- are limited to 5%. Instruments rated below BBB- are limited to 1% and no instruments rated below BB- may be held
- With the exception of those situations involving re-organisation of fund assets, debt securities should be made only in issuers with an outstanding value of at least R50 million, valued at par, at the time of purchase.

Derivatives

- Derivative instruments may be used for the purposes of hedging or protecting the Scheme's investment portfolio, re-balancing or facilitating cash flows in order to enhance the Scheme's investment returns. Derivatives may not be used for speculative and/or gearing purposes. Derivative investments are limited to 2.5% of the investment portfolio.

22.2.3 Insurance, trade and other receivables

The Scheme's exposure to credit risk is influenced by the individual characteristics of each member. The demographics of the Scheme's membership base, including the default risk of the industry in which the member operates, has less of an influence on credit risk. The Scheme's revenue streams are evenly spread thereby reducing credit risk exposure.

The majority of the Scheme's members have been loyal to the Scheme for many years, resulting in infrequent losses occurring. Credit risk is actively managed by suspending members' accounts on non-receipt of contributions.

Age analysis of insurance, trade and other receivables

	2018 R'000	2017 R'000
Not past due	**663 747**	734 060
Past due 1 – 30 days	**10 071**	10 257
Past due 31 – 60 days	**3 212**	4 202
Past due 61 – 90 days	**2 051**	2 960
Past due more than 90 days	**5 483**	6 470
Trade and other receivables (excluding prepayments)	**684 564**	757 949

With respect to the insurance assets that are neither impaired nor past due, there are no indications as of the reporting date that the debtors will not meet their payment obligations based on the nature of the counterparty, the historical information about the counterparty default rates and other information used to assess credit quality.

NOTES TO THE ANNUAL FINANCIAL STATEMENTS CONTINUED

FOR THE YEAR ENDED 31 DECEMBER 2018

22. FINANCIAL RISK MANAGEMENT continued

22.2 Credit risk continued

22.2.4 Cash and cash equivalents

Cash transactions are limited to high credit quality financial institutions. The Scheme has a policy of limiting the amount of credit exposure to any one financial institution and only uses the reputable banks.

22.2.5 Concentrations of credit risk

The Scheme establishes an allowance for impairment that represents its estimate of incurred losses in respect of trade and other receivables. The collective loss allowance is determined based on a set policy, while bearing in mind historical data of payment statistics for similar financial assets.

22.2.6 Impairment allowances

The Scheme establishes an allowance for impairment that represents its estimate of ECLs (IFRS 9) in respect of insurance receivables. The collective loss allowance is determined based on a set policy, while bearing in mind historical data of payment statistics for similar financial assets.

The movement in the allowance for impairment in respect of insurance receivables during the year was as follows:

	2018 R'000	2017 R'000
Balance at beginning of the year	**10 327**	13 280
Impairment loss recognised/(recovered)	**1 776**	(2 953)
IFRS 9 opening balance adjustment	**–**	(4 031)
Increase in provision charged to profit or loss	**1 776**	1 078
Balance at end of the year	**12 103**	10 327

The provision for impairment at 31 December 2018 was determined in accordance with the guidelines of the simplified approach (life time expected losses) of the ECL model as required by IFRS 9. It is in respect of contributions receivable, member and service provider debit balances and advances from savings plan accounts recoverable by management. In order for the Scheme to determine life time expected losses, a provision matrix was used. The provision matrix is based on historical observed default rates, adjusted for forward looking estimates. At every reporting date, the historical observed rates are updated.

The provision matrix is for the following categories:

a) Group debtors
b) Direct paying members
c) Members' portion debtors
d) Savings debtors
e) Provider debtors.

22.3 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.

The Scheme manages its cash flows on a daily basis to ensure sufficient liquidity to cover daily requirements. Furthermore, the Scheme has appointed asset managers to manage its liquidity requirements in the short, medium and long term.

The Scheme has strategically allocated 30% of its total investment assets to be invested in cash which provides a high degree of liquidity on investments. Furthermore, the asset managers are keeping a high degree of liquidity in their portfolios as a portion of their investment is in cash.

22. FINANCIAL RISK MANAGEMENT continued

22.3 Liquidity risk continued

As part of the Scheme's liquidity risk management on market linked investments, the following categories are specifically excluded from the investment portfolio unless the Board provides prior written approval for these investments:

- Private equity funding including venture capital and direct property investments
- Physical commodities or physical commodity contracts
- Unregistered and/or restricted instruments which are unlisted and/or not freely traded.

The contractual maturities of the financial liabilities at reporting date are tabled below. The amounts are gross and undiscounted:

	Within three months R'000	Three to 12 months R'000	Total R'000
2018			
Financial liabilities			
Personal medical savings account liability	**(73 587)**	**(518 917)**	**(592 504)**
Insurance, trade and other payables (excluding VAT)	**(641 417)**	**–**	**(641 417)**
Outstanding risk claims provision	**(648 888)**	**(164 943)**	**(813 831)**
	(1 363 892)	**(683 860)**	**(2 047 752)**
2017			
Financial liabilities			
Personal medical savings account liability	(125 346)	(478 466)	(603 812)
Insurance, trade and other payables (excluding VAT)	(752 891)	–	(752 891)
Outstanding risk claims provision	(632 990)	(57 329)	(690 319)
	(1 511 227)	(535 795)	(2 047 022)

Liquidity analysis assumptions

i) The carrying amount of the financial liabilities equals the undiscounted contractual values of these instruments due to the short period to maturity.

ii) The liquidity analysis above is based on a presumed ability to trade 20% of each share's daily volume in the fair value through profit or loss investment portfolio.

22.4 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 of financial instruments. The objective of market risk management is to manage and control market risk exposures within acceptable parameters, while optimising returns.

22.4.1 Currency risk

Currency risk is the risk that the value of a financial instrument will fluctuate in rand due to changes in foreign exchange rates. The Scheme had no material exposure to currency risk during the year under review as no material foreign currency denominated investments were held.

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FOR THE YEAR ENDED 31 DECEMBER 2018

22. FINANCIAL RISK MANAGEMENT continued

22.4 Market risk continued

22.4.2 Interest rate risk

The Scheme is exposed to interest rate risk on its money market investments (debt investments), cash and cash equivalents and the PMSA liability balances. The money market and cash and cash equivalents are managed on a net returns basis by the Scheme's asset managers. The balance of fixed and variable instruments being held in these portfolios is adjusted in response to movements in market interest rates to maintain an acceptable level of risk as well as returns. The net returns are benchmarked against the STeFi Composite Index.

The carrying amounts of fixed rate instruments in these portfolios approximate their fair values due to the short period to maturity, and no fair value adjustments are processed to the statement of profit or loss in respect of these instruments. Variable rate instruments are not linked to one specific market interest rate. The reported returns on these investments will vary in response to movements in market rates.

The Scheme does not discount insurance, trade or other receivables or payables as they are all settled or fall due within one year.

	2018 R'000	2017 R'000
Interest-bearing instruments		
Financial assets	**4 510 062**	4 014 528
Investments	**3 279 244**	2 708 526
Scheme cash and cash equivalents	**1 230 818**	714 712
Personal medical savings account investment	**–**	591 290
Financial liabilities		
Personal medical savings account liability	**(592 504)**	(603 812)
	3 917 558	3 410 716

22. FINANCIAL RISK MANAGEMENT continued

22.4 Market risk continued

22.4.2 Interest rate risk continued

Interest rate sensitivity analysis

At the end of December 2018, the Scheme earned interest income of R255.9 million (2017: R230.2 million) from its investments in bonds, cash and money market instruments. The following table illustrates the impact of negative and positive market returns to the overall Scheme as a result of the current interest rate exposure, assuming all other variables remain constant:

Decrease (%)	(2.5)	(2.0)	(1.5)	(1.0)	(0.5)	(0.25)	0.0
2018							
Scheme impact (R'000)	**(84 434)**	**(67 547)**	**(50 660)**	**(33 774)**	**(16 887)**	**(8 443)**	**–**
Solvency impact (%)	**(0.52)**	**(0.42)**	**(0.31)**	**(0.21)**	**(0.10)**	**(0.05)**	**–**
2017							
Scheme impact (R'000)	(82 225)	(65 780)	(49 335)	(32 890)	(16 445)	(8 222)	–
Solvency impact (%)	(0.53)	(0.42)	(0.32)	(0.21)	(0.11)	(0.05)	–

Increase (%)	0.0	0.25	0.5	1.0	1.5	2.0	2.5
2018							
Scheme impact (R'000)	**–**	**8 443**	**16 887**	**33 774**	**50 660**	**67 547**	**84 434**
Solvency impact (%)	**–**	**0.05**	**0.10**	**0.21**	**0.31**	**0.42**	**0.52**
2017							
Scheme impact (R'000)	–	8 222	16 445	32 890	49 335	65 780	82 225
Solvency impact (%)	–	0.05	0.11	0.21	0.32	0.42	0.53

22.4.3 Market price risk

Market price risk arises from fair value through profit or loss equity securities held for partially meeting the Scheme's financial obligations as well as to increase the return on investments, by continuous trading of equity securities. Material investments are managed by various asset managers on behalf of the Scheme. All buy and sell decisions are measured in terms of the investment mandate of the Scheme.

The following guidelines provide the current limits on each instrument:

Domestic equity investments

- Domestic equity investments shall be restricted to securities that are actively traded on the JSE and readily marketable
- Not more than 5% of the total share portfolio may be invested in the share of any one company at the time of purchase
- For investee companies that have a market capitalisation of below R5 billion, no more than 2.5% of the total Scheme investment portfolio may be invested in the share instrument of any one investee company
- In cases of investments into a pooled fund, the Scheme may invest in accordance with Regulation 30 requirements, in which case the Scheme may waive strict adherence to the guidelines above.

NOTES TO THE ANNUAL FINANCIAL STATEMENTS CONTINUED

FOR THE YEAR ENDED 31 DECEMBER 2018

22. FINANCIAL RISK MANAGEMENT continued

22.4 Market risk continued

22.4.3 Market price risk continued

Domestic fixed income and cash investments

- At the time of purchase, debt instruments should have a minimum quality rating of BBB- or equivalent as rated by Moody's and Standard & Poor's. Split-rated issues will be governed by the lower quality designation
- Debt instruments which are downgraded for which the asset manager believes it should continue to hold the instrument, a report providing reasons should be provided in one month
- Instruments that are rated AA- and above are limited to 10% per issuer. Those instruments rated below AA- but not lower than BBB- are limited to 5%. Instruments rated below BBB- are limited to 1% and no instruments rated below BB- may be held
- With the exception of those situations involving re-organisation of fund assets, debt securities should be made only in issuers with an outstanding value of at least R50 million, valued at par, at the time of purchase.

Derivatives

- Derivative instruments may be used for the purposes of hedging or protecting the Scheme's investment portfolio, re-balancing or facilitating cash flows in order to enhance the Scheme's investment returns. Derivatives may not be used for speculative and/or gearing purposes. Derivative investments are limited to 2.5% of the investment portfolio

The Scheme strives to minimise market risk as follows:

- The Scheme has established an investment strategy and in line with this strategy, the Scheme diversifies its investment portfolio by investing in domestic equities, domestic bonds and domestic cash to achieve a balance investment portfolio.
- Investments are limited to the types of securities listed in the investment policy statement. Furthermore, the following categories of securities are excluded and may only be considered with written approval from the Board:

  a) Private equity funding including venture capital and direct property investments

  b) Physical commodities or physical commodity contracts

  c) Unregistered and/or restricted instruments which are unlisted and/or not freely traded

- Diversifying the management of the Scheme's investment portfolio to four asset managers who have absolute return mandates thus mitigating the risk through diversification. The Scheme in addition to this has one asset manager responsible for managing the Scheme's cash
- Structuring the investment portfolio so that securities mature to meet cash requirements for ongoing cash flow needs, thereby avoiding the need to sell securities on the open market prior to maturity.

22. FINANCIAL RISK MANAGEMENT continued

22.4 Market risk continued

22.4.3 Market price risk continued

Sensitivity analysis

The analysis presented below assumes all other factors remain constant and is performed on the same basis for 2018 and 2017.

Listed equities

At the end of December 2018, the Scheme had 21.1% (2017: 27.5%) of its fair value through profit or loss investments invested in all equity instruments. The following table illustrates the impact of negative and positive market returns to the overall Scheme as a result of the current equity exposure, assuming all other variables remain constant:

Decrease (%)	(35.0)	(25.0)	(15.0)	(10.0)	(5.0)	(2.0)	0.0
2018							
Scheme impact (R'000)	**(308 756)**	**(220 540)**	**(132 324)**	**(88 216)**	**(44 108)**	**(17 643)**	**–**
Solvency impact (%)	**(1.90)**	**(1.35)**	**(0.81)**	**(0.54)**	**(0.27)**	**(0.11)**	**–**
2017							
Scheme impact (R'000)	(396 135)	(282 954)	(169 772)	(113 182)	(56 591)	(22 636)	–
Solvency impact (%)	(2.56)	(1.83)	(1.10)	(0.73)	(0.37)	(0.15)	–

Increase (%)	0.0	2.0	5.0	10.0	15.0	25.0	35.0
2018							
Scheme impact (R'000)	**–**	**17 643**	**44 108**	**88 216**	**132 324**	**220 540**	**308 756**
Solvency impact (%)	**–**	**0.11**	**0.27**	**0.54**	**0.81**	**1.35**	**1.90**
2017							
Scheme impact (R'000)	–	(22 636	(56 591)	(113 182)	(169 772)	(282 954)	(396 135)
Solvency impact (%)	–	(0.15)	(0.37)	(0.73)	(1.10)	(1.83)	(2.56)

NOTES TO THE ANNUAL FINANCIAL STATEMENTS CONTINUED

FOR THE YEAR ENDED 31 DECEMBER 2018

22. FINANCIAL RISK MANAGEMENT continued

22.5 Fair value

For financial assets held at fair value, disclosure is required of a fair value hierarchy which reflects the significance of the inputs used to make the measurements. Fair value disclosures are based on the level within which an instrument falls in the fair value hierarchy. The inputs are categorised into three levels, with the highest priority given to unadjusted quoted prices in active markets for identical assets or liabilities and the lowest priority given to unobservable inputs.

The three fair value hierarchy levels are as follows:

- Level 1 inputs are unadjusted quoted prices in active markets for identical assets or liabilities
- Level 2 inputs are inputs other than quoted prices included within level 1 that are either directly or indirectly (that is, derived from prices) observable for the asset or liability
- Level 3 inputs for the asset or liability that are not based on observable market data (that is, unobservable inputs).

The following table presents the Scheme's assets held at fair value:

	Level 1 R'000	Level 2 R'000	Level 3 R'000	Total R'000
At 31 December 2018				
Assets				
Financial assets held at fair value through profit or loss				
Listed equities	**882 161**	**–**	**–**	**882 161**
Unlisted equities*	**–**	**–**	**12 065**	**12 065**
Bonds	**1 689 998**	**–**	**–**	**1 689 998**
Unlisted property holding*	**–**	**–**	**2 540**	**2 540**
Money market instruments*	**–**	**1 527 338**	**–**	**1 527 338**
Fixed deposits	**–**	**61 908**		**61 908**
Investment properties*	**–**	**–**	**72 700**	**72 700**
Investment property held for sale	**–**	**–**	**9 000**	**9 000**
Total assets	**2 572 159**	**1 589 246**	**96 305**	**4 257 710**
At 31 December 2017				
Assets				
Financial assets held at fair value through profit or loss				
Listed equities	1 131 816	–	–	1 131 816
Unlisted equities*	–	–	12 065	12 065
Bonds	1 380 822	–	–	1 380 822
Unlisted property holding*	–	–	2 311	2 311
Money market instruments*	–	1 327 704	–	1 327 704
Investment properties*	–	–	70 000	70 000
Investment property held for sale	–	–	18 000	18 000
Total assets	2 512 638	1 327 704	102 376	3 942 718

* *Movements and valuation techniques relating to level 2 and level 3 category items are disclosed in notes 5, 6 and 7.*

22. FINANCIAL RISK MANAGEMENT continued

22.5 Fair value continued

Financial assets held at fair value through profit or loss held by the Scheme categorised as level 1 were invested in listed preference shares, equities and bonds and priced with reference to published price quotations (unadjusted) in an active market.

Financial assets held at fair value through profit or loss held by the Scheme categorised as level 2 were invested in:

- Unlisted money market instruments and valued using discounted cash flows based on applicable interest rates.

Financial assets held at fair value through profit or loss held by the Scheme categorised as level 3 were invested in:

- Unlisted equity investment of 26% in Louis Pasteur Holdings Proprietary Limited
- Investment properties lease to third parties valued annually by independent property valuators
- An unlisted property holding and valued with reference to commercial property yields on the existing average income stream received
- Unlisted insurance policy and valued based on underlying funds' investments.

The following table shows a reconciliation of the movement during the year for fair value measurements for investments through profit and loss in level 3 of the fair value hierarchy of the Scheme for 2018:

	Investment property R'000	Investment property held for sale R'000	Unlisted equity R'000	Unlisted property holding R'000	Total R'000
Opening balance	**70 000**	**18 000**	**12 065**	**2 311**	**102 376**
Fair value adjustment	**2 700**	**(9 000)**	**–**	**229**	**(6 071)**
Closing balance for the year ended 31 December 2018	**72 700**	**9 000**	**12 065**	**2 540**	**96 305**

Although the Scheme believes that its estimates of fair value are appropriate, the use of different methodologies or assumptions could lead to different measurements of fair value.

Key inputs and assumptions used in the model at 31 December 2018 include:

Investment property

Refer to note 5 for the details regarding key inputs and assumptions used in the valuation at 31 December 2018.

Unlisted equity

Refer to note 22.6 for the details regarding key inputs and assumptions used in the valuation at 31 December 2018.

Unlisted property holding

The unlisted holdings property value is based on the fair value of the underlying property. The property is valued using the net income of the property and applying a capitalisation rate to the net income.

The capitalisation rate applied is based on an assumed average commercial property yield simulating the risk characteristics of a similar investment.

NOTES TO THE ANNUAL FINANCIAL STATEMENTS CONTINUED

FOR THE YEAR ENDED 31 DECEMBER 2018

22. FINANCIAL RISK MANAGEMENT continued

22.5 Fair value continued

Unconsolidated investment structures

The asset managers invest the Scheme's monies in reputable funds which target returns to the Scheme. The Scheme views these funds as unconsolidated structured entities. The Scheme monitors the performance of the funds closely to ensure the Scheme earns high returns without unnecessary exposure to risk.

The Scheme has investments in pooled investment products and collective investment schemes ("the funds") as listed in the table below. The exposure the Scheme has to these funds is listed in the table below in terms of Regulation 30 to the Act. The Scheme's maximum exposure to loss from its interests in the fund is limited to the total fair value of its investments as detailed below:

	At 31 December 2018		At 31 December 2017	
Fund	**Fair value R'000**	**% exposure in terms of Regulation 30**	Fair value R'000	% exposure in terms of Regulation 30
IAL Stable Money	**175 847**	**4**	140 095	4
Nedgroup Structured Life Taquanta EIF	**252 581**	**6**	224 865	6
Nedgroup Investments Money Market Fund Class C4	**1 018 140**	**24**	83 161	2
Nedgroup Investments Core Income Fund Class C4	**624 397**	**15**	635 859	16
Prescient: Q18m SRI Low Liquidity Funding Portfolio	**2 899**	**0**	3 286	–
Prudential Global Fixed Income Fund	**97 236**	**2**	–	–
Momentum Inflation Linked Bond ABIL Retention Fund (A)	**456**	**0**	456	–
	2 171 556	**51**	1 087 722	28

22.6 Unlisted investments

Unlisted equities comprise a 26.0% investment in Louis Pasteur Hospital Holdings Proprietary Limited ("Louis Pasteur"). The investment in Louis Pasteur is valued annually using a net asset value approach and is based on the most recent set of audited financial statements. Louis Pasteur's net asset value at 31 December 2015 amounted to R46.4 million (refer note 7).

	2018 R'000	2017 R'000
Reconciliation of fair values		
Balance at 1 January	**12 065**	12 065
Fair value adjustment	**–**	–
Balance at 31 December	**12 065**	12 065

22. FINANCIAL RISK MANAGEMENT continued

22.7 Capital management

The Board's policy is to maintain a strong capital base so as to maintain investor, creditor and market confidence and to sustain future growth of the business. The Board appointed RisCura Solutions Proprietary Limited to manage the Scheme's portfolio of investments and cash and cash equivalents to achieve this objective effective 1 August 2018. These services were previously provided by Alexander Forbes Consultants, whose contract was terminated effective 31 July 2018.

The Board monitors the solvency ratio of the Scheme. The Scheme is required to maintain a minimum level of accumulated funds in terms of Regulation 29 of the Act. Accumulated funds expressed as a percentage of gross annual contributions for the accounting period under review may not be less than 25.0%. "Accumulated funds" is defined as the net asset value of the Scheme, excluding funds set aside for specific purposes and unrealised non-distributable reserves.

	2018 R'000	2017 R'000
Members' funds per the statement of financial position	**4 134 028**	3 969 191
Adjusted for:		
Regulation 29 exclusion of unrealised gains on investments	**(23 397)**	(156 341)
Cumulative net gain on re-measurement to fair value of investment properties included in the accumulated funds[#]	**(15 474)**	(21 774)
Accumulated funds per Regulation 29	**4 095 157**	3 791 076
Gross contributions (note 13)	**16 276 305**	15 497 049
Solvency ratio (%)	**25.2**	24.5

[#] *Cumulative net gains/(losses) on re-measurement to fair value of investment properties included in the accumulated funds are calculated as follows:*

At beginning of the year	**21 774**	20 374
Movement in unrealised (losses)/gains on re-measurement to fair value of investment properties included in accumulated funds	**(6 300)**	1 400
At end of the year	**15 474**	21 774

NOTES TO THE ANNUAL FINANCIAL STATEMENTS CONTINUED

FOR THE YEAR ENDED 31 DECEMBER 2018

	2018 R'000	2017 R'000
23. COMMITMENTS		
23.1 Lessee operating lease commitments		
The future aggregate minimum lease payments under non-cancellable operating leases are as follows:		
Not later than one year	**3 582**	2 747
Later than one year and not later than five years	**11 366**	12 379
	14 948	15 126
23.2 Lessor operating lease commitments		
The future aggregate minimum lease receipts under non-cancellable operating leases are as follows:		
Not later than one year	**5 252**	6 541
Later than one year and not later than five years	**4 215**	8 879
	9 467	15 420

24. RELATED PARTY TRANSACTIONS

24.1 Related party relationships

24.1.1 Key management personnel and their close family members

Key management personnel are those persons who have authority and responsibility for planning, directing and controlling the activities of the Scheme. Key management personnel include the Chairperson of the Board, the Board, the Principal Officer, the Chief Operations Officer and the Chief Financial Officer.

Close family members include direct family members of the Chairperson of the Board, the Board, the Principal Officer, the Chief Operations Officer and the Chief Financial Officer.

24.1.2 Key service provider

Medscheme Holdings Proprietary Limited is a key service provider for the Scheme as it has a significant role in the administering of Scheme's financial, actuarial and operating activities.

Health Risk Solutions, a division of Medscheme Holdings Proprietary Limited, is a key service provider for the Scheme as it participates in providing managed care services to the Scheme's members. It also provides the Scheme with actuarial consulting services.

AfroCentric Distribution Services Proprietary Limited is a key service provider as it handles the Scheme's advertising and marketing activities. It is a fellow subsidiary of the Scheme's administrator.

Aid for Aids Management Proprietary Limited is a key service provider for the Scheme as it participates in providing managed care services to the Scheme's members. It is a fellow subsidiary of the Scheme's administrator.

Helios IT Solutions Proprietary Limited is a key service provider as it handles the Scheme's software licensing and desktop support services. It is a fellow subsidiary of the Scheme's administrator.

Pharmacy Direct Proprietary Limited is a key service provider as it handles the Scheme's dispensing and delivery of chronic medication. It is a subsidiary of ACT Healthcare Assets Proprietary Limited, the holding company of the Scheme's administrator.

Wellness Odyssey Proprietary Limited is a key service provider as it handles the Scheme's wellness programmes. It is a subsidiary of ACT Healthcare Assets Proprietary Limited, the holding company of the Scheme's administrator as of 1 July 2017.

The Cheese Has Moved is a service provider that assists the Scheme with printing services. It is a fellow subsidiary of the Scheme's administrator.

Tendahealth Proprietary Limited is a service provider that provides the Scheme's members with brokerage services. It is a subsidiary of AfroCentric Distribution Services, a fellow subsidiary of the Scheme's administrator.

24.1.3 Other related parties

The Scheme has a 26% ordinary shareholding in Louis Pasteur. The members of the Scheme utilise the facilities of the Louis Pasteur Hospital on an ongoing basis for medical services.

24. RELATED PARTY TRANSACTIONS continued

24.2 Transactions with related parties

All transactions with related parties are commercially determined under terms that are no less favourable than those arranged with third parties.

		2018 R'000	2017 R'000
24.2.1	***Parties with significant influence over the Scheme***		
	Medscheme Holdings Proprietary Limited – Scheme administrator		
	Statement of comprehensive income		
	Administration fees paid		
	The administration agreement between Medscheme Holdings Proprietary Limited and the Scheme stipulates that Medscheme Holdings Proprietary Limited administers the Scheme in terms of the Rules of the Scheme and in accordance with the instructions given by the Board	**627 743**	595 482
	Third-party recoveries		
	As part of the administration agreement, Medscheme Holdings Proprietary Limited is entitled to a 30% fee on fraud, waste and abuse recoveries	**11 963**	9 970
	Statement of financial position		
	Balances payable to related party		
	The balances payable bear no interest, are unsecured and are due within 30 days	**(4 674)**	(925)
	Health Risk Solutions, a division of Medscheme Holdings Proprietary Limited		
	Statement of comprehensive income		
	Managed care fees		
	The managed care agreement between Health Risk Solutions and the Scheme stipulates that Health Risk Solutions renders managed healthcare services to the Scheme in terms of the Rules of the Scheme and in accordance with the instructions given by the Board	**432 292**	404 759
	Actuarial consulting fees		
	The actuarial consulting agreement between Health Risk Solutions and the Scheme stipulates that Health Risk Solutions renders actuarial consulting services and technical marketing services to the Scheme in accordance with the instructions given by the Board	**2 711**	2 545
	Statement of financial position		
	Balances payable to related party		
	The balances payable bear no interest, are unsecured and are payable upon presentation of an approved invoice	**(5 969)**	(703)
	AfroCentric Distribution Services Proprietary Limited (a fellow subsidiary of Medscheme Holdings Proprietary Limited)		
	Statement of comprehensive income		
	Sales and marketing fees	**137 702**	148 966
	Statement of financial position		
	Balances payable to related party		
	The balances payable bear no interest, are unsecured and are payable upon presentation of an approved invoice	**(8 134)**	(11 880)

NOTES TO THE ANNUAL FINANCIAL STATEMENTS CONTINUED

FOR THE YEAR ENDED 31 DECEMBER 2018

		2018 R'000	2017 R'000
24.	**RELATED PARTY TRANSACTIONS** continued		
24.2	**Transactions with related parties** continued		
24.2.1	***Parties with significant influence over the Scheme continued***		
	Aid for Aids Management Propriety Limited (a fellow subsidiary of Medscheme Holdings Proprietary Limited)		
	Statement of comprehensive income		
	Managed care fees		
	The managed care agreement between Aid for Aids Management Proprietary Limited and the Scheme stipulates that Aid for Aids Management Proprietary Limited renders management services to the Scheme in terms of the Rules of the Scheme and in accordance with the instructions given by the Board	**47 085**	43 012
	Statement of financial position		
	Balances payable to related party		
	The balances payable bear no interest, are unsecured and are payable upon presentation of an approved invoice	**(3 985)**	(3 581)
	Helios IT Solutions Proprietary Limited (a fellow subsidiary of Medscheme Holdings Proprietary Limited)		
	Statement of comprehensive income		
	Software licence agreement		
	The software licensing agreement regarding the Nexus claims administration system between Helios and the Scheme stipulates that Helios licences the software to the Scheme	**180 829**	183 458
	IT management and support services agreement		
	The IT management and support services agreement in place is to provide the Scheme with network infrastructure support, desktop support, connectivity support, security and integrity support services	**2 573**	2 296
	Statement of financial position		
	Balances (payable)/receivable from related party		
	The balance receivable bears no interest, is unsecured and is due within 30 days	**(7 209)**	5 896
	Pharmacy Direct Proprietary Limited (a subsidiary of ACT Healthcare Assets Proprietary Limited, the holding company of Medscheme Holdings Proprietary Limited)		
	Statement of comprehensive income		
	Claims paid during the year	**687 489**	626 991
	Statement of financial position		
	Balances payable to related party		
	The balance payable bears no interest, is unsecured and is due within 30 days	**(6 969)**	(4 851)

		2018 R'000	2017 R'000
24.	**RELATED PARTY TRANSACTIONS** continued		
24.2	**Transactions with related parties** continued		
24.2.1	*Parties with significant influence over the Scheme continued*		
	The Cheese Has Moved Proprietary Limited (a subsidiary of ACT Healthcare Assets Proprietary Limited, the holding company of Medscheme Holdings Proprietary Limited) – related party with effect from 1 March 2017		
	Statement of comprehensive income		
	Printing and marketing costs paid during the year	**2 482**	2 279
	Statement of financial position		
	Balances payable to related party		
	The balance payable bears no interest, is unsecured and is due within 30 days	**(49)**	(510)
	Wellness Odyssey Proprietary Limited (a subsidiary of ACT Healthcare Assets Proprietary Limited, the holding company of Medscheme Holdings Proprietary Limited) – related party with effect from 1 July 2017		
	Statement of comprehensive income		
	Wellness costs paid during the year	**17 062**	10 958
	Statement of financial position		
	Balances payable to related party		
	The balance payable bears no interest, is unsecured and is due within 30 days	**(1 842)**	(1 816)
	Tendahealth Proprietary Limited (a subsidiary of AfroCentric Distribution Services Proprietary Limited, a fellow subsidiary of Medscheme Holdings Proprietary Limited – related party with effect from 1 December 2017		
	Statement of comprehensive income		
	Broker fees paid	**3 214**	145
	Statement of financial position		
	Balances payable to related party		
	The balance payable bears no interest, is unsecured and is due within 30 days	**–**	–
24.2.2	*Key management personnel and their close family members*		
	Key management compensation		
	Trustees' remuneration and other disbursements (note 15)	**4 079**	4 495
	Principal Officer's remuneration other disbursements (note 15)	**5 271**	5 124
	Executive remuneration other disbursements	**5 839**	4 638
		15 189	14 257

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FOR THE YEAR ENDED 31 DECEMBER 2018

		2018 R'000	2017 R'000
24.	**RELATED PARTY TRANSACTIONS** continued		
24.2	**Transactions with related parties** continued		
24.2.2	***Key management personnel and their close family members continued***		
	Key management compensation continued		
	Statement of comprehensive income		
	Contributions received		
	This constitutes the contributions paid by the Executive Management and Trustees as members of the Scheme in their individual capacity. All contributions were at the same terms as applicable to third parties	**714**	863
	Claims paid		
	This constitutes amounts claimed by the Executive Management and Trustees 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 third parties	**238**	342
	Trustee savings balances		
	This constitutes savings balances held by the Scheme on behalf of the Trustees.	**–**	32
24.2.3	***Other related parties***		
	Louis Pasteur Hospital Holdings Proprietary Limited		
	Statement of comprehensive income		
	Claims paid during the year	**28 096**	31 593
	Statement of financial position		
	Unlisted equity held by the Scheme in the entity at fair value	**12 065**	12 065
	Balance payable to related party		
	The balance payable bears no interest, is unsecured and is due within 30 days	**(71)**	(611)

Dr HE Nematswerani

The Trustee of the Board owns a private practice in his personal capacity that the Scheme transacts with in the ordinary course of business. The transactions between the Scheme and his practice are commercially determined and in accordance with the Rules of the Scheme.

Activo Health Proprietary Limited

The structure and affected business transactions

Medscheme Holdings, a subsidiary of AfroCentric Investment Corporation Limited ("AfroCentric"), provides Bonitas Medical Fund ("Bonitas") with a number of administrative functions. As a result of this significant relationship, AfroCentric and its subsidiary companies are considered to be related parties to Bonitas.

A subsidiary of AfroCentric, ACT Healthcare Assets Proprietary Limited ("ACT") provides the following services to Bonitas:

a) Administration
b) Managed care
c) Advertising and marketing
d) Dispensing and delivery of chronic medicine
e) Wellness programmes
f) Brokerage services
g) IT services
h) Actuarial services.

24. RELATED PARTY TRANSACTIONS continued

24.2 Transactions with related parties continued

24.2.3 Other related parties continued

Activo Health Proprietary Limited continued

The structure and affected business transactions continued

ACT had a 26% investment in Activo Health Proprietary Limited ("Activo Health") and as a result Activo Health was treated as an associate company to AfroCentric. This investment was made in 2015.

Activo Health manufactures pharmaceutical medication which is sold to Curasana Wholesalers Proprietary Limited who stores and warehouses the medication. Curasana supplies Pharmacy Direct Proprietary Limited, a subsidiary of AfroCentric and key service provider to the Scheme, who in turn dispense and deliver the chronic medication to members on behalf of Bonitas.

Activo Health provides no services directly to Bonitas and therefore no transactions or related party balances are disclosed in these annual financial statements.

The transaction

AfroCentric issued a cautionary announcement to the public on 14 September 2018 advising shareholders that an agreement has been reached in principle with the Activo Health vendors to anticipate the exercise of the call option. This call option has been exercised and the effective date of the transaction was 1 March 2019, for the remainder of the shares in Activo Health not already owned by AfroCentric.

The ex-Chairperson of the Scheme's Board, Mr Stephen Claassen owned 11.2% shares in Activo Health and in his capacity as the shareholder in Activo Health was the recipient of a portion of the proceeds following the exercise of the call option by AfroCentric.

Impact of the transaction on the chairmanship of Mr Claassen

The Board has been fully aware of the current relationship between Mr Claassen and Activo Health and therefore a potential conflict of interest.

Various processes were put in place to manage the potential conflict of interest. These have included:

Mr Claassen declared his potential conflict of interest from the earliest possible stage and consistently until the actual purchase of the 26% shareholding by AfroCentric in Activo Health in 2015.

The Board interrogated the declarations, requested full disclosure and insisted on more than one legal opinion with regard to the potential conflict of interest.

The Board took a decision that the potential conflict of interest did not constitute an actual conflict of interest that required removal of Mr Claassen from the Board, but rather something that must be taken into consideration in their future dealings with AfroCentric, especially as far as Activo Health is concerned.

The Board had ongoing discussions with regard to Mr Claassen's declarations which is indicative of a transparent and well-balanced Board.

Mr Claassen recused himself at all relevant times as the Chairperson of the Board and across all sub-committees when he had a specific potential conflict of interest with regard to the AfroCentric group.

AfroCentric, following the approval by the Competition authorities, concluded the transaction and acquired 100% of Activo Health effected 1 March 2019. Upon notification of this approval by the Competition authority, Mr Claassen immediately resigned as a Trustee, being disqualified to hold this position in terms of the MSA.

NOTES TO THE ANNUAL FINANCIAL STATEMENTS CONTINUED

FOR THE YEAR ENDED 31 DECEMBER 2018

25. CONTINGENCIES

The Scheme has contingent assets in respect of the Road Accident Fund claim recoveries for members who are or may be involved in a motor vehicle accident of R472 million (2017: R535 million). Management is confident that the contingent assets will be recoverable, should they arise.

The Scheme has a contingent asset of R44 million in respect of the legal claims arising from its investment in Louis Pasteur.

26. NON-COMPLIANCE WITH THE ACT

The following areas of non-compliance with the Medical Schemes Act were identified during the course of the financial year:

26.1 Contravention of section 33(2) of the Act

26.1.1 Nature and cause

In terms of section 33(2) of the Act, the registrar may withdraw the approval of such benefit options which in his opinion are not financially sound. For the year ended 31 December 2018 the Scheme reported a net healthcare deficit on nine (2017: seven) of its benefit options:

	2018 R'000	2017 R'000
Standard Select	**30 830**	31 049
BonCap	**172 651**	87 216
BonClassic	**46 570**	42 483
BonComprehensive	**109 992**	97 405
BonEssential	**2 396**	–
BonComplete	**33 266**	7 764
BonSave	**6 052**	–
Hospital Standard	**13 548**	10 028
Hospital Plus	**25 116**	14 030

26.1.2 Possible impact

Loss-making benefit options erode the solvency margin of the Scheme. However, due to historical member reserves coupled with an efficient return on investments, the Scheme is able to absorb these losses.

26.1.3 Corrective course of action

The Scheme has experienced positive performance on its largest options. In 2018 Standard and Primary have reported a net healthcare surplus of R304.6 million and R52.4 million respectively. Much of the positive performance can be attributed to successful hospital negotiations, benefit design and the re-alignment of membership into the correct options. The Scheme continues to monitor the performance of the nine benefit options listed above on a monthly basis. There are also quarterly operational meetings held with the regulator advising on the performance of these options. The Scheme has adopted a long-term strategy to correct the loss-making options into the future, in particular on the BonCap and BonComprehensive options. The Scheme has also appointed a task team to drive initiatives which will reduce both healthcare and non-healthcare costs over the next 12 months. These cost-saving measures should have a positive impact across all options.

26.2.1 Nature and cause

Section 26(7) of the Act requires that all subscriptions and contributions be paid directly to a medical scheme not later than three days after payment thereof becomes due. The Scheme has aged debtors of up to 120 days for both group and direct paying members and is thus in breach of the three-day rule.

26.2.2 Possible impact

There is a risk of non-compliance with section 26(7) of the Act. Significant debt with members could affect the liquidity of the Scheme and its ability to service members and potential non-recoverability of such debtors. For the 2018 financial period the Scheme incurred bad debt write offs of R17.4 million (2017: R20.9 million) which equals 0.11% (2017: 0.14%) of risk contribution income.

26. NON-COMPLIANCE WITH THE ACT continued

26.2 Contravention of section 26(7) of the Act

26.2.3 Corrective course of action

It is not possible to receive all contributions within three days of becoming due, as there may be economic circumstances whereby contributions cannot be paid as per section 26(7). In such instances members are notified of the breach. In addition, the Scheme has mitigating controls in place to address the non-payment of contributions, which include the enforcement of the Scheme's Credit Control Policy. Other interventions include direct management engagement with affected groups to resolve such concerns.

26.3 Exemption of section 26(11) of the Act

26.3.1 Nature and cause

As a result of the amalgamation between the Scheme and Protector Health on 1 January 2006, a post-retirement health obligation arose with reference to the provisions stipulated in Protector Health's prior amalgamation agreement with Vaalmed. This resulted in an unavoidable contravention of section 26(11) of the Act as retirement funding of any sort is not considered to be the business of a medical scheme.

26.3.2 Possible impact

There is little negative impact to any members of the Scheme as the Scheme is currently honouring its obligation to the three members affected by these amalgamations.

26.3.3 Corrective course of action

The Scheme obtained an exemption notice on 1 June 2010 in terms of section 8(h) of the Act from the CMS in respect of the non-compliance raised.

26.4 Exemption of section 35(8) of the Act

26.4.1 Nature and cause

Section 35(8) of the Act prohibits a medical scheme from investing any of its assets in the business of or granting loans to: (a) an employer group who participates in the medical scheme or any administrator or any arrangement associated with the medical scheme; (b) any other medical scheme; (c) any administrator; and (d) any person associated with any of the above.

26.4.2 Possible impact

The Scheme has invested with various entities associated with its administrator and the Scheme's employer groups during the financial year.

26.4.3 Corrective course of action

The Scheme obtained an exemption in terms of section 35(8) of the Act from the CMS in respect of the non-compliance noted.

26.5.1 Nature and cause

Section 59(2) of the Act states that: "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."

Exceptions were found at the beginning of the financial year when claims were put on hold, to ensure that the approved tariff and benefit limits are loaded correctly on the administration platform. This process resulted in a delay in the processing of payments due to the backlog in claims.

Other exceptions were noted during the year where claims were delayed when providers exceeded their monthly limit. These providers are screened first by the forensic team prior to the limit being lifted, resulting in the claims being paid after 30 days.

26.5.2 Possible impact

The delay relating to the claims on hold awaiting the approval of the benefit limit loadings only occurs at the beginning of the financial year when new tariffs and benefit limits are loaded. Claims are paid within the first week of tariff and benefit limit approval. Provider limits are lifted before the next weekly payment run provided no fraud risk was identified.

26.5.3 Corrective course of action

The risk relating to claims on hold for tariff loading exercise is not considered to be significant due to the members and providers conforming to the annual practice. The practice above ensures accurate claims processing for the new benefit year and is in the interest of risk management for the Scheme.

The administrator will be introducing a special claims run and increasing the frequency of the payment runs to reduce the risk of these claims being paid after the 30 days for members and providers.

NOTES TO THE ANNUAL FINANCIAL STATEMENTS CONTINUED

FOR THE YEAR ENDED 31 DECEMBER 2018

27. EVENTS AFTER STATEMENT OF FINANCIAL POSITION DATE

27.1 Outstanding claims provision

The outstanding claims provision is expected to have a run-off period of four months after the date of the statement of financial position date, thereafter the stale claims mandate will apply which will assess each claim on merit.

27.2 CMS inspection

As referred to in the Board of Trustees' report, the Scheme received an interim final report late in 2018. The registrar intends appointing a new inspector in 2019 to finalise the inspection. The inspection does not impact members directly but may result in the Scheme incurring costs for legal remedies where appropriate.

27.3 Resignation of Principal Officer

The current Principal Officer of the Scheme, Mr GJ van Emmenis resigned from this position with effect from 30 April 2019. The Scheme has appointed a new Principal Officer, Mr LR Callakoppen with effect from 1 May 2019.

28. PRIOR YEAR CLASSIFICATION RE-STATEMENT

28.1 Restatement of non-healthcare costs

Circular 34 of 2018 issued by the CMS on 1 August 2018 advised schemes that all services should be properly demarcated relating to relevant healthcare services and managed care and administration agreements. Therefore the non-healthcare-related costs, wellness and network management fees, included in the risk transfer arrangement contracts with DENIS, ER24 and ISO LESO have been re-classified from "relevant healthcare expenditure" to "administration fees" in the statement of comprehensive Income for 2017.

28.2 Restatement of risk transfer recoveries

Furthermore, the Scheme re-visited the disclosure of the risk transfer recoveries in line with IFRS 4 Insurance Contracts. The Scheme previously included the cost of the actual claims paid by the capitation house/risk insurer. Instead, the recoveries should be calculated as the cost the Scheme would have incurred had the Scheme not entered into the risk transfer arrangement. The recoveries have therefore been re-stated using a fee for service approach which results in an increase in the recovery values across the three major risk transfer arrangements, DENIS, ER24 and ISO LESO. Refer to note 14.

Recoveries relating to the CDE risk transfer arrangement have not been restated for 2017 due to the fact that the net expense comprised 4% of the total reported "net expense on risk transfer arrangement" and is therefore considered immaterial. The reclassification and restatements have not affected of altered the "Net healthcare result" or net position of the Scheme.

The impact of the re-statement on the disclosure in the statement of profit or loss is reflected below:

	Difference R'000	2017 Restated R'000	2017 Previously R'000
Statement of profit or loss:			
Relevant healthcare expenditure	40 907	(13 124 594)	(13 165 501)
Net claims incurred	(187 395)	(12 751 091)	(12 563 696)
Net income on risk transfer arrangements	228 302	74 268	(154 034)
Gross healthcare results	40 907	1 781 811	1 740 904
Administrative expenditure	(40 907)	(1 139 228)	(1 098 321)
Net healthcare result	–	345 855	345 855
Surplus for the year	–	730 160	730 160

NOTES

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