2020

BONITAS MEDICAL FUND

ANNUAL REPORT

REGISTRATION NUMBER 1512

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ABBREVIATIONS AND DEFINITIONS

the administrator or Medscheme Medscheme Holdings Proprietary Limited

AfA Aid for Aids

ADS AfroCentric Distribution Services Proprietary Limited

AGM Annual general meeting

Board Board of Trustees

BHF Board of Healthcare Funders

Bonitas or the Scheme Bonitas Medical Fund

Bryte Bryte Insurance Company Limited

CAGR Compound annual growth rate

COVID-19 Coronavirus disease (COVID-19) is an infectious disease causing respiratory illness (like the flu) with symptoms such as a cough, fever, and in more severe cases, difficulty breathing

CMS Council for Medical Schemes

CPI Consumer Price Index

CSI Corporate social investment

Deloitte Deloitte & Touche

DENIS Dental Information Systems Proprietary Limited

DoA Delegation of Authority

EDO Efficiency discounted option

ER24 ER24 EMS Proprietary Limited

Europ Assistance Europ Assistance Worldwide (South Africa) Services Proprietary Limited

FWA Fraud, waste and abuse

GDP Gross domestic product

GP General practitioner

HBM Hospital benefit management

HMI Health Market Inquiry

HPCSA Health Professions Council of South Africa

IBNR Incurred but not reported

ICPS Improved Clinical Pathway Services

IIRC International Integrated Reporting Council

IFRS International Financial Reporting Standards

IMF International Monetary Fund

IPS Investment Policy Statement

I&T Information and technology

King IV™ King Report on Corporate Governance™ for South Africa, 2016[1]

LPHH Louis Pasteur Hospital Holdings Proprietary Limited

LTI Long-term incentive

MSA or the Act Medical Schemes Act of South Africa, No 131 of 1998, as amended

NHI National Health Insurance

PCR Polymerase chain reaction

PMB Prescribed minimum benefits

PMSA Personal medical savings account

POPIA Protection of Personal Information Act, No 24 of 2013

PPE Personal Protection Equipment

PPN Preferred Providers Negotiators Proprietary Limited

the report 2020 Annual Report

SAPC South African Pharmacy Council

SAPS South African Police Service

SCCU Specialised Commercial Crime Unit

Scriptpharm Scriptpharm Risk Management Proprietary Limited

SLA Service level agreement

WEF World Economic Forum

the year Financial year ended 31 December 2020

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OUR REPORT

AUDIENCE AND PURPOSE

This report is for our members, brokers, the regulator and other stakeholders. We keep it simple: we focus on the performance of Bonitas and the value we bring to our members.

SCOPE AND BOUNDARY

The report covers our financial and operational performance for the period 1 January 2020 to 31 December 2020 with outlook commentary that focuses on our strategic aspirations. We believe the report covers all material information to enable our members to determine whether Bonitas resources were applied efficiently and effectively.

In addition to the MSA requirement to produce an annual report with the scope as described above, we took guidance from the IIRC's Integrated Reporting Framework and King IV™. Financial information in this report was compiled using IFRS and was extracted from and agrees with the annual financial statements audited by Deloitte. Its unqualified audit opinion of their fair presentation and representation is on page 64.

The report was reviewed by Executive Management and the Audit and Risk Committee.

The structure of the report, data and measurements are comparable to previous reports. However, the Coronavirus disease (COVID-19) and the public health measures taken from 27 March 2020 in South Africa constitute a unique and infrequent event for the financial year. Readers should note the pervasive effect on the economy, the medical scheme sector and Bonitas, which is explained in our commentary throughout the report.

APPROVAL

The Bonitas Board and Executive Management are pleased to share this approved report detailing:

- The strategy to ensure the delivery of affordable and quality healthcare to members
- Performance against this strategy
- An overview of financial performance
- Challenges and opportunities faced this year
- How the Board exercised and discharged its responsibility for governance.

Approved on 19 April 2021 by

Mr LR Callakoppen
Principal Officer

Mr JD Ngwane
Chairperson of the Board

CONNECT WITH US

0860 002 108

@BonitasMedical

https://www.facebook.com/BonitasMedical/

www.bonitas.co.za

- **Emergency Assistance (ER24) –** call 084124 or email cqc@er24.co.za or claims@er24.co.za
- **Pharmacy Direct Registration –** call 086 0025 800 or please call me 083 690 8934 or email care@pharmacydirect.co.za
- **Optical Benefits (PPN) –** call 041 065 0650 or email bonitas@ppn.co.za
- **Mental Health Programme –** call 0860 106 155 or email mentalhealth@bonitas.co.za
- **HIV/AIDS Programme –** call 0860 100 646 or please call me 083 4109 087 or email afa@afadm.co.za
- **Hip and Knee Programme (Jointcare) –** call 011 568 3334 or visit https://joint-care.co.za/agreements/bonitas/
- **Hip and Knee Programme (ICPS) –** call 011 327 2599 or visit www.icpservices.co.za
- **Diabetes Programme –** call 0860 002 108 or email diabeticcare@bonitas.co.za
- **Dental Programme –** call 0860 336 346 or email denis@bonitas.co.za or claims@denis.co.za
- **Cancer Programme –** call 0860 100 572 or email oncology@bonitas.co.za
- **Back and Neck Programme (DBC) –** call 0860 105 104 or visit www.dbcsa.co.za

24/7 VIRTUAL HEALTHCARE FOR ALL SOUTH AFRICANS

Bonitas launched free virtual medical consultations for members in April 2020 and then opened the offer of free virtual healthcare to ALL South Africans until December 2020. Virtual care emerged worldwide as an effective and sustainable solution for precaution, prevention and treatment to stem the spread of COVID-19.

The Bonitas virtual care app offers medical advice about COVID-19, other medical problems, the writing of prescriptions where necessary and free delivery of chronic medication. This helps alleviate the burden on healthcare workers while making quality healthcare accessible to all South Africans.

Bonitas members and non-members can register on the app to book an online consultation with a doctor from our extensive network of family practitioners. By means of a virtual video consultation, the doctor can then advise on the most clinically appropriate steps for further care. We partnered with AfroCentric Health and Pharmacy Direct, enabling essential chronic medication to be delivered to the patient's doorstep.

Bonitas enabled 3 714 virtual consultations by the end of the year.

Bonitas

2020 PERFORMANCE AT A GLANCE

MEMBERS

710 157
TOTAL BENEFICIARIES

333 141
PRINCIPAL MEMBERS

35
AVERAGE BENEFICIARY AGE

10.2%
PENSIONER RATE

1.13
DEPENDANTS PER MEMBER

19.0%
CHRONIC PROFILE

8.9%
NON-HEALTHCARE EXPENDITURE AS A PERCENTAGE OF RISK

CLAIMS

1 489
HOSPITAL CLAIMS PROCESSED PER DAY

1 164
HOSPITAL AUTHORISATIONS PER DAY

R51.7 million
GROSS RECOVERIES FROM FWA

R346 million
IN NEGOTIATED HOSPITAL SAVINGS

FINANCES

R6.1 billion
IN RESERVES

32.7%
SOLVENCY RATIO

R1.7 billion
SURPLUS

R316.6 million
INVESTMENT INCOME

R3.0 billion
GROSS HEALTHCARE RESULT

COVID-19

184 031
PATHOLOGY TESTS PERFORMED

33 952
POSITIVE CASES

8 038
HOSPITAL ADMISSIONS

1 288
LIVES STILL IN HOSPITAL

1 123
FATALITIES

COUNTLESS
LIVES PROTECTED AND SAVED

ABOUT BONITAS

ABOUT US

TERMS OF REGISTRATION

Bonitas is an open medical scheme registered in terms of the MSA under registration number 1512.

Bonitas is the second largest open medical scheme in South Africa. Administered by Medscheme, Bonitas aims to make quality healthcare accessible to all South Africans and offers a wide range of plans that are simple to understand and easy to use. Bonitas has the largest GP network in South Africa, a specialist network and a host of supplementary benefits paid from risk and carefully crafted managed care programmes. Our programmes include cover for chronic conditions, cancer, diabetes, HIV/AIDS and mental health. This allows members to derive real value for money and stretch their benefits as far as possible.

WHAT WE DO

Bonitas has been part of the South African private healthcare landscape for almost 40 years. Over the four decades we have evolved and expanded our capabilities in response to the needs of our growing membership base.

We have a rich heritage and solid understanding of the South African private healthcare industry. We know the rising cost of healthcare is the top concern for our members. Therefore, our team of experts is constantly looking for innovative ways to reduce costs. Some of these include keeping our fingers on the pulse of technology, managing care to ensure lifestyle diseases are identified before they become chronic, and negotiating better rates.

We put our members first when we negotiate rates and source reputable service providers. We do not believe in one-size-fits-all. We adjust our wide range of benefit options every year while keeping it simple and user-friendly.

Bonitas is there for its members, whether they are go-getting entrepreneurs, chief executive officers, newlyweds, young couples with children, retirees, or minimum wage earners who all need peace of mind when it comes to healthcare.

This is how we fulfil our aim of providing affordable, quality healthcare for all South Africans.

OUR DYNAMIC VALUE SUMMARY

INPUTS

Manufactured capital

- Bonitas is an open medical aid scheme with our Scheme office in Johannesburg.
- We make use of an I&T system (Nexus) and digital platforms to take the hassle out of member and broker interactions with Bonitas.
- Members can visit one of our 15 walk-in centres for one-on-one assistance with all their medical aid queries.
- Alternatively, members can contact one of our customer service agents on 0860 002 108.

Financial capital

- As a medical scheme, we are a non-profit organisation.
- We receive members' contributions as our primary income source. These are invested and we aim to ensure a positive return for the benefit of our members.
- Our main cost drivers are hospital, specialist and medicine claims.
- We maintain a minimum regulatory solvency level of 25%.

Human capital

- Our 710 157 beneficiaries and 21 employees form a pool of human capital to maintain, serve and support Bonitas.
- We use an outsourced model and partner with the best service providers to ensure our members get access to care of the highest quality.

Natural capital

- We do not rely on natural capital to create value and have an immaterial impact in terms of natural resource use.

Intellectual capital

- Bonitas has 39 years' medical fund experience and our management team has 96 years' combined management experience.
- Our core competency is in the design and pricing of healthcare benefits and managed care plans. Benefits cover a range of 3 757 conditions based on the admission categories within HBM, 27 PMB chronic conditions for all options and an additional 33 conditions for certain options from a chronic medicine management perspective.
- Our protocols and formularies ensure high-quality treatment according to our list of safe and effective medicines that can be prescribed to treat certain conditions.
- Our digital channels act as resource hubs to help people understand their conditions and recommend steps they can take to remain healthy. These include virtual healthcare as well as self-service channels that allow members to access statements and tax certificates, submit and view claims and access electronic membership cards.
- Research identified specific attributes and benefits that members associate with the Bonitas brand.

Social and relationship capital

- We operate an outsourced model that makes use of strategic service providers to execute a range of our activities. These stakeholder relationships are pivotal to implementing our strategy and include:
  - Administrator and managed care providers (Medscheme)
  - ADS
  - Scriptpharm
  - Wellness Odyssey
  - DENIS
  - Europ Assistance
  - PPN
  - ER24
  - Hospital partnerships
  - GP and specialist network
  - Pharmacy Direct
- We collaborate across the healthcare value chain with industry stakeholders such as the CMS, the BHF, hospital groups and healthcare practitioners to enable systemic sustainability.
- Our network of hospitals, doctors and specialists provides full cover services and managed care options to members.
- We have a B-BBEE level 8 rating and are committed to transformation of the healthcare industry.

ACTIVITIES

We keep people healthy and assist when they are ill by removing healthcare-related stress.

We do this through the administration of members' funds evidenced by the **payment of 90.85% of hospital claims** within seven days.

We negotiate the best value and access to benefits for members by selecting the highest-quality service providers. In addition, Bonitas monitors the quality of care and the treatment plans designed by medical service providers. We also ensure effective beneficiary risk management.

Our members have access to discounted gap cover and value-added products. Cumulative positive saving balances are invested to earn a financial return for the member.

We invest contributions and manage reserves responsibly and for the long term to keep Bonitas financially stable and sustainable.

OUTPUT

We have medical aid and managed care options to suit members' needs (see page 4) and provide access to discounted **financial service products** and **lifestyle vouchers**. Bonitas offers various tools and services to provide clinical support, easier claim processing and access to information.

OUTCOME

- Our goal is to improve integration of care, enable more access to out-of-hospital services, clinical information and benefits via various solutions.
- We want to simplify healthcare, improve the quality of life of our members and create a productive society.
- Everything we do is in the best interests of our members, saving them money by making their benefits last longer and making Bonitas sustainable. This means our members can enjoy the value of private medical care while being protected against unexpected and expensive medical costs.
- For this reason, we focus on continually improving the healthcare value chain.

Our ultimate aim is to make quality healthcare more accessible and affordable.

THE WORLD OF HEALTHCARE

STAKEHOLDER ENGAGEMENT AND RELATIONSHIPS

We engage with stakeholders to create an effective network that benefits all. The network ultimately supports members as our first priority. We aim to resolve a member query at the first point of contact.

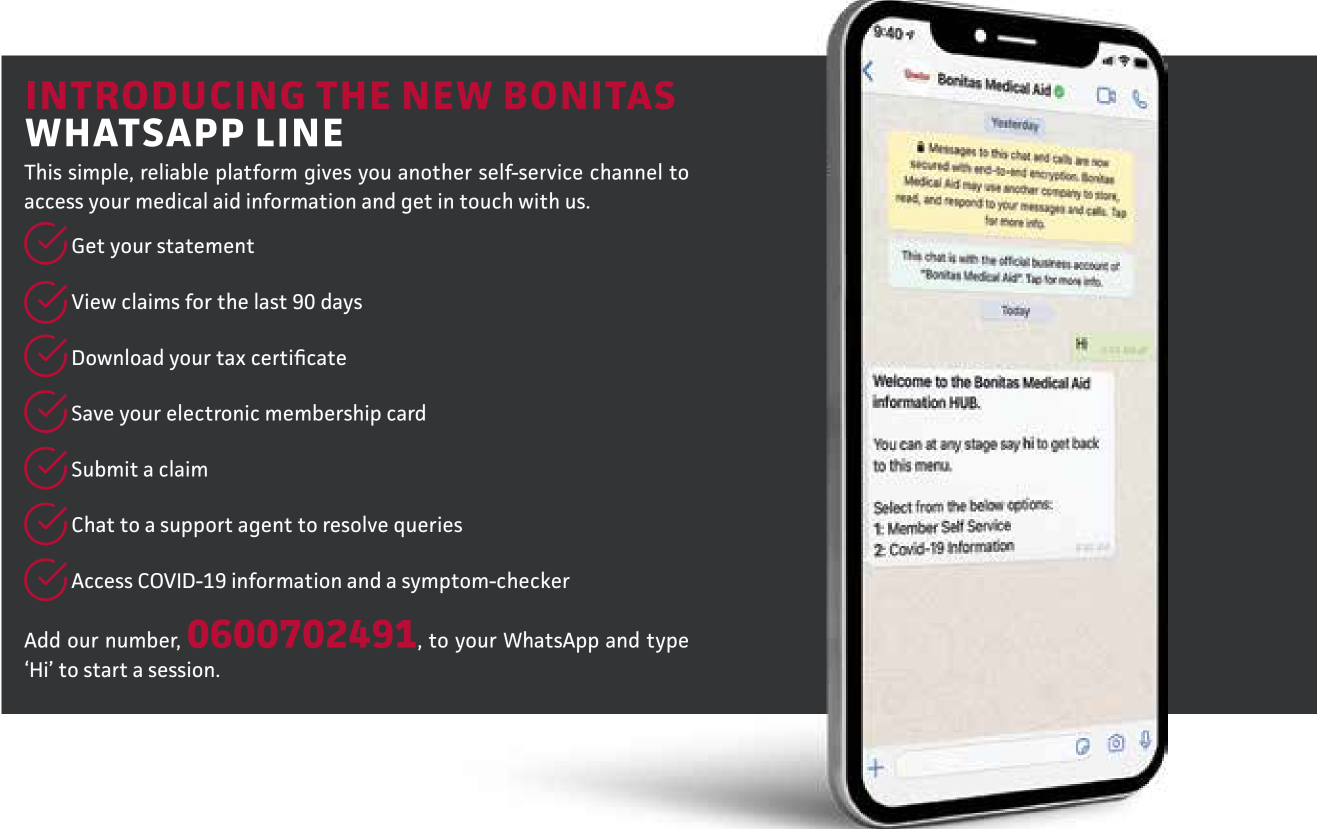
Our network relies on outsourced partners such as our administrator, brokers and specialists. Each is tasked with supporting and engaging with various stakeholders as and when a query arises. These are captured as operating procedures and are governed by SLAs with partners and service providers. Escalating a matter to Bonitas is defined in SLAs. Service providers send Bonitas monthly reports to highlight engagement interactions and matters of concern.

Internal stakeholder escalation processes allow for matters to be communicated to the relevant executives. They ensure that quarterly reports to the Board highlight material stakeholder concerns.

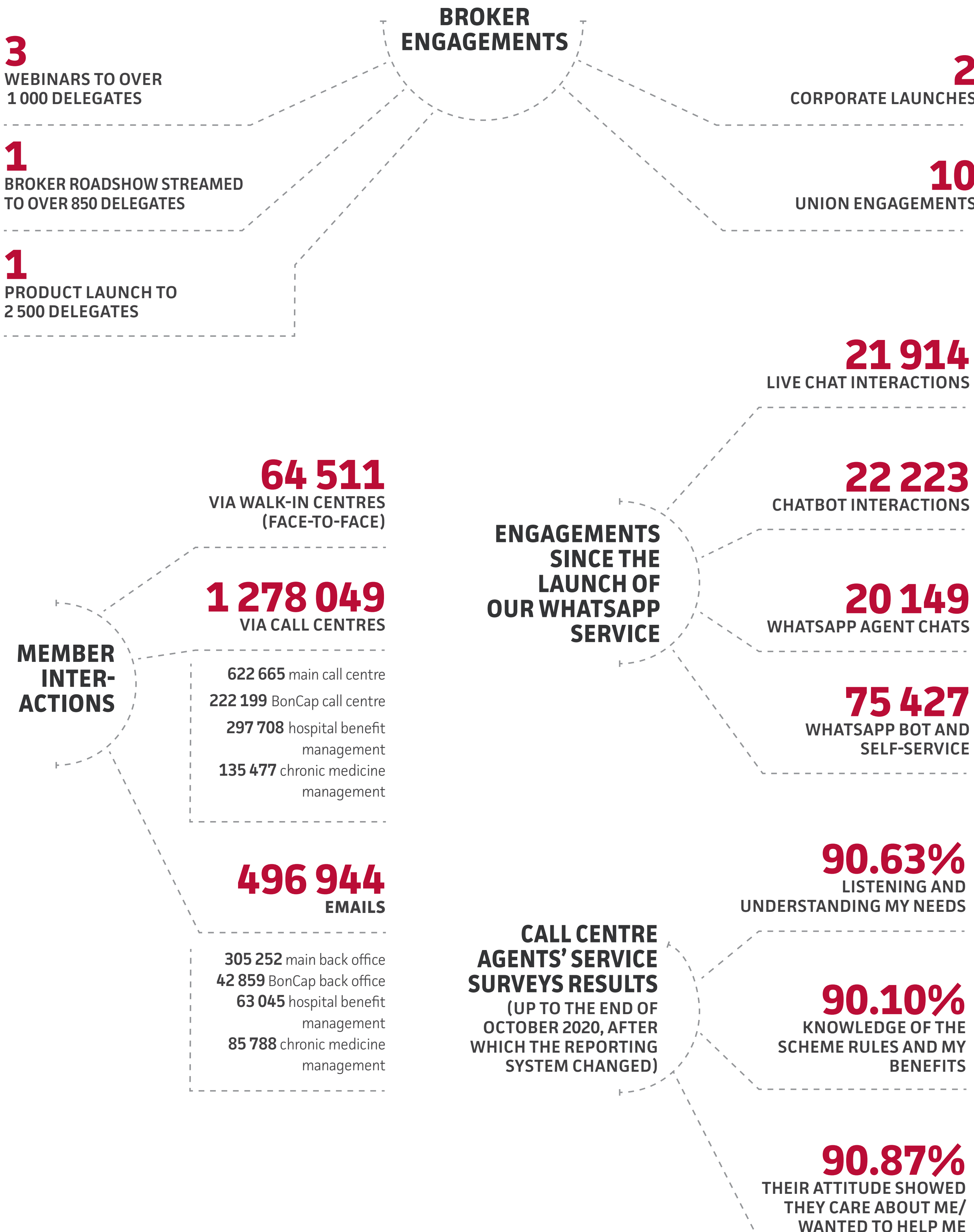
ENGAGEMENT TOPICS

KEY STAKEHOLDER	TYPICAL FREQUENCY OF INTERACTION	METHODS OF ENGAGEMENT	SUMMARY OF CONCERNS AND NEEDS ARISING FROM INTERACTIONS	BONITAS RESPONSE
Scheme partners	Medscheme: Weekly/ Monthly/ Quarterly	• Management Committee/Forum meetings • *Ad hoc* meetings	• COVID-19 responses • Healthcare expenditure • FWA exposure • Member interactions via call centre or social media • Managed healthcare value realisation initiatives • Loss-making options	• Regular reviews against the budget and market trends • Profile of membership and reviews to ensure members are on relevant managed care programmes • Review of Scheme's network geographically • Review of Scheme reserves • FWA process controls, detection methods and reviews
	ADS: Weekly/Monthly	• Management Committee/Forum meetings • *Ad hoc* meetings	• COVID-19 responses and economic impacts • Market trends • Growth of Bonitas at option level • Product comparisons • Broker concerns	• Competitor reviews • Broker engagement strategies • Macro environment analysis • Corporate strategy • Marketing plan implementation
	RisCura Solutions: Weekly/Monthly	• Board Committee meetings	• Global financial crisis • Market trends/outlook • Strategic asset allocation • Investment strategy • Asset management performance	• Updated investment policy • Amended strategic asset allocation • Asset manager review
	BHF: *Ad hoc*	• Forum meetings	• COVID-19 regulatory updates and requirements • COVID-19 vaccine procurement	• Resource planning • Funding and distribution models for vaccine

Members	Daily/Weekly/Monthly	• Bonitas member mobile app • Virtual medical consultations • Email • SMS • Survey • WhatsApp	• COVID-19 information and support • Vaccine information and support • Contribution relief measures • Understanding of benefits • Finding a network provider • Claims not paid	• Website information on COVID-19 • Continuous training of officials who engage with members • Enhancement on website to assist members to find a network provider • Communication on reasons for short or non-payment of claim • Communication and implementation of contribution relief measures to members in need
Regulators and government	CMS: *Ad hoc*	• Formal correspondence • Circulars	• Requests for data/ information • Changes in processes	• Collaboration and engagement • Compliance and adherence



ENGAGING WITH BROKERS AND MEMBERS



Feedback from our members

@BonitasMedical is the only healthcare provider that matters, they are innovative and always explore new ways to ensure South Africans have access to quality healthcare at all times. Virtual Care is of value to all South Africans!

13:20

This is why they are voted the best! They are truly the medical aid for South Africa.

13:20

@BonitasMedical is here for you and your family. Helping you and the family stay safe at home, avoiding traveling to the GP, hospital or clinic and minimising your risk of contracting the virus.

They are doing a great job indeed.

13:20

You are the best. Since May 2020 my husband has been in and out of hospital with a super bug. You have been amazing.

I love Bonitas, it has never given a problem, it's being a year now.

On Bonitas from 2009…never had any problems with them. My husband and daughter's chronic meds are delivered monthly to our door. Great medical aid!

ENGAGING WITH THE CMS

CMS inspection update

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. After legally challenging the ordering of the inspection on procedural grounds, Bonitas resolved to co-operate with the inspection.

As has previously been reported, the Registrar's inspection was due to be completed in March 2020. Since then, the Registrar sought to expand the scope of the inspection to a period terminating on 31 December 2019. Despite trying to engage the Registrar on the expansion of the scope, Bonitas has not been able to fully understand why the Registrar has sought to do so. In November 2020, the parties agreed that the inspector would finalise the inspection with the scope period terminating on 31 December 2019, and that the inspection would be finalised by 31 March 2021.

The inspection itself does not impact members directly. However, Bonitas may be held liable for the costs should the Registrar exercise its discretion as such. Bonitas has agreed that, should the Scheme be held liable, the costs of the expanded inspection shall be limited to a further amount of R600 000.

Section 59 Panel

The CMS acted on complaints that certain service providers and medical schemes were racially profiling practitioners, which exposed them to a higher probability of being the subject of investigations related to FWA. The CMS convened a panel (Section 59 Panel) to investigate these claims.

The Section 59 Panel released its interim report on 19 January 2021. All stakeholders have been given an opportunity to make inputs into the preliminary findings as contained in the interim report, and a final report will then be released.

Bonitas continues to monitor the process, and will make such representations as may be necessary at the appropriate time. Bonitas continues to try to find ways to limit incidences of fraud, waste and abuse. Read more about Bonitas's response in the Report of the Principal Officer on page 29.

EXTERNAL TRENDS SHAPING OUR WORLD

COVID-19 amplified the global struggle countries face to offer affordable healthcare and make it accessible to all citizens. Countries with minimal population growth and strong steady economic growth seem to be the only success stories in providing healthcare that is accessible, affordable and of a high quality.

South Africa has additional challenges, including a lack of economic growth, rising unemployment, a looming debt crisis and pervasive corruption. According to the IMF, South Africa's general gross debt is 78.8% of GDP and expected to peak at 87.3% in the next five years. Without the necessary fiscal consolidation, government will not be able to make critical investments in infrastructure, health, education and social protection.

Bleak economic forecasts mean that the vast gap between rich and poor will remain particularly evident in our industry: many urbanised cities are faced with an oversupply of healthcare services while remote, rural areas have only limited access to healthcare facilities.

According to the HMI in 2019, the South African private healthcare market is characterised by the rising cost of healthcare and medical scheme cover, and significant overuse, without stakeholders having been able to demonstrate associated improvements in health outcomes.

With the ongoing challenges within the public healthcare system, the uncertainties around the NHI, and the demarcation between insurance and medical aid products, it is important for Bonitas to define its future role in a dynamic environment.

Bonitas responds to external trends and the related risks and opportunities through seven strategic pillars, which are unpacked in detail from page 19.

OUR MOST SIGNIFICANT DRIVERS OF CHANGE

COVID-19 impact on medical scheme sustainability

The rise of virtual healthcare

Industry consolidation is accelerating

Changing private hospital market dynamics

Preparing for a new healthcare financing system

DRIVERS OF CHANGE

COVID-19 IMPACT ON MEDICAL SCHEME SUSTAINABILITY

The outbreak of COVID-19 towards the end of December 2019 and the resultant action by government from March 2020 to limit the spread had a significant health and economic impact.

According to a recent article by Deloitte entitled The impact of COVID-19 on medical schemes, the industry faces significant challenges in assessing the impact of the virus on overall claims expected, taking into account the incidence/infection rates, severity levels, treatment costs, duration and levels of PMBs that apply. Each scheme's specific demographic and disease profile has a direct impact on the severity of the symptoms, hospitalisation rates and death rates.

General areas of concern triggered by COVID-19 that potentially impact medical schemes' sustainability include:

Investments and economic growth: in addition to investment volatility, South Africa's sovereign credit rating was downgraded to sub-investment grade status with a negative outlook by the Moody's and Fitch ratings agencies. Both expect a weakening of South Africa's fiscal position. COVID-19 triggered a global financial crash, which saw local and global equity prices tumble as much as 30% in March 2020. According to the IMF, South Africa's real GDP contracted by 8% in 2020, but is expected to show 3% growth in 2021, before slowing again.

Claims expenditure: while some categories such as in-hospital admissions experienced a major decline, with a high number of elective surgeries cancelled, there was a marked increase in medicine claims and costs. Furthermore, underservicing could lead to higher downstream healthcare costs over the long term.

Growth and retention: to retain members under significant financial stress due to COVID-19, medical scheme members received lifelines such as access to their medical savings accounts to cover premiums. COVID-19 also resulted in a marked increase in queries about joining funds. According to the IMF, South Africa's unemployment rate is 37%, with a further 0.5% increase expected over the next five years. This remains a major concern as movements in medical scheme membership correlate closely with employment rates.

Contribution management and associated credit risk: volatile investment returns, solvency requirements and CMS guidance on very limited contribution increases for 2021 may erode reserves over the long term. This can potentially result in more non-performing options for medical schemes.

Vaccination logistics and cost: uncertainty about securing, funding and distributing vaccines as part of a comprehensive and inclusive vaccination plan could hamper medical schemes' ability to plan and govern reserves. The entire treatment process for COVID-19, from testing and treatment through to the vaccine, has been added to the PMB list. Government will procure all vaccines. Indications are that a co-funding model will be used and medical schemes will purchase the vaccines at a single exit price from government, and at a price high enough to fund the cost of multiple doses. This may have a significant impact on current and future reserves, depending on the effectiveness of vaccines and general uptake.

Additional emerging risks emanating from the epidemic include:

- Business continuity
- People and skills availability
- Cyber risk due to decentralisation and employees working remotely
- Supplier-induced demand for elective surgery
- Underwriting fraud
- Mental health concerns

Bonitas strategic response

Business development Connect with the customer Governance Optimise investment returns

THE RISE OF VIRTUAL CARE

Healthcare has proven generally immune to recessions. Demand for medical care has been a constant, as people require healthcare services whether times are good or bad. But COVID-19 has given rise to a different scenario. The requirements for physical distancing and minimal activities outside the home are driving people who would otherwise be using healthcare services to stay away.

The goal has also been to keep medical offices clear to reduce the risk of disease spread. This has resulted in people postponing non-urgent care.

Due to fears relating to the spread of COVID-19, healthcare providers around the world have minimised in-person contact with their patients, resulting in practice closures by doctors. Many have switched to telemedicine.

The transmissibility of COVID-19, its high potential for spreading in closed spaces, such as hospitals and emergency services, and the associated need to avoid mass use of health services during the pandemic made telehealth services a fundamental care strategy in 2020. COVID-19 has been a catalyst for the increased use of virtual primary care/telehealth services.

The use of telehealth in South Africa has been limited to date, as the HPCSA required doctors to have face-to-face consultations with their patients. Telemedicine was meant to be an add-on, not a replacement for consultations.

The HPCSA has since eased its guidelines, following the lockdown, to allow for virtual consultations between doctors and patients, without having to meet in person. The HPCSA also changed the term "telemedicine" to "telehealth" to include other practitioners like psychiatrists.

Since the change, more private healthcare providers now consult with patients over video or phone call. Numerous medical schemes also provide virtual consultations for their members.

Until a vaccine is widely available, primary care providers are likely to continue to demand solutions that keep high-risk patients out of primary health facilities where possible, and virtual care technology will be a core element of this strategy.

New technology, new processes/workflows, a change in attitude by providers, and a change in consumer culture are all expected to sustain higher rates of virtual consultations.

Bonitas strategic response

Business development Connect with the customer Create value through innovation

INDUSTRY CONSOLIDATION IS ACCELERATING

The consolidation of medical schemes is anticipated to take place at a faster rate than is currently the case, driven by administrators. The latter are prompting this by assisting schemes with amalgamations and by awarding tenders for the administration of specific schemes.

Medical schemes compete in an environment characterised by an incomplete regulatory framework that distorts the parameters of competition. The HMI report stated, for example, that medical schemes increasingly compete on the risk profiles of their members. This is due to the absence of a risk adjustment mechanism, and the requirement for schemes to pay PMBs at cost. Schemes therefore design benefit options to attract younger and healthier members. This competition on benefit design is at the expense of competition on metrics that improve consumer welfare, such as procuring value-for-money healthcare services, increasing benefits, adopting innovations, improving service quality, and/or directly competing on premiums.

Due to the small number of administrators in South Africa, medical schemes have limited options to change administrators. This also means that schemes tend to carry more healthcare risk, taking into account the increase in communicable diseases, ageing members and a reducing market pool in the private healthcare sector. As the cost of healthcare rises, many of the smaller schemes may not be in a position to meet the required solvency level, resulting in more amalgamations.

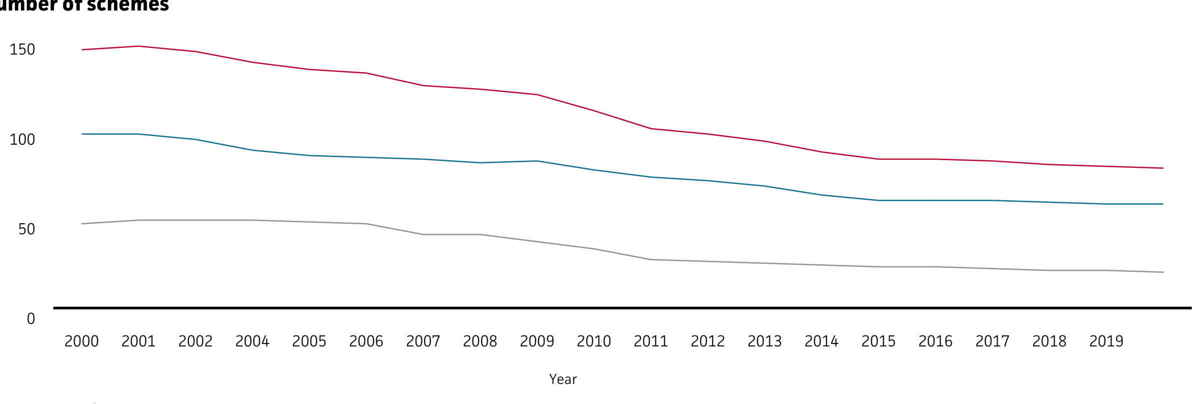
Bonitas strategic response

Strategic purchasing

Business development

Integration of value chain

Number of schemes



Source: CMS Annual report 2019/20.

CHANGING PRIVATE HOSPITAL MARKET DYNAMICS

The number of lives covered by the private healthcare sector increased marginally over the last decade, while the number of private hospitals increased noticeably. The expansion of private hospitals is therefore largely driven by supply-induced demand.

Three hospital groups dominate the facilities market and largely determine year-on-year price and costs increases for medical schemes. This means that they facilitate and benefit from excessive use of healthcare services, without the need to contain costs.

The supply side of the market is largely unregulated, with negative consequences for competition and for the consumer. The HMI recommended the establishment of a supply-side regulator for health to ensure a new needs-based system of licensing that would be more rational, effective, inclusive, and oriented to promote innovation. Such licensing would also be applied consistently across all provinces, with the aim of balancing capacity across the country by reducing or redirecting selective overcapacity and overinvestment to areas with lower capacity, which could contribute to curbing excessive utilisation.

Capacity constraints during COVID-19, including the need to apply temporary capacity diverts, resulted in public and private hospitals working together and co-operating successfully. Increased sharing of information and resources towards a common goal is paving the way for effective universal healthcare.

Bonitas strategic response

Integration of value chain

Strategic purchasing

PREPARING FOR A NEW HEALTHCARE FINANCING SYSTEM

South Africa is preparing for a healthcare future based on the principles of universal health coverage and the proposed NHI. The NHI aims to create a health financing system that is designed to pool funds to provide access to quality affordable personal health services for all South Africans based on their health needs, irrespective of their socioeconomic status. Delays due to the vast number of submissions to the NHI bill, which was published at the end of November 2019, meant continued high levels of uncertainty for stakeholders.

To enable the NHI, medical schemes must be empowered to assist administratively, but also to absorb some of the risk and burden that will lie with the NHI in respect of members of medical schemes. This will protect the funds to be deployed in the procurement of healthcare services from unnecessary exploitation through duplication of administrative functions.

Lessons learnt from the COVID-19 pandemic are likely to help shape the NHI. New partnerships and forced collaboration between the public and private sector laid a foundation for implementation in the current fragmented and complex system. Infectious disease is now regarded as the top global risk according to impact by the WEF and therefore is likely to significantly inform future healthcare systems and policy.

Bonitas strategic response

Integration of value chain

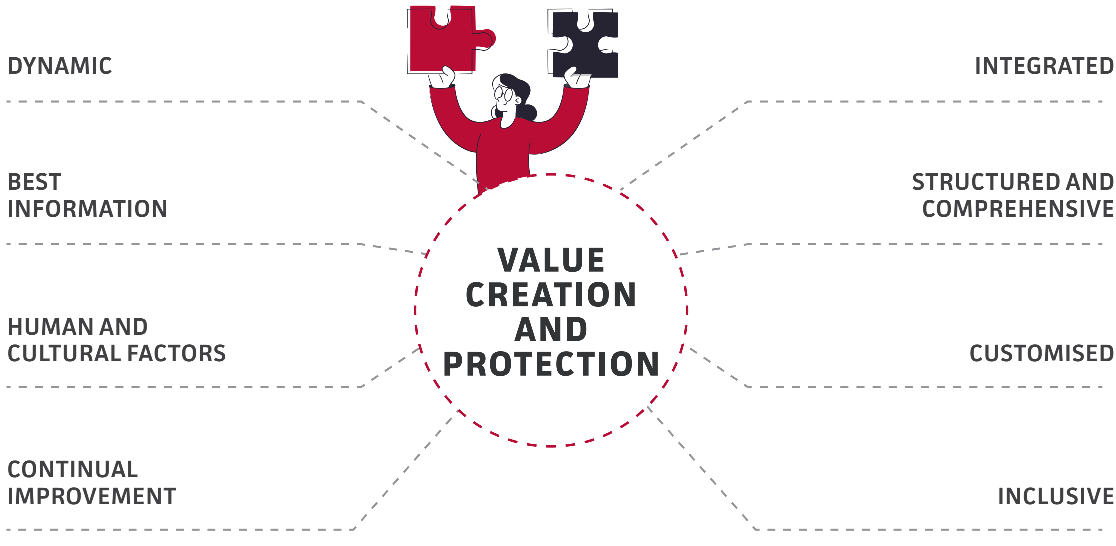
Governance

RISK AND OPPORTUNITY MANAGEMENT AT BONITAS

We want to proactively safeguard member interests as well as Bonitas's assets, market share, ability to pay claims and legitimacy. We also want to generate growth and increase our offering by identifying opportunities that can benefit members.

We have a Board-approved Risk Management Policy that includes a Risk Management Framework. The framework provides guidance on how to identify, evaluate and respond to key risks and opportunities in a way that is consistent, efficient and effective. Read more about risk management in the governance section on page 48.

The key risk management principles listed below aim to create and protect value for our members:



- **Integrated:** Risk management is integrated into our planning process, from strategy setting, expectations and performance targets, tactical production and service initiatives, through to execution
- **Structured and comprehensive:** We implement a practical framework that sets a clear policy, role definitions and requirements for reporting, i.e. registers and dashboards
- **Customised:** The process is customised to Bonitas in proportion to our external and internal environment
- **Inclusive:** Our stakeholders' needs and concerns are considered
- **Dynamic:** It is adapted for changes in the external and internal factors impacting Bonitas as they appear and disappear
- **Best information:** Inputs are based on previous knowledge (historic information), current know-how and forward-looking information based on future expectations within the industry
- **Human and cultural:** Human behaviour and culture significantly influence all aspects of risk management at each level and stage. Therefore, Bonitas promotes and embraces a culture that values the importance of risk management by entrenching it in the day-to-day processes, activities and decision-making
- **Continued improvement:** The process is continually assessed and revised to remain relevant.

The Risk Management Framework includes several important elements:

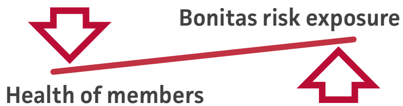
- The relationship between internal audit and risk management as part of a combined assurance approach
- Clear descriptions of risk appetite and tolerances. The framework shows tolerance levels which do not exclusively focus on the financial thresholds of acceptance; they also focus on the non-financial impacts of risk and opportunity
- Bonitas risk categories (strategic, operational, financial, legal and compliance).

We prioritise risks after considering related opportunities as well as the impact and likelihood in terms of levels: acceptable, tolerable, high or unacceptable. Our disclosure below focuses on the most strategic matters with unacceptable or high residual risk as these could have an impact – positive or negative – on our ability to create value.

Description	Context and causes	Mitigation through relevant strategic pillar
Unforeseen health pandemic	Global disease outbreaks such as COVID-19 create immediate health and operational concerns, widespread uncertainty and restrictive responses by governments that can lead to investment losses and increased claims. Economic impacts result in rising unemployment and pressure on disposable income, which can have a negative impact on membership growth and retention. Affordability is a significant barrier to accessing healthcare as is rising demand for limited hospital facilities. Read more about investment and membership risk mitigation under the specific risk in this table. Uncertainties and concerns remain in terms of the funding model and procurement processes for the COVID-19 vaccine.	Business development Connect with the customer Integration of value chain Create value through innovation Governance Optimise investment returns
NHI impact	Government aims to progressively implement NHI so that universal health coverage is available for at least 90% of South Africans by 2030. In the meantime, the industry is awaiting a report from Parliament's portfolio committee on health that responds to the submissions on the NHI Bill. Until then, many practical and constitutional issues remain unanswered. For Bonitas this means our value proposition to members and some of our plan options and benefits may change or become irrelevant. NHI may also bring additional regulatory implications.	Business development Create value through innovation Integration of value chain Governance
Data, information and cyber threats and vulnerabilities	Technology use increases exposure to cyber threats and vulnerabilities. However, Bonitas can unlock an integrated medical value chain by introducing technological innovation. Bonitas's advanced digital strategy renders many benefits for us and our stakeholders. Cyber risks can potentially affect supply chains and services and lead to healthcare data breaches. This can result in financial and reputational loss for us and have a negative impact on our reputation and brand. We face the risk of a fragmented approach where roles and responsibilities in terms of IT governance are not clear or understood by all stakeholders. This affects our ability to mine data for improved business intelligence. Further, POPIA, which came into effect in South Africa in July 2020, requires organisations to ensure that personal information is protected and stakeholders are aware of the lawful processing of personal information to prevent severe penalties. Health information (such as diagnoses, pathology results, blood pressure readings, etc.) is not only considered personal information, but is designated as "special personal information". Non-compliance with POPIA, the inability to protect personal and special personal information and lack of adequate user access management can have severe consequences for Bonitas. On the other hand, access to reliable, quality data and information can improve decision-making, leading to better outcomes for members and Bonitas.	Strategic purchasing Business development Governance Integration of value chain Create value through innovation
Impact of increasing regulation	As legislation changes, Bonitas could face a situation where the demand for products does not align with regulatory requirements, resulting in loss-making options and an unsustainable value-added product programme. Any non-compliance with regulation would have a negative impact on our reputation and brand. We operate in a challenging industry with high barriers to entry. These include the ability to build and contract with a network of partners, particularly for value-added products. Regulatory changes can impact our plan designs and enable opportunities for efficiencies in the value chain.	Strategic purchasing Business development Create value through innovation Integration of value chain Governance

Description	Context and causes	Mitigation through relevant strategic pillar
Membership risk profile	Amalgamations and/or members joining through the corporate distribution channel can result in changing member profiles, including the ratio of unhealthy and ageing members. Lost members can include healthy contributors, and members buying down can increase the ratio of unhealthy members for low-cost options, resulting in unsustainable loss-making options. Direct paying members who join from other schemes also tend to select low-cost options. These changes can have a negative impact on Bonitas's performance and sustainability. New sales and marketing platforms and channels allow us to target specific new markets or segments to attract members.	Business development Connect with the customer
Impact of investment strategy	South Africa's sub-investment grade rating by credit agencies and the economic effects of COVID-19 had a significant impact on investment returns. Combined with lower interest rates in capital markets, this highlighted the need for improved oversight and governance of our investment portfolio. The right controls are important to ensure an appropriate investment strategy, compliance with the Investment Policy and timely performance reports. By generating healthy returns, we can preserve cash and protect our solvency.	Optimise investment returns Governance
Fraudulent, wasteful and abusive activities by healthcare providers, employees, members and/or third parties	According to the South African Health Sector Anti-Corruption Forum, public and private healthcare markets are vulnerable to fraud and corruption because of large and varied numbers of transactions on goods and services, including fraudulent orders, tender irregularities, fiscal dumping by government departments through non-governmental organisations, bribery, overpricing, poor governance, transfer of liabilities to the state, and bogus and fraudulent qualifications. Bonitas could suffer reputational and/or financial losses as a result of FWA. Collusion between stakeholders can further contribute to such losses and lead to over-servicing. By improving the management of health claims we can limit losses and establish a strong ethical leadership tone.	Strategic purchasing Business development Connect with the customer Create value through innovation Integration of value chain Governance
Inadequate and insufficient stakeholder relationships	Quality stakeholder relationships build trust and resilience. Where stakeholder engagement is not effective, it can result in reputational damage, membership loss and financial loss. Indirect impacts include the loss of experienced employees and a drop in service levels. Strong relationships create trust and loyalty and enable us to deliver on the Bonitas brand purpose and benefits.	Connect with the customer Integration of value chain Governance
Negative media publicity and potential loss of stakeholder confidence	The Bonitas brand can only deliver functional and emotional benefits, and demonstrate our brand attributes, if our reputation and legitimacy as a medical scheme is intact. Negative publicity can harm our reputation and sustainability.	Integration of value chain Governance

MANAGEMENT OF INSURANCE RISK



Our priority is to manage the healthcare risk exposure of our members and their dependants. The extent of the risk directly relates to the health of our beneficiaries. As such, there is uncertainty about the timing and severity of claims.

ASSESSING INSURANCE RISK EXPOSURE

Bonitas uses internal risk measurement models, sensitivity and scenario analyses, and stress testing to assess and monitor risk exposure. This applies to both individual and overall risks.

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

MANAGING INSURANCE RISK

Bonitas manages insurance risk through:

- Inclusion of 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
- Centralised management of risk transfer arrangements.

There has been a steady insurance risk migration from systematic to unsystematic in terms of PMBs over the past three years. This is mainly a result of changing legislation, which requires Bonitas to pay PMBs at full invoice price and not according to benefit limits and sub-limits. Refer to note 21 of the annual financial statements for more information.

RISK TRANSFER ARRANGEMENTS

Bonitas Risk has transfer arrangements with the following service providers:

Service provider	Risk transfer arrangements
DENIS	Dental benefits **Standard**, **BonSave**, **BonComprehensive** and **BonClassic**
Scriptpharm	Chronic medicine management **BonComprehensive**, **BonClassic**, **Standard**, **BonComplete**, **BonSave**, **Primary**, **BonFit**, **Hospital standard**, **BonEssential** and **BonCap**
ER24	Ambulance and emergency services for **all** options
PPN	Optical benefit management **Standard**, **Primary**, **BonClassic** and **BonCap**
Europ Assistance	International travel benefits **All** members except for those on BonCap

Certain health risks are outsourced where it is considered beneficial to members. The cost of procurement, infrastructure and intellectual property would be disproportionate to member benefits. This would only add to rising healthcare costs and downstream costs such as hospital admissions.

In 2020, Bonitas launched a pilot on its Primary option to assess whether it may be beneficial to manage the risks in-house and not as part of the dental capitation model. However, as COVID-19 disrupted dental claims patterns, we elected to continue running the pilot in 2021 to obtain more reliable data. If the pilot is successful and there are attributable cost savings for members, Bonitas may consider moving other options in-house as opposed to the outsourced risk model with DENIS.

The service providers listed above have a national footprint across South Africa.

For more information on the risk transfer arrangements, refer to note 14.3 in the annual financial statements.

OUR STRATEGY FOR LEADERSHIP

Our strategic intent is to consolidate Bonitas's position as the obvious leading alternative open scheme in the industry.

Over the past three years, we have developed and implemented a strategy to position Bonitas correctly within the medical schemes industry. The strategy is reviewed annually to ensure consistent focus and to enhance our resilience in an ever-changing operating environment.

OUR STRATEGY IS BUILT ON SEVEN PILLARS:

We execute our strategy through the plans we offer. These have been designed for simplicity, flexibility and affordability, while meeting the different needs of our members at different stages throughout their lifespan.

Progress with implementing our seven strategic pillars

WHAT THIS MEANS	
Be a strategic purchaser	Over the past two decades, healthcare costs have outpaced inflation. This trend is a key concern for the medical aid industry and is exacerbated by FWA and the non-regulation of other costs. Bonitas has to make strategic purchases to maintain costs, ensure quality of service and minimise risk. The main focus of this pillar is to: • Contract with managed care service providers at an option level to reduce deficits • Define and optimise the purchase power of Bonitas with hospital groups • Build more efficient networks of service providers and enhance current networks • Introduce a day hospital strategy • Ensure preventative and primary services are available when required • Ensure secondary and tertiary healthcare only come in into play after the first level of relevant care has been accessed • Focus on reimbursement models with provider networks • Review existing risk transfer agreements

2020 progress

Bonitas is the second largest open medical aid scheme in South Africa. Sizeable market share enables us to negotiate preferential hospital tariffs.

Bonitas was the first medical scheme in the industry to exclude a number of hospitals in an attempt to control the supply of hospitals in the market. For many years hospitals groups only allowed schemes to negotiate with them on a global level, so all hospitals received the same price increase. This is changing. Medical schemes are now defining networks either per option or for the scheme overall.

Bonitas has demonstrated that adequate networks of services are accepted by members with little, if any, resistance.

This year we participated in the first collective negotiation process on hospital tariffs with five other medical schemes administered by Medscheme. This followed the finding by the HMI that collective negotiations would not contravene the Competition Act.

The objective of the negotiations was to use the weight of the beneficiaries of the collective schemes to negotiate competitive tariffs that would achieve parity across the funders in the collective as well as parity across the hospital groups. We established a common tariff file across the schemes per hospital group and negotiated no hospital or network exclusions for the plan main options.

A 3.1% saving in 2021 terms was achieved through this groundbreaking collective negotiation process. These savings on hospital costs could exceed R200 million in 2021.

Further to the tariff negotiations, we identified day hospital use as a viable option that is emerging to improve efficiency and reduce cost. In South Africa this alternative is not as developed as in many comparable healthcare markets abroad, but is on the rise. Some of the local hospital groups have responded aggressively to emerging competition from day facilities by splitting existing activities to form day facilities or by acquiring independent day facilities.

We believe the use of day hospitals and clinics should be encouraged, where possible. Some procedures, such as cataract surgery, circumcisions and scopes, are better suited to day hospitals or clinics than to larger hospitals. There is minimal disruption to members, speedier recovery times, less risk of infection, and day hospitals are a more cost- effective solution.

Our day surgery strategy will promote day facility use to reduce hospital costs. Specific procedures are targeted at an agreed tariff and co-payments for non-adherence have been implemented.

During COVID-19, home-based care received renewed interest and focus. This dovetails with our strategy to move more care to the home and out of hospital. As an example, post-surgery or mild pneumonia treatment can be effectively provided at home with the assistance of a nurse. Home-based care also better promotes healing. Studies show that patients recover faster in their comfort of their own homes.

We increased referrals for alternative options to hospitalisation, and we reduced unnecessary vacuum-assisted wound care therapy, sleep apnoea test management and scan costs.

Strategic purchasing yielded savings of R346 million (2019: R370.4 million), which is lower than the previous year in absolute terms due to lower outflows as a result of COVID-19 effects, including cancellation of elective procedures and a reduction in trauma and major medical-related categories.

Cumulative savings since the start of the strategic partnership agreement in 2017 were R1.247 billion.

Hospital costs and medical specialist costs reduced by 5.4% (2019: increased by 8.9%) and 5.3% (2019: increased by 10.0%) respectively on a per-member-per-month basis. Total claims per member per month declined by 8.7% (2019: increased by 8.1%).

The actual hospital and specialist claims experience over the latter part of 2020 was lower than actuarial projections at the point in time when the 2021 pricing and benefits structure was finalised.

Under this pillar, Bonitas also continued efforts, together with the industry, against FWA. This helped to contain claims cost.

WHAT THIS MEANS

Boost business development

Growing our membership base is critical to Bonitas's sustainability. Corporate business growth is a focus area to counterbalance the universal trend towards more direct paying member business, which traditionally carries a higher risk.

To grow membership, Bonitas has to demonstrate value for money in its product offerings, ease of doing business in its onboarding processes, and efficiency in its administration and claims handling procedures. Solvency, strong leadership and effective governance are also important components in Bonitas's overall appeal to corporate decision-makers.

Focus areas for this pillar are:

- The enhancement of distribution channels
- Improved retention (groups and direct paying members)
- Corporate membership growth and the integration of value-add products
- Market-orientated product development and targeted marketing to pursue growth in surplus generating options
- Defensive product development and broker collaboration to mitigate against loss-making options
- Increased targeted marketing initiatives and demand for measurable return on investment
- Brand awareness through sponsorships and mass marketing

2020 progress

Our focus shifted to attracting groups by providing specific support to corporate brokers, trade unions and employers.

Bonitas is well positioned to compete for membership at split-risk pay points. With the economy under significant strain for the foreseeable future, recruitment of new employees into the corporate sector is unlikely, but there are still pockets of uncovered lives in large organisations and an increased awareness of the necessity for medical aid cover for all.

We experienced a cumulative net decline in membership of 5 610 members (1.7%) in 2020, which compares well against a significant contraction in GDP and increase in unemployment. The largest membership losses occurred in the second half of 2020, which coincided with the months in which lockdown restrictions were most stringent.

Despite the challenges experienced in 2020, Bonitas acquired 37 814 new members (2019: 50 680).

To revitalise membership, we used our actuarial expertise and design capability to improve our offering to existing and potential members. For 2021 we introduced Edge as a new category with the BonStart plan designed for economically active singles or couples living in the larger metros. The plan includes access to a private hospital network and full cover for emergencies, PMB chronic medicine and excellent day-to-day benefits.

Affordability remains a key driver for business development. Pricing for 2021 was guided by the CMS Circular 52 of 2020: Guidance on benefit changes and contribution increases for 2021, which outlined the key industry-specific considerations the CMS considered when assessing the appropriateness of benefit changes, contribution rate increases, and overall cost increase assumptions for the 2021 benefit year.

The CMS encouraged schemes to consider members' affordability constraints and freeze their contribution increases for 2021 or limit their increases to 3.9%. Bonitas applied a competitive weighted average contribution increase of 4.6%, compared with an average of 4.8% for 27 of the largest medical schemes in the industry. The increase was only 1.61% higher than CPI, whereas contribution increases are set at a minimum of CPI +3,5% under normal scenarios.

Managed care programmes

One of the leading trends worldwide is the rise in non-communicable diseases, such as diabetes, high blood pressure and cancer. During the pandemic, the impact that lifestyle diseases and co-morbidities had on COVID-19 patients was put in the spotlight. 20% of our members have multiple co-morbidities which means, even without the pandemic, we need a stronger focus on behaviour management to prevent lifestyle-related disease. Poor diet, smoking and lack of exercise are the three lifestyle factors that contribute to over 80% of chronic conditions.

Managed care continues to be a focus, empowering members to take charge of their health and supporting them along the way.

To ensure access to quality healthcare during lockdown, the managed care model was strengthened, by:

- Reducing COVID-19 out-of-pocket expenditure for members
- Enhancing funding approaches to various services such as pathology testing and negotiating reduced costs for those tests
- Proactively engaging with hospitals to ensure members would be accommodated in private facilities and have access to the best private healthcare when required
- Assisting members in need when they had medical requirements over and above the standard benefits
- Engaging with providers and facilities in terms of PPE
- Ensuring member co-payments/shortfalls were either reduced or eliminated to improve accessibility for members
- Introducing free virtual care to provide uninterrupted healthcare, while safeguarding members
- Enhancing our agreement with Scriptpharm to be a DSP for chronic, acute and over-the-counter medicine

Our managed care interventions are reviewed annually to ensure affordability, accessibility and quality of care. Bonitas aims to meet the physical, emotional and social needs of our members while respecting their privacy and personal integrity. We also test legal compliance and competitiveness and assess whether our managed care interventions deliver on our retention and growth targets.

These interventions are outcomes-based, and will provide the framework and metrics for the managed care contract between Medscheme and Bonitas.

Costs saved through managed care programmes can help limit contribution increases for members. Significant cost savings initiatives this year included:

- Contracting a smaller but efficient designated service provider network of orthopaedic surgeons for hip and knee replacements
- Enrolling 49 758 members in the diabetes pilot programme aimed at creating an outcomes-based disease management project
- Establishing a value-based contracting model for an oncology formulary, medicine procurement, palliative care and oncology care pathway
- Negotiating a global fee for at-risk-mental states, creating a mental health hospital network and increasing out-of-hospital benefits while upskilling GPs and offering members support tools

MANAGED CARE DURING COVID-19

Unusual circumstances called for creative and pragmatic solutions this year. Bonitas ensured that members and partners were able to access facilities and navigate processes safely during COVID-19. Examples include:

- The greatest challenges raised by healthcare providers during the pandemic was lack of time for administrative duties. We adjusted authorisation days approved for COVID-19 admissions from three to eight days and removed the requirement for hospitals to submit daily updates for certain admissions. Less complicated admission requests were automated if the minimum criteria were provided.
- The need for letters of clinical motivation was removed as case managers obtained the most critical information telephonically without compromising quality of care and managed care interventions.
- Non-network co-payments were removed where access became a challenge due to hotspots and when certain hospitals had no capacity for admissions.
- In terms of discharged patients who required medication, hospital pharmacies were allowed to dispense all medication via a Bonitas mandate so that the discharged members and their families did not have to physically go to a pharmacy and thus risk exposing others to infection.
- From 6 April 2020, a Rapid Response Unit supported inbound member COVID-19 related queries specifically regarding benefits, funding and disease advice relating to test results, quarantine or self-isolation, or just general information. The unit also had outbound campaigns for high risk members at risk of developing COVID-19 complications due to their chronic risk profile.

WHAT THIS MEANS

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 IPS. Asset allocation is managed by considering our asset liability matching to ensure sufficient liquid funds exist to meet claims and other liabilities as they fall due.

Our liabilities are short-term in nature. Because of this, a significant portion of the investment portfolio is invested in cash instruments.

The investment pillar objectives are:

- To achieve a targeted net (of fees and taxes) return in excess of CPI+3.5% per annum over a rolling 36-month period
- To preserve capital over a rolling 12- to 18-month period
- To be proactive and reposition Bonitas when there are opportunities to maximise returns while adhering to the set strategic asset allocation parameters
- To manage investment risk to be within tolerable levels

2020 progress

Following the global market crash in March 2020, Bonitas's investment portfolio reported fair value losses approximating R750 million. However, following the fiscal stimulus packages and the relaxation of stringent lockdown measures, markets rebounded strongly, especially towards the latter part of the year. The Investment Committee was particularly active during 2020, given the volatility in equity markets. An updated Investment Policy was approved, which included the mandate to use derivative instruments to hedge equity risk on the investment portfolio. The Committee also reconsidered the strategic asset allocation and made tactical asset allocation decisions throughout the remainder of the financial period.

This active management contributed to a turnaround in performance returns, growing the investment portfolio (excluding cash and cash equivalents) from R5.01 billion in December 2019 to R7.14 billion at the end of December 2020 – delivering an overall return of 4.16%.

Read more about investment performance in the financial and operational review from page 35.

WHAT THIS MEANS

Connect with the customer

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

The focus of this pillar is to:

- Implement a comprehensive customer relationship management capability including a proper system
- Educate and engage patients to take responsibility for their health and conditions
- Form partnerships with doctors, health practitioners and patients
- Align brokers' efforts with those of Bonitas in the engagement of members
- Actively promote openness and approachability

2020 progress

This is the most challenging pillar as it requires increased resources to deliver impact. Schemes usually fail at marketing their offerings as they focus on defining the extent and the terms and conditions associated with that cover rather than defining the value and benefit of the cover. This is even more evident in a complicated high-volume transaction environment where the permutations are seemingly endless.

Communication is key to making members feel valued and at least safe with the cover they have purchased.

More than 19 000 people downloaded the Bonitas app and more than 1 000 made use of virtual consultations within three weeks of the launch of the virtual care app. Of these, 22% were non-members. The virtual care app not only provides access to a virtual nurse, advice in an emergency, auxiliary and home-based care, and comprehensive support for any condition, it contributes significantly to accessible healthcare for all South Africans. It bridged the gap between doctors and patients during lockdown.

We introduced a WhatsApp channel as a convenient new platform for members. It allows them to manage their medical aid through live chats and has a specific COVID-19 option that provides information on everything from symptoms to treatment, recovery, transmission, costs covered by the medical scheme, frequently asked questions, updated statistics on active cases, recoveries, deaths and a self-screening test.

Through the funding of a variety of projects we aim to stimulate and support social economic development and healthcare for all South Africans, including our members and their communities.

To help teachers prepare and be ready to open their classrooms and welcome students back, Bonitas collaborated with OnPoint HealthCare and Honourable MP Ms Simphiwe Mbatha to distribute 1 500 face masks and sanitisers to 80 primary, secondary and special needs schools in the Tshwane area. In addition, each school was provided with a sanitising stand and sanitiser.

Bonitas also provided 480 infographic posters and shared 10 educational videos with the schools. The videos, which are in four languages, address COVID-19 precautions and explain why they are important.

Read more about our COVID-19 contributions in the Report of the Principal Officer from page 29 and about the launch of virtual medical consultations on page 2.

The future focus areas for this pillar are:

- The use of technology to:
  - engage members while educating and empowering them
  - provide information quickly while verifying if the healthcare provider is on the network and, if not, what the co-payment will be
- Further broker engagement enhancements through technology
- Creation of a single integrated platform across the Bonitas contracted service providers to enable a one-stop shop for members

WHAT THIS MEANS

Create value through innovation

Healthcare innovation will be driven by technology for the next decade. Seamless processes will enable members to optimise their health and that of their dependants. Treatments and medicine are becoming community-based as drones and other technology enable integrated healthcare at local points of delivery.

The focus of this pillar is to:

- Issue communication that is focused on aligning providers in Bonitas's value chain as opposed to the supply and demand of the healthcare economy
- Educate role players to balance the triangle of affordability, quality and cost efficiencies
- Use disruptive strategies to make healthcare technology more readily available to more people
- Actively build a future for Bonitas to be part of the NHI in South Africa

Innovation can be segmented into three types:

1. Strategic innovation to ensure Bonitas remains sustainable and competitive in terms of affordability for members in the current economic climate. Expanding and integrating partnerships across the value chain can be a competitive advantage in terms of purchasing power.
2. Process innovation to improve the customer experience and ensure members are educated and empowered in relation to their health and wellness needs.
3. Product innovation to respond to the needs of our members.

2020 progress

Through innovative managed healthcare programmes we help members take control of their health and enjoy a better quality of life. There is an increased prevalence of lifestyle diseases such as diabetes, hypertension and cardiovascular disease as well as HIV/AIDS, cancer, back and neck pain, hip and knee replacements and mental illness. For this reason, managed care programmes aim to predict and prevent conditions before they become chronic and manage them in the most clinically appropriate way.

Lifestyle diseases can be significantly addressed with regular exercise and a healthier diet. To this end, we introduced partnerships with Run/Walk for Life to be scaled in the future.

Other examples of innovation include:

The Bonitas member app

A new Bonitas member app was launched to allow members to manage their medical aid. Features include:

- Virtual consultations with a GP for minor ailments or prescriptions
- Chat with a support agent to resolve queries
- Ease of locating a network provider
- Access to balances, benefits and limits
- Reminders of when to take medicine
- Ease of locating and booking a clinic appointment
- Digital membership card
- Ability to dial emergency contacts with a single tap

24/7 virtual care

We launched a free virtual service to all South Africans in 2020. Read more on page 2. Virtual care and telemedicine includes e-scripting, which enables scripts to be sent to a pharmacy and the medication delivered to the member. In some pharmacy clinics, a nurse is able to have a video consultation with a doctor via a mobile device for additional assistance.

The WhatsApp self-service channel

The new Bonitas WhatsApp line allows members to access their medical information and get in touch with us. Features include:

- Requesting a statement
- Submitting and viewing claims
- Downloading tax certificates
- Saving electronic membership cards
- Chatting to a support agent
- Accessing COVID-19 information and a symptom checker

The Bonitas maternity programme

Our maternity programme makes the pre- and post-birth period as stress-free and healthy as possible. The programme offers targeted support during each trimester, pregnancy education and specific related engagements, via telephone and digital channels. Features include:

- 24/7 maternity health advice line
- Access to dedicated clinical care advisers
- Online antenatal classes
- Weekly stage-appropriate SMSes
- Pregnancy education emails
- Digital webinars and events
- Baby vouchers

228 BROKER REGISTRATIONS (2019: 867)

7 090 MEMBER ACTIVATIONS FROM WEBSITE (2019: 6 261)

78 057 FORMS COMPLETED (2019: 63 869)

WHAT THIS MEANS

Integrate the value chain

Bonitas believes the key to successful value chain integration is quality inter-organisation relationships. The focus of the pillar on integration of the value chain is to:

- Actively move away from a relationship of client and service provider based on compliance of delivery, to partnerships that are co-dependent and invested in the future
- Define and achieve common future goals for these entities
- Brand Bonitas as the future of healthcare in South Africa

2020 progress

Long-standing partnerships and relationships with our network of service providers are one of our competitive strengths. This enables us to continually improve and integrate with other role players to create value.

We are moving to outcomes-based contracting and exploring alternative models such as risk sharing. We also ensure that all transactional and relational aspects in the value chain conform to governance standards.

We initiated a review of the capitation model and extended the pilot programme into 2021.

Further examples of progress include the issuing of vouchers as added lifestyle benefits to members. These vouchers are evidence of innovative partnerships that continue to evolve. 1 992 Bonitas members have MedGap cover, 1 148 use Sanlam Indie cover and 696 hold MiWay personal insurance policies.

Read more about our future brand positioning in the Report of the Principal Officer from page 29.

WHAT THIS MEANS

Apply best practice governance

Bonitas has a holistic, integrated approach to organisation-wide governance, risk and compliance. This ensures that Bonitas acts ethically correctly and in accordance with its risk appetite, internal policies and external regulations. It also aligns strategy, processes, technology and people, thereby improving efficiency and effectiveness.

THE CORE ELEMENTS OF OUR GOVERNANCE SYSTEM ARE

GOVERNANCE IS THE OVERALL SYSTEM OF RULES, PRACTICES AND STANDARDS THAT GUIDE BONITAS

- Strategy
- Organisational structure
- Integrity
- Fairness and transparency
- Accountability and responsibility
- Policies and standards

RISK MANAGEMENT IS THE PROCESS OF IDENTIFYING POTENTIAL HAZARDS TO OR OPPORTUNITIES FOR BONITAS AND ACTING TO REDUCE OR ENHANCE THEIR FINANCIAL IMPACT

- Risk identification and assessments
- Risk scores
- Monitoring and analysis
- Risk mitigation

COMPLIANCE IS THE SET OF PROCESSES AND PROCEDURES THAT BONITAS HAS IN PLACE TO MAKE SURE THE ORGANISATION AND ITS EMPLOYEES CONDUCT BUSINESS IN A LEGAL AND ETHICAL MANNER

- Compliance risk identification and assessment
- Regulatory compliance
- Operational compliance
- Risk and compliance coverage plan
- Monitoring of compliance
- Reporting of non-compliance matters

Read more about our governance structures and processes in the Governance section from page 48.

2020 progress

Medical schemes are not for profit and are owned by their members. Good governance and ethical behaviour is therefore critical to ensure Bonitas operates in the best interests of members.

The repercussions of fraud are widespread and directly impact every Bonitas member and members of other medical schemes. When a scheme is defrauded or money is wastefully spent, it impacts the funds available to pay member claims. It also has a direct link to increased membership contributions.

To protect members' interests, FWA is one of our focus areas. FWA management is not only a crucial part of risk management but is directly related to compliance and ethics within the industry. Bonitas maintains a zero-tolerance approach to FWA.

Over time the industry norm has been for healthcare practitioners to claim directly from medical schemes for professional services rendered. This has resulted in discrepancies between the payment for services and the relationship between the practitioner and the schemes' members. The increase in abuse of members' benefits by certain healthcare practitioners and the potential for fraudulent claims as a result of collusion between the member and practitioner has been of great concern.

This has resulted in an increasing trend of FWA, which undermines Bonitas's financial sustainability.

Bonitas has developed policies to ensure a consolidated approach is followed in dealing with FWA while protecting Bonitas's reputation and relationships with our own stakeholders, namely members, healthcare practitioners and other external parties.

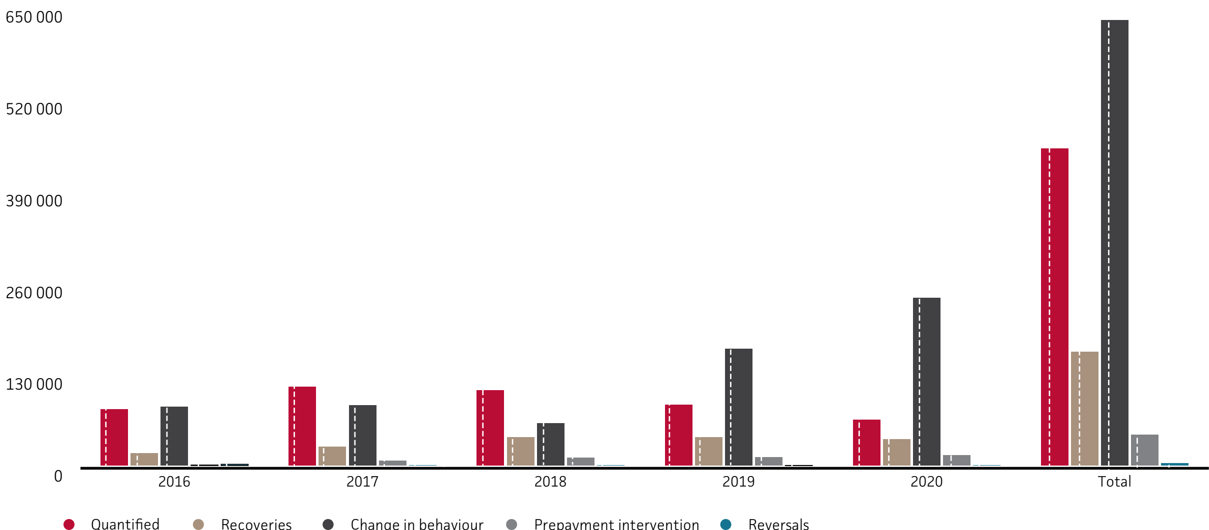
We entered into an agreement with a service provider for an analytical software programme to identify anomalies or irregularities that could be indicative of potential FWA. The analytical tool assists the service provider in its duty to detect, investigate and ultimately recover monies pertaining to FWA.

Bonitas currently has 35 active criminal cases. These cases are at various stages and are being processed at SAPS and the courts. There are several challenges to progress on cases reported to the regulatory bodies. However, we constantly engage with SAPS and SCCU to provide the necessary assistance to make headway on these cases.

We initiated 585 interventions against healthcare practitioners from various disciplines. During the year, Bonitas applied other sanctions including reporting them to HPCSA and SAPC and application of Section 59(3) of the MSA to recover the losses.

- 6 convictions of healthcare practitioners (2019: 7)
- 18 civil FWA cases to the value of R19.4 million (2019: 9 cases of R19.4 million)
- R448 million quantified in FWA since 2016
- 132 active cases reported to HPCSA (2019: 58)
- 370 hotline reports on FWA (2019: 836)

The following graph demonstrates the amounts quantified, recovered and saved because of the FWA Prevention Programme:



	2016 R'000	2017 R'000	2018 R'000	2019 R'000	**2020 R'000**	TOTAL R'000
Quantified	79 559	111 612	106 208	85 881	**64 920**	448 220
Recoveries	17 529	26 469	39 847	39 875	**37 060**	160 780
Change in behaviour	83 000	85 000	60 000	165 219	**237 309**	630 528
Prepayment intervention	729	6 521	10 942	11 338	**14 216**	43 746
Reversals	1 804	371	424	182	**401**	3 182

Changing the behaviour of healthcare practitioners who transgress and comparing their historical claims resulted in estimated savings of almost R631 million over a five year period. The change in behaviour across various claim disciplines contributed to improved option performance.

Read more about Bonitas's response to the Section 59 investigation as part of our engagement with the CMS on page 12.

Mr LR Callakoppen
Principal Officer

REPORT OF THE PRINCIPAL OFFICER

*As South Africa's second largest open medical scheme, Bonitas has two interdependent priorities: **to ensure the sustainability of the Scheme** while meeting the needs of our members, and to make **quality healthcare more affordable and more accessible** to more South Africans.*

In South Africa, we face stark realities. This year we experienced the moral and practical dilemmas of a system where only 8.9 million lives have access to private healthcare among a population of 60 million. We also experienced how co-morbidities and a population with a rising median age increase our overall health risk. Bonitas wants to make our total population healthier by managing clinical risk, and by growing membership in a way that delivers positive wellness outcomes for more South Africans.

A BRAND THAT PROTECTS

To support future growth, we embarked on a process at the end of 2019 to re-evaluate the way Bonitas was perceived in the market. We want to understand perceptions around the brand and our offering both among our existing and the broader potential market. This aligns with our strategic pillar to connect with the customer and our ultimate aim to make quality healthcare more accessible and affordable.

Key elements of our brand architecture:

Brand purpose	To make quality healthcare more affordable and more accessible
Brand essence	Protecting a generation of progress
Key supporting brand features	• Take the time to understand the people we serve • Leverage our strong relationships to offer a quality network of providers that deliver real value • Make decisions in the best interests of all our members
Functional benefit	A wide range of plans designed with every kind of South African in mind
Emotional benefit	The peace of mind that comes with knowing you and your family are protected by people who care
Brand attributes	• Dependable • Approachable • Proudly South African • Proactive

The brand process also considered Bonitas's response in terms of the HMI. Focus groups helped us understand and plan for the expectations of all stakeholders, including but not limited to members, brokers and health providers.

MACROECONOMIC REFLECTION ON 2020

Our strategy proved robust in a year when South Africa experienced a financial crisis: the investment market crashed, companies had to close and consumers took increasing financial, health and emotional strain.

South African financial markets rebounded after March 2020, but remained heavily constrained by an already weak economy and COVID-19 containment measures. Growth downgrades in 2020 were the fastest and steepest of all global recessions in the past three decades. Interest rates were at historic lows, but still did not effectively stimulate earnings or investment returns.

With disposable income under severe pressure, consumers faced a trade-off between the security of access to private healthcare via their medical scheme and the need to cut down on expenses, including other forms of insurance. Research[1] by a reputable audit firm's consulting unit showed that once an employee has been retrenched, it becomes very challenging for an impacted individual to hold on to their medical aid for more than six months if they are not re-employed. The current market is contracting as unemployment reaches levels not previously experienced. Unemployment is expected to peak in 2021.

Considering these macro trends, membership levels are only predicted to return to 2019 levels post-2022. Based on the aforementioned research and a set of assumptions made in the last quarter of 2020, the estimated medical scheme membership was expected to decrease by an average of 8.6% in 2020. Bonitas membership only decreased by 1.7%. By focusing on our strategy – and ensuring it is a living and iterative process core to the choices taken by Scheme management with oversight by the Board – we were able to mitigate risk and limit membership loss.

Our efforts in terms of brand positioning, service, product design and managed care initiatives responded well to the influencing factors that could have resulted in negative outcomes for Bonitas. Similarly, by relying on the expertise and competencies of our investment committee, we remained focused on monitoring our investment performance and asset managers in line with our adopted strategic asset allocation strategy. This enabled us to protect the reserves of our members despite market uncertainty and unpredictability due to the pandemic. In summary, we implemented a well-considered investment strategy that enjoyed an intensified sense of performance monitoring and responsiveness when it was demanded.

[1] *Deloitte: Impact of COVID-19 on Medical Scheme Membership (October 2020).*

GOOD GOVERNANCE AND A COMMITMENT TO TRANSFORMATION

This was also a year that highlighted the importance of strong governance. Bonitas is not geared towards profit, but towards ensuring we act in the best interests of our members. To ensure we discharge our duties as a Scheme, good corporate governance and a robust control environment is important. Expending funds within the defined Scheme Rules, benefits and prescribed regulatory framework remains core to the way Bonitas is managed: in the right way and with the necessary controls and compliance.

New risks emerged this year, including uncertainties around current and future healthcare costs, elevated by the impact of COVID-19. Questions abound about the vaccine funding model and roll-out strategy, both potentially having a significant impact on solvency. The continued deferral of elective procedures remains unclear and may result in a future rapid uptake. Coupled with the above, we face increasing healthcare costs due to the expansive nature of evolving regulations. Therefore Bonitas's governance structures have to remain responsive to the social, economic and financial impacts of this pandemic.

We also remain committed to advancing the transformation agenda. Medical schemes face regulatory uncertainty due to ambiguous and conflicting requirements between B-BBEE legislation and the MSA. This is particularly challenging in terms of enterprise and socioeconomic development. Nevertheless, we strive to improve our rating year on year and we are in the process of enhancing our transformation strategy. Our operational policies will continue to advance B-BBEE transformation where practically possible.

Bonitas supports broader transformation through our strategy, thereby supporting a non-racial, non-divided society.

We took the CMS launch of the Section 59 investigation into allegations of racial discrimination by medical schemes and administrators seriously. When the panel was established and the matter became known to us, we proactively engaged with our service providers on FWA, with oversight from the Board and the Audit and Risk Committee. We critically reviewed our systems and processes and related contracts for managing FWA. It is also important to note that Bonitas has, for many years and preceding the claims of racial discrimination, instituted structures to consider each case on its merits and applied oversight on its service providers to ensure the work done is without prejudice or favour. Our whistle-blowing structures allow members and any persons to confidentially report unlawful activities and concerns. The Scheme has a duty to investigate each report on its merits.

Our intent with FWA is to prevent losses for our members. By changing billing behaviour through effective forensic intervention, we were able to reduce billing costs. Over a five-year period, members' contributions could have been 4.4% higher without effective FWA management.

We have a specialised forum with a diverse profile that critically reviews all potential cases of FWA and monitors all investigations. Further oversight is provided by a senior FWA manager who refers any concerns to the Board and/or Audit and Risk Committee.

These structures date back years and have matured in a way that ensures fair outcomes. We therefore welcome the interim report from the CMS panel and will consider any further improvements to facilitate good governance and transformation within the healthcare system.

DEALING WITH A PANDEMIC

Looking back, there is ample evidence of Bonitas's proactive response to the changes brought about by COVID-19 in 2020. There was no blueprint for any of the situations we faced as a medical scheme, healthcare industry or society at large. Our priority was simply to see that members had access to quality healthcare, service and advice. We launched virtual healthcare, an advisory service from a rapid response perspective, and took care to support moms and dads who were expecting. We recognised the level of anxiety people experienced when dealing with healthcare, particularly in accessing emergency services. We took healthcare into homes, provided education and created awareness.

By their nature, these responses addressed many of the challenges highlighted in the HMI. We empowered members with knowledge and provided certainty where we could. We also contributed in practical ways. Bonitas delivered more than 100 000 hand sanitisers to high-risk members and over 18 000 packs of baby hygiene and care products to clinics and hospitals through COVID-19 relief initiatives. In addition, donations of buffs and sanitisers were made as requested by various employers in the essential services sectors.

The COVID-19 hub on our website allowed members to access the most updated, relevant, reliable information and statistics. This included a specific call centre with registered nurses ready to respond to any questions or concerns, provide support and give members updated clinical information from credible sources.

We intensified our managed care model by:

- Reducing COVID-19 out-of-pocket expenditure
- Enhancing funding approaches for services such as pathology testing and negotiating reduced costs for those tests
- Proactively engaging with hospitals to ensure members were accommodated in private facilities and received the best private healthcare when required
- Assisting members in need when they had medical requirements over and above the standard benefits
- Engaging with providers and facilities in terms of PPE to ensure patients and healthcare providers were protected
- Reducing or eliminating member co-payments/shortfalls.

We were one of the first schemes to announce we would pay for PCR tests – before any related regulations were announced. We also started engaging around vaccination early in the process. Vaccination is a key priority for 2021.

Around 3% of our members and beneficiaries work in the healthcare sector and will therefore be prioritised in terms of the vaccine roll-out. We are working on strategies to ensure rapid distribution to our membership base once vaccines have been procured. Members will have access to the vaccine, no matter what plan they are on, and will not have to pay for the vaccine from their own benefits. Bonitas is financially stable and has the required funds to cover the costs of the COVID-19 vaccines.

Based on preliminary reports and information from government, our estimates indicate a potential cost impact for Bonitas to be in the range of 0.9% to 1.7% of contributions, equating to a total estimated cost impact of between R180 million and R321 million. However, we need to be mindful that direct COVID-19 claims costs could range from R680 million to approximately R1.4 billion, depending on how long procurement takes and the length of delay before vaccine access, along with the risks of more waves of infection.

A STRATEGY FOR GROWTH

Our strategic pillars and pathway continue to serve our members well, despite changing and uncertain external drivers. On a tactical level we had to reprioritise, but our pillars remained relevant and appropriate.

The pillar of business development drives growth in our membership base, which is critical to Bonitas's sustainability. The focus for growth remains primarily in the corporate market. In this market, potential new members consider the offering and benefits, and look for reliability, capability, competency and expertise. Our reputation is a strength: Bonitas can be proud of the collective value in our partnerships, the Board and Executive Management. The corporate market wants to know its money is in safe and trustworthy hands.

The pillar of strategic purchasing ensures that members' claims are paid quickly and easily, based on optimised rates and benefit options. From a claims management perspective, the robustness of our systems remains critical.

The design of our 2021 plans and benefits had to address the growth imperative and retain members. We announced an unprecedented 0% increase on the BonFit Select plan and a weighted increase of 4.6% across all plans.

Our intent was to limit contribution increases as far as possible while also avoiding the need for members to suffer in coming years for a low increase in 2021. Our aim is for members to get access to full healthcare cover and avoid out-of-pocket expenses and co-payments.

Some of the factors we took into account:

- The CMS announced changes to benefit structures and prescribed minimum benefits
- Investment income was affected by a volatile market
- Claim patterns were unpredictable in terms of seasonality and volume due to the lockdown measures that came into effect
- The Consumer Price Index was lower than in previous years.

Some of these factors remain uncertain for the foreseeable future, which means we have to remain prudent in our decisions and serve the best interests of our members. As always, Bonitas has to make short-term decisions with the long-term view and sustainability in mind.

One of the highlights over the past few years has been the introduction of new EDOs. These plans allowed members to use network healthcare providers and pay around 15% less for the same benefits. The EDOs cover over 74 000 lives and the principal members who join are roughly 10 years younger than the average Bonitas member.

The success of EDOs informed the innovative thinking behind the Edge option, with a new plan launched for 2021.

We remain committed to our outsourced model for business processing. This model is not static: we have continuous and active engagement with our providers to allow our members to receive quality managed care at affordable prices. The focus is on value realisation for our members and achievement of contracted outcomes in every part of the value chain.

This year, Bonitas brought innovative change to a long-standing traditional approach to hospital negotiations. In alignment with the recommendations of the HMI (and confirmed by the Competition Commission notice to stakeholders September 2020), we adopted a collective bargaining strategy. Bonitas, together with a closed scheme and a number of smaller closed medical schemes, leveraged

We are looking forward to new and innovative ways of empowering members to manage their health in 2021 and beyond. Our focus is more primary healthcare, use of preventative care benefits, digitally enabled solutions and self-help facilities for members who want access to their benefits 24/7. Our goal is to improve integration of care, enable more access to out-of-hospital services, clinical information and benefits via various solutions.

the scale of the collective (1.25 million lives) to negotiate a more sustainable hospital tariff increase for 2021. This approach proved to be highly effective.

We established a day surgery network as part of the hospital negotiation strategy to shift day procedures to facilities. We implemented processes to increase the use of home-based care. These initiatives offer various benefits for the Scheme and its members, but importantly they support the strategy to provide members with access to quality healthcare.

The focus of our disease risk management framework shifted significantly during 2020, aligned to the success of the AfA disease management programme. We want to improve clinical outcomes for all chronic patients and incorporate a more personalised approach.

During 2021 this intervention will be scaled to include hypertension and depression.

Increased focus on mental health is driving a shift in the management of mental health conditions to the community rather than facilities. We are also enhancing case management to reduce the length of stay for current admissions. Members are supported with additional information on mental health conditions from an online resource hub in addition to implementing processes that provide mental healthcare in the community.

CONTRIBUTING TO A BETTER SOCIETY

We remain committed to the principles of universal healthcare and recognise that the pandemic interrupted and delayed progress with the NHI Bill for South Africa.

Bonitas provided submissions to the portfolio committee and remains primarily concerned about funding and our ability as a country to roll out healthcare in the suggested format. This became even more evident in the past year as the pandemic illustrated the need for universal healthcare, but also the necessity for closer collaboration between public and private sectors to ensure success. We believe in a collective effort that brings experience and resources together for the benefit of all South Africans.

Bonitas is a primary steward of social well-being, with the pandemic elevating a few urgent issues for the nation this year. As our agreement to sponsor the Comrades Marathon came up for review, it was the ideal moment to assess where we can make the biggest difference. We saw an opportunity to focus on broader and more immediate challenges. We want to engage with broader society and communities so we respond appropriately to developmental needs. To be part of the South African story, the programmes to be implemented will specifically focus on:

- Good corporate citizenship
- Access to healthcare

PRIORITIES FOR 2021

We are committed to increasing vigilance around cyber risk. The Bonitas I&T Governance Framework and Strategy was completed and approved by the Board in February 2020. The implementation phase extends into 2021 and includes the completion of a service catalogue that will be implemented with all service providers, along with relevant policies.

One of the learnings we take into 2021 is the responsibility to see that members understand what they are buying. We know that members accept they need affordable healthcare that delivers value. However, they need to be empowered to make choices around healthcare, and understand the implications of their purchase. Members have service expectations and our plans and benefits need to be explicit about these, while meeting regulatory requirements. For Bonitas this means further investment in education and information sharing through various channels.

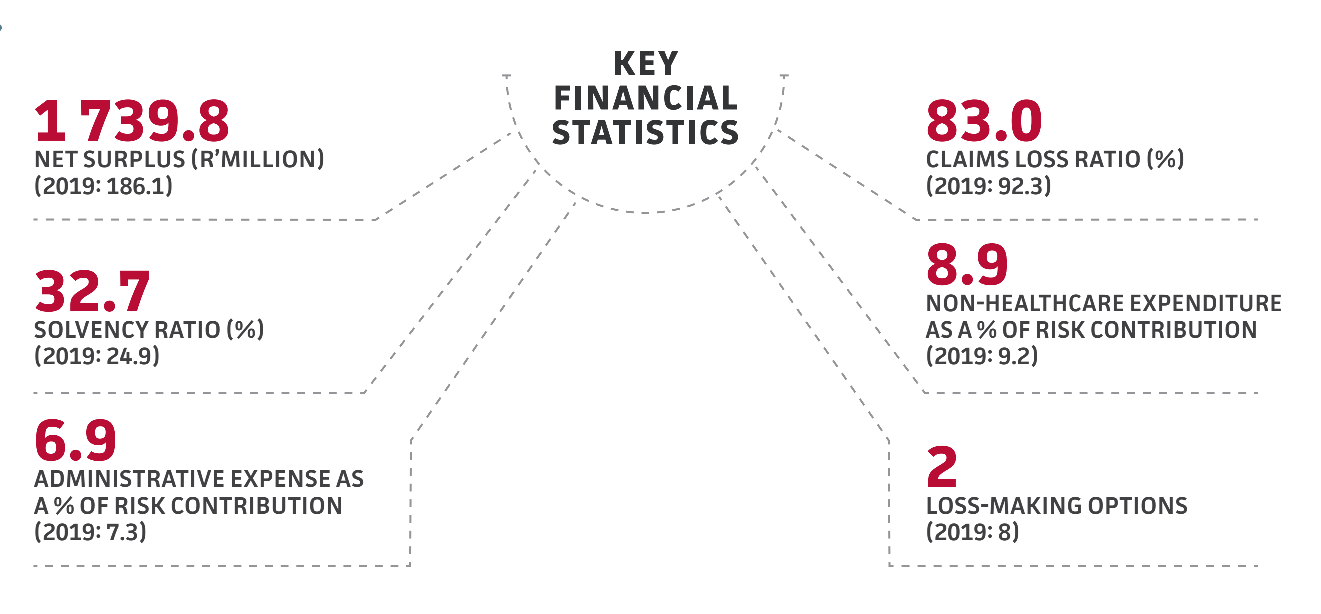
Technology has driven many advances in the healthcare industry, and Bonitas remains abreast of the latest developments. However, unlike competitors, our focus and main area of investment is not technology innovation. Our focus is accessibility and affordability. Where technology may meet the expectations of a certain segment of society, we recognise that a large part of our population has different needs for systems to serve them effectively. Our intent is to avoid further polarisation in terms of healthcare, to gain trust and execute our strategy responsibly, so South Africa can grow economically and inclusively.

Mr LR Callakoppen
Principal Officer

19 April 2021

Mr L Woodhouse
Chief Financial Officer

FINANCIAL AND OPERATIONAL RESULTS



OVERVIEW

Bonitas ended 2020 with an unprecedented surplus of R1.7 billion. Although COVID-19 induced severe capacity constraints in the healthcare system, the hiatus in all other areas of healthcare decelerated a long-term trend towards overuse and medical cost inflation. This occurred against an economic backdrop of market volatility, record low interest rates, rising unemployment and declining incomes.

The significant surplus capacity was systemic within the healthcare industry. Hospitals avoided elective procedures to safeguard their capacity to deal with COVID-19. Members preferred to delay physical interaction with providers and facilities to avoid the risk of infection. The combination of these factors led to lower claims in an environment where Bonitas actively continued to manage costs, promote managed care and supervise investment performance.

Our challenge now is to make meaningful strategic decisions about current reserves in the interests of our members, while facing significant uncertainty, especially in terms of the cost and roll-out of COVID-19 vaccines.

KEY COVID-19 COST-DRIVERS

- hospital admissions
- investment in PPE to ensure healthcare workers and patients are protected
- pathology test costs
- home care
- healthcare support to members in the workplace as the economy re-opens
- medication
- deferred elective surgeries

The CMS regulates the industry and has been very specific in terms of what medical aids may and may not do to support members during the pandemic. We applied for three concessions, and two of these were granted. The first of these was to allow the use of savings to fund contributions and the second was to defer contribution payments for small to medium employer groups. This had a negligible impact on performance.

STATEMENT OF PROFIT OR LOSS AND OTHER COMPREHENSIVE INCOME

FOR THE YEAR ENDED 31 DECEMBER 2020

	Notes	**2020 R'000**	2019 R'000
Risk contribution income	13	**17 797 746**	16 738 384
Relevant healthcare expenditure	14	**(14 771 240)**	(15 442 640)
Net claims incurred	14	**(14 346 005)**	(15 030 529)
Risk claims incurred		**(14 405 261)**	(15 098 893)
Third party claim recoveries		**59 256**	68 364
Accredited managed healthcare services	14	**(551 530)**	(517 478)
Net income on risk transfer arrangements	14	**126 295**	105 367
Risk transfer arrangement fees/premiums paid		**(1 360 518)**	(857 139)
Recoveries from risk transfer arrangements		**1 486 813**	959 019
Profit share arising from risk transfer arrangements		**–**	3 487
Gross healthcare result		**3 026 506**	1 295 744
Broker service fees		**(334 827)**	(318 857)
Administrative expenditure	15	**(1 221 891)**	(1 217 814)
Net impairment losses on healthcare receivables	16	**(20 281)**	(8 566)
Net healthcare result		**1 449 507**	(249 493)
Other income		**347 039**	494 953
Investment income - Scheme	17	**316 606**	420 087
Change in fair value of investment property	17	**2 900**	2 100
Sundry income	18	**27 533**	72 766
Other expenditure		**(56 785)**	(59 409)
Asset management fees		**(21 597)**	(16 609)
Interest expense	11/4.2	**(29 509)**	(36 903)
Operating expenses on rental of investment property		**(5 679)**	(5 897)
Surplus for the year		**1 739 761**	186 051
Total comprehensive income for the year		**1 739 761**	186 051

Membership and risk contribution income

Bonitas's membership declined by 1.7% in 2020. With a direct correlation between GDP growth and growth in the open scheme industry, the decline compares well with a GDP contraction of 8%. This was due to a strong retention focus and the inclusion of a lead aggregator model. The latter included the Hippo and Medquote platforms and stimulated membership growth. While 43 424 members terminated their membership, 37 814 new members joined Bonitas.

38.2% of uncontrollable terminations were retained, mostly through outbound calls and the offer of options for members to buy down. Retention successes can further be ascribed to:

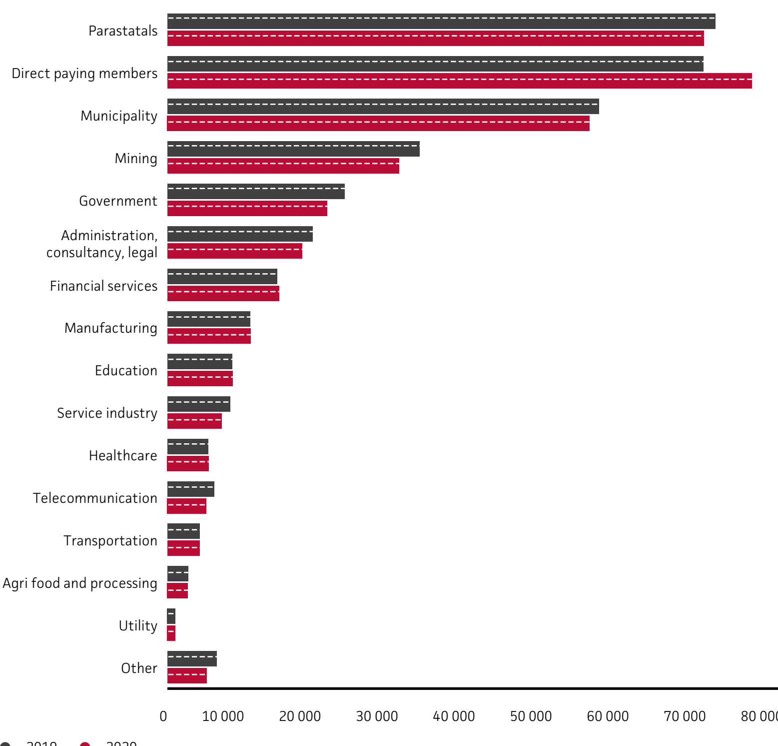
- Active retention by means of our follow-up process
- Redirection of group-focused retention projects
- Increasing capacity in the retention team.

COVID-19 contribution relief measures also helped members in financial difficulty.

Despite a decline in membership, risk contribution income at R17.8 billion (2019: R16.7 billion) increased by 6.3%. Of the total lives covered by Bonitas, 10.2% (2019: 9.73%) were 65 years and older. The total number of beneficiaries decreased by 12 786 (2019: increased by 12 737).

A total of 10 323 members moved to lower-cost options and 5 366 members moved to higher-cost options for the period January to December 2020. This was expected following the nationwide lockdown and economic pressures suffered by many industries and sectors across South Africa.

Membership distribution by industry



With small and medium enterprises taking the biggest knock during lockdown, membership numbers in the corporate sector were hardest hit.

Early indications are that membership in 2021 may stabilise despite further economic challenges. The new benefit option and low increases were specifically designed for affordability and to meet the needs of members who value medical cover but have pressure on their disposable income. Our corporate marketing strategies have also proven successful.

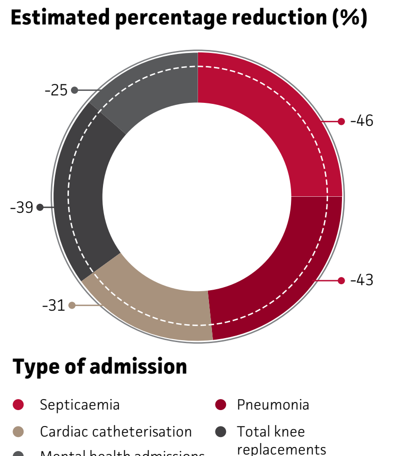
Starting the new year with positive momentum, we gained approximately 6 000 members in January and February 2021 and experienced growth of more than 2% in the early part of 2021, including February.

Net claims ratio

Net claims decreased by 4.7% to R14.3 billion (2019: increased by 8.9% to R15.0 billion) and was characterised by significant volatility from month to month due to changing lockdown rules and members' reluctance to interact with the healthcare system.

The financial year started with higher claims than anticipated in January and February, followed by a drop in claims from the last week in March. The months with the most notable drop in claims were April and May during the strictest lockdown levels. Predictably we experienced two COVID-19 claims peaks: in July and December.

Hospital admission categories showed significant variances compared to previous years, for example:



Other notable reductions were seen for acute bronchitis (64%), gastroenteritis (40%), upper gastro-intestinal scopes (43%), cataract procedures (18%) and tonsillectomies (59%). We continue to experience a hiatus in utilisation, and expect this to continue well into 2021.

The net claims ratio for the year ended on a low 83.0%. Excluding COVID-19 costs, the ratio was 76.3% compared to 92.3% in 2019.

Managed healthcare service cost

Costs incurred by accredited managed healthcare services increased by 6.6% (2019: 7.9%) as part of Bonitas's strategic investment in long-term prevention. Read more about managed care cost savings initiatives on page 21. We are confident the managed care expenses will result in retention and growth in membership, while also delivering savings in benefit use over the longer term.

Healthcare cost savings initiatives introduced this year realised savings of R221 million. The most significant of these were achieved through the risk transfer arrangements relating to Scriptpharm acute, chronic and oncology medicine, the management of outlier specialist engagements and renegotiated network maternity fees.

Administration expenses

Administration expenses were well controlled in a year with abnormal patterns. These expenses comprise operational expenses and the fee paid to the administrator. The latter increased by 3.3% to R876 million. Overhead expenses on aggregate were below budget, supported by COVID-19-induced shifts such as replacement of print and postage with digital communication. We also managed our marketing spend in line with prior year spend.

Surplus

Bonitas reported a surplus of R1.7 billion for the year (2019: R186.1 million). The significant surplus is largely attributable to the suppressed utilisation of non-COVID related claims expenditure. The surplus was also positively impacted as a result of the effective implementation of our strategic pillars, proactive risk management and prudent Board decisions in an unprecedented and volatile year.

Bonitas's medium-term objective is to sustain solvency levels above 30% and to determine how the bolstered reserves can best be used to benefit our members.

STATEMENT OF FINANCIAL POSITION

AT 31 DECEMBER 2020

	Notes	**2020 R'000**	2019 R'000
ASSETS			
Property and equipment	4	**9 125**	14 223
Investment properties	5	**77 700**	74 800
Financial assets held at fair value through profit or loss	6	**4 279 785**	2 951 402
Non-current assets		**4 366 610**	3 040 425
Financial assets held at fair value through profit or loss	6	**2 859 688**	2 057 524
Insurance, trade and other receivables	8	**719 066**	849 440
Cash and cash equivalents	9	**611 090**	613 040
Current assets		**4 189 844**	3 520 004
Total assets		**8 556 454**	6 560 429
MEMBERS' FUNDS AND LIABILITIES			
Accumulated funds		**6 059 840**	4 320 079
Members' funds		**6 059 840**	4 320 079
Lease liability	4.2	**3 047**	7 094
Non-current liabilities		**3 047**	7 094
Outstanding risk claims provision	10	**976 275**	769 108
Personal medical savings accounts liability	11,1	**812 078**	678 857
Insurance, trade and other payables	12	**669 731**	782 072
Lease liability	4.2	**3 605**	3 219
Derivative financial instruments	7	**31 878**	–
Current liabilities		**2 493 567**	2 233 256
Total Members' funds and liabilities		**8 556 454**	6 560 429

Investment market value

Bonitas reported an average return of 4.16% (2019: 6.7%) on its investment portfolio. The market made a strong recovery from a 40-year low at the time of the COVID-19 crash in March. We tracked performance closely to determine the best strategic asset allocation for our investments. This included repurchasing equity at low values to achieve parity. Unlike many entities, we remained committed to our long-term investment strategy, and did not opt for cash havens with short-term yields.

The market value of Bonitas's investment portfolio, excluding cash and cash equivalents and investment properties, was R7.1 billion at 31 December 2020 (2019: R5.1 billion), representing growth of 39%. We also entered into zero-cost fence derivative to hedge losses exceeding 2.5% up to a maximum of 15%. The derivatives expire in September 2021. Refer to note 22.4.3 of the annual financial statements for further information regarding derivatives.

Solvency ratio

	2020 R'000	2019 R'000
Members' funds per the statement of financial position	**6 059 840**	4 320 079
Adjusted for:		
Regulation 29 exclusion of unrealised gains on remeasurement of investments and investment property to fair value*	**(4 926)**	–
Accumulated funds per Regulation 29	**6 054 914**	4 320 079
Gross contributions (note 13)	**18 540 546**	17 384 459
Solvency ratio (%)	**32.66**	24.85
* *Cumulative net (losses)/gains on remeasurement to fair value of investments are calculated as follows:*		
At beginning of year	**(35 076)**	23 397
Net gains/(losses) on remeasurement to fair value of financial instruments included in accumulated funds	**19 528**	(58 473)
At end of year	**(15 548)**	(35 076)
# *Cumulative net gains on remeasurement to fair value of investment properties are calculated as follows:*		
At beginning of year	**17 574**	15 474
Movement in unrealised gains on remeasurement to fair value of investment properties included in accumulated funds	**2 900**	2 100
At end of year	**20 474**	17 574
Cumulative net gains/(losses) on remeasurement of investments and investment property at the end of the year	**4 926**	(17 502)

Cumulative net unrealised losses on remeasurement to fair value of investments and investment properties are excluded from the solvency calculation according to Regulation 29.

Bonitas's solvency ratio increased to 32.7% (2019: 24.9%) as a result of the high surplus, lower claims and the reduction in membership. We also experienced higher numbers of members buying down than up, which affected contributions and ultimately our solvency ratio.

This buy-down trend is a by-product of the economic challenges faced by everyday South African citizens and is prevalent across the greater medical scheme industry.

Outstanding claims provision

The outstanding claims reserve for 2020 is R976.3 million (2019: R769.1 million), which represents 6.6 % of relevant healthcare expenditure. This is higher than in previous years due to the large number of COVID-19 hospital admissions towards the end of December, brought on by the second wave of infections, and as such this reserve has a higher than normal degree of volatility.

Provisions have been mainly in the hospital, medical specialist and pathology claims categories. Acute medication use for December also exceeded previous years, most likely because members still had more benefits available due to lower use during lockdown, as well as self-medication for COVID-19 home treatment cases.

Actuarial valuation

The independent actuary reports monthly to Bonitas on the risk status and performs an annual actuarial evaluation. Contributions and benefit levels are redesigned based on the actuary's recommendations.

STATEMENT OF CHANGES IN MEMBERS' FUNDS AND RESERVES

FOR THE YEAR ENDED 31 DECEMBER 2020

R'000	**Accumulated funds R'000**	Total R'000
Balance as at 31 December 2018	**4 134 028**	4 134 028
Total comprehensive income	**186 051**	186 051
Surplus for the year	**186 051**	186 051
Balance as at 31 December 2019	**4 320 079**	4 320 079
Total comprehensive income	**1 739 761**	1 739 761
Surplus for the year	**1 739 761**	1 739 761
Balance as at 31 December 2020	**6 059 840**	6 059 840

STATEMENT OF CASH FLOWS

FOR THE YEAR ENDED 31 DECEMBER 2020

	Notes	**2020 R'000**	2019 R'000
Cash flows from operating activities			
Cash generated/(utilised) by operations before working capital changes	20.1	**1 690 147**	(207 815)
Working capital changes			
Decrease/(increase) in insurance, trade and other receivables	20.2.1	**109 525**	(181 143)
(Decrease)/increase in insurance, trade and other payables	20.2.2	**(112 341)**	140 951
Increase in personal medical savings account liability	20.2.3	**148 202**	92 008
Cash generated/(utilised) by operating activities		**1 835 533**	(155 999)
Interest paid	11	**(28 628)**	(36 045)
Interest received	17	**4 646**	42 450
Net cash inflow/(outflow) from operating activities		**1 811 551**	(149 594)
Cash flows from investing activities			
Acquisition of property and equipment	4	**(818)**	(1 353)
Proceeds on disposal of property and equipment		**4**	15
Proceeds on disposal of investment property		**–**	9 000
Acquisition of financial assets held at fair value through profit or loss	6	**(2 509 037)**	(2 088 547)
Disposal of financial assets held at fair value through profit or loss	6	**497 357**	1 362 309
Interest received	20.3.1	**145 492**	211 621
Dividends received	20.3.2	**68 526**	49 830
Asset management fees	20.3.3	**(19 914)**	(16 089)
Rentals received	20.3.4	**8 498**	8 664
Net cash outflow from investing activities		**(1 809 892)**	(464 550)
Cashflows from financing activities			
Lease payments		**(3 609)**	(3 634)
Net cash outflow from financing activities		**(3 609)**	(3 634)
Net decrease in cash and cash equivalents		**(1 950)**	(617 778)
Cash and cash equivalents at beginning of the year		**613 040**	1 230 818
Cash and cash equivalents at end of the year		**611 090**	613 040
Analysed as follows:			
Cash and cash equivalents	9	**611 090**	613 040
		611 090	613 040

AN OUTLOOK REGARDING THE FINANCIAL IMPACT OF COVID-19

We are confident that 2021 will be a better year for Bonitas and our members. Lockdown measures are expected to be much less restrictive, and even the likelihood of further waves will be absorbed by a healthcare system that has built experience and resilience in dealing with COVID-19, or potential related variants.

International trends and predictions point to three possible scenarios in the next year:

- A third wave in winter, comparable to the second wave, followed by a smaller fourth wave towards the end of 2021.
- A third wave in winter, peaking at a level significantly lower than the second wave due to vaccinations and people having already been infected.
- No third wave with low levels of positive cases.

Vaccinations will be a major factor to reduce the impact of potential next waves. Costing of vaccination remains uncertain due to variables such as uptake, distribution, administration and application of the second dose, where applicable. We also do not expect COVID-19 vaccinations to be a once off cost, but possibly an annual cost to factor in once vaccines are updated and in case protection periods prove to be limited.

We do not expect healthcare claims levels to return to pre-2020 levels in 2021. Additional waves may continue to dampen the demand for elective procedures and treatment. However, many of the admissions that were delayed in 2020 cannot be postponed indefinitely. Admissions for cardiac and oncology conditions, for example, are therefore expected to increase, but will remain muted.

See below for a summary of claims assumptions and estimated costs, based on the above scenarios:

		Scenario		
Category	**Description of main assumptions**	Two more waves	One more wave	No third wave
Direct COVID-19 costs	Total number of hospital admissions	9 963	8 089	4 907
	Total number of pathology tests	211 160	171 441	104 001
Vaccine costs	85% eligibility; DOH cost estimates	Medium scenario, refer Note 28.2.2 of the annual financial statements		
Non-COVID use	Offsetting impact in non-COVID utilisation relative to 2021 budgeted levels; based on projected 2021 admissions relative to 2020 admissions. Utilisation patterns were inferred from 2020 experience, noting the exclusion of the April/May 2020 lockdown effect and allowing for 30% efficiency improvement factor from 2020 levels (refer Note 28.2.3)	(10.80%)	(7.20%)	(5.30%)
Electives Catch-Up	Proportion claims catch-up of postponed 2020 elective procedures in 2021 between COVID-19 waves	50%	70%	90%

		Scenario		
Category	**2021 Cost projections (R'million)**	Two more waves	One more wave	No third wave
Direct COVID-19 Costs	Total for hospital admissions, pathology tests and home care	1 397	1 134	688
Vaccine costs	Total cost, including logistics and administration	247	247	247
Non-COVID utilisation	Total offsetting Rand impact in non-COVID utilisation relative to the 2021 budget	(1 558)	(1 046)	(805)
Electives catch-up	Total cost based on 2020 procedures "lost" and assumed catch-up percentage	241	338	434
Projected net claims impact		327	673	564

Bonitas budgeted a net claims impact of R613 million pertaining to COVID-19 in 2021. Under two of the three scenarios, the overall claims expenditure will likely be lower than budget.

Even considering more extreme scenarios than those listed here, Bonitas has adequate reserves to remain sustainable and able to support our members. The scenarios above confirm that we are well positioned to absorb the projected healthcare impact of 2021 COVID-19 infections.

Our priority will be to secure a vaccine for members to protect their health. We are mindful of economic pressures that will remain the daily reality for South Africans, and are committed to build on the groundbreaking shifts in cost management achieved in 2020.

This includes the negotiation of four major contracts for administration, managed care, HIV/AIDS disease management and wellness this year. These contracts were due to terminate in June 2020 but were extended to allow us to prepare and negotiate new fees and service levels.

Our intent remains to provide accessible and affordable healthcare to even more South Africans in 2021. We want to ensure a wider Bonitas family enjoys the peace of mind that comes from being protected by people who care.

Mr L Woodhouse
Chief Financial Officer

19 April 2021

OPERATIONAL STATISTICS

Bonitas Medical Fund 2020	**Consolidated total**	**Standard**	**BonSave**	**Primary**
Average number of members during the year (n)	**335 425**	**116 755**	**35 843**	**88 643**
Number of members at 31 December (n)	**333 141**	**114 297**	**35 548**	**89 445**
Average number of beneficiaries during the year (n)	**714 989**	**256 016**	**83 595**	**209 314**
Number of beneficiaries at 31 December (n)	**710 157**	**250 255**	**83 150**	**211 137**
Proportion of dependants at the end of the year (n)	**1.13**	**1.19**	**1.34**	**1.36**
Risk contributions per average member per month (R)	**4 422**	**6 085**	**3 553**	**3 804**
Risk contributions per average beneficiary per month (R)	**2 074**	**2 775**	**1 523**	**1 611**
Healthcare expenditure per average beneficiary per month (R)	**1 722**	**2 261**	**1 195**	**1 325**
Non-healthcare expenditure per average beneficiary per month (R)	**184**	**196**	**185**	**180**
Relevant healthcare expenditure as a percentage of gross contributions (%)	**79.7**	**81.5**	**63.3**	**82.3**
Relevant healthcare expenditure as a percentage of risk contributions (%)	**83.0**	**81.5**	**78.5**	**82.3**
Non-healthcare expenditure as a percentage of gross contributions (%)	**8.5**	**7.1**	**9.8**	**11.2**
Average beneficiary age (n)	**35**	**38**	**31**	**30**
Pensioner ratio at 31 December (%)	**10.2**	**14.5**	**6.6**	**4.8**
Chronic profile at 31 December (%)	**19.0**	**30.6**	**13.3**	**12.2**

Bonitas Medical Fund 2019	Consolidated total	Standard	BonSave	Primary
Average number of members during the year (n)	336 651	123 823	35 738	81 155
Number of members at 31 December (n)	338 751	121 960	35 782	83 096
Average number of beneficiaries during the year (n)	718 919	274 503	83 246	192 611
Number of beneficiaries at 31 December (n)	722 943	270 195	83 540	197 026
Proportion of dependants at end of the year (n)	1.13	1.22	1.33	1.37
Risk contributions per average member per month (R)	4 143	5 614	3 386	3 552
Risk contributions per average beneficiary per month (R)	1 940	2 532	1 454	1 497
Healthcare expenditure per average beneficiary per month (R)	1 790	2 265	1 277	1 338
Non-healthcare expenditure per average beneficiary per month (R)	179	191	180	175
Relevant healthcare expenditure as a percentage of gross contributions (%)	88.8	89.5	74.0	89.4
Relevant healthcare expenditure as a percentage of risk contributions (%)	92.3	89.5	87.9	89.4
Non-healthcare expenditure as a percentage of gross contributions (%)	8.9	7.5	10.4	11.7
Average beneficiary age (n)	35	37	31	30
Pensioner ratio at 31 December (%)	9.7	13.2	6.2	4.5
Chronic profile at 31 December (%)	18.0	28.1	12.1	11.1

	BonCap	BonClassic	BonCompre-hensive	BonEssential	BonFit	Hospital standard	BonComplete
	48 491	**9 409**	**5 243**	**10 411**	**5 600**	**5 530**	**9 500**
	48 206	**9 134**	**5 087**	**11 228**	**5 739**	**5 347**	**9 110**
	75 337	**16 807**	**9 227**	**23 205**	**12 088**	**10 381**	**19 019**
	74 843	**16 212**	**8 898**	**25 139**	**12 406**	**10 002**	**18 115**
	0.55	**0.77**	**0.75**	**1.24**	**1.16**	**0.87**	**0.99**
	1 794	**6 270**	**8 640**	**2 989**	**2 770**	**3 837**	**5 166**
	1 155	**3 510**	**4 910**	**1 341**	**1 283**	**2 044**	**2 581**
	1 100	**3 109**	**4 753**	**1 090**	**921**	**1 708**	**2 183**
	123	**223**	**239**	**181**	**195**	**222**	**216**
	95.3	**76.1**	**78.7**	**81.3**	**60.5**	**83.5**	**72.1**
	95.3	**88.6**	**96.8**	**81.3**	**71.8**	**83.5**	**84.6**
	10.7	**5.5**	**4.0**	**13.5**	**12.8**	**10.9**	**7.1**
	34	**52**	**54**	**35**	**30**	**48**	**43**
	8.7	**33.7**	**39.6**	**10.5**	**5.0**	**26.6**	**19.2**
	11.2	**47.1**	**49.5**	**11.2**	**9.6**	**20.0**	**28.4**

	BonCap	BonClassic	BonCompre-hensive	BonEssential	BonFit	Hospital standard	BonComplete
	49 308	10 291	5 936	8 731	4 861	6 157	10 650
	51 320	10 093	5 584	9 263	5 060	5 966	10 357
	76 039	18 779	10 670	19 268	10 355	11 662	21 786
	79 782	18 347	10 474	20 405	10 864	11 277	21 033
	0.55	0.82	0.70	1.20	1.15	0.89	1.03
	1 567	5 674	7 839	2 811	2 619	3 433	4 681
	1 016	3 109	4 361	1 274	1 230	1 813	2 289
	1 142	3 124	5 002	1 203	1 000	1 809	2 177
	115	213	230	179	192	216	208
	112.4	86.3	93.2	94.4	69.3	99.8	81.1
	112.4	100.5	114.7	94.4	81.4	99.8	95.1
	11.3	5.9	4.3	14.1	13.3	11.9	7.8
	33	50	53	35	29	47	42
	7.8	31.0	37.7	10.6	4.7	25.0	17.5
	9.5	44.5	47.9	10.9	8.2	18.9	26.0

BOARD OF TRUSTEES: PROFILES

Mr JD Ngwane (64) Chairperson (Elected Trustee)

Mr JD Ngwane is employed by the National Union of Mineworkers as Unit Head: Social Benefits. He assisted union-negotiated retirement funds with a process involving harmonisation of benefits, resulting in consolidation of funds. His self-insurance experience on retirement funds helped to reduce repudiated permanent disability claims. This also assisted with insurance premiums no longer paid to an appointed insurance company, but rather paid into an established fund account thus accruing interest to the benefit of the fund members, and those reverting to the members fund credit. He assisted with medical aid comparisons across the mining industry, ensuring the options, benefits and costs were favourable to members and their families during hard financial times.

2019 1 July 2019; **appointed Chairperson with effect from 4 December 2020.**

Mr O Komane (55) (Elected Trustee – Term Ended)

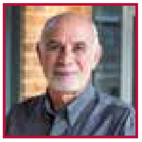
Mr O Komane holds an MSc in Engineering Business Management from the University of Warwick. He is the founder and Chairman of Bambatha Engineers and Mining Services. Before this, he served as the Deputy General Secretary of the National Union of Mineworkers. He brings experience in strategic corporate management and negotiations, served on numerous boards in various capacities and acquired extensive knowledge as a non-executive director and trustee. He also served as a trustee in the MWPF (Mine Workers Provident Fund) from 2005 to 2011. He introduced a self-administration model, which is still in use today.

2016 2 January 2016; appointed Vice-Chairperson with effect from 1 October 2017; **appointed Chairperson with effect from 13 March 2019 to 3 December 2020**; Trustee **term ended with effect 4 January 2021.**

Ms M Lesunyane (68) (Elected Trustee)

Ms M Lesunyane holds a BA from the University of South Africa. She is the co-founder of Lesunyane Enterprises, with over 30 years of business experience. She worked at RAF until 2017.

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



Mr J Bagg (68) Vice Chairperson (Elected Trustee)

Mr J Bagg is a qualified actuary with over 40 years' actuarial, financial management and consulting experience. He served as Statutory Actuary for numerous life insurance companies and is a Trustee of various retirement funds. He also holds directorships at life insurance and reinsurance companies.

15 October 2016 (previous Trustee of LMS. Appointed to the Bonitas Board pursuant to the amalgamation with LMS); re-appointed by the Board as a Trustee with effect from 1 April 2019 as part of a casual vacancy (appointment was approved by the members at the AGM held on 19 August 2019); **appointed Vice Chairperson with effect from 4 December 2020.**

Mr R Cowlin (66) (Appointed Trustee)

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

2 January 2016; **appointed Vice-Chairperson with effect from 13 March 2019 to 3 December 2020**; Trustee term ended with effect 4 January 2021; **appointed by the Board with effect 5 January 2021.**

Adv L Koch (56) (Elected Trustee)

Adv L Koch holds a BLC and LLB. She is an admitted Advocate of the High Court and is employed as a senior at the Specialised Commercial Crimes Unit, where she has worked since 2001. She has over 20 years' experience in the investigation and prosecution of complex commercial crimes, including medical aid fraud, money laundering and financial crimes. She has sound knowledge of corporate governance principles, frameworks and guidelines.

1 October 2017

Trustee appointment/election date

Mr PJ Ribbens (49) (Elected Trustee)

Mr PJ Ribbens started his business in 1997 and has run it for the past 24 years. He has vast experience in marketing and sales and is a director of Ribbens Office National. His responsibilities include overseeing assigned accounts and monitoring and evaluating project activities. He provides guidance to the marketing department by evaluating and developing marketing strategies and planning and coordinating marketing efforts. He positions the company's brand and also develops pricing strategies with the sales department.

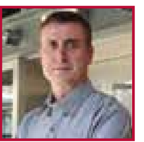
1 July 2019.

Ms J Usher (61) (Elected Trustee)

Ms J Usher is a qualified Chartered Accountant with 36 years' senior executive board experience across various industries, including medical schemes, fast-moving consumer goods, industrial manufacturing, conservation tourism and emerging economic empowerment.

She is skilled in corporate governance, financial management, legal contracting, commerce, strategic growth and skills development. She is Chief Financial Officer of Great Plans Conservation Limited.

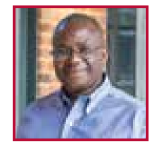
7 July 2015 and re-elected on 1 September 2017



Mr JR Venter (39) (Elected Trustee)

Mr JR Venter holds a BCom from the University of Pretoria. He has extensive experience in business development, corporate governance, strategic member relationship, retention management and financial management. He is employed by the largest technology service provider in Africa with more than 15 years' ICT experience. Mr Venter is member-focused and drives SLA adherence from service providers, thorough due diligence for contracts and value creation for members.

1 July 2019.



Mr MG Netshisaulu (44) (Elected Trustee)

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 has extensive experience in the tax industry from SARS Large Business Centre, as well as corporate and non-profit organisations. He recently completed a Council for Medical Schemes Trustee Development Programme with GIBS. He is currently employed as a Financial Strategic Analyst at the University of South Africa and is studying towards an LLB. He serves as a UNISA member of the professional research fund committee. He also previously served at the Nehawu Megawatt Park Branch as Chairperson and Deputy Chairperson.

1 September 2017

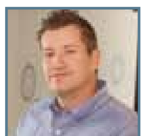
EXECUTIVE MANAGEMENT: PROFILES

Mr LR Callakoppen (44)

Principal Officer

Mr LR Callakoppen holds a Master HR Professional (SA Board for People Practices) and MPhil (Human Resource) & Industrial Soc Hons Degree and Information Science Degree from the University of Johannesburg. He has a wealth of experience at an executive level with specialisation in Human Capital, Transformation and Operational Management. Over the past 12 years he has been involved with Medscheme and the AfroCentric Group in various functions including heading up the Bonitas Business Unit.

Appointment date: 1 May 2019



Mr L Woodhouse (40)

Chief Financial Officer

Mr L Woodhouse is a qualified Chartered Accountant (CA)SA and holds a BCompt (Hons) Accounting Science. He has over 10 years' experience in the healthcare sector, previously heading up finance and operational roles within the AfroCentric Group. He has a wealth of practical experience when managing technical finance matters relating to the medical scheme environment.

Appointment date: 1 October 2019

GOVERNANCE PRACTICES AND STRUCTURES

EXECUTIVE SUMMARY OF OUR GOVERNANCE DECISIONS AND DELIBERATIONS FOR 2020

Updates to main Scheme Rules	The CMS approved a change to the main Scheme Rules that allows the Board to appoint a maximum of three Trustees. This will help the Board meet specific skills and expertise requirements, and will improve diversity.
COVID-19 intensified Board and Board Committee oversight	The Board and Board Committees held additional meetings during 2020 to provide oversight in terms of cost projections, fluctuating investment market performance and to consider the impact of COVID-19 on medical scheme membership and claims.
Ethics enjoyed focus and new policies	The Board and the responsible Board Committees focused on the review and approval of key governance-related policies such as (but not limited to) the Gifts Policy, Conflicts of Interest Policy, Code of Ethics and Professional Conduct Policies (both from an employee and Trustee/Independent Member perspective) and Whistle Blowing Policy. These policies guide ethical conduct and facilitate the reporting of unethical behaviour.
Independent performance evaluations completed	The Board contracted an independent service provider to evaluate its performance and that of the Board Committees. Overall, the analysis of the evaluation results and commentaries noted from the Board and Board Committee members revealed that the Board and the Board Committees are perceived as formally structured and functioning well in line with good corporate governance principles, with only some areas for improvement.
A new Board Committee established	A Managed Healthcare Committee was established as the fifth Board-mandated committee. Previously a management forum, it aims to ensure the most cost-effective treatment for members' medical conditions with continuous quality improvement of clinical care within budgetary constraints and legislative requirements.

The Board is accountable for governance and oversight at Bonitas. This includes providing direction, monitoring strategy implementation and guiding decision-making in the interests of our members.

The Board's main objective is to ensure that Bonitas acts in the best interests of members while safeguarding the Scheme's long-term sustainability. Therefore, the Board is committed to lead ethically and effectively and promote the characteristics of integrity, competence, responsibility, accountability, fairness and transparency.

The recently approved Bonitas Governance, Risk and Compliance Framework defines structures and processes in line with the requirements of the MSA, Scheme Rules and good corporate governance principles as defined in the King IV™ Report.

The Bonitas Governance, Risk and Compliance Framework is implemented according to the following three functions and accountabilities:

GOVERNANCE DEFINES THE OVERALL SYSTEM OF RULES, PRACTICES AND STANDARDS THAT GUIDE BONITAS

- Strategy
- Organisational structure
- Integrity
- Fairness and transparency
- Accountability and responsibility
- Policies and standards

RISK MANAGEMENT IS THE PROCESS OF IDENTIFYING POTENTIAL HAZARDS TO OR OPPORTUNITIES FOR BONITAS ON WHICH TO ACT

- Risk identification and assessments
- Risk scores
- Monitoring and analysis
- Risk mitigation

COMPLIANCE DEFINES THE SET OF PROCESSES AND PROCEDURES THAT BONITAS HAS IN PLACE TO CONDUCT BUSINESS LEGALLY AND ETHICALLY

- Compliance risk identification and assessment
- Regulatory compliance
- Operational compliance
- Risk and compliance coverage plan
- Monitoring of compliance
- Reporting of non-compliance matters

The Framework aims to achieve four outcomes as defined by King IV. Initiatives related to these outcomes include:

Ethical culture

Bonitas aims to maintain an ethical environment where employees and Trustees (including Independent Members sitting on Board Committees) are encouraged to report violations, co-operate with investigations and seek advice when facing a difficult situation.

This year we redeveloped two codes:

- The Code of Ethics and Professional Conduct for Trustees and Independent Members
- The Code of Ethics and Professional Conduct for Executives and Staff

Trustees/Independent Members and all employees will be required to acknowledge the respective Code of Conduct on an annual basis. Through this process, Trustees specifically agree to abide by certain ethical standards and to remain in good standing for their term of election or appointment.

A revised Gifts Policy defines business courtesy, entertainment, promotional items and invitations that can be considered as gifts and describes the process for declaring these.

The Board follows established practices to promote ethics and effectiveness in its deliberations. These include declaring any conflicts of interest at all Board and Board Committee meetings (in line with the Conflicts of Interest Policy) and ensuring transparency through its communication efforts.

The Board has to ensure that members receive adequate and appropriate information about their rights, benefits, contributions and duties.

Future focus areas

- Continued focus on always acting in the best interests of members.

Effective control

The Scheme Rules stipulate that the Board has to have proper control systems in place. This ensures the integrity of information the Board uses to make decisions.

The Board approved a Combined Assurance Framework this year. We adopted the “four layers of defence” governance model. This uses a co-ordinated approach in which assurance providers work closely, effectively and efficiently towards a control environment where the right assurance is received in the right areas.

Internal audit services are outsourced to PwC; and Deloitte & Touche has been appointed as the external auditor through member voting at the annual general meeting for the year ended 31 December 2020.

Future focus areas

- Ongoing focus and consistent business operation within the:
  - Strategy and risk appetite/tolerance set
  - Agreed business objectives
  - Agreed policies and processes
  - Laws and regulations

Good performance

According to the Scheme Rules, the Board is responsible for the proper and sound management of Bonitas and has to apply business principles to ensure financial soundness. It has to steer Bonitas to realise its purpose and remain sustainable.

The Board, supported by the Audit and Risk Committee and Investment Committee, reviews Bonitas’s financial performance and key performance indicators at the respective meetings, including the going concern status, solvency and investment performance.

The Board holds an annual strategy meeting where progress with and relevance of the strategic pillars are assessed. The Board approves targets for specific strategic indicators.

These targets form part of the approved annual Organisational Performance Matrix, which now also includes non-financial aspects. The matrix determines employee performance objectives and is implemented according to the Performance Management and Incentive Scheme Policies.

The Board further ensures regular and transparent performance reporting to members through the annual general meeting.

Future focus areas

- Financial sustainability to ensure member healthcare costs are covered
- Membership growth
- Healthcare cost efficiency and accessibility
- Member education and empowerment in terms of healthcare.

Legitimacy

As a membership organisation, Bonitas has to maintain the trust of its members and show responsiveness to the legitimate concerns of all stakeholders.

Our operations also need to be consistent with the values we advocate.

Based on the outcome of the HMI, our focus is on member education and empowerment.

Marketing initiatives have been geared towards member awareness and member education.

During April 2020, we launched a dedicated COVID-19 rapid response unit call centre for our members.

The Board approved a revised Sponsorship and Donations Policy. Sponsorships are treated as business arrangements that should deliver a positive return on investment and be aligned to our brand.

We do not sponsor political parties or entities involved in extreme sports that are controversial or disruptive.

The Board approved a range of COVID-19 contributions to assist stakeholders in need. We collaborated closely with the industry on mutual issues, such as vaccine distribution.

Future focus areas

- Revised sponsorship strategy to be more focused on corporate responsibility, to position Bonitas effectively as a good corporate citizen.

MAIN ELEMENTS OF OUR GOVERNANCE SYSTEM

The Board is responsible for the proper and sound management of Bonitas in terms of the governing legislation and regulation. These require the Board to act with due care, diligence, skill and in good faith.

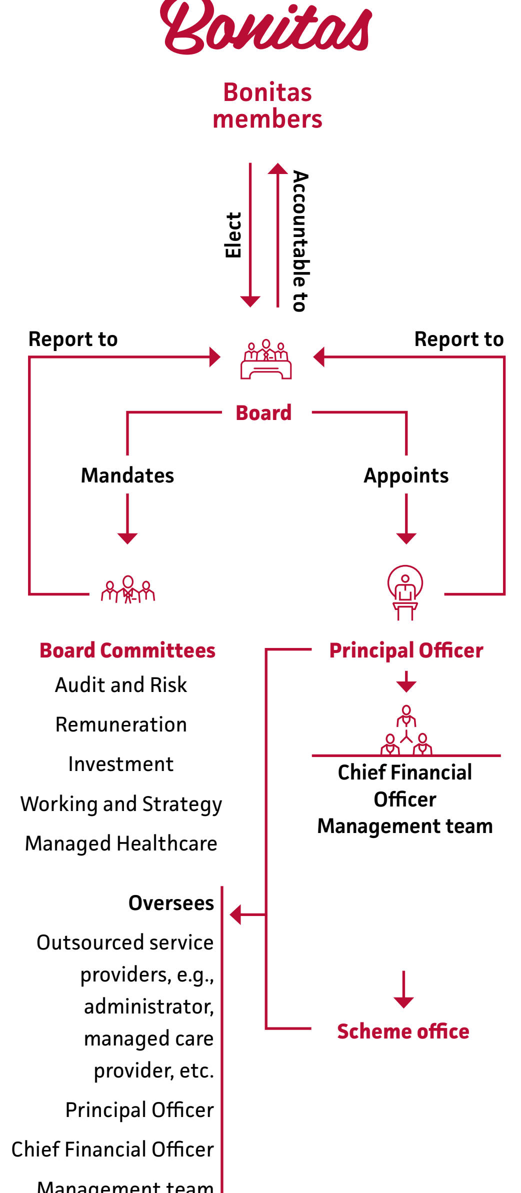
Governing legislation and regulation

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 or appointed by the Board for a five-year term, as stipulated in the Scheme Rules
- Fit and Proper
- Accountable to Bonitas members
- Appoints and contracts with the administrator and other relevant service providers

Board Committees

- Board supported by five Board Committees to fulfil its duties and responsibilities effectively
- Consist of both Trustees and Independent Members
- Mandated through defined 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 a management team

BOARD COMPOSITION

The Board currently consists of eight Trustees, elected by members, and one appointed Trustee, appointed by the Board in line with the Scheme Rules. During 2020, the Board consisted of ten Trustees, elected by members. The Board composition changed during January 2021. The CMS approved changes to the Scheme Rules in July 2020 that provide for the appointment of a maximum of three Trustees who bring specific skills and diversity to the Board without undergoing elections. Such an appointed Trustee must be a member of the Scheme and must possess qualifications or belong to professions such as attorney/advocate, accountant/auditor, actuary, medical practitioner/specialist, or any other specialist expertise identified by the Board.

The option to appoint specific Trustees allows the Board to source capabilities that will benefit Bonitas and improve race and gender diversity in its composition.

Board and Executive skills profile

Skills	Bagg	Callakoppen	Cowlin	Koch	Komane	Lesunyane	Netshisaulu	Ngwane	Ribbens	Usher	Venter	Woodhouse
Corporate governance	✓	✓	✓	✓	✓		✓			✓	✓	✓
Medical and retirement funds	✓	✓	✓					✓		✓		✓
Strategy		✓	✓		✓	✓	✓		✓	✓		✓
Financial management	✓	✓	✓				✓		✓	✓	✓	✓
Business development		✓	✓			✓			✓	✓	✓	
Law			✓	✓			✓					
Marketing			✓						✓			
Taxation							✓			✓		
Skills development			✓					✓		✓		✓
Medical		✓	✓									
Engineering					✓							
Actuarial science	✓											
Leadership	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Information Technology											✓	
Clinical			✓									

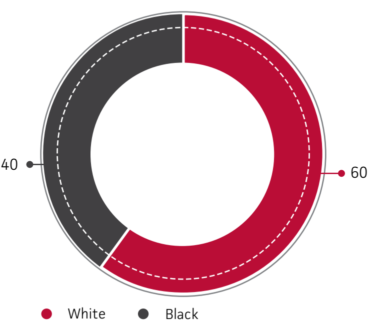
Gender profile as at 31 December 2020 (%)

30

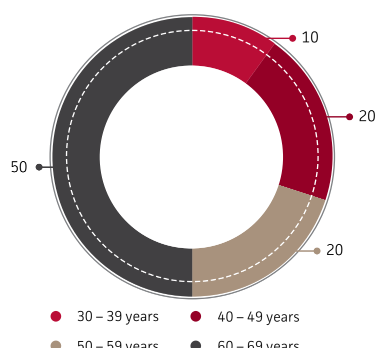
70

Male Female

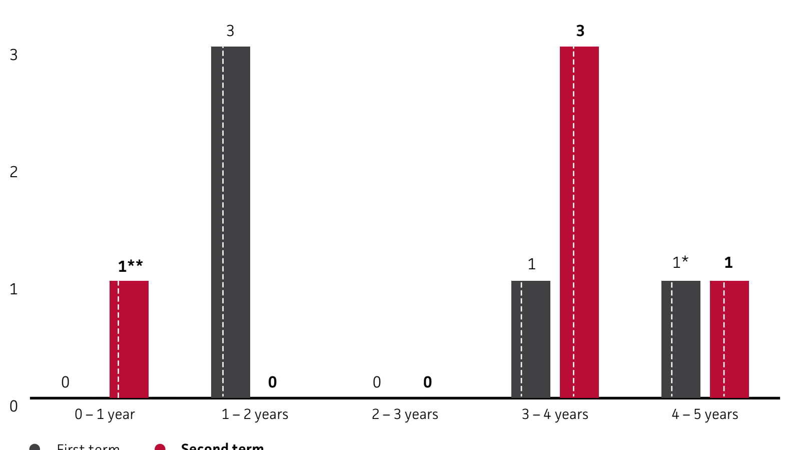
Race profile as at 31 December 2020 (%)



Age profile as at 31 December 2020 (%)



Tenure as a Board member



The Board strives to always focus on having the appropriate mix of skills and experience including gender and race diversity

* *O Komane – Term 1 ended with effect 4 January 2021.*

** *R Cowlin – Term 1 ended with effect 4 January 2021. Appointed as Trustee for term 2 with effect 5 January 2021.*

TRAINING AND EVALUATION

Board training scheduled for 2020 had to be postponed due to COVID-19 restrictions and is taking place in March 2021. Trustees and Senior Management will attend a Trustee Development Programme presented through BHF and Wits Business School. One focus area will be ethical leadership.

PwC was appointed to conduct independent performance evaluations on the Board and all the Board Committees. The process involved a combination of questionnaires and interviews and was completed in December 2020.

The analysis of the evaluation results and commentaries from Board and Board Committee members revealed the following:

- All Board Committees and the Board are perceived as formally structured and functioning well with some areas of improvement.
- In general, a marked improvement was noted in the governance practices/processes and support functions (such as the Scheme Secretariat) as well as risk management when compared to prior years.
- The governing body has shown agility during the COVID-19 pandemic and is commended for the manner in which it has been able to be agile and proactively responsive during the pandemic.
- Members are of the opinion that, in general, there are good dynamics within the structures and healthy relationships in place with the Executive.
- The Board and Board Committees are seen to be effectively discharging their responsibilities and understand their accountability.
- The governing body and the Scheme are seen to be ethical and decisions are made in the best interests of Scheme members.

KEY BOARD ACTIVITIES IN 2020

Highlights from the Board's activities in fulfilment of the Board Charter are included in this table to demonstrate how governance supports value creation and preservation:

Financial

- Evaluated financial performance, including going concern status, loss-making options, appropriateness of insurance cover and completion of year-end IBNR provision
- Approved annual financial statements and Board of Trustees report, budget 2021 and inflationary increase in administration and managed care service costs
- Appointed the external auditor and approved the audit fee
- Approved the revised investment strategy
- Approved financial derivative instruments

Operational

- Considered and approved the pricing and benefit option design for 2021
- Considered and approved administration and managed care contracting process and fees
- Considered and agreed to ensure progress with transformation, including B-BBEE
- Approved new risk transfer agreement with Scriptpharm

Stakeholders

- Supervised the process of Board elections, nominations and appointments
- Made arrangements for virtual meeting and voting at AGM
- Considered updates on legal proceedings and, where required, provided official responses to matters such as the CMS investigation

Governance

- Approved amended Scheme Rules
- Considered the appropriateness of the Board Charter, charters for the Board Committees and the Board Committee structures
- Established the Managed Healthcare Committee with approved work plan and charter
- Contracted and completed Independent Board and Board Committee evaluation
- Approved changes to the Delegation of Authority mandate
- Approved new frameworks: Governance, Risk and Compliance, Combined Assurance and Succession Management
- Approved revised and updated the following policies: Gifts, Learning and Development, Compliance, Membership, Sponsorship and Donations, Petty Cash, Performance Management, Leave, Credit Control, Impairment, and Talent and Succession Management
- Completed registers for declaration of interests and gifts
- Submitted Trustee Annual Declaration and Interest forms

Strategy, people and performance

- Considered strategy and risk alignment
- Approved the Organisational Performance Matrix 2020
- Recruited and appointed a Head of Operations who joined the Scheme's management team on 1 February 2021
- Considered regular updates on COVID-19 mitigation measures, actuarial impacts and special arrangements

Risk and compliance

- Provided oversight of the key risks facing Bonitas, and reviewed and monitored the effectiveness of the risk management process
- Reviewed and monitored the effectiveness of the compliance management process

MEETING ATTENDANCE

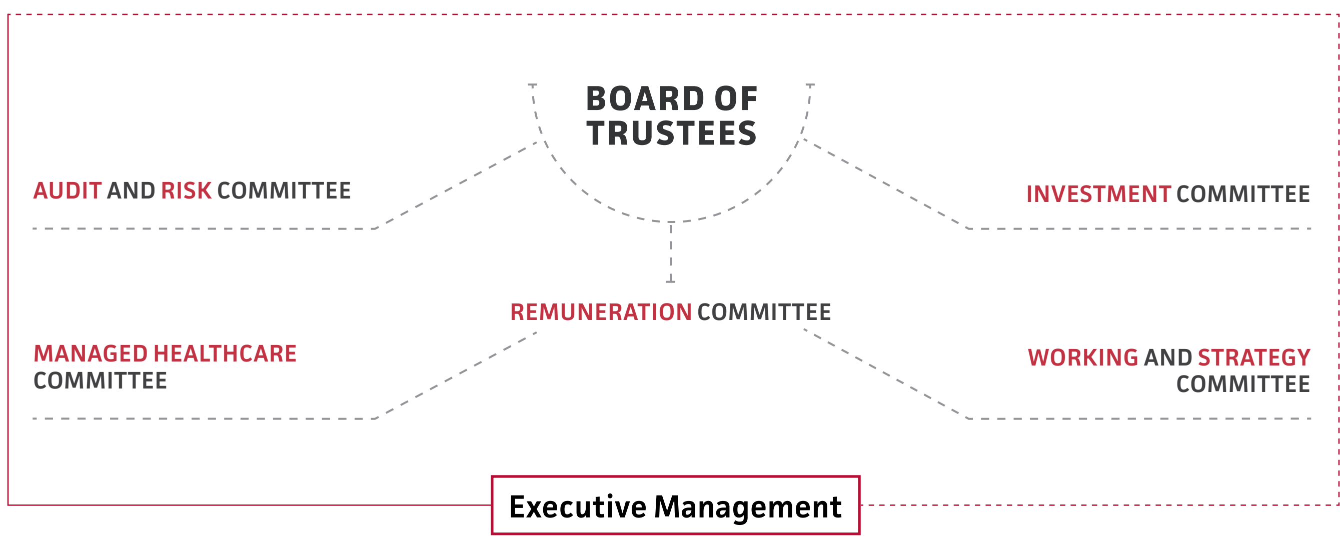
The schedule below summarises mandatory Board and Board Committee meetings held during 2020. This includes special meetings and attendance by invitation.

Trustee and/or Independent Member	Board[1]	Audit and Risk Committee[2]	Remuneration Committee	Investment Committee[3]	Working and Strategy Committee	Managed Healthcare Committee[4]
	Actual number of meetings attended/total number of meetings members could have attended during the period.					
J Bagg	11/11	1/1^		6/6		
R Cowlin	11/11			6/6	11/11	3/3
L Koch	11/11			1/1*^		
O Komane	11/11	8/8	6/6	6/6	11/11	3/3
M Lesunyane	11/11		6/6			
M Netshisaulu	11/11		3/3^^	1/1*^	11/11	
D Ngwane	11/11			1/1*^		
P Ribbens	11/11			6/6		3/3
J Usher	11/11	8/8			11/11	
J Venter	11/11	8/8		1/1*^		
J Prinsloo	1/1*	8/8				
P Kekana	1/1*		5/6			
W Kirima				6/6		
C van Zyl			6/6	6/6		
P van der Nest	1/1*	8/8				
Y Carrim	1/1*	8/8				
T Poho	1/1*	8/8				

Notes

1 *There were 11 Board meetings for the year and, of the 11, four were special meetings.*
2 *There were eight Audit and Risk Meetings of which two were special meetings.*
3 *There were six Investment Committee meetings of which one was a special meeting and one an investment workshop day.*
4 *Converted to a full Board Committee effective July 2020.*
* *Independent Members attended the Board meeting by invitation.*
^ *Trustees attended the Audit and Risk Committee meetings by invitation.*
^^ *Joined the committee during 2020.*
*^ *Attended the investment workshop by invitation.*

BOARD COMMITTEES AND ACTIVITIES FOR 2020



The Board Committees reviewed their performance in terms of each Committee's mandate and were satisfied they had performed their responsibilities under the relevant charter.

AUDIT AND RISK COMMITTEE

Mandate

In terms of section 36 of the MSA, Bonitas is obliged to have an Audit and Risk Committee. The Committee is duly constituted and functional. The Committee comprises a majority of Independent Members whose mandate is to assist the Board in discharging its duties relating to:

- Safeguarding of assets
- Operation of adequate and effective systems, internal controls and processes
- Preparation of annual financial statements that fairly represent Bonitas's financial position
- Oversight of the external and internal audit appointments and functions
- Oversight of the policies and processes for identifying and assessing business risks
- Oversight of the risk management processes
- Oversight of the governance, risk and compliance functions
- Provision of advice on any matter referred to the Committee by the Board.

KEY ACTIVITIES FOR 2020

- Considered the reports issued by internal audit
- Focused on assurance provided around cybersecurity and business continuity given the impact from a COVID-19 perspective
- Provided oversight of risk management and compliance reporting
- Assessed financial and investment performance, including the appropriateness of cyber insurance cover
- Considered the effectiveness of contract management
- Considered the content of the Risk Register, Policy Register and Contracts Register
- Considered Bonitas's FWA initiatives and Section 59 investigation (racial profiling), including pending legal and criminal matters
- Considered pending CMS-related matters
- Provided oversight of the Combined Assurance Forum feedback and the Forum's Terms of Reference
- Monitored the implementation of the I&T Governance Framework and Strategy
- Evaluated the performance of the internal audit service provider
- Considered and gave input on the strategic procurement contracting process relating to key contracts reaching their termination periods
- Participated in Committee performance evaluation
- Recommended to the Board for approval:
  - Updated Committee Charter
  - Appointment of external auditors
  - External audit plan and fees
  - External auditors' report
  - Updated policies, i.e. Internal Audit Charter, Governance, Risk and Compliance Framework, Compliance Policy, Combined Assurance Framework, Credit Control Policy, Petty Cash Policy and Impairment Policy
  - Audited annual financial statements and related disclosures (including the report of the Board)
  - Going concern

Members as at 31 December 2020	Capacity	Member since
J Prinsloo**	Independent Member	1 January 2012; appointed Chairperson 1 February 2019
J Usher*	Trustee Member	1 January 2012
D van der Nest***	Independent Member	1 August 2019
YO Carrim	Independent Member	1 August 2019
T Poho	Independent Member	1 August 2019
J Venter	Trustee Member	1 August 2019

* *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.*

** *J Prinsloo – term as member of the Committee and Chairperson ended with effect 31 January 2021.*

*** *D van der Nest – appointed as new Chairperson of the Committee with effect 1 February 2021.*

INVESTMENT COMMITTEE

Mandate

The Investment Committee manages the investment portfolio in line with the Bonitas Investment Strategy and Policy 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.

KEY ACTIVITIES FOR 2020

- Agreed and finalised a revised Investment Strategy based on deliberations at the Investment Committee workshop
- Considered and approved annual report disclosure on investment performance
- Monitored the performance of asset managers
- Interrogated investment reports, conducted an investment benchmarking exercise and considered a derivative strategy
- Provided oversight of process for cash flow management and strategic asset balancing
- Requested and considered a report on investment concentration risk
- Reviewed Bonitas's strategic asset allocation and investment target
- Considered the delivery of services of the appointed investment consultant
- Participated in Committee performance evaluation
- Recommended to the Board for approval:
  - Updated Committee Charter
  - Updated Investment Policy Statement

Members as at 31 December 2020	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
P Ribbens	Trustee Member	16 November 2019

** R Cowlin – Trustee term ended on 4 January 2021 and appointed by the Board with effect from 5 January 2021.*
*** W Kirima – Re-appointed as an Independent Member for another term effective 1 June 2020.*

REMUNERATION COMMITTEE

Mandate

The Remuneration Committee provides oversight of the Bonitas Remuneration Strategy and related policies and ensures compliance with these policies. The Committee oversees the remuneration of Trustees and employees.

KEY ACTIVITIES FOR 2020

- Provided oversight of employee performance management reviews
- Considered the workforce profile to progress transformation within Bonitas
- Considered updates on the recruitment processes for vacant positions and the appointment of learners through Bonitas's learnership programme
- Considered employee training plans including learning and development interventions
- Evaluated changes to the employee benefits structures
- Participated in Committee performance evaluation
- Recommended to the Board for approval:
  - Increases and variable pay prior to implementation
  - Talent and Succession Management Policy
  - Updated Incentive Policy
  - Updated Performance Management Policy
  - Updated Travel and Reimbursement Policy
  - Updated Leave Policy
  - Updated Incentive Policy
  - Updated Committee Charter

Statements by the Committee

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 2020	Capacity	Member since
P Kekana	Independent Member (Chairperson)	2 January 2016; appointed Chairperson 1 October 2017
C van Zyl	Independent Member	1 March 2018
M Netshisaulu	Trustee Member	16 July 2020
O Komane*	Trustee Member (previous Board Chairperson)	1 July 2016
M Lesunyane	Trustee Member	1 October 2017

* *O Komane – As Chairperson of the Board – changed from member of the Committee to Ex-Officio capacity with effect 16 July 2020. Chairperson of the Board term ended 4 December 2020. Trustee term ended 4 January 2021.*

WORKING AND STRATEGY COMMITTEE

Mandate

The Working and Strategy Committee directs and monitors 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.

KEY ACTIVITIES FOR 2020

- Facilitated and approved the annual strategic review process and monitored progress on the implementation of a strategic dashboard
- Reviewed and provided oversight of the strategic procurement contracting process, service levels and outcome-based measures
- Monitored operational reports regarding any non-adherence to SLAs by service providers
- Analysed Bonitas's financial performance, membership movements, strategic options for savings to be derived from medicine management and proposed initiatives on loss-making options and the 2021 annual budget
- Provided oversight of the pilot programmes for dental management and oncology
- Monitored the chronic medicine benefits pilot programme and risk transfer agreement with Scriptpharm
- Provided oversight of arrangements for the virtual annual general meeting held on 11 November 2020
- Appointed a service provider to render I&T Services at Bonitas's office
- Reviewed and adjusted the Trustee Indemnity Insurance cover and the Public Liability Insurance relating to Melrose Arch and Bonitas Park
- Evaluated the Bonitas B-BBEE rating level
- Considered updates on the CMS inspection
- Participated in Committee performance evaluation
- Recommended for approval by the Board:
  - The appointment of a service provider to undertake the Board and Board Committee evaluation, including the proposed costs
  - Changes to the annual benefit options and contribution increases
  - Strategic procurement contracting process regarding renewal negotiations of key service contracts, including extensions
  - The composition and reporting accountability of the contract negotiation team
  - The appointment of a service provider for the maternity programme
  - The revised marketing budget
  - Leads aggregator and communications contracts and appointments of service providers
  - The Learning and Development Policy, Gifts Policy, Sponsorships and Donations Policy, Performance Management Policy and Membership Management Policy
  - The Scriptpharm contract

Members as at 31 December 2020	Capacity	Member since
O Komane*	Trustee Member (previous Board Chairperson and Chairperson of this Committee)	Member of this Committee since 1 October 2017, appointed Chairperson of this Committee 13 March 2019
R Cowlin**	Trustee Member (previous Board Vice-Chairperson)	1 October 2017
D Ngwane	Trustee Member (Board Chairperson and Chairperson of this Committee)	4 December 2020
J Bagg	Trustee Member (Board Vice-Chairperson)	4 December 2020
J Usher	Trustee Member	28 November 2015
M Netshisaulu	Trustee Member	16 November 2019
LR Callakoppen	Principal Officer	1 May 2019
L Woodhouse	Chief Financial Officer	1 October 2019

** O Komane – Chairperson of the Board term ended 4 December 2020. Trustee term ended 4 January 2021.*
*** R Cowlin – Vice-Chairperson of the Board term ended 4 December 2020.Trustee term ended on 4 January 2021 and appointed by the Board with effect from 5 January 2021.*

MANAGED HEALTHCARE COMMITTEE

Mandate

The Managed Healthcare Committee provides direction, oversight and guidance on all strategic and operating matters relating to the Scheme's managed healthcare activities, to ensure these activities are managed in the best interests of the Scheme's members.

Managed healthcare is about comprehensive care including preventative, rehabilitative and curative care with a view to promoting appropriateness and cost.

KEY ACTIVITIES FOR 2020

- Formulated and agreed a Managed Care Strategy
- Provided oversight of the implementation and monitoring of the Managed Care Strategy relating to clinical and financial risk management
- Implemented key managed care interventions
- Reviewed actuarial reports on financial performance including option performance, especially given the impact of COVID-19
- Reviewed reports provided by the Managed Care Organisation and made appropriate recommendations to the Board, especially regarding COVID-19 requirements
- Provided oversight of the hospital negotiations strategy
- Reviewed presentation by Health Quality Assessment on the results of clinical outcomes-based measurements
- Participated in Committee performance evaluation
- Recommended to the Board for approval:
  - Committee Charter

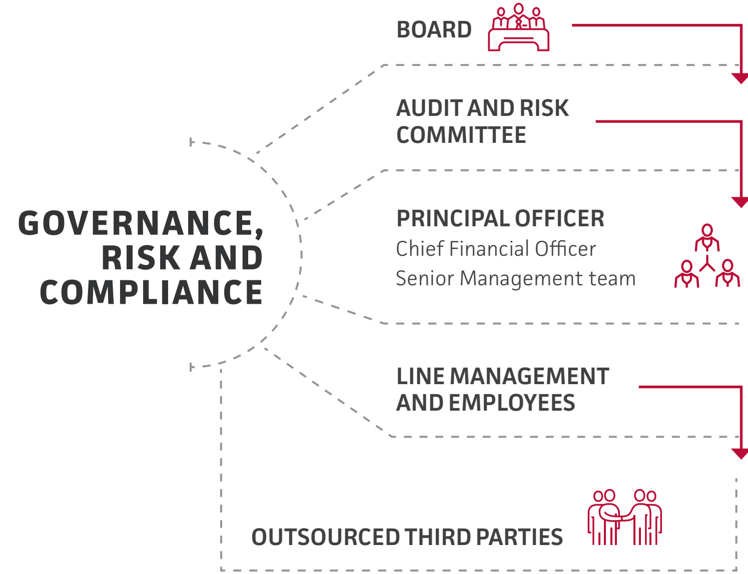
Members as at 31 December 2020	Capacity	Member since
R Cowlin*	Trustee Member (Chairperson)	16 July 2020
P Ribbens	Trustee Member	16 July 2020
Vacant	Independent Member	To be confirmed

* *R Cowlin – Trustee term ended 4 January 2021 and appointed by the Board with effect from 5 January 2021.*

RISK, COMPLIANCE AND COMBINED ASSURANCE

The Board, through the Audit and Risk Committee, is responsible for the oversight of risk management, compliance and combined assurance at Bonitas. The Board is also responsible for setting the risk appetite and tolerance.

The governance of risk and compliance encompasses internal and external role players:



RISK MANAGEMENT

Bonitas faces numerous risks that can disrupt our ability to implement strategy. Risk management enables us to make better-informed decisions and improve the probability of achieving our objectives.

Risk management is a key, embedded component in all activities throughout Bonitas's operations and is approached in a structured and disciplined way. The Board is responsible for risk management, whereas Executive Management is responsible for the risk management process, including risk identification, assessment, measurement, monitoring and reporting to the Audit and Risk Committee.

The Risk Management Policy provides guidance on risk management principles, whereas the Risk Management Framework ensures that risk management is integrated into significant activities and functions. This ensures, for example, compliance with the MSA in providing healthcare and related services to members, and enables the Board and Executive Management to discharge their fiduciary duties to Bonitas and members. This leads to the implementation of a consistent, efficient and effective risk approach that identifies, evaluates and responds to key risks that may impact our ability to achieve our strategic objectives.

The Risk Management Framework is based on the principles of the COSO Framework of the Treadway Commission, the International Guideline on Risk Management (ISO 31000:2018) and the King IV™ governance outcomes, i.e., ethical culture, good performance, effective control and legitimacy.

Read more about our strategic risks and opportunities in 2020, as well as mitigation through our strategic pillars, on page 19.

COMBINED ASSURANCE

The Board approved a Combined Assurance Framework this year to ensure integration, co-ordination and alignment between risk management and assurance processes. This seeks to optimise and maximise the level of governance, risk and control oversight based on Bonitas's risk appetite, taking into account the role players involved in providing assurance.

The Board provides assurance oversight. The Audit and Risk Committee is responsible for advising the Board on Bonitas's system of internal controls, risk management and governance. These bodies are supported by key assurance role players:

A Combined Assurance Forum was established to apply the framework, optimise assurance activities and enable an effective control environment, awareness and discipline. The forum provides the Audit and Risk Committee with one view of all assurance efforts across the lines of defence aligned to the key risks in terms of the Scheme's risk register. This is done by means of a combined assurance dashboard.

COMPLIANCE

The Board approved a revised Compliance Policy this year. The policy sets out the principles for compliance management and the expectations for the implementation of compliance procedures, and provides the foundation for compliance at Bonitas.

Bonitas operates in a complex and highly regulated environment. It also uses an outsourced model for its main activities, including administration. The policy therefore extends to monitoring compliance by these service providers and includes regulatory and operational compliance aspects.

A compliance function was established to assist the Board and management to deliver affordable and quality healthcare with integrity and compliance with all relevant regulatory and leading practice requirements and to the highest ethical standards.

The compliance function reports administrative matters to the Principal Officer, who is the custodian of the policy and reports functionally to the Board through the Audit and Risk Committee. The compliance function does not have any operational responsibilities that could pose a conflict of interest and impair independent reporting.

Compliance is implemented via a compliance programme that sets out roles, processes, activities and responsibilities.

NON-COMPLIANCE WITH THE MSA

The following areas of non-compliance with the MSA were identified during 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)	Section 26(11)

What does it say?

Section 33(2)

The registrar may withdraw the approval of such benefit options that, in its opinion, are not financially sound.

Section 26(7)

Requires all subscriptions and contributions to be paid directly to a medical scheme not later than three days after payment becomes due.

Section 26(11)

Retirement funding of any sort is not considered to be the business of a medical scheme and is prohibited.

Nature and cause

Section 33(2)

For the year, Bonitas reported a net healthcare deficit on two (2019: eight) of its benefit options.

	2020 R'000	2019 R'000
BonCap	**62 540**	219 646
BonClassic	**–**	51 334
BonComprehensive	**9 076**	111 665
BonEssential	**–**	24 981
BonComplete	**–**	25 294
BonSave	**–**	4 210
Hospital Standard	**–**	29 807
Primary	**–**	37 668

Section 26(7)

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.

Section 26(11)

Due to 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.

Possible impact

Section 33(2)

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

Section 26(7)

Bonitas incurred bad debt write-offs of R10.8 million during 2020 (2019: R13.4 million), which equals 0.06% (2019: 0.08%) 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.

Section 26(11)

There is a limited negative impact on members as Bonitas is honouring its obligation to the three members affected by these amalgamations.

Corrective course of action

Section 33(2)

Bonitas has experienced positive performance on its largest options. In 2020 Standard and Primary have reported a net healthcare surplus of R976.5 million and R265.4 million respectively. Much of the positive performance can be attributed to successful hospital negotiations, benefit design and the realignment of membership into the correct options. In addition utilisation reduced due to the impact of COVID-19, lockdown, and the consequential decrease in elective procedures resulting in a decrease in hospital and associated costs.

Bonitas continues to monitor the performance of the eight 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. Bonitas has adopted a long-term strategy to correct the loss-making options into the future, in particular on the BonCap and BonComprehensive options. Bonitas 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.

Section 26(7)

It is not possible to receive all contributions within three days of the due date, as there may be reasons preventing 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 Bonitas's Credit Control Policy. Other interventions include direct management engagement with affected groups to resolve such concerns.

Due to the financial and economic burden experienced by members with the impact of COVID-19, Bonitas obtained an exemption from Section 26(7). Refer to note 22.6.2 in the annual financial statements for details of the applications granted and note 27 for the financial impact.

Section 26(11)

Bonitas obtained an exemption notice on 1 June 2010 from the CMS in respect of this non-compliance.

Which part of the Act?		
Section 35(8)	**Section 59(2)**	**Section 10(6)**
What does it say?		
A medical scheme may not invest any of its assets in the business of or grant loans to: • An employer group participating 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 was 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.	The funds in a member's medical savings account shall not be used to pay the cost of a prescribed minimum benefit.
Nature and cause		
Bonitas invested in various entities associated with its administrator and Bonitas'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 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 were first screened by the forensic team, before the limit was lifted, resulting in claims being paid after 30 days.	Regulation 10(6) of the Act prohibits the funding of a Prescribed Minimum Benefit ("PMB") from the members' medical savings accounts. An error occurred where potential PMB claims were processed as non-PMB related claims due to the loading of the Scheme Rules and paid incorrectly from members' medical saving accounts instead of being paid from the Scheme's risk reserves. This error was limited to the Wellness extender benefit linked to approved wellness authorisations causing claims to be paid incorrectly.
Possible impact		
Bonitas invested with various entities associated with its administrator and Bonitas's employer groups during the financial year.	The delay relating to 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.	Non-compliances with Regulation 10(6) is the risk. This may result in escalation of member complaints whose claims were incorrectly paid from their medical savings accounts and causing the member's out-of-pocket expenses to increase.
Corrective course of action		
Bonitas obtained an exemption from the CMS in respect of this non-compliance.	The risk relating to claims on hold for tariff loading 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 errors were rectified when the incorrect claims process was identified. The affected members' medical saving accounts were credited with the respective amounts, where applicable. All PMB claims that are affected by the error have been rectified.

ANNUAL FINANCIAL STATEMENTS

STATEMENT OF RESPONSIBILITY OF THE BOARD OF TRUSTEES

FOR THE YEAR ENDED 31 DECEMBER 2020

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 2020, 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 67 to 124 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.

Going concern

The going concern basis has been adopted in preparing these financial statements.

The Board has reviewed detailed impact analyses and stress scenarios to determine the financial impact of COVID-19 on its reserves, profitability and liquidity and has determined that the Scheme has the sufficient reserves and liquidity in place to manage the associated financial risk.

The Scheme's forecasts support the long-term viability of the Scheme.

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.

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 page 64. 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 19 April 2021.

Mr JD Ngwane
Chairperson of the Board

19 April 2021

Mr LR Callakoppen
Principal Officer

19 April 2021

J Bagg
Trustee

19 April 2021

STATEMENT OF CORPORATE GOVERNANCE

FOR THE YEAR ENDED 31 DECEMBER 2020

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 best 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 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 policy.

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. PricewaterhouseCoopers confirmed in an Assessment of the systems of Internal Control, Risk Management and Governance Management Report issued to the Audit and Risk Committee (dated 9 February 2021) for the year ended 31 December 2020 that: "Notwithstanding the fact that there were internal audit findings reported, PricewaterhouseCoopers do not have significant concerns about the control environment in the areas reviewed (based on specific scope and results of sample testing) including the risk management control environment, should the areas raised be addressed by management in a timely manner. Although a formal governance assessment was not performed for the year ended 31 December 2020, to the extent that the individual reviews considered governance areas, PricewaterhouseCoopers concluded that no significant concerns were noted in this regard."

Mr JD Ngwane
Chairperson of the Board

19 April 2021

Mr LR Callakoppen
Principal Officer

19 April 2021

J Bagg
Trustee

19 April 2021

Deloitte.

Private Bag X6
Gallo Manor 2052
South Africa

Deloitte & Touche
Registered Auditors
Financial Services Team - FIST
Deloitte
5 Magwa Crescent
Waterfall City
Waterfall
Docex 10 Johannesburg

Tel: +27 (0)11 806 5200
Fax: +27 (0)11 806 5222
www.deloitte.com

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 67 to 124, which comprise the statements of financial position as at 31 December 2020, and the statements of profit or loss and other comprehensive income, the statements of changes in equity and the statements 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 the Scheme as at 31 December 2020, 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 corresponding sections of the International Ethics Standards Board for Accountants' (IESBSA) International Code of Ethics for Professional Accountants (including International Independence Standards) (IESBA code). 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. These matters were addressed in the context of our audit of the financial statements as a whole, and in forming our opinion thereon, and we do not provide a separate opinion on these matters.

INDEPENDENT AUDITOR'S REPORT

TO THE MEMBERS OF BONITAS MEDICAL FUND

Key Audit Matter	How the matter was addressed in the audit
Outstanding claims provision	
As disclosed in Note 10, the carrying amount of the Outstanding Claims Provision ("IBNR") at year end was R976.3 million (2019: R769.1 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 Scheme's 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 which included: • 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 to test the accuracy and completeness of data used in the valuation of IBNR, • With the assistance of our internal actuarial specialist, performed 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 Board of Trustees' estimate of the provision, • Testing a sample of claims paid in the current year against the related IBNR reserve held to assess the reasonability of assumptions used to calculate the IBNR estimate, • Performing tests of detail on the current year IBNR including testing actual claims paid subsequent to year end to determine if these have been appropriately reserved for at balance sheet date, and • Assessing the presentation and disclosure in respect of the IBNR and considered the adequacy of these disclosures. The assumptions applied in the IBNR calculation 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 Annual Report as required by the 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 on the other information obtained prior to the date of this auditor's report, 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 Trustees for the Financial Statements

The 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 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 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 trustees either intend to liquidate the Scheme or to cease operations, or have no realistic alternative but to do so.

INDEPENDENT AUDITOR'S REPORT

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 trustees.
- Conclude on the appropriateness of the 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.
- Obtain sufficient appropriate audit evidence regarding the financial information of the entities or business activities within the Scheme to express an opinion on the consolidated financial statements. We are responsible for the direction, supervision and performance of the Scheme audit. We remain solely responsible for our audit opinion.

We communicate with the 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 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 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.

Audit tenure

In terms of CMS Circular 38 of 2018 *Audit tenure*, we report that Deloitte & Touche has been the auditor of Bonitas Medical Fund for 4 years.

The engagement partner, Penny Binnie, has been responsible for Bonitas Medical Fund audit for 4 years.

Deloitte & Touche
Per Penny Binnie
Partner

21 April 2021

STATEMENT OF FINANCIAL POSITION

AT 31 DECEMBER 2020

	Notes	**2020 R'000**	2019 R'000
ASSETS			
Property and equipment	4	**9 125**	14 223
Investment properties	5	**77 700**	74 800
Financial assets held at fair value through profit or loss	6	**4 279 785**	2 951 402
Non-current assets		**4 366 610**	3 040 425
Financial assets held at fair value through profit or loss	6	**2 859 688**	2 057 524
Insurance, trade and other receivables	8	**719 066**	849 440
Cash and cash equivalents	9	**611 090**	613 040
Current assets		**4 189 844**	3 520 004
Total assets		**8 556 454**	6 560 429
MEMBERS' FUNDS AND LIABILITIES			
Accumulated funds		**6 059 840**	4 320 079
Members' funds		**6 059 840**	4 320 079
Lease liability	4.2	**3 047**	7 094
Non-current liabilities		**3 047**	7 094
Outstanding risk claims provision	10	**976 275**	769 108
Personal medical savings accounts liability	11,1	**812 078**	678 857
Insurance, trade and other payables	12	**669 731**	782 072
Lease liability	4.2	**3 605**	3 219
Derivative financial instruments	7	**31 878**	–
Current liabilities		**2 493 567**	2 233 256
Total Members' funds and liabilities		**8 556 454**	6 560 429

STATEMENT OF PROFIT OR LOSS AND OTHER COMPREHENSIVE INCOME

FOR THE YEAR ENDED 31 DECEMBER 2020

	Notes	**2020 R'000**	2019 R'000
Risk contribution income	13	**17 797 746**	16 738 384
Relevant healthcare expenditure	14	**(14 771 240)**	(15 442 640)
Net claims incurred	14	**(14 346 005)**	(15 030 529)
Risk claims incurred		**(14 405 261)**	(15 098 893)
Third party claim recoveries		**59 256**	68 364
Accredited managed healthcare services	14	**(551 530)**	(517 478)
Net income on risk transfer arrangements	14	**126 295**	105 367
Risk transfer arrangement fees/premiums paid		**(1 360 518)**	(857 139)
Recoveries from risk transfer arrangements		**1 486 813**	959 019
Profit share arising from risk transfer arrangements		**–**	3 487
Gross healthcare result		**3 026 506**	1 295 744
Broker service fees		**(334 827)**	(318 857)
Administrative expenditure	15	**(1 221 891)**	(1 217 814)
Net impairment losses on healthcare receivables	16	**(20 281)**	(8 566)
Net healthcare result		**1 449 507**	(249 493)
Other income		**347 039**	494 953
Investment income - Scheme	17	**316 606**	420 087
Change in fair value of investment property	17	**2 900**	2 100
Sundry income	18	**27 533**	72 766
Other expenditure		**(56 785)**	(59 409)
Asset management fees		**(21 597)**	(16 609)
Interest expense	11/4.2	**(29 509)**	(36 903)
Operating expenses on rental of investment property		**(5 679)**	(5 897)
Surplus for the year		**1 739 761**	186 051
Total comprehensive income for the year		**1 739 761**	186 051

STATEMENT OF CHANGES IN MEMBERS' FUNDS AND RESERVES

FOR THE YEAR ENDED 31 DECEMBER 2020

R'000	**Accumulated funds R'000**	Total R'000
Balance as at 31 December 2018	**4 134 028**	4 134 028
Total comprehensive income	**186 051**	186 051
Surplus for the year	**186 051**	186 051
Balance as at 31 December 2019	**4 320 079**	4 320 079
Total comprehensive income	**1 739 761**	1 739 761
Surplus for the year	**1 739 761**	1 739 761
Balance as at 31 December 2020	**6 059 840**	6 059 840

STATEMENT OF CASH FLOWS

FOR THE YEAR ENDED 31 DECEMBER 2020

	Notes	2020 R'000	2019 R'000
Cash flows from operating activities			
Cash generated/(utilised) by operations before working capital changes	20,1	**1 690 147**	(207 815)
Working capital changes			
Decrease/(increase) in insurance, trade and other receivables	20.2.1	**109 525**	(181 143)
(Decrease)/increase in insurance, trade and other payables	20.2.2	**(112 341)**	140 951
Increase in personal medical savings account liability	20.2.3	**148 202**	92 008
Cash generated/(utilised) by operating activities		**1 835 533**	(155 999)
Interest paid	11	**(28 628)**	(36 045)
Interest received	17	**4 646**	42 450
Net cash inflow/(outflow) from operating activities		**1 811 551**	(149 594)
Cash flows from investing activities			
Acquisition of property and equipment	4	**(818)**	(1 353)
Proceeds on disposal of property and equipment		**4**	15
Proceeds on disposal of investment property		**–**	9 000
Acquisition of financial assets held at fair value through profit or loss	6	**(2 509 037)**	(2 088 547)
Disposal of financial assets held at fair value through profit or loss	6	**497 357**	1 362 309
Interest received	20.3.1	**145 492**	211 621
Dividends received	20.3.2	**68 526**	49 830
Asset management fees	20.3.3	**(19 914)**	(16 089)
Rentals received	20.3.4	**8 498**	8 664
Net cash outflow from investing activities		**(1 809 892)**	(464 550)
Cashflows from financing activities			
Lease payments		**(3 609)**	(3 634)
Net cash outflow from financing activities		**(3 609)**	(3 634)
Net decrease in cash and cash equivalents		**(1 950)**	(617 778)
Cash and cash equivalents at beginning of the year		**613 040**	1 230 818
Cash and cash equivalents at end of the year		**611 090**	613 040
Analysed as follows:			
Cash and cash equivalents	9	**611 090**	613 040
		611 090	613 040

NOTES TO THE ANNUAL FINANCIAL STATEMENTS

FOR THE YEAR ENDED 31 DECEMBER 2020

1. GENERAL INFORMATION

The Scheme is a registered non-profit, open medical scheme in terms of the Medical Schemes Act 131 of 1998 ("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 International Financial Reporting Standards ("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 instruments 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.

2.1.3 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

(a) New standards, amendments and interpretations issued and not yet effective in 2020 and relevant to the Scheme

Standard	Details of amendment	Effective date Periods beginning on or after
IFRS 16 COVID-19 Related Rent Concession	The International Accounting Standards Board (IASB) has published 'COVID-19-Related Rent Concessions (Amendment to IFRS 16)' amending the standard to provide lessees with an exemption from assessing whether a COVID-19-related rent concession is a lease modification. Concurrently, the IASB also published a proposed Taxonomy Update to reflect this amendment. The COVID-19 pandemic has led to some lessors providing relief to lessees by deferring or relieving them of amounts that would otherwise be payable. When there is a change in lease payments, the accounting consequences will depend on whether that change meets the definition of a lease modification. The Scheme leases its head office building through an operating lease agreement however there has been no change in lease payment arrangements as at 31 December 2020 therefore no assessment required to apply amendment.	1 June 2020
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 contract, 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 2023

NOTES TO THE ANNUAL FINANCIAL STATEMENTS CONTINUED

FOR THE YEAR ENDED 31 DECEMBER 2020

2. SIGNIFICANT ACCOUNTING POLICIES CONTINUED

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 - 5 years
- Leasehold improvements - 5 years
- Computer equipment - 1 to 5 years
- Office equipment - 1 to 5 years
- Furniture and fittings - 1 to 5 years
- Right of use asset - 5 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.

2.4 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 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.

NOTES TO THE ANNUAL FINANCIAL STATEMENTS CONTINUED

FOR THE YEAR ENDED 31 DECEMBER 2020

2. SIGNIFICANT ACCOUNTING POLICIES CONTINUED

2.6 Financial instruments

2.6.1 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;
- Derivatives;
- Insurance, trade and other receivables;
- Cash and cash equivalents;
- Insurance, trade and other payables; and
- Personal member savings accounts liability.

The classification and measurement of the financial instruments depend on the objective of the Fund's business model whether it is to hold assets only to collect cash flows, or to collect cash flows and to sell and whether the contractual cash flows of an asset give rise to payments on specified dates that are solely payments of principal and interest on the principal amount outstanding. Management applies this assessment on financial instruments at initial recognition and re-evalulates this for Financial assets when the objective of the Fund's business model changes.

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.

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

These financial assets are initially recognised 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.

Derivative financial instruments are carried at fair value through profit or loss and these are recognised as either current or non-current assets/liabilities based on the contractual period and fair value movement.

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 of '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.

NOTES TO THE ANNUAL FINANCIAL STATEMENTS CONTINUED

FOR THE YEAR ENDED 31 DECEMBER 2020

2. SIGNIFICANT ACCOUNTING POLICIES CONTINUED

2.6 Financial instruments continued

2.6.1 Classification, recognition and measurement continued

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 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.

Derivative liabilities include liabilities that exist at year end as a result of marked-to-market losses accrued on derivative instruments.

A derivative with a positive fair value is recognised as a financial asset whereas a derivative with a negative fair value is recognised as a financial liability.

a) Insurance, trade and other payables

Insurance, trade and other payables include payables relating to healthcare insurance contracts and amounts owing to South African Revenue Services.

2.6.2 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 that result from all possible default events over the expected life of a financial instrument (ECL) 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; or national or local economic conditions that correlate with defaults on the assets in the Scheme.

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.

2.6.3 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.

NOTES TO THE ANNUAL FINANCIAL STATEMENTS CONTINUED

FOR THE YEAR ENDED 31 DECEMBER 2020

2. SIGNIFICANT ACCOUNTING POLICIES CONTINUED

2.6 Financial instruments continued

2.6.4 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.

2.7 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. Refer note 2.12 for the accounting policies relating to risk transfer arrangements.

2.8 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; and 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.

2.9 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.

2.10 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.

Member unused savings at year-end are retained in the members' PMSA. 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.

2.11 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.

NOTES TO THE ANNUAL FINANCIAL STATEMENTS CONTINUED

FOR THE YEAR ENDED 31 DECEMBER 2020

2. SIGNIFICANT ACCOUNTING POLICIES CONTINUED

2.12 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.

2.12.1 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.

2.12.2 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 reinsurer”) 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. This cost is determined by the claims paid out for members on options that are not included in the capitation agreements taking into account adjustments for differences in the benefit thresholds. 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.

2.13 Employee benefits

2.13.1 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.

2.13.2 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.

2.14 Leases

The Scheme leases property which is accounted for under IFRS 16. The contracts contains a lease as defined because it conveys the right to control the use of the identified asset for a period of time in exchange for consideration. For contracts for which the Scheme is a lessee the initial measurement requires the recognition of a right of use asset and lease liability recognised at commencement date.

The right of use asset is initially recognised at cost which includes the initial amount of the lease liability adjusted for any lease payments made on or before commencement date plus initial direct costs incurred.

The right of use asset is subsequently depreciated on a straight line basis over the useful life which is the same basis as the lease period. Additionally the right of use asset is periodically reduced by impairments if any and adjusted for changes in the remeasurement of the lease liability.

NOTES TO THE ANNUAL FINANCIAL STATEMENTS CONTINUED

FOR THE YEAR ENDED 31 DECEMBER 2020

2. SIGNIFICANT ACCOUNTING POLICIES CONTINUED

2.14 Leases continued

The lease liability is initially measured at the present value of lease payments that are not paid at the commencement date discounted at the interest rate implicit in the lease or the Scheme's incremental borrowing rate.

Lease payments included in the measurement of the lease liability comprise fixed payments including in substance fixed payments

Contracts wherein the Scheme is a lessor, are either classified as an operating lease or a finance lease based on an overall assessment to determine whether substantially all the risks and rewards are transferred or retained by the Scheme. Payments made under operating leases are recognised in profit or loss on a straight-line basis over the period of the lease.

2.15 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.

2.15.1 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.

2.15.2 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.

2.15.3 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.

2.16 Allocation of income and expenses to benefit options

The following items are directly allocated to benefit options:

- Risk contribution income;
- Net claims incurred;
- Net income on risk transfer arrangements;
- Net impairment losses
- Administration fees;
- Managed care: management services;
- Broker service fees; and
- 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; and
- Asset management fees.

NOTES TO THE ANNUAL FINANCIAL STATEMENTS CONTINUED

FOR THE YEAR ENDED 31 DECEMBER 2020

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 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.

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, fair value through profit or loss financial instruments and derivative financial instruments are measured at fair value and include an estimation component. 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 of Trustees 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; and
- 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.

NOTES TO THE ANNUAL FINANCIAL STATEMENTS CONTINUED

FOR THE YEAR ENDED 31 DECEMBER 2020

4. PROPERTY AND EQUIPMENT

Property and equipment comprise owned and leased assets that do not meet the definition of investment property.

	Notes	2020 R'000	2019 R'000
Property and equipment	4.1	**3 881**	4 902
Right of use asset	4.2	**5 244**	9 321
		9 125	14 223

4.1 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 2018	359	4 290	5 222	105	4 558	14 534
Additions	–	49	248	1 056	–	1 353
Disposals/scrappings	–	–	(26)	–	–	(26)
Balance at 31 December 2019	359	4 339	5 444	1 161	4 558	15 861
Additions	**–**	**–**	**110**	**–**	**708**	**818**
Disposals/scrappings	**–**	**–**	**(40)**	**–**	**–**	**(40)**
Balance at 31 December 2020	**359**	**4 339**	**5 514**	**1 161**	**5 266**	**16 639**
Accumulated depreciation						
Balance at 31 December 2018	144	981	4 498	74	3 398	9 095
Disposals/scrappings	–	–	(22)	–	–	(22)
Depreciation for the period	72	892	437	56	427	1 886
Balance at 31 December 2019	216	1 873	4 913	130	3 825	10 959
Disposals/scrappings	**–**	**–**	**(38)**	**–**	**–**	**(38)**
Depreciation for the period	**71**	**894**	**368**	**219**	**283**	**1 837**
Balance at 31 December 2020	**287**	**2 767**	**5 243**	**349**	**4 108**	**12 758**
Carrying amount						
Balance at 31 December 2019	143	2 466	531	1 031	733	4 902
Balance at 31 December 2020	**72**	**1 572**	**271**	**812**	**1 158**	**3 881**

NOTES TO THE ANNUAL FINANCIAL STATEMENTS CONTINUED

FOR THE YEAR ENDED 31 DECEMBER 2020

4. PROPERTY AND EQUIPMENT CONTINUED

4.2 Lease

The Scheme leases the building from which it operates its head office. The remaining lease term on 31 December 2020 was determined to be one year and nine months. Depreciation charge is determined on a straight line basis over the remaining lease term. Information about the lease for which the Scheme is the lessee is presented below:

	Building R'000	Total R'000
Right of use asset		
Balance at 1 January 2020	**8 601**	**8 601**
Depreciation charge for the year	**(3 357)**	**(3 357)**
Balance at 31 December 2020	**5 244**	**5 244**
Lease liabilities		
Maturity Analysis- contractual undiscounted cashflows:		
Not later than one year	**3 929**	**3 929**
Later than one year and not later than five years	**7 636**	**7 636**
Total undiscounted lease liabilities as at 31 December 2019	**11 565**	**11 565**
Not later than one year	**4 009**	**4 009**
Later than one year and not later than five years	**3 149**	**3 149**
Total undiscounted lease liabilities as at 31 December 2020	**7 158**	**7 158**

Included in the Statement of Financial Position is the lease liability for the remaining lease term of one year and 9 months as at 31 December 2020:

	2020 R'000	2019 R'000
Current lease liability	**3 605**	3 219
Non-current lease liability	**3 047**	7 094
	6 652	10 313

The Scheme's interest rate per the lease contract of 8% was used to discount the cashflows to the present value of the lease liability from which the interest expense is derived. The variable costs relating to the lease were expensed in profit or loss and largely relate to the utility bill which is driven by usage. These expenses comprise 34% of the fixed lease payments and are excluded in the determination of the lease liability and related right of use asset.

Included in the Statement of profit or loss and other comprehensive income at 31 December 2020:

	2020 R'000	2019 R'000
Interest on lease liability	**(670)**	(858)
Rental costs-variable in nature	**(1 852)**	(1 786)
	(2 522)	(2 644)

Total cash outflow with respect to the leases for 31 December 2020 is as follows:

	2020 R'000	2019 R'000
Lease liability cashflows	**(3 609)**	(3 634)
Rental costs-variable in nature	**(1 852)**	(1 786)
	(5 461)	(5 420)

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 2020

	2020 R'000	2019 R'000
5. INVESTMENT PROPERTIES		
Balance at the beginning of the year	**74 800**	72 700
Fair value increase in investment property	**2 900**	2 100
Balance at the end of the year	**77 700**	74 800
Direct operating expenses incurred in the generation of rental income applicable to investment properties	**5 679**	5 897

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 rental receipts amounting to R9.2 million (2019: R9.0 million) relating to the lease of investment properties are included in profit or loss, refer to note 17 of the financial statements.

The estimated open market value for developed commercial property leased to third parties was determined by independent property valuators DDP Valuations & Advisory Services (Pty) Ltd using an Income capitalisation approach. The capitalisation rate used in determining the open market value was 9% (2019: 9%).

	2020 R'000	2019 R'000
6. FINANCIAL ASSETS HELD AT FAIR VALUE THROUGH PROFIT OR LOSS		
Balance at the beginning of the year	**5 008 926**	4 176 010
Additions/reinvestments	**2 509 037**	2 088 547
Withdrawals	**(497 357)**	(1 362 309)
Interest income reinvested	**87 897**	50 445
Dividend income reinvested	**7 998**	9 483
Asset management fees capitalised to investments	**(1 683)**	(520)
Net fair value gains on fair value assets through profit or loss (note 17)	**24 655**	47 270
Balance at the end of the year	**7 139 473**	5 008 926
Non-current	**4 279 785**	2 951 402
Current	**2 859 688**	2 057 524
	7 139 473	5 008 926
Comprises:		
Listed equities	**2 332 973**	1 793 976
Unlisted equities	**22 000**	22 000
Bonds	**3 633 929**	2 350 997
Money market instruments	**1 148 983**	837 806
Unlisted property holding	**1 588**	2 820
Fixed deposits	**–**	1 327
	7 139 473	5 008 926

NOTES TO THE ANNUAL FINANCIAL STATEMENTS CONTINUED

FOR THE YEAR ENDED 31 DECEMBER 2020

	2020 R'000	2019 R'000
7. DERIVATIVE FINANCIAL INSTRUMENTS		
Financial liabilities held at fair value through profit or loss		
Current liabilities		
– Derivative financial instruments	**31 878**	–
Derivative financial liability at the end of the year	**31 878**	–
Reconciliation of the balance at the end of the year:		
Losses on revaluation of derivative financial instruments to fair value		
Fair value losses on derivative financial instruments		
– Zero-cost equity fences	**31 878**	–
Derivative financial liability at the end of the year	**31 878**	–

In September 2020 Bonitas Medical Fund entered into a contractual agreement with Khumo Capital (Pty) Ltd to act as an agent for the Fund and enter into derivative agreements with counterparty banks on the Fund's behalf. The Fund signs a trade instruction before any trade is implemented.

The Fund is exposed to market risk resulting from equity price fluctuations. The Fund implemented 85%_97.5% Zero Cost Fence structures to protect a portion of the Fund's equity portfolio from market declines. The structures also limit the potential upside from market increases. These derivatives were both entered into in September 2020 and are set to expire in September 2021. Refer to note 22.4.3 for further detail.

	2020 R'000	2019 R'000
8. INSURANCE, TRADE AND OTHER RECEIVABLES		
8.1 Insurance receivables		
Contributions outstanding	**618 752**	792 804
Recoveries due from members for co-payments	**6 474**	7 639
Service provider receivables	**6 556**	4 930
Amounts owing from Managed care organisation	**2 262**	–
Receivables under risk transfer arrangements	**99 332**	44 548
Savings plan account advances (note 11)	**1 448**	3 790
Allowance for impairment losses	**(24 556)**	(11 006)
Balance at 1 January	**(11 006)**	(12 103)
(Increase)/decrease in provision charged to profit or loss	**(13 550)**	1 097
Total insurance receivables	**710 268**	842 705
8.2 Trade and other receivables		
Prepaid expenses	**4 923**	4 089
Other receivables	**3 875**	2 646
Interest receivables	**26**	15
Rent receivables	**615**	200
Rent deposit	**1 533**	1 533
Sundry receivables	**1 701**	899
Total trade and other receivables	**8 798**	6 735
Total insurance, trade and other receivables	**719 066**	849 440

The carrying amounts of receivables approximate their fair values, due to the short-term maturities of these assets.

	2020 R'000	2019 R'000
9. CASH AND CASH EQUIVALENTS		
Cash with investment managers	**197 937**	291 210
Call accounts with investment managers	**57 697**	48 827
Current accounts with banks	**355 456**	273 003
Total cash and cash equivalents	**611 090**	613 040

The carrying amount of the cash and cash equivalents approximates the fair values due to the short-term nature of the investments.

NOTES TO THE ANNUAL FINANCIAL STATEMENTS CONTINUED

FOR THE YEAR ENDED 31 DECEMBER 2020

	2020 R'000	2019 R'000
10. OUTSTANDING RISK CLAIMS PROVISION		
Covered by risk transfer arrangements	**43 787**	41 061
Not covered by risk transfer arrangements	**932 488**	728 047
Outstanding risk claims provision - incurred but not yet reported (IBNR)	**976 275**	769 108

	Covered by risk transfer arrangements R'000	Not covered by risk transfer arrangements R'000
2020		
Analysis of movements in outstanding risk claims		
Balance at 1 January	**41 061**	**728 047**
Payments in respect of prior year claims	**(41 061)**	**(709 919)**
Over provision in prior year	**–**	**18 128**
Adjustment for current period	**43 787**	**914 360**
Balance at 31 December	**43 787**	**932 488**
Net exposure in respect of outstanding risk claims		
Gross outstanding risk claims		**976 275**
Less: Estimated risk transfer arrangements recoveries		**(43 787)**
Net outstanding risk claims		**932 488**
2019		
Analysis of movements in outstanding risk claims		
Balance at 1 January	48 823	765 008
Payments in respect of prior year claims	(48 823)	(739 836)
Over provision in prior year	–	25 172
Adjustment for current period	41 061	702 875
Balance at 31 December	41 061	728 047
Net exposure in respect of outstanding risk claims		
Gross outstanding risk claims		769 108
Less: Estimated risk transfer arrangements recoveries		(41 061)
Net outstanding risk claims		728 047

* *The over provision of R18m in the prior year was as a result of faster run-off speeds observed for 2019 treatments when compared to earlier years' trends, on which these assumptions were based. This mainly impacted hospitals and specialists and can be illustrated as follows:*

	Hospitals		**Specialists**	
Month	Actual run-off observed	Assumed run-off	Actual run-off observed	Assumed run-off
0	22%	22%	48%	43%
1	76%	72%	86%	82%
2	92%	90%	91%	91%
3	96%	95%	94%	94%
4	98%	97%	96%	96%
5	99%	98%	96%	97%
6	99%	99%	97%	98%
7	100%	99%	98%	98%
8	100%	99%	99%	99%
9	100%	99%	99%	99%
10	100%	100%	99%	99%
11	100%	100%	99%	99%
12+	100%	100%	100%	100%

NOTES TO THE ANNUAL FINANCIAL STATEMENTS CONTINUED

FOR THE YEAR ENDED 31 DECEMBER 2020

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 Fund. The data used included all claim payments and membership movements up to the end of December 2020.

Data was compared to the Scheme's December 2020 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 2020. 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 Fund'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 homogenous 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 dependents.
- Random fluctuations, including the impact of large losses.

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

NOTES TO THE ANNUAL FINANCIAL STATEMENTS CONTINUED

FOR THE YEAR ENDED 31 DECEMBER 2020

10. OUTSTANDING RISK CLAIMS PROVISION CONTINUED

Data, methodology and assumptions continued

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 2018, 2019 and 2020 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 Fund's estimation process. Information from the managed healthcare provider 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 Fund.

The Fund 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 claims R'million	Outstanding risk claims provision# R'million	Change in outstanding risk claims provision R'million
2020			
As at 31 December	**13 538**	**932**	**–**
Run-off factors 20% faster than assumed	**13 416**	**810**	**(122)**
Run-off factors 20% slower than assumed	**13 662**	**1 056**	**124**
2019			
As at 31 December	14 131	728	-
Run-off factors 20% faster than assumed	14 009	606	(122)
Run-off factors 20% slower than assumed	14 258	856	128

Not covered by risk transfer arrangements.

NOTES TO THE ANNUAL FINANCIAL STATEMENTS CONTINUED

FOR THE YEAR ENDED 31 DECEMBER 2020

	2020 R'000	2019 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	**678 857**	592 504
Less: Personal medical savings plan advances	**(3 790)**	(5 407)
Balance of Personal medical savings account liability at 1 January	**675 067**	587 097
Add: Savings account contributions received	**742 800**	646 075
Savings plan liabilities transferred to the scheme from other schemes in terms of Regulation 10 (4)	**3 334**	5 753
Net interest paid on savings plan account	**28 628**	36 045
Interest paid	**29 324**	37 102
Investment expenses/fees	**(696)**	(1 057)
Less: Claims paid on behalf of members	**(566 192)**	(556 566)
Refunds on death or resignation in terms of Regulation 10 (5)	**(56 931)**	(38 109)
Savings used to fund contributions	**(1 151)**	–
Personal medical savings plan advances (note 8)	**1 448**	3 790
Advances on savings accounts written off	**56**	427
Unclaimed Personal medical savings account liability written off to scheme funds	**(14 981)**	(5 655)
Balances due to members on Personal medical savings accounts held at 31 December	**812 078**	678 857

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, 16.0% on BonFit, 15.0% on BonComplete, 19.5% 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 enrolls in another benefit option or medical scheme without a PMSA, or does not enroll in another medical scheme.

It is estimated that the claims to be paid out of members' PMSA in respect of claims incurred in 2020 but not reported will amount to R5.9 million (2019: R7.7 million). Advances paid on personal medical savings accounts are funded by the Scheme and are included in trade and other receivables (refer to note 8).

The Scheme obtained exemption from Regulation 10(3) of the Medical Schemes Act, 131 of 1998, personal medical savings account, which prohibits the medical savings funds to be used to offset contributions unless to settle the scheme upon termination of membership. Thus R1.2m of accumulated savings balances were used to offset contributions in 2020.

The exemption from the Council for Medical Schemes was provided to the Scheme as part of a contribution relief measure to assist members who were in financial difficulty following the economic challenges driven by COVID-19 and the ensuing financial crisis. The exemptions were to provide temporary relief to Bonitas Medical Fund members and expired 31 December 2020.

The following Scheme Rules were adopted from 1 January 2019:

- The funds should no longer be ring-fenced.
- Interest would still be paid to members on PMSA monies at the rate achieved by the Scheme's 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. The effective interest rate earned was 5.9% (2019: 7.8%) and 4.4% was allocated to the PMSA balances.

NOTES TO THE ANNUAL FINANCIAL STATEMENTS CONTINUED

FOR THE YEAR ENDED 31 DECEMBER 2020

		2020 R'000	2019 R'000
12.	**INSURANCE, TRADE AND OTHER PAYABLES**		
12.1	**Insurance payables**		
	Contributions received in advance	**495 497**	636 336
	Dorbyl contributions received in advance	**1**	71
	Reported claims not yet paid (note 12.3)	**104 787**	83 073
	Credit balances due to members - overpayments	**13 804**	10 065
	Total insurance payables	**614 089**	729 545
12.2	**Trade and other payables**		
	Accrual of external audit fees	**2 667**	2 430
	Accrual of internal audit fees	**571**	419
	Amounts owing to administrator and related entities (including marketing costs)	**37 607**	26 481
	South African Revenue Service	**243**	244
	Accrual for advertising and marketing expenses (excluding related entity)	**4 953**	7 572
	Sundry payables	**9 601**	15 381
	Total trade and other payables	**55 642**	52 527
	Total insurance, trade and other payables	**669 731**	782 072

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

The prior year comparatives have been reclassified. Marketing accruals associated with a related entity have been reclassified from 'Accrual for advertising and marketing expenses' to 'Amounts owing to administrator and related entities'.

		2020 R'000	2019 R'000
12.3	**Reported claims not yet paid**		
	Balance at 1 January	**83 073**	79 698
	Net movement - members and providers	**21 714**	3 375
	Claims received	**13 297 111**	14 115 433
	Claims paid	**(13 275 397)**	(14 112 058)
	Reported claims not yet paid	**104 787**	83 073

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.

		2020 R'000	2019 R'000
13.	**RISK CONTRIBUTION INCOME**		
	Gross contributions per registered rules#	**18 540 546**	17 384 459
	Less: personal medical savings account contributions received*	**(742 800)**	(646 075)
	Risk contribution income	**17 797 746**	16 738 384

Gross contribution income includes concessions granted for contribution relief measures. Refer to note 27.3.

* *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.*

NOTES TO THE ANNUAL FINANCIAL STATEMENTS CONTINUED

FOR THE YEAR ENDED 31 DECEMBER 2020

		2020 R'000	2019 R'000
14.	**RELEVANT HEALTHCARE EXPENDITURE**		
	Net risk claims (14.1)	**14 346 005**	15 030 529
	Accredited managed healthcare services (14.2)	**551 530**	517 478
	Net income on risk transfer arrangements (14.3)	**(126 295)**	(105 367)
	Total relevant healthcare expenditure	**14 771 240**	15 442 640
14.1	**Net claims incurred**		
	Claims incurred excluding claims incurred in respect of risk transfer arrangements	**12 918 448**	14 139 874
	Current year claims per registered rules	**13 280 199**	14 733 401
	Movement in outstanding claims provision	**204 441**	(36 961)
	Provision in prior year	**(728 047)**	(765 008)
	Provision for the current year	**932 488**	728 047
	Claims paid from Personal Medical Savings Account**	**(566 192)**	(556 566)
	Claims incurred in respect of risk transfer arrangements	**1 486 813**	959 019
	Current year claims incurred in respect of risk transfer arrangements	**1 443 026**	917 958
	Movement in outstanding claims provision (note 10)	**43 787**	41 061
	Third party claims recoveries (note 14.4)	**(59 256)**	(68 364)
	Net risk claims incurred	**14 346 005**	15 030 529

*** 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.*

		2020 R'000	2019 R'000
14.2	**Accredited managed healthcare services**		
	Hospital benefit management	**203 061**	196 267
	Medicine benefit management	**87 916**	84 928
	Disease management	**118 679**	115 371
	HIV/AIDS management	**53 525**	51 187
	Provider network management	**72 155**	69 725
	Dental risk management*	**16 194**	–
		551 530	517 478

** A managed care dental programme was introduced in the current year for Primary and Primary EDO options which were previously managed through a Risk transfer arrangement with Dental Information Systems Proprietary Limited.*

The prior year comparatives have been updated to include the effect of the apportionment of the EDO options fees to all managed care services.

		2020 R'000	2019 R'000
14.3	**Risk transfer arrangements**		
	Premiums/fees paid	**1 360 518**	857 139
	Dental Information Systems Proprietary Limited*	**307 861**	486 206
	Scriptpharm Risk Management Proprietary Limited*	**703 422**	–
	Preferred Provider Negotiators Proprietary Limited*	**217 111**	241 312
	ER24 EMS Proprietary Limited	**122 171**	113 601
	Bryte Insurance Company Limited	**–**	16 020
	Europ Assistance Worldwide Services (South Africa) Proprietary Limited	**9 953**	–
	Recoveries received	**(1 486 813)**	(959 019)
	Claims recoveries	**(1 486 813)**	(959 019)
	Profit share on risk transfer arrangements - Preferred Provider Negotiators Proprietary Limited	**–**	(3 487)
	Net income on risk transfer arrangements	**(126 295)**	(105 367)

** Given the reduction of utilisation as a result of the COVID-19 pandemic, the Fund negotiated a refund of capitation fees relating to both Dental Information Systems Proprietary Limited (R56m) and Preferred Provider Negotiators Proprietary Limited (R46m). In good faith these were made to the Scheme as the utilisation during 2020 was not an accurate representation of a normal year. From a claims aspect utilisation pertaining to the other risk transfer arrangements were not significantly impacted and no additional refunds were negotiated on these agreements. The premiums paid and recoveries received increased due to the addition of the Scriptpharm Risk Management Proprietary Limited risk transfer arrangement contract during the year. Dental Information Proprietary Limited premiums paid reduced due to benefit changes relating to the BonFit and BonSave options whilst the Primary option changed from a risk transfer arrangement to a fee for service model.*

NOTES TO THE ANNUAL FINANCIAL STATEMENTS CONTINUED

FOR THE YEAR ENDED 31 DECEMBER 2020

14. RELEVANT HEALTHCARE EXPENDITURE CONTINUED

14.3 Risk transfer arrangements continued

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

	2020 R'000	2019 R'000
Dental Information Systems Proprietary Limited	**(61 113)**	(52 193)
Scriptpharm Risk Management Proprietary Limited*	**(21 791)**	–
Preferred Provider Negotiators Proprietary Limited	**(36 504)**	(34 910)
ER24 EMS Proprietary Limited	**(15 639)**	(21 433)
Bryte Insurance Company Limited	**–**	3 169
Europ Assistance Worldwide Services (South Africa) Proprietary Limited	**8 752**	–
Net income on risk transfer arrangements	**(126 295)**	(105 367)

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 Dental Information Systems Proprietary Limited;
- Chronic medicine benefits provided by Scriptpharm Risk Management Proprietary Limited;
- Optical benefit management provided by Preferred Provider Negotiators Proprietary Limited;
- Ambulance and emergency services provided by ER24 EMS Proprietary Limited; and
- International travel benefits provided by Europ Assistance Worldwide Services (South Africa) Proprietary Limited.

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.

Dental Information Systems Proprietary Limited ("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.

Scriptpharm Risk Management Proprietary Limited ("Scriptpharm")

The Scheme has entered into a risk transfer arrangement with Scriptpharm to provide Chronic medicine benefits for the members with an effective date of 1 February 2020. The Scheme pays Scriptpharm a monthly fixed fee per beneficiary on the BonComprehensive, BonClassic, Standard, BonComplete, BonSave, Primary, BonFit, Hospital Standard, BonEssential and BonCap options.

Preferred Provider Negotiators Proprietary Limited ("PPN")

The Scheme has entered into a risk transfer arrangement with PPN for optometrical services and pays a monthly fee per member per month on the Standard option, Primary Option, Classic Options and BonCap Option. Included in the contract is a risk sharing arrangement whereby any surplus or deficit above a maximum of 10% of the total of the premiums paid is due by or to the service provider.

ER24 EMS Proprietary Limited ("ER24")

The Scheme re-appointed ER24 to render emergency medical services whereby they will maintain a twenty-four (24) hour 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 for all members of the Scheme.

Bryte Insurance Company Limited ("Bryte")

The Scheme had 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. The contract was terminated effective 31 December 2019.

Europ Assistance Worldwide Services (South Africa) Proprietary Limited ("EASA")

The Scheme has entered into a risk transfer arrangement with EASA for the provision of international travel benefits for members who travel overseas for a period of not more than 90 days at a fixed fee per member per month with an effective date of 1 January 2020. This contract applies to all members of the Scheme except for those on the BonCap option.

14.4 Claim recoveries

Third party claim recoveries of R59.3 million (2019: R68.4 million) are included in net claims incurred. Included in this are third party recoveries for motor vehicle accident ("MVA") and injury on duty ("IOD") claims of R27.3 million (2019: R38.1 million). These claims are currently being administered by Gildenhuys Malatji Attorneys and Batsumi Claims Management Solutions Proprietary Limited. The net claims recoveries in the current year includes R27.1 million (2019: R28.0 million) in relation to forensic recoveries pertaining to the fraud waste and abuse services provided by the Administrator, R0.3 million (2019: R0.4 million expense) in relation to diabetes clawbacks and R4.6 million (2019: R2.7 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 2020

	2020 R'000	2019 R'000
15. ADMINISTRATIVE EXPENDITURE		
Administrator's fees	**876 461**	848 654
Actuarial services	**3 712**	3 549
Annual general meeting costs	**1 520**	2 946
Audit remuneration - external	**2 942**	6 467
Audit fees	**2 667**	2 438
Fees for other non-audit services	**–**	3 450
Prior year under provision	**275**	579
Audit remuneration - internal	**3 649**	2 959
Audit fees	**3 728**	2 959
Prior year over provision	**(79)**	–
Bank charges	**3 421**	3 710
Benefit management services	**20 908**	24 199
Communication expenses	**175**	237
Consulting fees	**2 286**	2 947
Council for Medical Schemes levies	**13 025**	12 658
Committee fees - Independent members	**1 831**	1 735
Audit and risk committee fees	**1 051**	850
Investment committee fees	**372**	565
Remuneration committee fees	**408**	320
Computer maintenance	**3 046**	3 575
Depreciation	**5 194**	5 159
Fidelity, professional indemnity and other insurance premiums	**868**	615
Forensic fees	**8 275**	9 032
Hire of equipment	**176**	175
Human resourcing and payroll management fees	**962**	2 457
Legal fees and inspection costs	**6 558**	6 632
Marketing and advertising expenses	**187 256**	187 230
Meeting venue and catering costs	**104**	301
Office expenses	**371**	467
Postage and courier service	**233**	1 657
Principal Officer short-term employee benefits	**5 614**	6 315
Principal Officer remuneration	**4 522**	4 876
Performance bonus	**777**	960
Defined contribution benefits	**213**	267
Other disbursements	**102**	212
Printing and stationery	**596**	3 643
Professional services	**2 288**	3 587
RAF administration expense	**11 612**	15 781
Rental costs	**1 852**	1 786
Repairs and maintenance	**20**	9
Staff short-term employee benefits	**21 495**	19 432
Staff remuneration	**16 015**	15 745
Performance bonus	**1 750**	2 002
Termination benefit	**1 934**	–
Defined contribution benefits	**800**	932
Other disbursements	**996**	753
Subscription fees	**2 782**	776
Sundry expenses	**863**	674
Travel, accommodation and conferences	**78**	472
Trustee elections	**–**	8 395
Trustees' remuneration and other disbursements	**5 635**	4 634
Trustees' remuneration	**5 536**	4 201
Other disbursements	**99**	433
Wellness expenses	**26 083**	24 949
	1 221 891	1 217 814

NOTES TO THE ANNUAL FINANCIAL STATEMENTS CONTINUED

FOR THE YEAR ENDED 31 DECEMBER 2020

15. ADMINISTRATIVE EXPENDITURE CONTINUED

15.1 Trustees' remuneration and considerations

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	Training and annual subscription fees	Conference fees	Total
2020								
Mr O Komane	**500 644**	**342 416**	**365 814**	**1 208 874**	**17 524**	**2 215**	**–**	**1 228 613**
Adv L Koch	**140 151**	**218 952**	**8 400**	**367 503**	**1 692**	**2 215**	**–**	**371 410**
Mr J Bagg	**190 895**	**218 952**	**50 658**	**460 505**	**–**	**2 215**	**–**	**462 720**
Mr MG Netshisaulu	**253 429**	**218 952**	**34 217**	**506 598**	**3 192**	**2 215**	**–**	**512 005**
Mr R Cowlin	**343 899**	**218 952**	**168 007**	**730 858**	**26 440**	**2 215**	**–**	**759 513**
Ms J Usher	**348 188**	**218 952**	**–**	**567 140**	**428**	**2 215**	**–**	**569 783**
Ms MP Lesunyane	**178 209**	**218 952**	**–**	**397 161**	**2 472**	**2 215**	**–**	**401 848**
Mr JD Ngwane	**140 151**	**225 299**	**27 558**	**393 008**	**3 816**	**2 215**	**–**	**399 039**
Mr JR Venter	**241 468**	**218 952**	**8 400**	**468 820**	**1 590**	**2 215**	**–**	**472 625**
Mr P Ribbens	**190 895**	**218 952**	**25 888**	**435 735**	**19 160**	**2 215**	**–**	**457 110**
	2 527 929	**2 319 331**	**688 942**	**5 536 202**	**76 314**	**22 150**	**–**	**5 634 666**
2019								
Mr S E Claassen	26 983	43 266	23 749	93 998	2 340	2 445	–	98 783
Mr O Komane	315 152	301 721	417 098	1 033 971	34 075	2 445	15 548	1 086 039
Adv L Koch	97 899	197 974	–	295 873	7 401	2 445	598	306 317
Dr HE Nematswerani	15 833	46 897	7 916	70 646	–	2 445	–	73 091
Mr J Bagg	114 215	197 974	105 981	418 170	4 310	2 445	598	425 523
Mr MG Netshisaulu	165 914	197 974	77 382	441 270	21 442	4 945	15 548	483 205
Mr R Cowlin	307 181	197 974	28 916	534 071	168 436	2 445	15 548	720 500
Ms J Usher	222 296	197 974	48 949	469 219	13 980	2 445	15 548	501 192
Ms MP Lesunyane	127 948	197 974	–	325 922	9 978	4 945	598	341 443
Mr JD Ngwane	66 233	104 181	18 900	189 314	16 523	–	15 548	221 385
Mr JR Venter	66 233	104 181	12 600	183 014	8 459	–	17 043	208 516
Mr P Ribbens	41 033	104 181	–	145 214	22 554	–	598	168 366
	1 566 920	1 892 271	741 491	4 200 682	309 498	27 005	97 175	4 634 360

[1] *Fees for meeting attendance refers to remuneration payable to Trustees for attending meetings of Board of Trustees.*

[2] *Fees for holding office refers to remuneration payable to individuals to act in their capacity as trustee, including carrying out their fiduciary duty.*

[3] *Fees for other meeting attendance refers to remuneration payable to Trustees for attendance of other meetings at which their attendance is required to act in the interest of the Scheme.*

NOTES TO THE ANNUAL FINANCIAL STATEMENTS CONTINUED

FOR THE YEAR ENDED 31 DECEMBER 2020

	2020 R'000	2019 R'000
16. IMPAIRMENT LOSSES ON INSURANCE, TRADE AND OTHER RECEIVABLES		
Increase/(decrease) in provision for healthcare receivables (note 8)	**13 550**	(1 097)
Bad debts written off	**10 797**	13 378
Contributions	**2 436**	5 050
Members portion	**8 045**	8 069
Other receivables	**316**	259
Previous impairment losses recovered	**(4 066)**	(3 715)
	20 281	8 566
17. INVESTMENT INCOME		
Cash and cash equivalents interest income	**4 646**	6 695
Financial assets held at fair value through profit or loss	**309 913**	321 379
Interest income	**233 389**	262 066
Dividend income	**76 524**	59 313
Net fair value gains on financial assets held at fair value through profit or loss	**24 655**	47 270
Net fair value losses on derivative instruments	**(31 878)**	–
Rentals received	**9 270**	8 988
Contractual rental	**8 913**	8 630
Straight-lining of lease accrual	**357**	358
Other income	**–**	35 755
Interest received on cession of judgement debt claim	**–**	35 755
Investment income - Scheme	**316 606**	420 087
Change in fair value of investment properties	**2 900**	2 100
	319 506	422 187
18. SUNDRY INCOME		
Profit on sale of property and equipment	**2**	15
Forensic recoveries	**1 776**	1 322
Sundry income	**25 755**	71 429
Unclaimed personal medical savings account write backs (note 11.1)	**14 981**	5 655
Recovery of personal medical savings account investment and administration expense	**9 563**	8 677
Louis Pasteur - Cession of judgement debt		44 245
Service Level Agreement penalty recovery from Administrator	**–**	11 778
Other income	**1 211**	1 074
	27 533	72 766

Claim recoveries from Healthcare practitioners are offset against claims paid. 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.

NOTES TO THE ANNUAL FINANCIAL STATEMENTS CONTINUED

FOR THE YEAR ENDED 31 DECEMBER 2020

19. SURPLUS/(DEFICIT) PER BENEFIT OPTION

19.1 SURPLUS/(DEFICIT) PER BENEFIT OPTION

For management purposes the traditional Scheme is organised into the following ten benefit options: Standard, BonSave, Primary, BonCap, BonFit, BonClassic, BonComprehensive, BonComplete, BonEssential and Hospital Standard. The features of the benefit options are disclosed in the Board of Trustees report.

R'000	Standard	BonSave	Primary	BonCap	BonFit	BonClassic	BonCompre-hensive	Bon-Essential	Bon-Complete	Hospital Standard	Scheme total
2020											
Gross contribution income	8 525 114	1 892 851	4 046 174	1 043 753	220 877	823 861	668 964	373 439	690 844	254 669	18 540 546
Less : Savings contributions	–	(364 853)	–	–	(34 743)	(115 976)	(125 335)	–	(101 893)	–	(742 800)
Risk contribution income	8 525 114	1 527 998	4 046 174	1 043 753	186 134	707 885	543 629	373 439	588 951	254 669	17 797 746
Relevant healthcare expenditure	(6 947 016)	(1 198 835)	(3 329 204)	(994 827)	(133 605)	(627 121)	(526 224)	(303 502)	(498 153)	(212 754)	(14 771 240)
Net claims incurred	(6 786 586)	(1 151 376)	(3 222 211)	(953 052)	(124 958)	(619 289)	(497 998)	(289 463)	(494 693)	(206 379)	(14 346 005)
Claims incurred	(6 807 224)	(1 157 708)	(3 237 859)	(961 620)	(125 946)	(620 953)	(498 925)	(291 295)	(496 373)	(207 358)	(14 405 261)
Third party recoveries	20 638	6 332	15 648	8 568	988	1 664	927	1 832	1 680	979	59 256
Managed healthcare services	(217 524)	(53 493)	(152 324)	(60 748)	(8 245)	(14 163)	(8 315)	(14 177)	(14 848)	(7 694)	(551 530)
Net income on risk transfer arrangements	57 094	6 034	45 331	18 973	(402)	6 331	(19 911)	138	11 388	1 319	126 295
Risk transfer arrangement fees /premiums paid	(806 741)	(99 062)	(184 709)	(64 261)	(8 634)	(75 125)	(49 445)	(15 846)	(44 707)	(11 988)	(1 360 518)
Recoveries from risk transfer arrangements	863 835	105 096	230 040	83 234	8 232	81 456	29 534	15 984	56 095	13 307	1 486 813
Profit sharing arising from risk transfer arrangements	–	–	–	–	–	–	–	–	–	–	–
Gross healthcare result	1 578 098	329 163	716 970	48 926	52 529	80 764	17 405	69 937	90 798	41 915	3 026 506
Broker service fees	(126 679)	(39 363)	(95 113)	(31 188)	(5 461)	(6 685)	(5 158)	(9 174)	(10 733)	(5 273)	(334 827)
Administrative expenditure	(467 827)	(143 850)	(351 080)	(77 356)	(22 466)	(37 693)	(21 004)	(40 503)	(38 078)	(22 034)	(1 221 891)
Net impairment losses on healthcare receivables	(7 083)	(2 172)	(5 348)	(2 922)	(336)	(573)	(319)	(608)	(582)	(338)	(20 281)
Net healthcare result	976 509	143 778	265 429	(62 540)	24 266	35 813	(9 076)	19 652	41 405	14 270	1 449 507
Other income	107 024	42 779	87 779	45 736	6 424	17 411	8 899	11 785	14 290	4 912	347 039
Investment income - Scheme	96 435	39 528	79 731	41 340	5 915	16 557	8 424	10 838	13 429	4 409	316 606
Sundry income	9 594	2 942	7 269	3 976	459	774	431	849	782	457	27 533
Change in fair value of investment property	995	309	779	420	50	80	44	98	79	46	2 900
Other expenditure	(9 781)	(11 703)	(7 462)	(4 067)	(1 128)	(9 787)	(4 649)	(886)	(6 859)	(463)	(56 785)
Interest on savings plan liability - PMSA	–	(8 695)	–	–	(656)	(9 000)	(4 211)	–	(6 066)	–	(28 628)
Interest expense	(306)	(94)	(233)	(127)	(15)	(25)	(14)	(28)	(25)	(14)	(881)
Asset management fees	(7 494)	(2 307)	(5 731)	(3 119)	(363)	(602)	(335)	(684)	(606)	(356)	(21 597)
Operating expenses on investment property	(1 981)	(607)	(1 498)	(821)	(94)	(160)	(89)	(174)	(162)	(93)	(5 679)
Net surplus/(deficit) for the year	1 073 752	174 854	345 746	(20 871)	29 562	43 437	(4 826)	30 551	48 837	18 719	1 739 761
Number of members (n)	114 297	35 548	89 445	48 206	5 739	9 134	5 087	11 228	9 110	5 347	333 141

NOTES TO THE ANNUAL FINANCIAL STATEMENTS CONTINUED

FOR THE YEAR ENDED 31 DECEMBER 2020

19. SURPLUS/(DEFICIT) PER BENEFIT OPTION CONTINUED

19.2 SURPLUS/(DEFICIT) PER BENEFIT OPTION

For management purposes the traditional Scheme is organised into the following ten benefit options: Standard, BonSave, Primary, BonCap, BonFit, BonClassic, BonComprehensive, BonComplete, BonEssential and Hospital Standard. The features of the benefit options are disclosed in the Board of Trustees report.

R'000	Standard	BonSave	Primary	BonCap	BonFit	BonClassic	BonCompre-hensive	Bon-Essential	Bon-Complete	Hospital Standard	Scheme total
2019											
Gross contribution income	8 341 735	1 724 577	3 459 011	927 283	179 290	815 690	686 967	294 507	701 733	253 666	17 384 459
Less : Savings contributions	–	(272 536)	–	–	(26 489)	(114 988)	(128 624)	–	(103 439)	–	(646 075)
Risk contribution income	8 341 735	1 452 042	3 459 011	927 283	152 801	700 702	558 343	294 507	598 294	253 666	16 738 384
Relevant healthcare expenditure	(7 462 151)	(1 276 114)	(3 092 864)	(1 042 240)	(124 320)	(703 991)	(640 500)	(278 073)	(569 196)	(253 192)	(15 442 640)
Net claims incurred	(7 324 685)	(1 210 240)	(2 983 397)	(987 499)	(118 175)	(696 836)	(633 632)	(265 981)	(565 396)	(244 687)	(15 030 529)
Claims incurred	(7 349 838)	(1 217 498)	(2 999 876)	(997 503)	(119 162)	(698 927)	(634 838)	(267 752)	(567 561)	(245 938)	(15 098 893)
Third party recoveries	25 153	7 258	16 479	10 004	987	2 091	1 206	1 771	2 164	1 251	68 364
Managed healthcare services	(222 652)	(50 743)	(119 913)	(58 851)	(6 733)	(14 804)	(8 387)	(11 473)	(15 772)	(8 150)	(517 478)
Net income on risk transfer arrangements	85 186	(15 131)	10 447	4 110	588	7 649	1 520	(619)	11 972	(356)	105 367
Risk transfer arrangement fees /premiums paid	(470 293)	(83 180)	(197 527)	(34 987)	(5 648)	(33 681)	(2 352)	(3 410)	(23 626)	(2 435)	(857 139)
Recoveries from risk transfer arrangements	552 406	68 049	207 974	39 097	6 236	40 916	3 872	2 791	35 598	2 080	959 019
Profit sharing arising from risk transfer arrangements	3 073	–	–	–	–	414	–	–	–	–	3 487
Gross healthcare result	879 584	175 928	366 148	(114 957)	28 481	(3 289)	(82 156)	16 434	29 099	474	1 295 744
Broker service fees	(128 162)	(37 585)	(82 406)	(28 175)	(4 510)	(7 065)	(5 859)	(7 256)	(11 961)	(5 878)	(318 857)
Administrative expenditure	(497 702)	(141 640)	(319 354)	(75 285)	(19 280)	(40 715)	(23 498)	(33 941)	(42 155)	(24 244)	(1 217 814)
Net impairment losses on healthcare receivables	(3 177)	(913)	(2 056)	(1 229)	(122)	(265)	(152)	(218)	(275)	(159)	(8 566)
Net healthcare result	250 543	(4 210)	(37 668)	(219 646)	4 568	(51 334)	(111 666)	(24 981)	(25 292)	(29 807)	(249 493)
Other income	168 509	60 148	110 802	67 319	7 279	25 234	13 016	11 991	22 271	8 385	494 953
Investment income - Scheme	141 390	52 227	92 528	56 084	6 171	22 986	11 715	9 977	19 959	7 050	420 087
Sundry income	26 363	7 699	17 759	10 917	1 077	2 185	1 265	1 957	2 247	1 297	72 766
Change in fair value of investment property	756	222	515	318	31	63	36	57	64	38	2 100
Other expenditure	(8 595)	(13 941)	(5 631)	(3 419)	(977)	(11 951)	(5 340)	(606)	(8 521)	(428)	(59 409)
Interest on savings plan liability - PMSA	–	(11 460)	–	–	(638)	(11 236)	(4 928)	–	(7 782)	–	(36 045)
Interest expense	(313)	(91)	(208)	(127)	(13)	(26)	(15)	(23)	(27)	(15)	(858)
Asset management fees	(6 108)	(1 763)	(4 004)	(2 434)	(240)	(508)	(293)	(431)	(525)	(303)	(16 609)
Operating expenses on investment property	(2 174)	(627)	(1 419)	(858)	(85)	(181)	(104)	(152)	(187)	(110)	(5 897)
Net surplus/(deficit) for the year	410 457	41 997	67 503	(155 746)	10 871	(38 051)	(103 989)	(13 596)	(11 545)	(21 850)	186 051
Number of members (n)	121 960	35 782	83 096	51 320	5 060	10 093	5 854	9 263	10 357	5 966	338 751

NOTES TO THE ANNUAL FINANCIAL STATEMENTS CONTINUED

FOR THE YEAR ENDED 31 DECEMBER 2020

	2020 R'000	2019 R'000
20. CASH FLOW NOTES		
20.1 CASH (UTILISED)/GENERATED BY OPERATIONS BEFORE WORKING CAPITAL CHANGES		
Surplus for the year	**1 739 761**	186 051
Adjusted for:		
Investment income - Scheme (note 17)	**(316 606)**	(420 087)
Change in fair value of investment properties (note 5)	**(2 900)**	(2 100)
Bad debts written off (note 16)	**10 797**	13 378
Increase/(decrease) in provision for doubtful debts (note 8)	**13 550**	(1 097)
Interest on savings plan liability	**28 628**	36 045
Interest on lease liability	**670**	858
Depreciation	**5 194**	5 159
Profit on sale of property and equipment	**(4)**	(15)
Asset management fees	**21 597**	16 609
Unclaimed Personal medical savings account write backs	**(14 981)**	(5 655)
Increase/(decrease) in outstanding claims provision not covered by risk transfer agreements	**204 441**	(36 961)
	1 690 147	(207 815)
20.2 CASH FLOW MOVEMENTS IN WORKING CAPITAL		
20.2.1 Insurance, trade and other receivables		
Movement per statement of financial position	**130 374**	(161 424)
Adjusted for non-cash movements:		
Receivables under risk transfer arrangements - provision	**2 726**	(7 762)
Rent receivables	**415**	(34)
Allowance for impairment losses	**(24 347)**	(12 281)
Straight-lining of lease receivables	**357**	358
	109 525	(181 143)
20.2.2 Insurance, trade and other payables		
Movement per statement of financial position	**(112 341)**	140 452
Adjusted for non-cash movements:		
Straight-lining of lease payables	**–**	499
	(112 341)	140 951
20.2.3 Personal medical savings account liability		
Movement per statement of financial position	**133 221**	86 353
Adjusted for non-cash movements:		
Unclaimed Personal medical savings account write backs	**14 981**	5 655
	148 202	92 008

NOTES TO THE ANNUAL FINANCIAL STATEMENTS CONTINUED

FOR THE YEAR ENDED 31 DECEMBER 2020

20. CASH FLOW NOTES CONTINUED

20.3 RETURNS ON FINANCIAL ASSETS AT FAIR VALUE THROUGH PROFIT OR LOSS

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

		2020 R'000	2019 R'000
20.3.1	***Interest received***		
	Finance income (note 17)	**233 389**	262 066
	Interest capitalised in investments	**(87 897)**	(50 445)
		145 492	211 621
20.3.2	***Dividends received***		
	Dividend income (note 17)	**76 524**	59 313
	Dividends capitalised in investments	**(7 998)**	(9 483)
		68 526	49 830
20.3.3	***Asset management fees***		
	Asset management fees per statement of comprehensive income	**(21 597)**	(16 609)
	Fees capitalised in investments	**1 683**	520
		(19 914)	(16 089)
20.3.4	***Rentals received***		
	Rentals received (note 17)	**9 270**	8 988
	Straight-lining of lease receivables	**(357)**	(358)
	(Increase)/decrease in rent receivables (20.2.1)	**(415)**	34
		8 498	8 664

NOTES TO THE ANNUAL FINANCIAL STATEMENTS CONTINUED

FOR THE YEAR ENDED 31 DECEMBER 2020

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 dependents 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 is greater than expected. Insurance events are, by their nature, random, and the actual number and size of events during any one year may vary from those estimated using established statistical techniques.

This variation could be due to adverse experience due to for example an unexpected pandemic, 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.

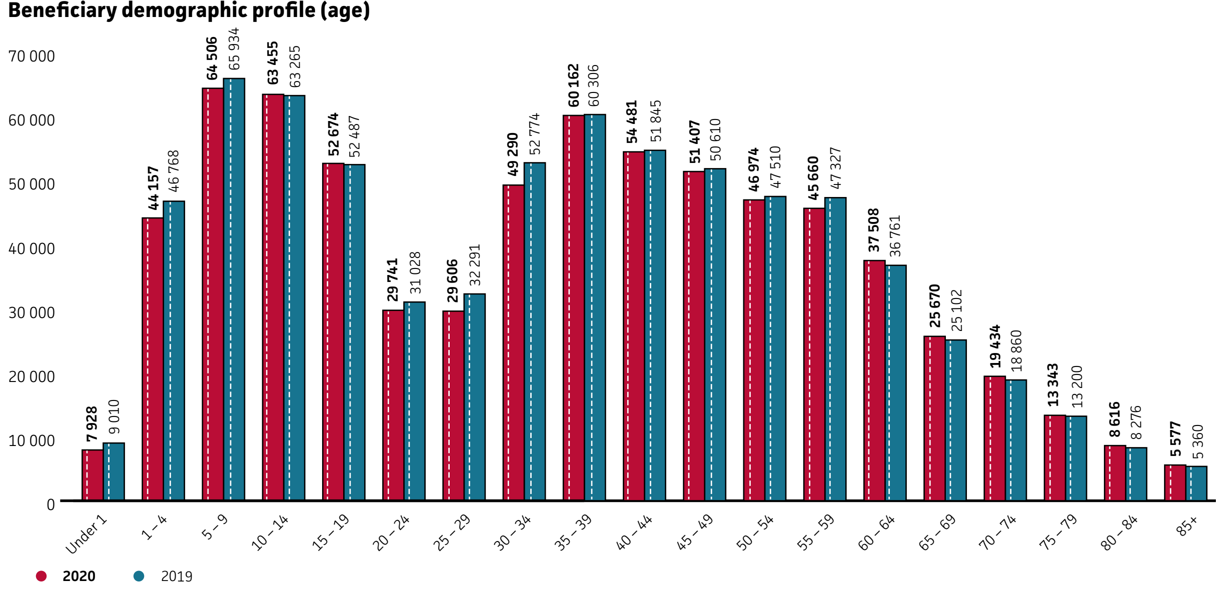
A major risk affecting the future sustainability of the Scheme is the possibility of deterioration in the risk profile of members. Schemes with a better member risk profile can offer the same benefits at a lower contribution rate than other schemes, as their members will be claiming less.

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 beneficiaries demographic profile:

Beneficiary demographic profile (age)



NOTES TO THE ANNUAL FINANCIAL STATEMENTS CONTINUED

FOR THE YEAR ENDED 31 DECEMBER 2020

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.

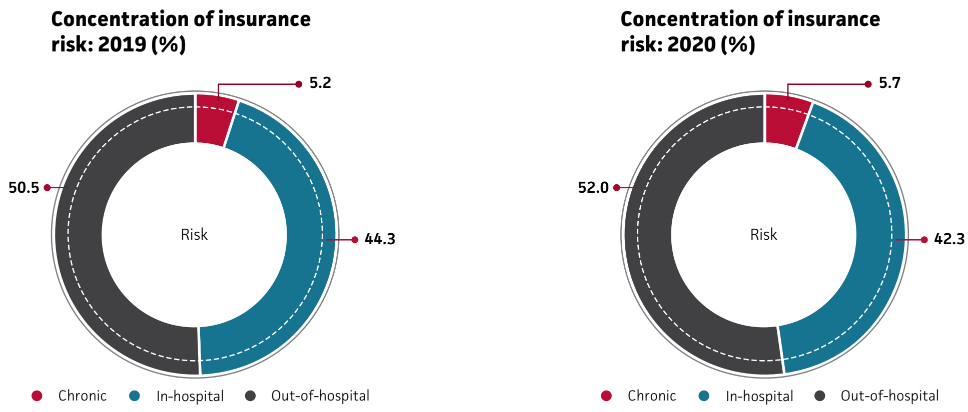
- **In-hospital benefits**

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:



The following graphs summarise the concentrations of insurance risk, with reference to the carrying amount of the insurance claims incurred (before risk transfer arrangements), by age category in years of the 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 system-wide cost-containment of quality care. These strategies for each benefit category are also summarised on the next page.

NOTES TO THE ANNUAL FINANCIAL STATEMENTS CONTINUED

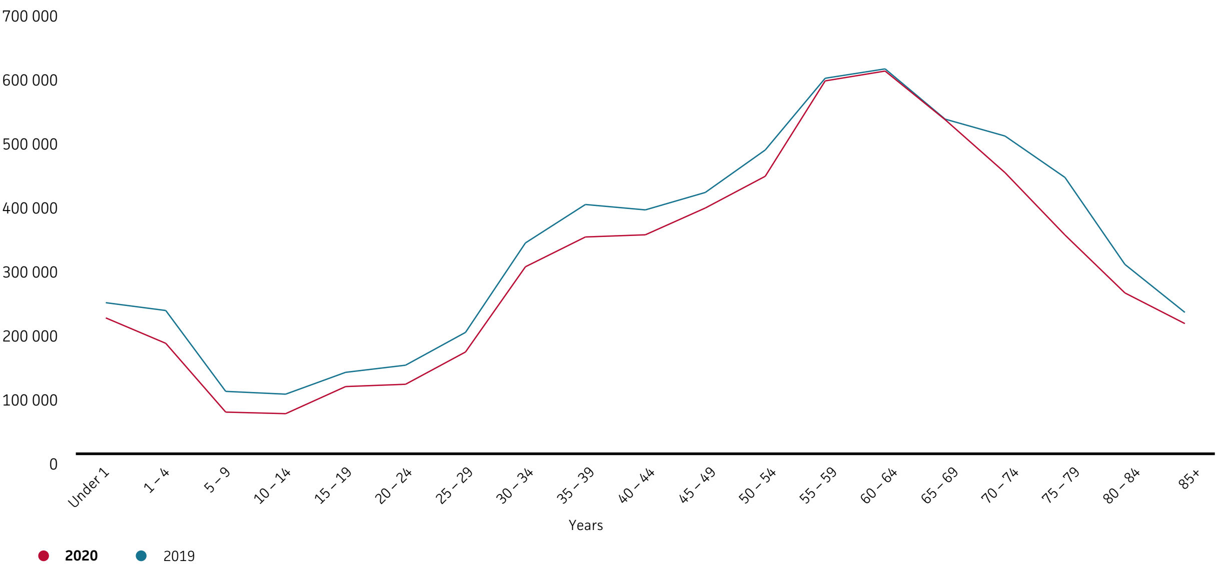
FOR THE YEAR ENDED 31 DECEMBER 2020

21. INSURANCE RISK MANAGEMENT CONTINUED

21.2 Concentrations of insurance risk continued

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 readmission 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 or/and Medical Advisor engagement in answering questions and offering choice in terms of funding alternatives.
- Monitoring compliance to care pathways to reduce the risk of readmission. 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.

NOTES TO THE ANNUAL FINANCIAL STATEMENTS CONTINUED

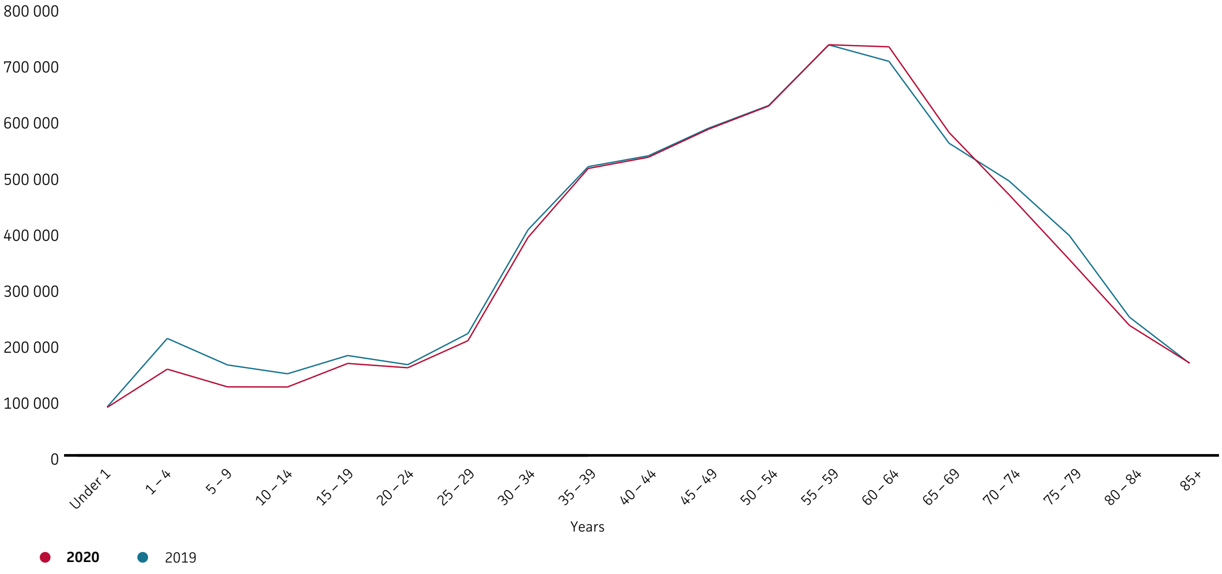
FOR THE YEAR ENDED 31 DECEMBER 2020

21. INSURANCE RISK MANAGEMENT CONTINUED

21.2 Concentrations of insurance risk continued

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 coordinating 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 coordination 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.
- 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 GP network at agreed reimbursement rates.

NOTES TO THE ANNUAL FINANCIAL STATEMENTS CONTINUED

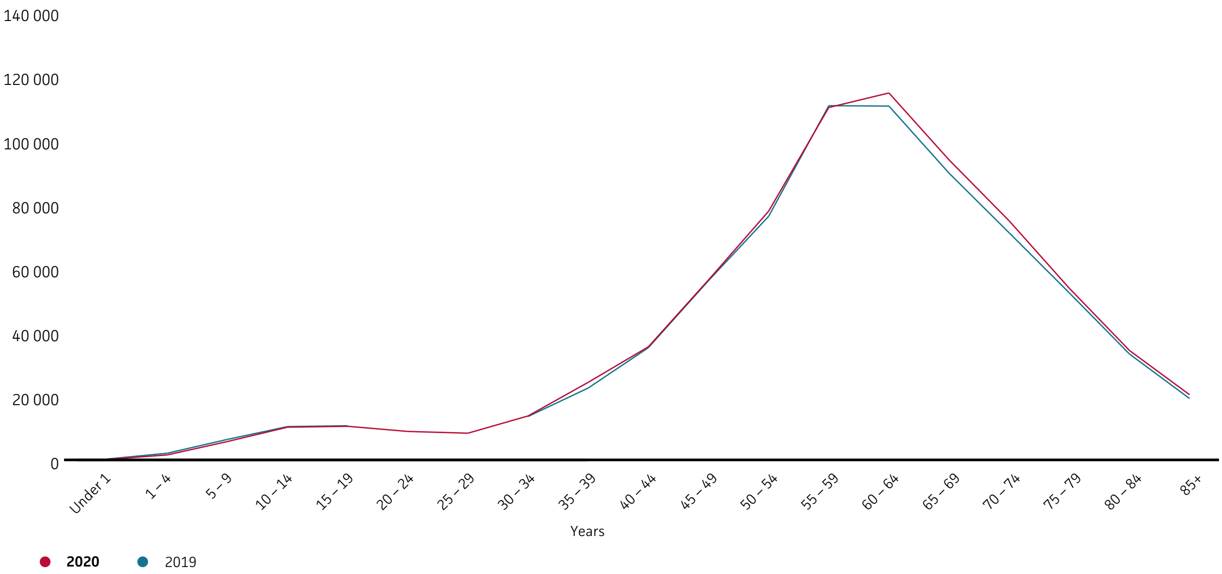
FOR THE YEAR ENDED 31 DECEMBER 2020

21. INSURANCE RISK MANAGEMENT CONTINUED

21.2 Concentrations of insurance risk continued

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 up skilling 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 the chronic programme.
- 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.

NOTES TO THE ANNUAL FINANCIAL STATEMENTS CONTINUED

FOR THE YEAR ENDED 31 DECEMBER 2020

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 9.3% of the Scheme's Relevant Healthcare Expenditure.

The Scheme entered into capitation agreements directly with DENIS, SCRIPTPHARM, PPN, ER24, and EUROP ASSISTANCE. 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.

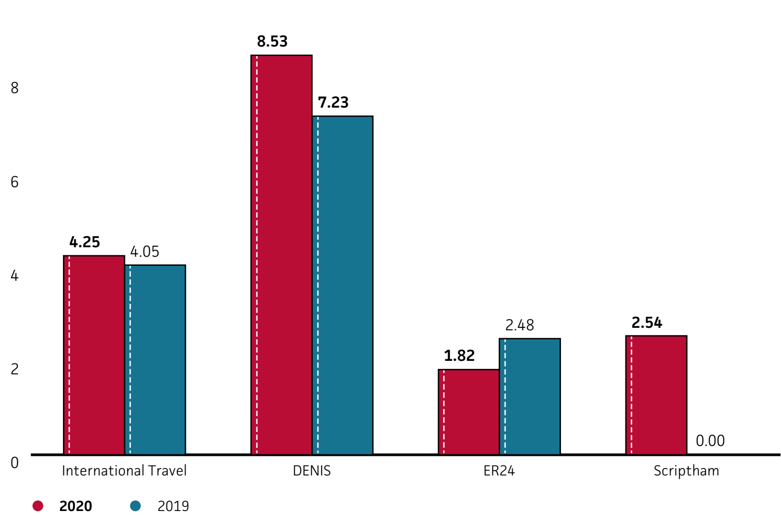
These risk transfer arrangements spread the insurance risk and minimise the effect of losses. The amount of each risk retained depends on the Scheme's evaluation of the specific risk, subject in certain circumstances, to maximum limits on the basis of characteristics of coverage. According to the terms 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 renegotiates 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.

Average net income per beneficiary per month (R)



21.3.1 *Dental Information Systems Proprietary Limited ("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 anesthetist costs 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 R88.43 (2019: R80.87) for beneficiaries on the Standard Option, R46.59 (2019: R69.30) for beneficiaries on the BonSave Option, R0 (2019: R47.53) for beneficiaries on the Primary Option, R86.87 (2019: R76.69) for beneficiaries on the BonClassic Option, R92.10 (2019: R73.68) for beneficiaries on the BonComplete Option and R29.40 (2019: R30.64) for beneficiaries on the BonFit Option. The Primary Option changed from a risk transfer arrangement to a fee for service model in 2020.

The current contract took effect from 1 January 2016 for a period of 5 years. Fees and benefits have been approved for the 2021 benefit year.

NOTES TO THE ANNUAL FINANCIAL STATEMENTS CONTINUED

FOR THE YEAR ENDED 31 DECEMBER 2020

21. INSURANCE RISK MANAGEMENT CONTINUED

21.3 Risk transfer arrangements continued

21.3.2 Scriptpharm Risk Management Proprietary Limited ("Scriptpharm")

The Scheme contracted Scriptpharm as an accredited managed care organisation, to provide Chronic medicine benefits to beneficiaries of the Fund on a capitated basis. Scriptpharm creates and provides the Fund with a Network of Providers which shall ensure the delivery of chronic medicines to the beneficiaries of the Fund. Scriptpharm pays all valid Medicine claims which shall be submitted to Scriptpharm by any pharmacy that is a Designated Service Provider and any General Practitioner or Specialist. Scriptpharm will provide the Fund with all information, data and reports as required.

The Scheme pays Scriptpharm a monthly fixed fee per beneficiary, in advance of R464.46 for beneficiaries on the BonComprehensive Option, R251.39 for beneficiaries on the BonClassic Option, R132.95 for beneficiaries on the Standard option and R166.28 for beneficiaries on the Standard EDO Option, R106.65 for beneficiaries on the BonComplete Option, R47.13 for beneficiaries on the Bonsave Option, R39.27 for beneficiaries on the Primary Option, R49.04 for beneficiaries on the Primary EDO option, R32.39 for beneficiaries on the BonFit option, R85.04 for beneficiaries on the Hospital Standard Option, R47.10 for beneficiaries on the BonEssential Option, R45.11 for beneficiaries on the BonEssential EDO Option and R34.92 for beneficiaries on the BonCap Option.

The contract commenced on 1 February 2020 and endured for an initial period of 11 (eleven) months, and was renewed for a period of 24 (twenty four) months. Fees for the 2021 financial year have been approved.

21.3.3 Preferred Providers Negotiators Proprietary Limited ("PPN")

The Scheme has contracted PPN for optometrical services and pays a monthly fee of R46.75 for members on the Standard Option, R24.49 for members on the Primary Option, R54.33 for members on the BonClassic Options and R20.24 for members on the BonCap Option. The contract provides for a MSA shaping element whereby 100% of the deferred surplus is due to PPN, but limited to 10% of the monthly fee paid.

The contract commenced on 1 January 2019 and will remain in force for three years until 31 December 2021. Fees and benefits have been agreed for the 2021 financial year.

21.3.4 ER24 EMS Proprietary Limited ("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 R32.36 (2019: R29.97) per member per month.

The contract terminated on 31 December 2018. Through a request for proposal exercise ("RFP"), ER24 was reappointed as the provider for emergency medical evacuation services and the contract commenced on 1 January 2019 and will remain in force for three years until 31 December 2021. Fees and benefits have been agreed for the 2021 financial year.

21.3.5 Bryte Insurance Company Limited ("Bryte")

The Scheme had 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 until June 2019, and R7.33 per member per month from July to December 2019. This contract applied to all members of the Scheme except for those on the Boncap Option.

The contract was terminated effective 31 December 2019.

21.3.6 Europ Assistance Worldwide Services (South Africa) Proprietary Limited ("EASA")

The Scheme has entered into a risk transfer arrangement with EASA 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 R2.46 per member per month. This contract applies to all members of the Scheme, below the age of 65 years, except for those on the Boncap Option.

The contract commenced on the effective date of 1 January 2020 and it shall remain in force for a period of 24 (twenty-four) months. Fees and benefits have been agreed for the 2021 financial year.

NOTES TO THE ANNUAL FINANCIAL STATEMENTS CONTINUED

FOR THE YEAR ENDED 31 DECEMBER 2020

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 2021 Budget.

Claims category	Change in variable	Estimated impact on expected 2021 claims R'000	Estimated impact on expected 2021 solvency %
Inflation assumptions			
Represents the increase in the price of service units rendered			
In-hospital claims (ward/theatre/consumables)	Tariff inflation 1% higher	66 678	(0.35%)
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	69 325	(0.37%)
Acute Medicine claims	Average member age 0.5 years higher	6 497	(0.03%)
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	68 366	(0.36%)
Specialist costs	Utilisation rate 1% higher	20 299	(0.11%)

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; and
- 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 of Trustees 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 page 22 of the annual report for further details of 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 and insurance, 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:

	2020 R'000	2019 R'000
Investments (current and non-current)	**7 139 473**	5 008 926
Insurance, trade and other receivables (excluding prepayments)	**714 144**	845 351
Cash and cash equivalents	**611 090**	613 040
	8 464 707	6 467 317

NOTES TO THE ANNUAL FINANCIAL STATEMENTS CONTINUED

FOR THE YEAR ENDED 31 DECEMBER 2020

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; and
- 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 Fitch and Standard and 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 no more than 20% per issuer. Instruments below A but not lower than BBB are limited to not more than 10% and no instruments rated below BB- may be held; and
- With the exception of those situations involving reorganisation of Scheme 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 are used for the purposes of hedging or protecting the Scheme's investment portfolio, rebalancing or facilitating cash flows in order to enhance the Scheme's investment returns. The mark-to-market value of investments are limited to 2.5% of the investment portfolio. Refer to note 7.1.

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

	2020 R'000	2019 R'000
Not past due	**703 038**	825 394
Past due 1 – 30 days	**8 032**	8 431
Past due 31 – 60 days	**1 942**	3 321
Past due 61 – 90 days	**727**	1 195
Past due more than 90 days	**405**	7 010
Trade and other receivables (excluding prepayments)	**714 144**	845 351

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 2020

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 expected credit losses (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:

	2020 R'000	2019 R'000
Balance at the beginning of the year	**11 006**	12 103
Impairment loss recognised/(reversed)	**13 550**	(1 097)
Balance at the end of the year	**24 556**	11 006

The provision for impairment at 31 December 2020 was determined in accordance with the guidelines of the simplified approach (life time expected losses) of the expected credit loss 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 split for the following categories:

a) Group debtors

b) Direct paying members

c) Members portion debtors

d) Savings debtors

e) Provider debtors

The expected credit loss estimates were updated to account for future economic conditions, relative to historic conditions, given the severity of the economic impacts of COVID-19. The Beta risk factors were increased from 15% to 25%. Cash flows were impacted due to contribution relief granted to defer contribution payments for the period 1 June 2020 to 31 August 2020 and 1 October 2020 to 31 December 2020. Members who qualified per the stipulated criteria, considering credit risk, utilised accumulated savings balances to offset contribution debt up to a maximum period of 3 months and Employer Groups, as well as Small and Medium Enterprises less than 200 employees, who qualified, were granted deferred contribution payment for 30 days. Payment defaults were managed according to the Credit Policy. Refer note 27 for the financial impact of the relief measures granted.

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 of which the rental costs make up a non-significant portion of cash flow requirements on a monthly basis. Furthermore, the Scheme has appointed asset managers to manage its liquidity requirements in the short, medium and long-term.

The Scheme has strategically allocated 25% of its total investment assets to be invested in cash which provides a high degree of liquidity on investments. Additionally, the other asset managers are keeping cash in their portfolios at no more than 5% of total investments.

NOTES TO THE ANNUAL FINANCIAL STATEMENTS CONTINUED

FOR THE YEAR ENDED 31 DECEMBER 2020

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 of Trustees provides prior written approval for these investments:

- Private equity funding including venture capital and direct property investments;
- Physical commodities or physical commodity contracts; and
- 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 twelve months R'000	Total R'000
2020			
Financial liabilities			
Personal medical savings account liability	**(51 762)**	**(760 316)**	**(812 078)**
Insurance, trade and other payables (excluding VAT)	**(669 488)**	**–**	**(669 488)**
Outstanding risk claims provision	**(927 461)**	**(48 814)**	**(976 275)**
Derivative financial instruments	**–**	**(31 878)**	**(31 878)**
	(1 648 711)	**(841 008)**	**(2 489 719)**
2019			
Financial liabilities			
Personal medical savings account liability	(55 543)	(623 314)	(678 857)
Insurance, trade and other payables (excluding VAT)	(781 828)	–	(781 828)
Outstanding risk claims provision	(618 847)	(150 261)	(769 108)
	(1 456 218)	(773 575)	(2 229 793)

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.

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 Rands 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.

NOTES TO THE ANNUAL FINANCIAL STATEMENTS CONTINUED

FOR THE YEAR ENDED 31 DECEMBER 2020

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.

	2020 R'000	2019 R'000
Interest-bearing instruments		
Financial assets	**5 394 002**	3 803 170
Investments – interest bearing assets (note 6)	**4 782 912**	3 190 130
Cash and cash equivalents	**611 090**	613 040
Financial liabilities		
Personal medical savings account liability	**(812 078)**	(678 857)
	4 581 924	3 124 313

Interest rate sensitivity analysis

At the end of December 2020, the Scheme earned interest income of R238m (2019: R268.8m) from its investments in bonds, cash and money market instruments. The following tables 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**
2020							
Scheme impact (surplus) (R'000)	**(112 275)**	**(89 820)**	**(67 365)**	**(44 910)**	**(22 455)**	**(11 227)**	**–**
Solvency impact	**(0.61%)**	**(0.48%)**	**(0.36%)**	**(0.24%)**	**(0.12%)**	**(0.06%)**	**–**
2019							
Scheme impact (surplus) (R'000)	(88 794)	(71 035)	(53 277)	(35 518)	(17 759)	(8 879)	–
Solvency impact	(0.51%)	(0.41%)	(0.31%)	(0.20%)	(0.10%)	(0.05%)	–

Increase (%)	**0.0**	**0.25**	**0.5**	**1.0**	**1.5**	**2.0**	**2.5**
2020							
Scheme impact (surplus) (R'000)	**–**	**11 227**	**22 455**	**44 910**	**67 365**	**89 820**	**112 275**
Solvency impact	**–**	**0.06%**	**0.12%**	**0.24%**	**0.36%**	**0.48%**	**0.61%**
2019							
Scheme impact (surplus) (R'000)	–	8 879	17 759	35 518	53 277	71 035	88 794
Solvency impact	–	0.05%	0.10%	0.20%	0.31%	0.41%	0.51%

22.4.3 Market price risk

Market price risk arises from fair value through profit or loss in equity securities held for partially meeting the Scheme's financial obligations although this downside risk is partly managed through an equity hedge (derivative). The Scheme's assets 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 Johannesburg Stock Exchange (JSE) and readily marketable;
- Not more than 5% of the Investment Portfolio of the Scheme may be invested in the share instrument of any one company;
- For investee companies that have a market capitalisation of below R5 million, no more than 2.5% of the total Scheme investment portfolio may be invested in the share instrument of any one investee company; and
- 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 2020

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 Fitch and Standard and 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 no more than 20% per issuer. Instruments below A but not lower than BBB are limited to not more than 10% and no instruments rated below BB- may be held; and
- In addition to a per issuer limits, a minimum of ninety percent of the debt securities held by the fund must be investment grade (AAA to BBB- or equivalent) credit rating.

Derivatives

- The Fund is permitted to invest into derivative structures as per Annexure B of the Medical Schemes Act. Annexure B of Regulation 30 Section 7 a(ii) allows for an allocation of no more than 2.5% of Fund's assets towards any other local assets not referred to in Annexure B and derivative instruments are not referred to anywhere in Annexure B. Therefore, this provision qualifies derivatives as "other" among other assets not referred to in Annexure B.
- The Regulation 30 limitation would therefore permit the Fund to invest in derivative instruments not exceeding 2.5% of the Fund's assets. For clarity, the 2.5% would relate to the value of the derivative asset/liability recognised and not the value of the underlying assets held by the Fund.

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, derivative instruments 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 of Trustees:

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

  b) Physical commodities or physical commodity contracts; and

  c) Unregistered and/or restricted instruments which are unlisted and/or not freely traded.
- Diversifying the management of the Schemes investment portfolio to specific specialised 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 sufficient cash and cash like securities are available to meet cash requirements for ongoing cash flow needs, thereby avoiding the need to sell securities on the open market during periods of market volatility.

Sensitivity analysis

The analysis presented below assumes all other factors remain constant and is performed on the same basis for 2020 and 2019, incorporating the impact of the new derivative arrangements entered into in September 2020.

Listed equities

At the end of December 2020, the Scheme had 32.7% (2019: 35.9%) of its fair value through profit or loss investments invested in equity instruments. The following tables 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 before zero cost fence derivatives:

Decrease (%)	**(35.0)**	**(25.0)**	**(15.0)**	**(10.0)**	**(5.0)**	**(2.0)**	**(0.0)**
2020							
Scheme impact (surplus) (R'000)	**(816 541)**	**(583 243)**	**(349 946)**	**(233 297)**	**(116 649)**	**(46 659)**	**–**
Solvency impact	**(4.40%)**	**(3.15%)**	**(1.89%)**	**(1.26%)**	**(0.63%)**	**(0.25%)**	**–**
2019							
Scheme impact (surplus) (R'000)	(627 892)	(448 494)	(269 096)	(179 398)	(89 699)	(35 880)	–
Solvency impact	(3.61%)	(2.58%)	(1.55%)	(1.03%)	(0.52%)	(0.21%)	–

Increase (%)	**0.0**	**2.0**	**5.0**	**10.0**	**15.0**	**25.0**	**35.0**
2020							
Scheme impact (surplus) (R'000)	**–**	**46 659**	**116 649**	**233 297**	**349 946**	**583 243**	**816 541**
Solvency impact	**–**	**0.25%**	**0.63%**	**1.26%**	**1.89%**	**3.15%**	**4.40%**
2019							
Scheme impact (surplus) (R'000)	–	35 880	89 699	179 398	269 096	448 494	627 892
Solvency impact	–	0.21%	0.52%	1.03%	1.55%	2.58%	3.61%

NOTES TO THE ANNUAL FINANCIAL STATEMENTS CONTINUED

FOR THE YEAR ENDED 31 DECEMBER 2020

22. FINANCIAL RISK MANAGEMENT CONTINUED

22.4 Market risk continued

22.4.3 Market price risk continued

Equity derivative financial instrument (Zero-cost equity fence)

In September 2020 the Scheme entered into zero-cost equity fence arrangements to hedge the exposure to changes in market prices for investments in the equity portfolios. The contracts provide downside protection against market decline of between 2.5% and 15%. To achieve this, the Scheme agreed to forego upside benefit from an increase in equity prices above 10.1% for contract 1 and 11.2% for contract 2. These contracts as listed below will expire in September 2021.

2020 CONTRACTS

Index level	Nominal Value R'000	Index level at trade date	Short put level ('lower floor") %	Long put level ("upper floor") %	Call level ("cap") %
CAPPED SWIX40, BBG: J430PR Index	500 000	14 597	85.00	97.50	110.10
CAPPED SWIX40, BBG: J430PR Index	148 000	14 619	85.00	97.50	111.20

These contracts are categorised at fair value through profit or loss. The fair value of these contracts have been included in financial assets and financial liabilities. Gains and losses on these arrangements are included in the Net surplus.

The following tables illustrate the impact of negative and positive market returns to the overall Scheme which assumes an increase or decrease of 2% to 35% as a result of the current equity exposure, assuming all other variables remain constant after zero cost fence derivatives:

Increase in spot rate (%)	35.0	25.0	15.0	10.0	5.0	2.0	0.0
CAPPED SWIX40", BBG: J430PR Index 500 000 000	(171 295)	(166 752)	(64 600)	(40 617)	(18 910)	(7 211)	–
CAPPED SWIX40", BBG: J430PR Index 148 000 000	(49 545)	(33 539)	(18 383)	(11 507)	(5 338)	(2 033)	–
	(220 840)	(150 281)	(82 893)	(52 124)	(24 248)	(9 244)	–

Decrease in spot rate (%)	(0.0)	(2.0)	(5.0)	(10.0)	(15.0)	(25.0)	(35.0)
CAPPED SWIX40", BBG: J430PR Index 500 000 000	–	6 748	16 060	29 847	42 319	65 202	81 189
CAPPED SWIX40", BBG: J430PR Index 148 000 000	–	1 900	4 523	8 413	11 943	18 454	23 130
	–	8 648	20 583	38 260	54 262	83 656	104 319

Impact on surplus and solvency

Increase in spot rate (%)	35.0	25.0	15.0	10.0	5.0	2.0	0.0
2020							
Scheme impact (surplus) (R'000)	(220 840)	(150 281)	(82 983)	(52 124)	(24 248)	(9 244)	–
Solvency impact	(1.19%)	(0.81%)	(0.45%)	(0.28%)	(0.13%)	(0.05%)	–

Decrease in spot rate (%)	(0.0)	(2.0)	(5.0)	(10.0)	(15.0)	(25.0)	(35.0)
2020							
Scheme impact (surplus) (R'000)	–	8 648	20 583	38 260	54 262	83 656	104 319
Solvency impact	–	0.05%	0.11%	0.21%	0.29%	0.45%	0.56%

NOTES TO THE ANNUAL FINANCIAL STATEMENTS CONTINUED

FOR THE YEAR ENDED 31 DECEMBER 2020

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 a 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:

- 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 2020				
Assets				
Financial assets held at fair value through profit or loss				
Listed equities	**2 332 973**	**–**	**–**	**2 332 973**
Unlisted equities*	**–**	**–**	**22 000**	**22 000**
Bonds	**3 633 929**	**–**	**–**	**3 633 929**
Unlisted property holding*	**–**	**–**	**1 588**	**1 588**
Money market instruments*	**–**	**1 148 983**	**–**	**1 148 983**
Investment properties*	**–**	**–**	**77 700**	**77 700**
Total assets	**5 966 902**	**1 148 983**	**101 288**	**7 217 173**
at 31 December 2019				
Assets				
Financial assets held at fair value through profit or loss				
Listed equities	1 793 976	–	–	1 793 976
Unlisted equities*	–	–	22 000	22 000
Bonds	2 350 997	–	–	2 350 997
Unlisted property holding*	–	–	2 820	2 820
Money market instruments*	–	837 806	–	837 806
Fixed deposits	–	1 327		1 327
Investment properties*	–	–	74 800	74 800
Total assets	4 144 973	839 133	99 620	5 083 726

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

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, 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:

- 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 leased 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; and
- Unlisted insurance policy and valued based on underlying Funds investments.

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

	Level 1 R'000	Level 2 R'000	Level 3 R'000	Total R'000
at 31 December 2020				
Liabilities				
Financial liabilities held at fair value through profit or loss		**31 878**		**31 878**
Derivative instruments				
Total liabilities	**–**	**31 878**	**–**	**31 878**

Financial liabilities held at fair value through profit or loss held by the Scheme categorised as level 2:

- Derivative financial instruments measured using inputs other than quoted prices included within Level 1 that are observable for the liability, either directly or indirectly.

NOTES TO THE ANNUAL FINANCIAL STATEMENTS CONTINUED

FOR THE YEAR ENDED 31 DECEMBER 2020

22. FINANCIAL RISK MANAGEMENT CONTINUED

22.5 Fair value continued

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 2020:

	Investment property R'000	Unlisted equity R'000	Unlisted property holding R'000	Total R'000
Opening balance	**74 800**	**22 000**	**2 540**	**99 340**
Fair value adjustment	**2 900**	**–**	**(952)**	**1 948**
Closing balance	**77 700**	**22 000**	**1 588**	**101 288**

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 2020 include:

Investment property

Refer to note 5 for the details regarding key inputs and assumptions used in the valuation at 31 December 2020.

Unlisted equity

Refer to note 22.6 for the details regarding key inputs and assumptions used in the valuation at 31 December 2020.

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.

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 of 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 2020		At 31 December 2019	
Fund	**Fair value R'000**	**% exposure in terms of Regulation 30**	Fair value R'000	% exposure in terms of Regulation 30
Nedgroup Structured Life Taquanta EIF	**278 579**	**4**	258 557	5
Nedgroup Investments Money Market Fund Class C4	**314 500**	**4**	421 838	8
27four Life: QML8 SRI Low Liquidity Funding Portfolio	**2 650**	**0**	2 652	0
	595 729	**8**	683 047	13

NOTES TO THE ANNUAL FINANCIAL STATEMENTS CONTINUED

FOR THE YEAR ENDED 31 DECEMBER 2020

22. FINANCIAL RISK MANAGEMENT CONTINUED

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 at fair value. An offer of R22m was received to purchase the investment and the sale was executed post year end.

	2020 R'000	2019 R'000
Reconciliation of fair values		
Balance at 1 January	**22 000**	12 065
Fair value adjustment	**–**	9 935
Balance at 31 December	**22 000**	22 000

22.7 Capital management

The Board of Trustees' 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. RisCura Solutions (Pty) Ltd manages the Scheme's portfolio of investments and cash and cash equivalents to achieve this objective.

The Board of Trustees 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.

	2020 R'000	2019 R'000
Members' funds per the statement of financial position	**6 059 840**	4 320 079
Adjusted for:		
Regulation 29 exclusion of unrealised gains on remeasurement of investments and investment property to fair value*	**(4 926)**	–
Accumulated funds per Regulation 29	**6 054 914**	4 320 079
Gross contributions (note 13)	**18 540 546**	17 384 459
Solvency ratio (%)	**32.66**	24.85
** Cumulative net (losses)/gains on remeasurement to fair value of investments are calculated as follows:*		
At beginning of year	**(35 076)**	23 397
Net gains/(losses) on remeasurement to fair value of financial instruments included in accumulated funds	**19 528**	(58 473)
At end of year	**(15 548)**	(35 076)
# Cumulative net gains on remeasurement to fair value of investment properties are calculated as follows:		
At beginning of year	**17 574**	15 474
Movement in unrealised gains on remeasurement to fair value of investment properties included in accumulated funds	**2 900**	2 100
At end of year	**20 474**	17 574
Cumulative net gains/(losses) on remeasurement of investments and investment property at the end of the year	**4 926**	(17 502)

Cumulative net unrealised losses on remeasurement to fair value of investments and investment properties are excluded from the solvency calculation according to Regulation 29.

NOTES TO THE ANNUAL FINANCIAL STATEMENTS CONTINUED

FOR THE YEAR ENDED 31 DECEMBER 2020

	2020 R'000	2019 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	**4 009**	3 929
Later than one year and not later than five years	**3 149**	7 636
	7 158	11 565
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	**1 271**	2 850
Later than one year and not later than five years	**95**	1 366
	1 366	4 216

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 Chairman of the Board, the Board of Trustees, the Principal Officer, the Chief Operations Officer and the Chief Financial Officer.

Close family members include direct family members of the Chairman of the Board, the Board of Trustees, 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.

Medscheme Holdings Proprietary Limited is also the accredited managed care service provider.

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.

Aids 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.

Afrocentric Technologies 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.

Dental Information Systems Proprietary Limited, is a key service provider as it handles the Scheme's dental claims management. It is a fellow subsidiary of the Scheme's administrator.

Scriptpharm Risk Management Proprietary Limited, is a key service provider as it handles the Scheme's chronic risk management. 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.

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 Hospital Holdings Proprietary Limited. The members of the Scheme utilise the facilities of the Louis Pasteur Hospital on an ongoing basis, for medical services.

NOTES TO THE ANNUAL FINANCIAL STATEMENTS CONTINUED

FOR THE YEAR ENDED 31 DECEMBER 2020

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.

	2020 R'000	2019 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 of Trustees. From 1 January 2019 software licensing fees, for the claims administration system, were incorporated into the administration agreement.	**876 461**	848 654
Service Level Agreement penalty recovery		
As part of the administration agreement, the Scheme is entitled to penalty fees if service level agreements are not satisfied.	**–**	(11 778)
Third party recoveries		
As part of the administration agreement, the Administrator is entitled to a 30% fee on fraud, waste and abuse recoveries.	**10 386**	12 008
Statement of financial position		
Balances payable to related party		
The balances payable bear no interest, are unsecured and are due within 30 days.	**(3 115)**	(3 937)
Medscheme Holdings Proprietary Limited - Managed care provider		
Statement of comprehensive income		
Managed care fees		
The managed care agreement between Medscheme Holdings (Pty) Ltd and the Scheme stipulates that Medscheme Holdings (Pty) Ltd 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 of Trustees.	**481 811**	466 291
Statement of financial position		
Balances owed/(payable) by/(to) related party		
The balances owed/(payable) bear no interest, are unsecured and are owed/(payable) upon presentation of an approved invoice.	**2 262**	(7 114)
Medscheme Holdings Proprietary Limited - Actuarial service provider		
Statement of comprehensive income		
Actuarial consulting fees		
The actuarial consulting agreement between Medscheme Holdings (Pty) Ltd and the Scheme stipulates that Medscheme Holdings (Pty) Ltd renders actuarial consulting services and technical marketing services to the Scheme in accordance with the instructions given by the Board of Trustees.	**2 552**	2 445
Statement of financial position		
Balances owed/(payable) by/(to) related party		
The balances owed/(payable) bear no interest, are unsecured and are owed/(payable) upon presentation of an approved invoice.	**–**	–
Afrocentric Distribution Services Proprietary Limited (a fellow subsidiary of Medscheme Holdings Proprietary Limited)		
Statement of comprehensive income		
Sales and marketing fees	**109 391**	127 620
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.	**(8 738)**	(8 633)

NOTES TO THE ANNUAL FINANCIAL STATEMENTS CONTINUED

FOR THE YEAR ENDED 31 DECEMBER 2020

	2020 R'000	2019 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 of Trustees.	**53 525**	51 187
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.	**(4 492)**	(4 315)
Afrocentric Technologies Proprietary Limited (a fellow subsidiary of Medscheme Holdings Proprietary Limited)		
Statement of comprehensive income		
Software licence 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	**597**	2 376
Statement of financial position		
Balances (payable)/receivable from related party		
The balance receivable bears no interest, is unsecured and is due within 30 days.	**–**	(432)
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*	**400 176**	721 059
Statement of financial position		
Balances payable to related party		
The balance payable bears no interest, is unsecured and is due within 30 days.	**–**	–

* *Claims paid reduced due to the introduction of the Scriptpharm Risk Management Proprietary Limited risk transfer agreement, which covers the chronic costs previously covered by Pharmacy Direct*

	2020 R'000	2019 R'000
Scriptpharm Risk Management (Pty) Ltd (a subsidiary of ACT Healthcare Assets Proprietary Limited, the holding company of Medscheme Holdings Proprietary Limited)		
Statement of comprehensive income		
Risk transfer arrangement premiums/fees paid		
The capitated risk management agreement between the Scheme and Scriptpharm Risk Management (Pty) Ltd, as an accredited managed care organisation, stipulates that Scriptpharm Risk Management (Pty) Ltd renders Chronic medicine benefits to beneficiaries of the Fund on a capitated basis.	**703 422**	–
Statement of financial position		
Balances payable to related party		
The balance payable bears no interest, is unsecured and is due within 30 days.	**(13 397)**	–

NOTES TO THE ANNUAL FINANCIAL STATEMENTS CONTINUED

FOR THE YEAR ENDED 31 DECEMBER 2020

	2020 R'000	2019 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*		
Dental Information Systems Proprietary Limited		
In December 2019, AfroCentric Investment Corporation Limited (AfroCentric Group), reached an agreement through one of its subsidiaries to acquire 100% of the shareholding of DENIS for R250 million. The Commission approved the deal and allowed for finalisation of the details of this acquisition which has come into full effect on 01 October 2020		
Statement of comprehensive income		
Risk transfer arrangement premiums/fees paid		
The capitated risk agreement between Dental Information Systems Holdings Proprietary Limited and the Scheme stipulates that Dental Information Systems Holdings Propertary Limited renders dental risk management to the members of the Fund.		
Capitation fees payable (including fees for wellness and administration costs)	**93 427**	–
Refund of capitation fees negotiated as a result of COVID-19	**(55 545)**	–
Managed care services		
The managed care agreement between Dental Information Systems Holdings Proprietary Limited and the Scheme stipulates that Dental Information Systems Holdings Proprietary Limited renders managed care services for Primary and Primary EDO options of the Fund.		
Dental risk management	**4 117**	
Statement of financial position		
Balances owing by related party		
The balance owing bears no interest, is unsecured and is due within 30 days, as the Fund negotiated a refund of capitation fees due to a reduction in utilisation as a result of the COVID-19 pandemic.	**55 545**	–
Wellness Odyssey (Pty) Ltd (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	**18 261**	17 901
Statement of financial position		
Balances payable to related party		
The balance payable bears no interest, is unsecured and is due within 30 days.	**(7 866)**	(2 051)
Tendahealth (Pty) Ltd (a subsidiary of Afrocentric Distribution Services (Pty) Ltd, a fellow subsidiary of Medscheme Holdings (Pty) Ltd) - Related party with effect from 1 December 2017		
Statement of comprehensive income		
Broker fees paid	**10 196**	6 361
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		
Trustee's remuneration and other disbursements (note 15)	**5 635**	4 634
Principal Officer's remuneration and other disbursements (note 15)	**5 614**	6 315
Executive remuneration and other disbursements	**4 456**	4 129
	15 705	15 078
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.	**886**	741
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.	**280**	264
Trustee savings balances		
This constitutes savings balances held by the Scheme on behalf of the trustees.	**2**	-

NOTES TO THE ANNUAL FINANCIAL STATEMENTS CONTINUED

FOR THE YEAR ENDED 31 DECEMBER 2020

	2020 R'000	2019 R'000
24. RELATED PARTY TRANSACTIONS CONTINUED		
24.2 Transactions with related parties continued		
24.2.3 Other related parties		
Louis Pasteur Hospital Holdings Proprietary Limited		
Statement of comprehensive income		
Claims paid during the year	**23 808**	36 941
Cession of judgement debt-realisation of prior year contigent asset	**–**	(80 000)
Statement of financial position		
Unlisted equity held by the Scheme in the entity at fair value	**22 000**	22 000
Balance payable to related party		
The balance payable bears no interest, is unsecured and is due within 30 days.	**(280)**	–

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 R454m (2019: R479m). Management is confident that the contingent assets will be recoverable, should they arise.

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 2020 the Scheme reported a net healthcare deficit on two (2019: eight) of its benefit options:

	2020 R'000	2019 R'000
BonCap	**62 540**	219 646
BonClassic	**–**	51 334
BonComprehensive	**9 076**	111 665
BonEssential	**–**	24 981
BonComplete	**–**	25 294
BonSave	**–**	4 210
Hospital Standard	**–**	29 807
Primary	**–**	37 668

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 2020 Standard and Primary have reported a net healthcare surplus of R976.5 million and R265.4 million respectively. Much of the positive performance can be attributed to successful hospital negotiations, benefit design and the realignment of membership into the correct options. In addition, utilisation reduced due to the impact of COVID-19, lockdown, and the consequential decrease in elective procedures resulting in a decrease in hospital and associated costs. The Scheme continues to monitor the performance of the eight 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.

NOTES TO THE ANNUAL FINANCIAL STATEMENTS CONTINUED

FOR THE YEAR ENDED 31 DECEMBER 2020

26. NON-COMPLIANCE WITH THE ACT CONTINUED

26.2 Contravention of Section 26(7) of the Act

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 2020 financial period the Scheme incurred bad debt write offs of R10.8 million (2019: R13.4 million) which equals 0.06% (2019: 0.08%) of risk contribution income.

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.

Due to the financial economic burden experienced by the members of the Fund, with the impact of COVID-19, the Scheme obtained an exemption from Section 26(7) of the Act from the Council for Medical Schemes. Refer to note 22.2.6 and 27.3 for details of the applications granted and the financial impact.

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 Council for Medical Schemes, 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 Council for Medical Schemes in respect of the non-compliance noted.

26.5 Contravention of Section 59 (2) of the Act

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 are 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 the 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.

NOTES TO THE ANNUAL FINANCIAL STATEMENTS CONTINUED

FOR THE YEAR ENDED 31 DECEMBER 2020

26. NON-COMPLIANCE WITH THE ACT CONTINUED

26.6 Contravention of Regulation 10 (6) of the Act

26.6.1 Nature and cause

Regulation 10(6) of the Act prohibits the funding of a Prescribed Minimum Benefit ("PMB") from the members' medical savings accounts. An error occurred where potential PMB claims were processed as non-PMB related claims due to the loading of the Scheme Rules and paid incorrectly from members' medical saving accounts instead of being paid from the Scheme's risk reserves. This error was limited to the Wellness extender benefit linked to approved wellness authorisations causing claims to be paid incorrectly.

26.6.2 Possible impact

Non-compliances with Regulation 10(6) is the risk. This may result in escalation of member complaints whose claims were incorrectly paid from their medical savings accounts and causing the member's out-of-pocket expenses to increase.

26.6.3 Corrective course of action

The errors were rectified when the incorrect claims process was identified. The affected members' medical saving accounts were credited with the respective amounts, where applicable. All PMB claims that are affected by the error have been rectified.

27. FINANCIAL IMPACT OF CORONAVIRUS (COVID-19) DURING THE 2020 YEAR

The COVID-19 pandemic impacted the Scheme's membership growth rate, it subdued claims expenditure, following a reduction in utilisation and the consequential decrease in elective procedures and hospital and associated costs, and it also placed a financial economic burden on members that hampered their ability to make contribution payments. Government lockdown restrictions resulted in challenging circumstances for Small and Medium Enterprises (SMEs) who were not considered essential services. This resulted in widespread retrenchments and salary cuts.

Recognising the affordability issues, the Scheme introduced the following financial relief measures to its members:

1) Utilisation of accumulated Personal Medical Savings account balances to offset contributions for up to a maximum of 3 months to members and Groups; and

2) Deferred contribution payment for a 30 day term to provide assistance to SMEs of less than 200 employees.

The above relief measures were granted for the period 1 June 2020 to 31 August 2020 and again from 1 October 2020 to 31 December 2020 to members and Groups who qualified according to the stipulated criteria, considering the credit risk.

The tables below represent the membership and financial impact experienced by the Scheme during the 2020 financial period.

27.1 COVID-19 Membership impact

The Scheme was unable to make growth targets due to a slowdown in Gross Domestic Product and the pressures experienced by the industry. Hence despite terminations remaining aligned to previous year, growth targets were not achieved. Buy downs in terms of members moving to lower cost option was a continuing trend which was exacerbated in 2020 through affordability challenges.

The following table represents the membership statistics:

	2020	2019
Average number of members during the year	**335 425**	336 651
Total number of membership losses for the year	**43 424**	43 032
Total number of new members joining the Scheme for the year	**37 814**	50 790
Average net membership (loss)/growth for the year (%)	**(1.7)**	2.3
Total number of members moving to lower cost options	**10 323**	8 764
Total number of members moving to higher cost options	**5 366**	4 825

27.2 COVID-19 Claims impact

The following table represents the COVID-19 claims financial impact as at 31 December 2020:

Total lives infected by COVID-19	**33 952**
% of total lives infected by COVID-19	**4.7**
Total lives recovered from COVID-19	**30 142**
Total deaths from COVID-19	**1 123**
Total COVID-19 related claims (including outstanding risk claims provision) in Rands	**1 189 827 999**

The claims ratio excluding COVID-19 claims reduced from 92.3% in 2019 to 76.3% in 2020 due to:

- Change in members behaviour where members wanted to avoid physical contact during pandemic;
- Cancellation of elective procedures surgeries by both practitioners, facilities and members;
- Lack of capacity in some instances where facilities were forced to focus purely on COVID-19 related treatments; and
- Members practicing social distancing and mask-wearing also helped to reduce the spread of other infectious diseases.

NOTES TO THE ANNUAL FINANCIAL STATEMENTS CONTINUED

FOR THE YEAR ENDED 31 DECEMBER 2020

27. FINANCIAL IMPACT OF CORONAVIRUS (COVID-19) DURING THE 2020 YEAR CONTINUED

27.3 Types of COVID-19 contribution relief measures granted to members

27.3.1 COVID-19 relief granted via the Personal Medical Savings Account (PMSA) utilisation to offset contribution

The following table represents the COVID-19 relief measures granted via the PMSA utilisation as at 31 December 2020:

Total members utilising PMSA for COVID-19 relief	**155**
Total Rand amount of PMSA COVID-19 relief utilised to offset contributions	**1 151 442**
Total Rand amount of the PMSA Liability of the Scheme (before relief granted)	**813 229 787**

27.3.2 COVID-19 relief granted via deferred contribution payment of a 30-day term to SMEs less than 200 employees

The following table represents the COVID-19 relief measures granted via the deferred contribution payment of a 30-day term to SMEs as at 31 December 2020:

Total number of members of the SMEs who were granted contribution deferrals	**183**
Total number of SMEs of less than employees who were granted contribution deferrals	**2**
Total Rand amount of contribution deferrals granted to SMEs	**608 178**
Total Rand amount of deferrals recovered / paid back by SMEs	**608 178**
Total accounts receivable balance of the scheme	**719 065 940**

27.4 COVID-19 impact on the investment market

The crash in global financial markets was most severe in March 2020 where the market contraction eroded as much as 33% of the Scheme's equity portfolio value. The Scheme experienced extreme fair value losses on investments following the panic reactions to the onset of Covid-19, the impact of the Lockdown on the general level of business activity in the country, as well as the significant fall in the oil price, projected worsening revenue collection, worsening sovereign debt-to-GDP, worsening budget deficit and the subsequent sovereign credit downgrade. This pull back was deepened by the shutdown of global economies in an attempt to curb the spread of the pandemic. Equity markets rebounded in the second quarter as did bonds, which enjoyed massive recoveries. In the third quarter bonds continued returning significant gains for the Scheme whilst equities detracted with their performance. Towards the latter part of the year equities and bonds improved as most of the Scheme's portfolios outperformed set benchmarks in line with the JSE All Share Index recovery.

Interest and dividend income experienced a significant decrease in returns due to the drop in the Reserve Bank's Repo rate which impacted cash returns on money markets and fixed deposits detrimentally and inflation linked bonds.

The Scheme reported an investment return of 4.16% for the year.

The following table represents the financial impact on fair value losses and gains, interest and dividend income for the 2020 financial year:

	Fair value gains/ (losses) on financial assets held at fair value through profit or loss R'000	Interest and dividend income on financial assets held at fair value through profit or loss R'000	Total investment income (excluding rental income and derivatives) on financial assets held at fair value through profit or loss R'000
Investment income for Quarter 1 of 2020	**(763 234)**	**70 194**	**(693 040)**
Investment income for Quarter 2 of 2020	**403 315**	**89 781**	**493 096**
Investment income for Quarter 3 of 2020	**(27 050)**	**77 068**	**50 018**
Investment income for Quarter 4 of 2020	**411 624**	**77 516**	**489 140**
	24 655	**314 559**	**339 214**

NOTES TO THE ANNUAL FINANCIAL STATEMENTS CONTINUED

FOR THE YEAR ENDED 31 DECEMBER 2020

28. EVENTS AFTER STATEMENT OF FINANCIAL POSITION DATE AND EXPECTED IMPACT OF COVID-19

28.1 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.

28.2 COVID-19 Impact Assessment for 2021

28.2.1 Impact of COVID-19 on claims values for 2021

On the basis of international experience and trends across the world, management believe that there are three potential scenarios for 2021 which should be considered as follows:

1) ***Third and Fourth waves:*** a third wave in the southern hemisphere winter of magnitude similar to the second wave, as well as a smaller fourth wave towards the end of 2021. The third wave would be driven by the emergence of new variants.

2) ***Third wave only:*** a third wave in the southern hemisphere winter, but peaking at a level significantly lower than the second wave. This allows for some level of population immunity due to vaccinations and many people already having been infected.

3) ***No Third wave:*** this assumes that positive cases continue occurring throughout 2021 at very low levels.

The cost projections have primarily been made on admissions, as these have emerged as the primary cost drivers as the pandemic has progressed. Pathology costs are the other significant cost, and it is assumed that the number of pathology tests per admission will mirror the second wave.

The tables below represent the membership and financial impact experienced by the Scheme during the 2020 financial period.

	High	Medium	Low
	High 3rd and moderate 4th wave	Third wave only	No Third wave
Number of hospital admissions	9 963	8 089	4 907
Number of cases	50 225	40 778	24 737
Hospital costs including Personal Protective Equipment (PPE) in Rands	1 150 726 500	934 279 500	566 758 500
Pathology test costs Rands	179 486 000	145 724 850	88 400 850
Home care costs in Rands	66 510 625	54 000 218	32 757 968
Total costs in Rands	**1 396 723 125**	**1 134 004 568**	**687 917 318**
As % of gross annual contributions	**7.3%**	**5.9%**	**3.6%**

The 2020 estimated COVID-19 direct outgo is projected at approximately 6.4% of gross contributions. An estimated R411 million of the projected cost has already been incurred for 2021.

As observed over 2020, an increase in COVID-19 cases and admissions were offset by a reduction in other healthcare spend as people delayed elective procedures and treatment, and trauma cases also fell when alcohol sale and movement restrictions were implemented.

The overall impact of additional waves in 2021 may therefore actually be an overall reduction in Budgeted claims. Scenarios in this regard are presented in note 28.2.4.

28.2.2 COVID-19 Vaccine Costs – 2021

Summary of Vaccine Cost Estimates

Updated cost estimates show the potential cost impact for the Scheme to be in the range of 0.9% to 1.7% of contributions, translating to a total estimated cost impact of between R180 million and R321 million.

			Total 2021 estimated cost in R'm at NDOH indicated price		
% lives under 18	Total lives eligible	Total doses assumed	Low	Medium	High
29,7%	530 245	667 048	180	247	321
	Estimated impact on 2021 solvency		0.90%	1.30%	1.70%

NOTES TO THE ANNUAL FINANCIAL STATEMENTS CONTINUED

FOR THE YEAR ENDED 31 DECEMBER 2020

28. EVENTS AFTER STATEMENT OF FINANCIAL POSITION DATE AND EXPECTED IMPACT OF COVID-19 CONTINUED

28.2 COVID-19 Impact Assessment for 2021 continued

28.2.3 NON-COVID Utilisation

COVID-19 expenditure was approximately 7% of the 2020 Budget, however, the additional incurred COVID-19 expenditure went hand-in-hand with a reduction in general utilisation ("non-COVID" utilisation) of approximately 16%, resulting in a net claims reduction of approximately 9% relative to Budget. Also expressed as, for every R1 of COVID expenditure, non-COVID expenditure dropped by more than R2.

Postponement of elective surgical admissions were evident during both the peaks of the first and second waves. Travel restrictions and people spending more time at home also resulted in a large reduction in admissions such as pneumonia and bronchitis. Additional lockdown restrictions such as the alcohol ban and curfew rules also resulted in far fewer trauma cases than observed in prior years.

28.2.4 Total projected impact of COVID-19 on 2021

Combining the main cost levers identified in Note 28.2.1 to 28.2.3, three possible scenarios for the 2021 Financial Year (including the main underlying assumptions) are shown below:

		Scenario		
Category	**Description of Main Assumption(s)**	**2 more Waves**	**1 more Wave**	**No 3rd Wave**
Direct COVID-19 Costs	Total number of Hospital Admissions	**9 963**	**8 089**	**4 907**
	Total number of Pathology tests	**211 160**	**171 441**	**104 001**
Vaccine Costs	85% Eligibility DOH cost estimates	**Medium Scenario, refer Note 28.2.2**		
Non-COVID utilisation	Offsetting Impact in non-COVID utilisation relative to 2021 Budgeted levels; based on projected 2021 admissions relative to 2020 admissions. Utilisation patterns were inferred from 2020 experience, noting the exclusion of the April/May 2020 lockdown effect' and allowing for 30% efficiency improvement factor from 2020 levels (refer Note 28.2.3)	**(10.80%)**	**(7.20%)**	**(5.30%)**
Electives Catch-Up	Proportion claims catch-up of postponed 2020 elective procedures in 2021 between COVID-19 waves	**50%**	**70%**	**90%**

		Scenario		
Category	**2021 Cost Projections (R'm)**	**2 more Waves**	**1 more Wave**	**No 3rd Wave**
Direct COVID-19 Costs	Total for hospital admissions, pathology tests and home care	**1 397**	**1 134**	**688**
Vaccine Costs	Total cost, including logistics and administration	**247**	**247**	**247**
Non-COVID utilisation	Total offsetting Rand impact in non-COVID utilisation relative to the 2021 Budget	**(1 558)**	**(1 046)**	**(805)**
Electives Catch-Up	Total cost based on 2020 Procedures "lost" and assumed catch-up percentage	**241**	**338**	**434**
	Projected Net Claims Impact	**327**	**673**	**564**

		Scenario
Category	**2021 Cost Projections (R'm)**	**2021 Pricing Budget**
Direct COVID-19 Costs Non-COVID utilisation	A combined assumption of 20% of 2020 Projected COVID-19 Levels (at the time of Pricing) was made at the time	**159,1**
Vaccine Costs	A combined assumption of a 3% overall increase in utilisation relative to 2019 levels (at the time of Pricing) were assumed, in addition to normal Fund ageing and profile changes	**454,2**
	2021 Budgeted Net Claims Impact	**613,3**

NOTES TO THE ANNUAL FINANCIAL STATEMENTS CONTINUED

FOR THE YEAR ENDED 31 DECEMBER 2020

28. EVENTS AFTER STATEMENT OF FINANCIAL POSITION DATE AND EXPECTED IMPACT OF COVID-19 CONTINUED

28.2 COVID-19 Impact Assessment for 2021 continued

28.2.4 Total projected impact of COVID-19 on 2021 continued

Conclusion and Other Considerations

The scenarios considered show that the Scheme is suitably positioned to absorb the projected healthcare impact of the 2021 COVID-19 infections.

Under two of the three scenarios presented, the overall claims expenditure will likely be lower than what was budgeted for 2021.

The assessment has not evaluated the impact of investment performance in 2021, nor the possibility of any market crashes and the impact therefore on any significant changes to membership numbers and profile. Management believe the likelihood and/or probability of another market crash is highly unlikely and for that reason, the impact thereof has not been factored into the COVID-19 impact assessment. However, note 22.4 does illustrate the impact of both negative and positive market movements on the Funds reserves and solvency for reference.

28.3 Negotiation and Renewal of Administration and Managed Care Contracts

The following contracts with Bonitas Medical Fund were due to terminate in June 2020:

- Administration – Medscheme Holdings Proprietary Limited
- Managed Care – Medscheme Holdings Proprietary Limited
- HIV/AIDS disease management - Aid for Aids Proprietary Limited

The following contract with Bonitas Medical Fund was due to terminate in July 2020:

- Wellness program management - Wellness Odyssey Proprietary Limited

Bonitas Medical Fund and the third parties, who are all subsidiaries of the AfroCentric Group, agreed to extend the above mentioned contracts which terminated in June and July 2020, on the same terms and conditions as approved by the Board of Trustees. The contracts are currently running on a month-to-month basis expiring in June 2021, but will automatically expire if the new contracts become effective prior to June 2021.

OUR CONTACT DETAILS

Officers of the Scheme

Principal Officer	Chief Financial Officer
LR Callakoppen	**L Woodhouse**
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

Registered office and postal address of the Scheme

	Administrator Medscheme Holdings Proprietary Limited	Managed care provider Medscheme Holdings Proprietary Limited 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

Asset/Investment managers

Taquanta Asset Management Proprietary Limited Financial service provider number: 618	Allan Gray Investment Managers Financial service provider number: 40592	Prudential Portfolio Managers Financial service provider number: 615	Fairtree Investment Manager Financial service provider number: 25917
Physical address 7th Floor Newlands Terrace Boundary Road Newlands Cape Town 7735	**Physical address** 1 Silo Square V&A Waterfront Cape Town 8001	**Physical address** 7th Floor Protea Place 40 Dreyer Street Claremont Cape Town 7700	**Physical address** Ground Floor Willowbridge Place Corners of Carl Cronje Drive and Old Oak Bellville 7530
Postal address PO Box 23450 Claremont 7700		**Postal address** PO Box 44813 Claremont 7735	

OTHER INFORMATION CONTINUED

Asset/Investment managers

Sesfikile Capital
Financial service provider number: 39946

Physical address
2nd Floor
18 The High Street
Melrose Arch
Johannesburg
2076

Catalyst Fund Managers
Financial service provider number: 36009

Physical address
4th Floor
Protea Place
Protea Road
Claremont
7708

Postal address
PO Box 44845
Claremont
7735

Vunani Fund Managers
Financial service provider number: 49846

Physical address
6th Floor
Letterstedt House
Newlands on Main
Newlands
7700

Aluwani Capital Managers
Financial service provider number: 46196

Physical address
EPPF Office Park
24 Geogian Crescent East
Bryanston East
2152

Actuaries

Medscheme Holdings Proprietary Limited
Accreditation number MC053

Physical address
The Boulevard
Building F
Searle Street
Woodstock
7925

Postal address
PO Box 38632
Pinelands
7430

NMG Consultants and Actuaries Proprietary Limited
Financial service provider number: 12968

Physical address
NMG House
411 Main Avenue
Randburg
2125

Postal address
PO Box 3075
Randburg
2125

External auditor

Deloitte

Physical address
5 Magma Crescent
Waterfall City
2090

Postal address
Private Bag x6
Gallo Manor
2052

Internal auditor

PwC

Physical address
4 Lisbon Lane
Waterfall City
Jukskei View
2090

Postal address
Private Bag x36
Sunninghill
2157

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www.bonitas.co.za
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