PROFMED

ANNUAL INTEGRATED REPORT 2018

PROFMED

Annual Integrated Report
For the year ended 31 December 2018

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Glossary of acronyms

B-B BEE	Broad-Based Black Economic Empowerment
CDL	Chronic Disease List
CMS	Council for Medical Schemes
FVOCI	Fair value through other comprehensive income
FVPL	Fair value through profit or loss
HMI	Health Market Inquiry
IAM	Investec Asset Managers
IAS	International Auditing Standards
IFRS	International Financial Reporting Standards
MSA	Medical Schemes Act
NHI	National Health Insurance
PMB	Prescribed Minimum Benefit
RAF	Road Accident Fund
SAICA	South African Institute of Chartered Accountants
SARS	South African Revenue Services
VAT	Value Added Tax

PROFMED

Our Chairman's report

In 2019, Profmed celebrates 60 years of providing excellent healthcare benefits for professionals. Although Profmed was registered as a medical scheme in 1969, it was operated out of The Professional Provident Society providing benefits to professionals as early as 1959. This milestone is befitting of the results presented here for 2018. Despite the many challenges facing medical schemes, and set-backs in certain investment categories and the socio-political arena in particular, Profmed's results are satisfying.

Financial results

The number of high-cost claims incurred by Profmed in 2017 was not repeated in 2018 and Profmed's claims are in line with budget for 2018. Our property and equity portfolios were negatively affected by the global economic climate and the domestic socio-political environment, which impacted the Scheme's investment returns.

The one percentage point increase in VAT which came into effect on 1 April 2018 cost the Scheme R10 million. As medical schemes are not VAT registered, the Scheme elected to absorb this additional expense rather than pass it on to members through contribution increases or a reduction in benefits.

Membership growth was positive in 2018 with new members joining the Scheme exceeding target. Overall membership increased by 1.6% to 33 125 but this increase in membership put a strain on the Scheme's solvency ratio, which closed at 49.4% at the end of December 2018 – 3.1% down from 2017. This is still a very healthy solvency from which the Scheme can draw to ensure members continue to receive quality healthcare benefits.

Imperative to the sustainability of the Scheme is continued membership growth. While the Scheme continued to grow in an industry that is stagnating in membership, the tough economic situation in South Africa constrained the decision-making of potential members. To meet the needs of these potential members, the Scheme introduced the Savvy network options in the 2019 benefit year. Initial indications are that these options have been very well received by both existing members and the market, which augurs well for the Scheme's future growth.

Service levels

Profmed's service is amongst the best in the medical scheme industry. The calibre of call centre staff, the structure of processes, the design of benefits and the channels of communication for members are all driven by Profmed's objective and business model of meeting the expectation of excellence by professionals. Call centres operate eleven hours a day, as well as on Saturday mornings, with a focus on outbound engagement with members to resolve queries quickly and satisfactorily.

The results of a member satisfaction survey undertaken in September showed that 88% of participants were satisfied with Profmed as their medical scheme. This is above the industry benchmark.

Profmed's mobile App aims to make engagement by members with us quick and convenient, and is successfully used to communicate important information and messages to members. The App enjoys good uptake by members and the features on the App are continually enhanced to remain relevant and to meet the needs of busy professionals.

Scheme governance

The Scheme has a robust approach to governance. The tenets of governance are not merely principles that are applied to the running of the Scheme. They form the essence of how we conduct our relationships with our members and stakeholders, how we formulate protocols and processes, and how we live out our responsibilities – both as trustees on the Board and as staff of the Scheme.

To further enhance/increase our transparency with all our stakeholders, the Profmed website houses a Corporate Governance page that contains policies, charters and other documents to provide assurance of the Scheme's commitment to good business practices.

Our Chairman's report

Healthcare environment

The healthcare industry was put under pressure in 2018 with the release of three important pieces of legislation and reports that required detailed consideration and comment by the various players in the industry. The long-awaited Medical Schemes Amendment Bill and the National Health Insurance Bill were gazetted on 21 June 2018 and the Health Market Inquiry Provisional Report was released shortly thereafter on 5 July 2018. Significant time and resources were expended in providing meaningful comment to these proposed reforms. See page 8 of this Annual Integrated Report for further comment in this regard.

Our new Principal Officer

After more than 15 years at the helm of Profmed, Graham Anderson retired as Principal Officer and Chief Executive effective 31 December 2018. We thank Graham for imparting his extensive knowledge and experience to bringing Profmed to where it is today, and we wish him well in his retirement.

Craig Comrie, a Chartered Accountant, took over as Principal Officer and Chief Executive on 1 January 2019 and brings with him 17 years' experience in the medical scheme administration field. We welcome Craig and look forward to his contribution to the future success and growth of the Scheme.

Closing

After having served as a trustee on the Board for 12 years, the last of which as Chairman, I will be retiring from the Board at the annual general meeting on 4 June 2019. It has been a pleasure and a privilege to serve the members of Profmed and to work with trustees of such high calibre and integrity.

I thank my fellow trustees for their insight and the experience and skill they have made available to the Board, and for the critical and robust debate that ensured sound decision-making. I also wish to thank the staff in the Executive Office and at our Administrator, PPS Healthcare Administrators, for putting Profmed first as they carry out their roles and responsibilities, and for embodying the authenticity of Profmed's brand and ethos.

The future of Profmed is in good hands.

Dr RD Shuttleworth
Chairman

10 April 2019

Report scope and boundaries

This Report aims to provide a concise overview of the Scheme, integrating and connecting important information about strategy, risks and opportunities and relating them to the financial, economic, social and environmental performance for the reporting period 1 January to 31 December 2018. Material and relevant issues that affect the Scheme have been identified in this Report.

Use of guidelines

Profmed's policies align with the Medical Schemes Act 131 of 1998 (MSA) and the recommendations set out in the King Report on Governance for South Africa (King IV), and incorporate guidance from the International Integrated Reporting Council.

The Board has adopted King IV. The financial accounting policies align with International Financial Reporting Standards (IFRS), with guidance from the Medical Schemes Accounting Guide, issued by the South African Institute of Chartered Accountants (SAICA).

Materiality

Material topics are defined as those reflecting significant economic, environmental and social impacts or those that would influence the decisions of the Scheme's stakeholders. Regulatory obligations, internal financial and non-financial reports and voluntary disclosure standards inform the material topics disclosed in this Report.

Stakeholder inclusiveness

The principle of stakeholder inclusiveness ensures that disclosures are material and relevant to the legitimate interests of Profmed's stakeholders.

The Scheme's main stakeholders are Profmed members, future Profmed members, brokers, healthcare service providers, the third-party administrator, managed care service providers, employees and the Council for Medical Schemes (CMS).

The primary vehicles used to inform stakeholders are the Scheme's Annual Integrated Report, an interactive website, the Scheme Rules, claims statements and individual communication where relevant. Communication to members includes governance communication as required by the MSA, communication in respect of benefits and contributions as well as any other matters that affect members. Profmed's mobile App gives members easy access to the Scheme and to their personal information, and provides useful functionality that adds value to the member experience.

Data measurement

Data measurement techniques are replicable and the data warehouse is used extensively to identify trends and risks. This information is used to make informed decisions about the Scheme's performance against predetermined budgets and health related outcomes. Measurement techniques, estimates and underlying assumptions are described where it is materially necessary to do so.

Assurance

PricewaterhouseCoopers Inc., the Scheme's external auditor, has audited the annual financial statements and their report is presented on page 31. The Scheme's independent actuaries have been consulted where estimates and projections are presented. The internal audit function of the Scheme's administrator performed a limited review of the non-financial information and qualitative data presented in this Report.

The rating of the Scheme by Global Credit Rating Co. remained stable at AA in 2018. This is an independent assessment of the Scheme's financial position and claims-paying ability.

PROFMED

Organisational overview and external environment

1. About Profmed

Profmed is a not-for-profit organisation exclusively for graduate professionals. It provides a risk-pooling arrangement to fund members' medical costs and also assists in the control, management and administration of medical services provided to its members.

1.1 Our terms of registration

Profmed is a restricted medical scheme registered in terms of the Medical Schemes Act No. 131 of 1998, as amended. Registration number 1194.

1.2 The healthcare options we offer

During the year, the following benefit options were available:

- ProPinnacle
- ProSecure Plus
- ProSecure
- ProActive Plus
- ProActive.

2 Our external environment

Profmed operates in a complex, competitive and highly legislated environment. The introduction of the MSA in 1998 required medical schemes to admit members irrespective of their health status or age. The intention was to introduce mechanisms, namely, risk equalisation and mandatory medical scheme cover, to assist medical schemes to mitigate their claims risk.

Risk equalisation was intended to spread the risk of the burden of disease across all medical schemes, and mandatory membership of a medical scheme by individuals earning above a certain threshold was meant to enlarge the risk pool and thereby stabilise necessary cross-subsidisation. These mechanisms would have relieved the State of the burden of disease of the employed population and were the reason for the income tax subsidy being granted on medical scheme contributions.

Neither risk equalisation nor mandatory medical scheme cover have been implemented, which results in schemes being exposed to anti-selection that increases the age and risk of the Scheme and makes healthcare less affordable to younger members. This situation has been exacerbated by the requirements of the legislation in terms of the PMBs, which require medical schemes to cover the diagnosis, treatment and care costs of 270 conditions in full.

2.1 Economic environment

The South African economy continued to struggle with a first quarter recession recovering to virtually no growth in GDP in 2018 due to continued domestic constraints. Equity markets showed a significant decline in a volatile year.

Rising interest rates and consumer inflation have an impact on the affordability of healthcare insurance. This hampers the rate at which the Scheme can grow its membership. Profmed’s results for 2018 continue to reflect the impact these factors are having on the Scheme. Profmed manages affordability carefully by limiting contribution increases, and ensures the sustainability of the Scheme through appropriate benefit design and the wise investing of reserves.

2.2 Regulatory environment

Profmed operates within the MSA and Scheme Rules and is regulated by the CMS. In 2018, the healthcare industry saw the publishing of a number of draft reports and Bills setting the scene for the anticipated National Health Insurance plan. The suggested reforms will have far-reaching consequences for medical schemes and the industry as a whole. However, Profmed believes these will happen in a more gradual manner, allowing participation in shaping the final NHI implementation strategy. We provide a snapshot here of what happened in the regulatory environment in 2018.

Organisational overview and external environment *(continued)*

Findings of the Health Market Inquiry
After considerable delays, the Preliminary Report of the Health Market Inquiry (HMI) was released on 5 July 2018. Findings were made against medical schemes (health funders), healthcare providers and facilities, medical scheme administrators, as well as against the Council for Medical Schemes, the Health Professions Council of South Africa and the Department of Health. In particular, the Preliminary Report called for a review of the healthcare regulatory environment as it pertains to the lack of implementation of a risk adjustment mechanism, mandatory medical scheme cover and a lack of regulated tariffs.

The overall recommendations include changes to the way medical scheme options are structured to increase comparability between schemes and increase competition in the medical scheme market; the introduction of a system to increase transparency on health outcomes to allow for value purchasing; and the implementation of interventions to improve competition in the market through a supply-side (healthcare provider) regulator. Another critical recommendation of the HMI is the implementation of regulated tariffs for healthcare providers.

The final report was due to be released on 29 March 2019 but, due to budgetary constraints, this has been further delayed to 30 September 2019.

Profmed's comments on the Preliminary Report, our initial submission to the Inquiry, together with those of other stakeholders and other reports, are available on the Competition Commission's website.

Medical Schemes Amendment Bill was published for comment
The Bill makes provision for a common benefit package which will provide a standard set of benefits that all medical schemes will provide, with no co-payments permitted on these benefits; medical schemes will have fewer mechanisms to mitigate ante-selection risk; and the Registrar of Medical Schemes will have greater authority over medical schemes.

Contrary to what we reported in our 2017 Annual Integrated Report, the Bill does not address the concerns around the requirement of Regulation 8 for medical schemes to fund prescribed minimum benefit (PMB) conditions at full invoice price, nor reforms to allow for the introduction of low-cost benefit options, which seem to be delayed in favour of a future NHI implementation.

Profmed submitted comprehensive comments to the Bill and we await the outcome of this process.

NHI Bill published
The National Health Insurance (NHI) Bill makes provision for the establishment of a National Health Insurance Fund but provides no mechanisms for how the fund will be financed nor what benefits the fund will cover. It imbues the Minister of Health with ultimate autonomy over the NHI fund without any structures of accountability or separation of powers. Medical schemes will provide complementary benefits, but it is unclear what the implications of this are as the Bill does not stipulate what benefits it will cover.

Potential impact of NHI on the Scheme
The Scheme has submitted comments to the Bill but the political quagmire surrounding the Bill is disquieting. Nevertheless, it remains Profmed's considered view that NHI will be phased in over the next 15 to 20 years and the Board is consequently of the opinion that it is a low risk in the short to medium term. The Board and management of the Scheme remain alert to the potential impact of NHI on Profmed and our members.

Protecting the personal information of our members
For purposes of the Beneficiary Registry, medical schemes continue to engage with the CMS to find alternative ways of collaborating with the Department of Health to make available to it the personal information of all their members and beneficiaries in a manner that does not compromise the confidentiality of the information requested and the risk this poses to medical schemes and their beneficiaries. The Beneficiary Registry is supposedly to allow the Department to verify whether patients visiting public hospitals and facilities are members in good standing of a medical scheme in order for the medical scheme to be billed for treatment provided by the public facility.

Council for Medical Schemes proposes a Consolidation Framework
Circular 42 of 2018 from the Council for Medical Schemes called for comments to the proposed framework to consolidate benefit options within schemes and to consolidate medical schemes. It is not clear on what mandate this framework is based nor the purpose for consolidation. Profmed has submitted comments to the circular and we await the outcome of this process.

Profmed's view on the current regulatory environment
Profmed is cognizant of the need for change in the healthcare sector in South Africa to make healthcare accessible to all South Africans. The Board of Trustees views the current regulatory environment as part of the process in achieving this goal through a workable universal healthcare model. The trustees on the Board are highly skilled individuals who remain vigilant to the economic and political challenges facing medical schemes and the country and will continue to work towards achieving a solution in the best interests of our members as well as the country as a whole.

2.3 Competitive environment

Fierce competition exists in the medical scheme industry and growth of the number of insured members has stagnated over the past few years. The majority of medical schemes that have grown in membership have done so through amalgamation. Profmed is one of the few medical schemes that has experienced steady organic membership growth for the past ten years. Profmed's contribution increases for 2018 were in line with the industry and remain competitive. This, together with Profmed's comprehensive benefits, sound governance and excellent service, has attracted members from competitor schemes. Profmed remains the medical scheme of choice for professionals.

PROFMED

Strategy, risk and business model

The Board meets annually to determine the strategy of the Scheme. Risks that could impact the Scheme are taken into account when setting the strategy. The Board has an oversight role in the implementation of the strategy by the management team and regularly assesses performance against the defined strategy.

Strategy

Profmed's key long-term strategy is to grow the membership of the Scheme. By growing the membership, the risk pool will be enlarged, which, in turn, will reduce the effects of high-impact claims.

The Board is satisfied with the continued rate of growth for the period under review, which resulted in an average age of Scheme beneficiaries of 40.9 years.

The Scheme's ongoing efforts to reduce member loss include a robust member retention project, the provision of excellent service to members and appropriate benefit design, which have largely stabilised member loss. The three leading resignation reasons are firstly, members joining their employer's medical scheme; secondly, members emigrating; and thirdly, members joining their spouse/partner's medical scheme. These resignations are beyond our control and the membership losses are attributed to members moving to employers with restrictive subsidy policies.

Management continually seeks meaningful and relevant ways to meet the needs of members in order to minimise member attrition. The diagram below outlines the movement in the number of principal members for the period under review.

	2018	**2017**	*Y/Y change*
Opening balance	**32 621**	31 787	
New members joining	**2 978**	3 305	*(9.9%)*
Members resigning	**(2 474)**	(2 471)	*0.1%*
Closing balance	**33 125**	32 621	
Joining rate	9.1%	10.4%	
Resignation rate	7.6%	7.8%	
Net growth rate	1.6%	2.6%	

Despite the paralysing effect the socio-economic circumstances had on membership growth, Profmed maintained its overall growth strategy. This was achieved through a robust and integrated marketing campaign aimed at the Scheme's target market, which generated new business.

Many opportunities exist for Profmed in terms of growth. With our healthy reserves, sound governance, an excellent administration system and service levels, a strong brand and intelligent benefits, Profmed is an obvious choice for graduate professionals.

Risk

Profmed has a robust risk-identification and monitoring process. Identified risks are evaluated and monitored by the Board as well as the Audit and Risk Committee. Both these forums provide input to the Risk Register relating to their spheres of responsibility. The Medical Committee and Investment Committee do not review the Risk Register but provide input to the register on any matters of risk pertaining to their respective scope of responsibility.

The Board and the Audit and Risk Committee assess the mitigating controls of each risk to ascertain the impact of the risk on the Scheme.

Strategy, risk and business model *(continued)*

The private healthcare industry in South Africa is highly sophisticated and is ranked as one of the best internationally in terms of access to care, healthcare outcomes and the use of advanced technology. However, despite these advantages, various risks could threaten the achievement of our strategy.

The cost of providing this world-class quality care, as well as the increasing burden of disease, is a major challenge for the healthcare funding industry globally.

Medical inflation has outpaced consumer inflation for many years, driven by various supply and demand factors. The Competition Commission's inquiry into the private healthcare industry may shed some light on the reasons for the high cost of private healthcare.

The age of the membership of the Scheme, increasing benefit utilisation and increased burden of disease pose significant risks to the sustainability of the Scheme. However, Profmed has an aggressive growth strategy aimed at the Scheme's target market and the results of this are evident in that Profmed remains one of the few medical schemes that grew organically in membership during the year under review.

Medical scheme membership is voluntary in South Africa. The nature of medical schemes is that the young and healthy subsidise the ill and ageing members. The risk is that the young and healthy do not join medical schemes until they are older or become ill. This compromises the necessary cross-subsidisation in the industry.

Profmed is in the fortunate position that its Board and executive management have a wealth of knowledge and experience in the healthcare industry. The Scheme has specialised data-mining tools and, together with its administrator, carefully monitors these risks. The Scheme's actuaries are specialists in the healthcare industry, further enhancing the Board's ability to monitor and manage risk.

Business model
Profmed creates value for stakeholders without a motive to derive profit.

Profmed's business model is that of a restricted medical scheme which operates in terms of the provisions of the MSA and takes risk by providing healthcare benefits in return for contributions. Administration, managed healthcare services, investment management, actuarial, legal and marketing services are outsourced. These services are outsourced to experts in their field, which is more cost-effective and provides for greater accountability. These services are managed by a strong Profmed executive management team, which reports to the Board.

The success of the Scheme's business model depends on healthcare product differentiation, affordability and service excellence.

Profmed's philosophy is to provide our discerning members with cost-effective, evidence-based and clinically appropriate treatment at the most appropriate facilities, and to provide peace of mind that their contributions are utilised appropriately and effectively.

In 2018, the following were the main features of the benefit options available:

- **ProPinnacle**: Unlimited in-hospital cover in private wards, and comprehensive chronic and day-to-day cover. In- and out-of-hospital GP and specialist costs, i.e. consultations and procedures, were covered at Profmed Premium Tariff (300% of Profmed Tariff).

- **ProSecure Plus**: Unlimited in-hospital cover in general wards, and private ward rates for maternity (post-delivery) as well as cover for chronic and day-to-day medical expenses and cover over and above the PMBs. In-hospital GP and specialist costs, i.e. consultations and procedures, were covered at Profmed Plus Tariff (200% of Profmed Tariff). Out-of-hospital GP and specialist costs, i.e. consultations and procedures, were covered at Profmed Specific Tariff (120% of Profmed Tariff).

Strategy, risk and business model ***(continued)***

- **ProSecure**: Unlimited in-hospital cover in general wards, as well as chronic and day-to-day medical expenses cover over and above the PMBs. In- and out-of-hospital GP and specialist costs, i.e. consultations and procedures, were covered at Profmed Specific Tariff (120% of Profmed Tariff).

- **ProActive Plus**: Unlimited in-hospital cover in general wards, and cover for PMBs. In-hospital GP and specialist costs, i.e. consultations and procedures, were covered at Profmed Plus Tariff (200% of Profmed Tariff). Out-of-hospital dentistry, i.e. consultations and procedures, were covered at Profmed Tariff. Out-of-hospital GP and specialist consultations and procedures were covered at Profmed Specific Tariff (120% Profmed Tariff).

- **ProActive**: Unlimited in-hospital cover in general wards, and cover for PMBs. In-hospital GP and specialist costs, i.e. consultations and procedures, were covered at Profmed Specific Tariff (120% of Profmed Tariff). Out-of-hospital dentistry, i.e. consultations and procedures, were covered at Profmed Tariff.

The Profmed Tariff is calculated using the 2006 National Health Reference Price List with annual inflationary increases.

Medical schemes operate in an evolving, complex and challenging environment. The Scheme has the responsibility of maintaining the fragile balance between competitive contribution rates, cost, and sustainability, while ensuring members' healthcare needs are appropriately met.

We use risk management tools in the form of managed healthcare services and refined benefit design techniques to provide access to quality healthcare while managing the cost and ensuring the sustainability of the Scheme.

Board of Trustees in office during 2018

Dr RD Shuttleworth *(Chairman)*	MBChB, FCS (SA), FRCS (Ed)
Dr AD Behrman	MBChB (UCT), DOH (UCT), DNS, FFLFM (RCP), Accredited Mediator (UCT) (Term of office expired 5 June 2018)
Mr HP du Toit	BSc, FASSA
Ms MM Geringer	BCom Insurance Science, FFA, FASSA (Appointed 5 June 2018)
Prof WM Gumede	Dip. Econ & Public Finance (UNISA), MA (Wits) & Joint MA (Utrecht, Aarhus & Cardiff) (Term of office expired 5 June 2018)
Mr M Jeena	BCom, BCompt (Hons), CA (SA), MBA
Mr GS Harvey	BSc (Hons) Comp. Sciences (Appointed 5 June 2018)
Dr BH Modi	MBChB, FCFP (SA), Dip ABM (Cum Laude), MMed (Fam Med), MBA (Cum Laude)
Dr AP Newell	BDS (Term of office expired 5 June 2018)
Adv HB Smalberger SC	BA LLB
Mr RN Theunissen	BAcc, CA (SA), RA, Dip CJ & FA (Term of office expired 5 June 2018)
Dr SJ Velzeboer	MBBS BSc (Medical), FFARCS, FFA (SA), MBA (Cum Laude)

In line with Profmed's status as a medical scheme exclusively for graduate professionals, Profmed's Board is made up of professionals who bring to the Board a wealth of expertise and experience, not only in the clinical field, but also in the IT, financial, legal, investment and business fields. This range and depth of skills enables the Board to function in a professional and efficient manner and provides members with comfort that the Scheme is being managed by highly competent individuals.

The Board implemented the principle of rotation of trustees in keeping with the recommendations of King IV and the requirements of the CMS. One term of office is three years. Trustees may not serve more than two consecutive terms of office and no more than three terms in total. This affected all trustees serving on the Profmed Board as at 1 January 2017.

The succession plan implemented by the Board has achieved the necessary stability and continuity on the Board. This is partly attributable to the high calibre of Profmed's professional membership from which the Scheme can draw to add value and bring fresh thinking as trustees to the Board.

As at the date of the annual general meeting on 5 June 2018, the size of the Board reduced from ten to eight trustees. The reduction in the number of trustees on the Board will reduce non-healthcare costs without compromising the Board's ability to fulfil its fiduciary responsibilities.

1. Management

1.1 Principal Officer

With the retirement of Mr Graham Anderson on 31 December 2018, the Board appointed Mr Craig Comrie to take over the position of Principal Officer effective 1 January 2019. Mr Comrie is a Chartered Accountant and brings with him 17 years of experience in healthcare administration. We are confident Mr Comrie will continue Profmed's legacy of excellence.

1.2 Corporate governance

The pillars upholding the Scheme's governance are:

- the Profmed Charter, incorporating the Code of Conduct and Conflict of Interest Policy;
- the King Report on Governance for South Africa (King IV);
- the Medical Schemes Act 131 of 1998 (as amended); and
- the Rules of the Scheme.

The Board annually reviews these documents to ensure their relevance and alignment with new legislation and developments relating to corporate governance.

Corporate governance ***(continued)***

The criteria for trustees and key office bearers and the ethics requirements for trustees and employees are addressed in the Profmed Charter, Code of Conduct and Conflict of Interest Policy.

The Nominations Committee, which is an ad hoc committee of the Board, scrutinises nominations received by the Scheme for both appointed and elected trustees in accordance with these policies.

Internal control
Profmed outsources the administration of the Scheme to PPS Healthcare Administrators (Pty) Ltd. The internal audit function of the administrator performs a review of the design, implementation and effectiveness of the internal financial, process and governance controls of the Scheme. The Board is of the opinion that the Scheme's and the administrator's systems of internal control and risk management are effective and that the internal financial controls form a sound basis for the preparation of reliable financial statements. The Audit and Risk Committee concurs with the Board.

The Board ensures that manageable risks are managed effectively, that mitigating controls are implemented and that risks which fall outside the control of the Scheme are monitored closely. The management team is responsible for the management of risk. Refer to page 10 for further details on the Scheme's approach to risk.

2 Attendance at trustee and committee meetings
The following schedule sets out Board of Trustee and committee meeting attendance. Trustee remuneration is disclosed in Note 16 on page 55.

	Board of Trustees		Board Strategy Session		Audit and Risk Committee		Medical Committee		Investment Committee		Remuneration Committee		Nominations Committee		Ad Hoc Meetings
Name	A	B	A	B	A	B	A	B	A	B	A	B	A	B	
Mr DC Arnold*											2	2			1
Dr AD Behrman	4	4					1	1							1
Mr HP du Toit	8	8	1	1					2	2			3	3	
Mr JS Gardner*											2	2			
Ms MM Geringer	5	5	1	1					1	1					3
Prof WM Gumede	4	4							1	1			3	3	2
Mr GS Harvey	5	4	1	1					1	1					5
Mr M Jeena	8	7	1	1	3	3									4
Mr PL Marais*											2	2			
Mr KG Mockler*					3	3									15
Dr BH Modi	8	7	1	1			3	3							4
Dr AP Newell	4	4					3	3							1
Dr Y Omar Carrim*					3	3									
Mr J Prinsloo*					3	3									
Dr RD Shuttleworth	8	8	1	1	2	1†	3	3‡	2	2‡	1	1∞			6
Adv HB Smalberger	8	8	1	1	3	3							2	2	3
Mr RN Theunissen	4	4			1	1†	1	1‡	1	1‡	1	1∞	3	3	1
Dr SJ Velzeboer	8	8	1	1			2	2	2	2					1

A - Total number of meetings
B - Number of meetings attended
* - Independent committee member
† - By invitation
‡ - *Ex officio*
∞ - Non-voting member

3. Audit and Risk Committee

The independent Audit and Risk Committee, set up in accordance with the MSA, is mandated by the Board to assist it in carrying out its duties relating to the Scheme's accounting policies, internal control systems and financial reporting practices. The Audit and Risk Committee monitors the Scheme's risk and governance function.

The Audit and Risk Committee is satisfied that the Scheme has optimised the assurance coverage obtained from management and internal and external assurance providers in accordance with an appropriate combined assurance model.

The Scheme's internal control process monitors and audits the activity of risk management. Using its enhanced risk assurance model, the Committee reviewed a report in respect of the findings of a phishing test undertaken on the staff at the Executive Office of the Scheme and the administrator, and the recommendations to improve IT security were implemented.

The Committee further reviewed a report of an audit undertaken by Grant Thornton to assess the adequacy of the scope of the internal audit function of the administrator. The Committee is of the view that the findings in the report were not significant and did not compromise the efficacy of the internal audit function. A recommendation in the report to align the internal audit plan with the Scheme's Risk Management Plan was implemented.

Composition of the Audit and Risk Committee:

Independent members

Mr KG Mockler CA (SA) (Chairman)	Re-appointed 6 June 2018
Dr Y Omar Carrim MBChB, BCom Acc (Hons), CTA, Dip.Sleep Med (SA), FC Rad (SA) DIAG	Re-appointed 6 June 2018
Mr J Prinsloo BCom Acc (Hons), CA (SA)	Re-appointed 6 June 2018

Trustee members

Adv HB Smalberger SC	Re-appointed 6 June 2018
Mr M Jeena	Re-appointed 6 June 2018

By invitation

Mr RN Theunissen	Chairman of the Board of Trustees (Outgoing 5 June 2018)
Dr RD Shuttleworth	Chairman of the Board of Trustees (Incoming 6 June 2018)

Internal auditors
External auditors.

In attendance

Mr GR Anderson BSc Pharm	Principal Officer and Chief Executive
Mr SJ van Molendorff CA (SA), BCompt (Hons)	Chief Financial Officer (Administrator)
Ms BA Carrozzo	Scheme Manager

The above parties have unrestricted access to the chairman of the Committee.

The effectiveness of the Committee and its individual members is assessed annually. The external and internal auditors meet separately with the Committee at least once a year without the presence of management. Management meets at least once a year with the Committee without the presence of the auditors.

The Audit and Risk Committee discharged its responsibilities for the year under review as follows:

- Examined and reviewed the Scheme's Annual Integrated Report, which includes the annual financial statements, prior to submission to and approval by the Board;
- Reviewed the effectiveness of internal controls;
- Recommended to the annual general meeting, with the approval of the Board, the appointment of the external auditor, after considering the independence of the proposed auditor;
- Approved the external auditor's terms of engagement, the audit plan and audit fees;
- Approved the provision of all non-audit services by the external auditor;
- Reviewed the adequacy and effectiveness of the system for monitoring compliance with laws and regulations;
- Reviewed the performance of the internal audit function;
- Reviewed the finance function;
- Reviewed the Profmed Charter;
- Reviewed the disclosure of sustainability matters in the Annual Integrated Report;
- Provided independent and objective oversight of the financial, operational and strategic risks through a review of the risk management plan;
- Ensured that the register of key sustainability risks facing the Scheme, with responses to address these key risks, was maintained;
- Considered two significant matters, namely, the amount of the outstanding claims provision and the incidence of fraud. The Committee discussed with management and the internal and external auditors how the outstanding claims provision was computed. It also took note of how the actuaries arrived at their conclusions. Regarding fraud, the Committee discussed with the internal auditors their activities in connection with fraud prevention and identification and considered the adequacy of the internal controls in connection therewith.

4. Medical Committee

The Scheme has an established Medical Committee. The Committee is mandated by the Board to assist it in approving clinical protocols and procedures for appropriate and cost-effective funding of members' benefits. The Committee also considers *ex gratia* requests from members and reports to the Board on requests granted.

Composition of the Medical Committee:

Trustee members

Dr SJ Velzeboer (Chairman)	Appointed 6 June 2018
Dr AD Behrman	Outgoing 5 June 2018
Dr BH Modi	Re-appointed 6 June 2018
Dr AP Newell	Co-opted 6 June 2018

Ex officio

Mr RN Theunissen	Chairman of the Board of Trustees (Outgoing 5 June 2018)
Dr RD Shuttleworth	Chairman of the Board of Trustees (Incoming 6 June 2018)

In attendance

Mr GR Anderson	Principal Officer and Chief Executive
Sr W Schleifer	Scheme Clinical Advisor

By invitation

Ms S Bassudev	Chief Executive Officer (Administrator)
Dr SJ Slabbert	Medical Advisor (Administrator)
Ms BA Carrozzo	Scheme Manager.

The Medical Committee discharged its responsibilities for the year under review as follows:

- Reviewed the performance and quarterly reports of the managed healthcare providers;
- Reviewed and approved clinical protocols as proposed by the Medical Advisor as well as by the managed healthcare providers;

- Considered *ex gratia* requests and reported in the Medical Committee report to the Board any requests granted;
- Participated in the benefit design to ensure clinical appropriateness, quality of care and cost-effectiveness;
- Considered appeals from members;
- Provided support to the medical and clinical advisors;
- Attended to any other relevant matters referred to it.

The Committee considered and recommended to the Board the adjustment in the Rand value of the tariff paid to healthcare providers for procedures and consultations on certain options for the 2019 benefit year.

5. Investment Committee

The Board annually appoints an Investment Committee comprising trustees with the relevant expertise and experience, and the Principal Officer. The Committee is mandated by the Board to assist it in setting the Scheme's investment policy, the appointment of the investment advisor and portfolio managers, and monitoring of investment performance.

Composition of the Investment Committee:

Trustee members

Mr HP du Toit (Chairman)	Re-appointed 6 June 2018
Ms MM Geringer	Appointed 6 June 2018
Prof WM Gumede	Outgoing 5 June 2018
Mr GS Harvey	Appointed 6 June 2018
Dr SJ Velzeboer	Re-appointed 6 June 2018

Ex officio

Mr RN Theunissen	Chairman of the Board of Trustees (Outgoing 5 June 2018)
Dr RD Shuttleworth	Chairman of the Board of Trustees (Incoming 6 June 2018)

Voting member

Mr GR Anderson	Principal Officer and Chief Executive

The Investment Committee discharged its responsibilities for the year under review as follows:

The Committee monitored, reviewed and assessed:

- Profmed's investments in accordance with:
    - the Investment Policy approved by the Board;
    - Section 35 of the Medical Schemes Act;
    - Regulation 30, read with Annexure B to the Medical Schemes Act;
- the performance of investments (cash, cash equivalents, property, equities) against the performance benchmarks and against peer managers within each asset class;
- the performance of portfolio managers and the investment advisor;
- the performance of peer-group asset managers in the broader investment management market;
- the allocation of funds between categories of assets and asset managers;
- the fees charged by the portfolio managers and investment advisor;
- the ongoing appropriateness of Profmed's investment policy.

The Scheme's policy is to review the services provided by its investment advisors every three years. In line with this policy, the Committee reviewed requests for proposal from six investment advisors and recommended to the Board the appointment of Willis Towers Watson effective 1 February 2019.

6. Remuneration Committee

The Board annually appoints a Remuneration Committee comprising three independent members with relevant expertise and experience, and the Chairman of the Board. The Committee is mandated by the Board to assist it in setting the policy for, and determining the recommended remuneration of the trustees, committee members and the Principal Officer.

Composition of the Remuneration Committee

Independent members	
Mr DC Arnold (Chairman)	Re-appointed 6 June 2018
Mr JS Gardner	Re-appointed 6 June 2018
Mr PL Marais	Re-appointed 6 June 2018
Non-voting member	
Mr RN Theunissen	Chairman of the Board of Trustees (Outgoing 5 June 2018)
Dr RD Shuttleworth	Chairman of the Board of Trustees (Incoming 6 June 2018)
In attendance	
Mr GR Anderson	Principal Officer and Chief Executive
By invitation	
Ms C Lamprecht	Consultant

The Remuneration Committee discharged its responsibilities for the year under review as follows:

- Recommended the general policy in respect of the Board and Board committee remuneration;
- Recommended a revised policy in respect of the Principal Officer remuneration;
- Recommended the remuneration package of the Principal Officer;
- Recommended the fees and other allowances and the policy with regard to the reimbursement of expenses relating to Board and Board committee members.

Remuneration policy

The Remuneration Policy in respect of the Board and committees recognises that most persons occupying such positions sacrifice income from their professional practices to do so and must recognise the serious responsibilities borne by these individuals serving on the Board and its committees. Accordingly, remuneration must be reasonable, fair and market-related to attract the most appropriately skilled and competent people with relevant experience to make themselves available.

Trustee remuneration is benchmarked each year to determine the relative position of the trustees to the market.

In order to ensure the best service to Profmed members, the Remuneration Policy recognises the need to remunerate the Principal Officer and staff of the Executive Office in such a way as to attract and retain persons of above average ability.

Principal Officer

The total cost-to-company remuneration of the Principal Officer aims to remunerate in line with the 60th percentile of the market of comparable positions as indicated by annual market surveys conducted by independent consultants with access to up-to-date and reliable survey data. It takes into account the appropriateness of the fixed to variable remuneration mix to ensure it reflects the remuneration philosophy and strategy. It also takes into account the performance of the Principal Officer.

The remuneration element of the Principal Officer comprises a fixed component, which is guaranteed, and an incentive of a maximum of 30% of the fixed component, which is linked to performance.

Guaranteed component for Executive Office staff

All permanent employees receive a guaranteed element of remuneration. This comprises a fixed cash portion as well as compulsory benefits (medical scheme and retirement fund membership). The target level for the guaranteed portion of the remuneration package is market-related.

Increases in the guaranteed component are determined in line with market increases, whilst annual performance-related assessments may cause remuneration increases at a higher rate such that superior performance by an individual will result in the employee earning above the benchmark for his or her position. The level of this remuneration is also benchmarked to the general market.

Short-term incentive component for Executive Office staff
The Scheme uses short-term incentives to achieve stipulated annual objectives, thereby ensuring that a portion of pay is variable and linked to performance. The performance-related remuneration of employees relates directly to their function and is allocated annually. Employees in a sales function also receive a variable monthly remuneration linked directly to their productivity. No long-term incentive schemes are available to employees.

7. Management of the Scheme's investments
The Scheme's investments are subject to Regulation 30 of the Regulations to the MSA, read with Annexure B, and the Scheme's investment strategy complies with these regulations. The Board regularly reviews the investment strategy and performance against the strategy.

The Scheme's investment objective: CPI + 3% per annum measured over a rolling three-year period.

The investment advisor's objective: to outperform the composite benchmark, as set out in the table below. This composite benchmark has been aligned with the objectives of the Scheme and the regulatory parameters within which the Scheme must operate. The investment advisors are expected to outperform the benchmark by:

- selecting portfolio managers that outperform the benchmark's indices by means of superior stock selection within each asset class; and
- altering the asset class composition allocation relative to the benchmark within the bands indicated.

This was to be achieved by means of deviations from the stocks comprising the individual indices, and by means of deviation, within the overall limits, from the asset allocation of the composite index, as set out in the table below.

Asset class	**Index**	**Proportion of composite index**	**Bands**
Equities	Capped SWIX	40%	25 – 50%
Fixed income	ALBI 1-3	40%	20 – 65%
Cash	STEFI	14%	10 – 75%
Property	SAPY	6%	0 – 7%

Included in the property investment portfolio is the building in which the Executive Office of the Scheme is housed. As the property was intended to be a long-term investment, the building has been modernised, which attracted long-term tenants. The property remains a sound investment and is fully let.

8. Management of insurance risk
The primary insurance activity carried out by the Scheme is taking on the risk of paying healthcare costs on behalf of members and their dependants. The risk the Scheme is exposed to is the uncertainty surrounding the timing and quantum of claims.

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;
- protocols; and
- monitoring of emerging events and trends.

The Scheme uses several methods to assess and monitor insurance risk exposure, both for individual types of risks insured and overall risks. These methods include:

- internal risk measurement models;
- sensitivity analyses;
- scenario analyses; and
- stress testing.

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

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

Medical schemes are required to fund PMBs in full at invoice price in terms of Regulation 8 of the Regulations to the MSA. This poses a financial risk to the Scheme as there is no regulated tariff for providers.

9. Broad-Based Black Economic Empowerment (B-B BEE)

Profmed is not required to comply with the Broad-Based Black Economic Empowerment Act, No. 53 of 2003, due to the restrictions of the MSA. Nevertheless, the Board fully subscribes to the principles of transformation and the ethos of the Act. Profmed implements the principles with regard to Board composition, staff complement and procurement.

10. Adherence to the Medical Schemes Act 131 of 1998 and Regulations

10.1 Contribution income must be received within three days of becoming due

The MSA requires that contributions shall be received within three days of becoming due. There were instances where the Scheme did not receive all contributions as required. This is mainly due to:

- members paying contributions after the third day of becoming due;
- members having insufficient funds in their bank accounts at the time of collection; and
- members exiting without informing the Scheme.

We do, however, actively pursue contributions not received within three days.

10.2 Financial soundness of benefit options

In 2018, three of our options had deficits. This was caused by the limitations placed on the contribution increases by the CMS, together with the consideration of the potential impact on members and the Scheme in terms of buy-down risk and loss of members. These options remain financially sound as they are supported by the remaining options and sufficient income from reserves.

10.3 Payment of claims within 30 days of receipt

The MSA requires that a valid claim submitted to the Scheme must be paid within 30 days after the day on which the claim is received. In limited instances claims were paid after this timeframe, mostly as a result of incorrect coding by service providers.

10.4 Investment in medical scheme administrators

The MSA requires that no medical scheme shall invest any of its assets in a medical scheme administrator. The Scheme, through its collective investments, has indirect investments in medical scheme administrators and has received exemption from this section of the MSA.

10.5 Limitation of exposure to equities

The MSA requires that medical schemes shall invest no more than 40% of reserves in South African equities. The CMS, however, granted exemption to Profmed to invest up to 50% of its reserves in South African equities.

10.6 Limitation of exposure to credit-linked instruments

The Regulations to the MSA require that medical schemes may not hold credit-linked instruments which were reclassified into restricted categories by the CMS. In terms of Circular 6 of 2017 issued on 1 February 2017, certain asset instruments were reclassified by the CMS into category 7 (restricted category) of Annexure B of the Regulations as at 31 December 2017, which caused the Scheme to become non-compliant. Profmed's asset managers have engaged the CMS, who indicated that Credit Linked Floating Rate Notes may be classified outside of category 7, but this will result in non-compliance with the CMS' Circular 21 of 2019. If the instruments are classified in terms of Circular 21 of 2019 the Scheme would be non-compliant in terms of assets held under category 7(b) as there should be no investment in this category according to the Regulations. The relevant investment houses and insurance bodies continue to engage with the CMS to find a solution to this dilemma. If this cannot be resolved, Profmed will take the necessary steps to become compliant.

PROFMED

Performance

1. Financial performance

1.1 Financial health of the Scheme

Profmed is the medical scheme of choice for professionals and its core focus is to provide funding for quality healthcare when members are in need of medical attention. Funding quality healthcare in a sustainable and affordable manner is achieved through appropriate benefit design, sound financial and risk management as well as through effective governance structures.

Profmed's financial strength and claims-paying ability are supported by strong reserves and good investment returns. Global Credit Rating Co., an independent credit-rating agency, maintained the Scheme's rating at AA in 2018, indicating the Scheme's financial strength and claims-paying ability. This is the highest rating a medical scheme the size of Profmed can achieve. The results of the Scheme's operations are set out in the Statement of Comprehensive Income.

The following are the Scheme's performance indicators:

	Results	
Measure	**2018**	**2017**
Claims ratio	90%	91%
Net healthcare result	(R34.0 million)	(R44.6 million)
Net (deficit)/surplus	(R35.0 million)	R22.3 million
Asset growth	(4.8%)	8.0%
Solvency ratio	49.4%	52.5%
Investment return	(0.4%)	11.3%
New membership growth	9.1%	10.4%
Member resignations	7.6%	7.8%
Net membership growth	1.6%	2.6%

Accumulated funds ratio (Solvency ratio)

The accumulated funds percentage is calculated as follows:

	2018 R'000	**2017 R'000**
Total members' funds per Statement of Financial Position	**829 971**	864 979
Less: Cumulative unrealised investment gains	**(6 502)**	(60 910)
Accumulated funds per Regulation 29 of the Regulations to the MSA	**823 469**	804 069
Annual contribution income per Statement of Comprehensive Income	**1 668 455**	1 532 948
Accumulated funds ratio calculated as the ratio of accumulated funds/gross annual contributions x 100	**49.4%**	52.5%
Minimum ratio required by Regulation 29 of the Regulations to the MSA	**25.0%**	25.0%

1.2 Operational statistics per benefit option

2018	ProPinnacle	ProSecure Plus	ProSecure	ProActive Plus	ProActive	Total Scheme
Non-financial highlights						
Number of members at year-end	1 641	2 246	7 661	7 907	13 670	33 125
Average number of members for the year	1 653	2 282	7 774	7 850	13 661	32 220
Number of beneficiaries at year-end	2 907	4 306	15 820	17 552	30 154	70 739
Average number of beneficiaries for the year	2 949	4 398	16 108	17 429	30 158	71 042
Dependant ratio at year-end	0.77	0.92	1.07	1.22	1.21	1.14
Average age of beneficiaries	59.6	53.1	48.0	35.6	36.8	40.9
Pensioner ratio (65 years and older)	50%	40%	29%	10%	10%	18%
Financial highlights						
Average net contributions per beneficiary per month	R5 977	R3 444	R2 726	R1 437	R1 237	R1 957
Average relevant healthcare expenditure per beneficiary per month	R6 743	R3 214	R2 614	R1 125	R968	R1 759
Average non-healthcare expenditure per beneficiary per month	R286	R264	R246	R230	R231	R238
Relevant healthcare expenditure as a percentage of gross contributions (claims ratio)	113%	93%	96%	78%	78%	90%
Non-healthcare expenditure as a percentage of gross contributions	4.8%	7.7%	9.0%	16.0%	18.7%	12.2%

1.3 Operational statistics per benefit option *(continued)*

2017	ProPinnacle	ProSecure Plus	ProSecure	ProActive Plus	ProActive	Total Scheme
Non-financial highlights						
Number of members at year-end	1 709	2 362	7 988	7 211	13 351	32 621
Average number of members for the year	1 729	2 399	8 106	7 191	13 241	32 665
Number of beneficiaries at year-end	3 127	4 598	16 650	16 109	29 708	70 192
Average number of beneficiaries for the year	3 203	4 689	16 947	16 051	29 453	70 342
Dependant ratio at year-end	0.83	0.95	1.08	1.23	1.23	1.15
Average age of beneficiaries	58.3	51.6	46.9	34.9	36.5	40.6
Pensioner ratio (65 years and older)	46%	36%	27%	9%	9%	17%
Financial highlights						
Average net contributions per beneficiary per month	R5 310	R3 108	R2 470	R1 299	R1 136	R1 816
Average relevant healthcare expenditure per beneficiary per month	R5 817	R3 480	R2 378	R985	R850	R1 650
Average non-healthcare expenditure per beneficiary per month	R254	R241	R225	R211	R212	R219
Relevant healthcare expenditure as a percentage of gross contributions (claims ratio)	110%	112%	96%	76%	75%	91%
Non-healthcare expenditure as a percentage of gross contributions	4.8%	7.8%	9.1%	16.2%	18.6%	12.0%

1.3 Operational statistics for the Scheme

	2018	2017
Average accumulated funds and reserves per member	**R26 056**	R26 516
Investment return	**(0.4%)**	11.3%

The value created by administration and managed care providers is a topic of debate in the healthcare industry. Profmed monitors this quarterly to ensure that these interventions are cost-effective. The table below illustrates the favourable intervention of the administrator and the managed healthcare providers by correctly applying the Rules of the Scheme, and reflects the value added by third-party service providers.

2018	PPSHA R'000	MediKredit R'000	Opticlear R'000	Dental Risk Company R'000	Total R'000
Total claims received	1 494 841	272 277	24 669	98 167	1 889 954
Favourable impact of intervention	312 017	89 013	16 929	60 817	478 774
Intervention (% of total)	20.9%	32.7%	68.6%	62.0%	25.3%
Cost to provide intervention	133 672	6 226	547	1 504	141 949

1.4 Members' funds and reserve accounts

Movements in the members' funds and reserve accounts are set out in the Statement of Changes in Funds and Reserves on page 37. With the implementation of IFRS 9 in 2018, unrealised investment gains now form part of accumulated funds.

1.5 Outstanding claims

Movements in the outstanding claims provision are set out in Note 8 to the financial statements. The outstanding claims provision is made up of estimated claims incurred up to 31 December 2018 that had not been reported to the Scheme as at that date.

1.6 Actuarial services

The Scheme's actuaries were consulted regarding the determination of the contribution and benefit levels. They also assisted in determining the assumptions used in the calculation of the outstanding claims provision noted in 1.5 above. This is fully explained in the notes to the financial statements.

1.7 Subsequent events

No adjusting or non-adjusting events have occurred between the accounting date and the date of this Report that affected the 2018 results.

2. Contributing to sustainability

2.1 Economic sustainability

As a medical scheme for professionals, Profmed contributes to the health, and therefore the sustainability of the professionals under our care, who in turn add value to the economy in their spheres of expertise.

This is achieved through appropriate benefit design by funding treatment that facilitates shorter time in hospital and quicker recovery time, thereby contributing to the productivity of our professional members.

Profmed's risk management approach is broadened by offering the Multiply Wellness Programme to our members. Participation is voluntary and the programme encourages a healthy lifestyle, which is expected to have a positive impact on the Scheme's claims experience.

Encouraging professionals to live more healthily also has a positive impact on the country as a whole as a healthier lifestyle leads to longevity, enabling the professionals covered by the Scheme to practise their skills for longer and to contribute productively for longer to both the economy and society.

The Scheme annually publishes the results of a stress survey undertaken by its members to highlight the effect of stress on the lives of professionals. This creates awareness of the need to manage stress and contributes to the wellbeing of members.

2.2 Environmental sustainability

While our first priority is to ensure the financial sustainability of the Scheme in the best interests of our members, we also recognise the effect of environmental sustainability and responsible corporate citizenship on the Scheme and our members. Profmed contributes to environmental sustainability through the use of technology. Video-conferencing equipment ensures we continue to benefit from a decrease in travel by trustees, management and staff, which leads to a reduction in travel costs and carbon emissions. It has also optimised the time of trustees, management and staff of the Scheme, leading to greater productivity and efficiency.

We continue to recycle our paper and to make optimal use of water. A reverse osmosis system installed at our building allows for the appropriate use of grey water, thereby optimising the use of this scarce commodity. The Scheme also participates in an owl rehabilitation programme to re-introduce owls into the urban environment to restore the natural balance of rodent control.

PROFMED

Outlook

We will ensure our future sustainability through the creation and protection of value for all stakeholders by effectively managing financial and non-financial factors impacting the Scheme's clinical outcomes and economic performance.

The goal of the Board is to sustain the Scheme's business model. This will be achieved by:

1. providing excellent service;
2. appropriate benefit design;
3. growing our membership;
4. close monitoring of external factors.

The Scheme will continue to take appropriate steps to limit the rise in healthcare costs by way of negotiation with healthcare providers and contracted outsourced providers, and through the implementation of managed healthcare principles.

We will continue to structure benefit options appropriately with the objective of providing quality healthcare when it is most needed.

The investments of the Scheme will continue to be managed by professional fund managers in order to provide the maximum benefit for members, without incurring undesirable risks.

Growth in membership will be achieved by providing benefits appropriate to the Scheme's target market, and by providing outstanding service.

We will continually strive to improve service to our members and implement sound marketing, and brand management.

Our future sustainability will be achieved by:

1. Scheme administration

Profmed will ensure that the administration of the Scheme is effective and that the administrator performs in line with strict service level agreements. To achieve this:

- service levels will be monitored weekly by the Principal Officer and quarterly by the Board;
- the Scheme will ensure that the administration platform remains robust and adaptable to enable the Scheme to be agile in navigating the challenging healthcare landscape and in supporting the Scheme to achieve its strategic objectives.

The Board has an IT governance policy to ensure that the IT systems of the Scheme's administrator and the contracted outsourced partners remain relevant, secure and adaptable, and that service level agreements are strictly adhered to.

2. Benefit design

Profmed's benefits are designed using an appropriate and effective two-pronged approach:

1. To provide primary healthcare, which includes, among others, preventative care and diagnostic benefits in an endeavor to proactively prevent the onset of illness and disease and to ensure better treatment outcomes.
2. To be reactive in providing comprehensive cover for catastrophic illness and for trauma and injuries, as well as unlimited hospitalisation.

To support this approach, the Scheme employs managed healthcare protocols to ensure that members receive best-practice treatment, resulting in better outcomes and reducing down-stream medical costs for both our members and the Scheme.

Outlook ***(continued)***

Profmed has a traditional benefit design where benefits are transparent and clearly defined, providing members with peace of mind in times of trauma and severe illness. Profmed does not offer medical savings accounts as our professional members are discerning and understand the inflexibility of, and high administration fees associated with medical savings accounts. This design differentiates us from our competitors, making Profmed more attractive and sustainable for the future.

3. Membership growth

Profmed remained one of the few medical schemes that grew organically in membership during the year under review. However, the most important challenge to the Scheme is to attract younger members to the Scheme to reduce the average age of our membership.

Using an aggressive and innovative growth strategy, Profmed aims to accelerate growth with a view to lowering the age profile and growing the risk pool of the Scheme. This will mitigate the risk of the Scheme ageing and reduce the Scheme's burden of disease.

The solvency ratio is the Scheme's reserves as a percentage of its annual contribution income. The Scheme's solvency ratio could therefore come under strain as the Scheme grows. The solvency is further placed under pressure by the eroding effects of medical inflation, resulting in annual contribution increases. However, the Scheme's membership growth strategy is supported by a healthy solvency ratio.

The age profile of the membership has been relatively stable over the past few years with Profmed attracting younger members to the Scheme, which has counteracted the expected ageing of the current membership.

4. External factors

Medical schemes face a plethora of legislative and industry factors that will continue to impact the landscape in which they operate. These factors include:

- the revision of the PMB benefit package;
- the final outcome of the HMI;
- the possible enactment of the NHI Bill;
- the proposed introduction by the CMS of the Beneficiary Registry;
- the possible enactment of the Medical Schemes Amendment Bill; and
- the outcome of the proposed consolidation framework by the CMS.

The Scheme's views and approach to these factors are expounded under Regulatory Environment on page 7.

PROFMED

Statement of responsibility by the Board of Trustees

The trustees are responsible for the preparation, integrity, and fair presentation of the Annual Integrated Report of Profmed. The annual financial statements, presented on pages 35 to 71, have been prepared in accordance with International Financial Reporting Standards and the Medical Schemes Act of South Africa, and include amounts based on judgements and estimates made by management.

The trustees consider that, in preparing the annual financial statements, the most appropriate accounting policies have been used, consistently applied and supported by reasonable and prudent judgements and estimates, and that all the standards in the International Financial Reporting Standards that the trustees consider to be applicable have been followed.

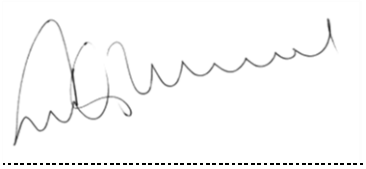
The trustees are satisfied that the information contained in the annual financial statements fairly presents the results of operations for the year and the financial position of the Scheme at year-end. The trustees are also responsible for the other information included in the Annual Integrated Report and are responsible for both its accuracy and its consistency with the annual financial statements.

The trustees are responsible for ensuring the effectiveness of internal controls and that proper accounting records are kept. The accounting records disclose with reasonable accuracy the financial position of the Scheme to enable the trustees to ensure that the annual financial statements comply with the relevant legislation.

The going-concern basis has been adopted in preparing the annual financial statements. The trustees have no reason to believe that the Scheme will not be a going concern in the foreseeable future, based on forecasts and available cash resources. This view is endorsed by the external auditor and the Audit and Risk Committee. These annual financial statements confirm the viability of the Scheme.

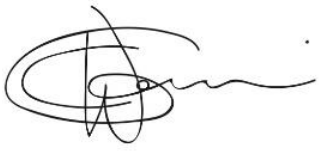
The Scheme's external auditor, PricewaterhouseCoopers Inc., has audited the annual financial statements and their report is presented on page 31.

The annual financial statements were approved by the Board of Trustees on 10 April 2019 and are signed on its behalf by:



Chairman

Trustee



Principal Officer

10 April 2019

PROFMED

Report of the Profmed Audit and Risk Committee

The Audit and Risk Committee operates in terms of formal terms of reference, which are approved annually by the Board. The terms of reference were reviewed and approved by the Board during 2018. The Committee conducted its affairs and discharged its responsibilities in compliance with the terms of reference.

External auditor

- The Committee satisfied itself that the auditor was independent.
- In consultation with management, the Committee agreed to the engagement letter, audit plan and audit fees for 2018.
- The Committee approved the terms of an agreement to carry out non-audit services.
- During the year, the Committee met with the external auditor without management being present.

Financial statements and accounting policies and practices

- The Committee reviewed the accounting policies and practices and the financial statements and was satisfied that they were appropriate and complied with International Financial Reporting Standards (IFRS) and the requirements of the Medical Schemes Act No. 131 of 1998, as amended.

Integrated reporting

- On 6 March 2019, the Committee agreed to recommend to the Board the approval of the Annual Integrated Report, which includes the annual financial statements.
- The Committee endorsed the Board's statement on the going-concern status of the Scheme, which appears in the Statement of Responsibility on page 29.

Governance of risk

- The Board has assigned oversight of the Scheme's risk management function to the Committee.
- The Committee verified that the Scheme has implemented an effective policy and plan for risk management.

Internal audit

- The Committee determined that the internal audit function of the administrator operated effectively.
- The Committee approved the annual audit plan relating to the Scheme.
- During the year, the Committee met with the chief internal audit executive of the administrator without management being present.

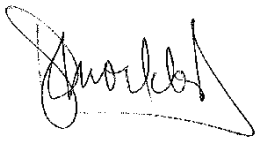
Finance function

- The Committee considered the expertise, adequacy of resources and experience of senior members of management of the Scheme and of the management of the administrator responsible for the finance function, and concluded that these were appropriate.

Internal financial controls

- The Committee considered the internal financial controls, both at the administrator and at the Executive Office of the Scheme, and found them to be effective.

Information regarding the composition, attendance and responsibilities of the Audit and Risk Committee, together with the other information relating to its activities, is provided on page 15.



KG Mockler
Chairman: Audit and Risk Committee

6 March 2019

PROFMED

Independent auditor's report to the members of Profmed

Opinion
We have audited the financial statements of Profmed (the Scheme), set out on pages 35 to 71, which comprise the statement of financial position as at 31 December 2018, and the statement of comprehensive income, the statement of changes in funds and reserves and the statement of cash flows for the year then ended, and notes to the financial statements, including a summary of significant accounting policies.

In our opinion, these financial statements present fairly, in all material respects, the financial position of the Scheme as at 31 December 2018, and its financial performance and cash flows for the year then ended in accordance with International Financial Reporting Standards and the requirements of the Medical Schemes Act of South Africa.

Basis for Opinion
We conducted our audit in accordance with International Standards on Auditing (ISAs). Our responsibilities under those standards are further described in the *Auditor's Responsibilities for the Audit of the Financial Statements* section of our report. We are independent of the Scheme in accordance with the Independent Regulatory Board for Auditors *Code of Professional Conduct for Registered Auditors (IRBA Code*) and other independence requirements applicable to performing audits of financial statements in South Africa. We have fulfilled our other ethical responsibilities in accordance with the IRBA Code and in accordance with other ethical requirements applicable to performing audits in South Africa. The IRBA Code is consistent with the International Ethics Standards Board for Accountants *Code of Ethics for Professional Accountants* (Parts A and B). We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

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

Key audit matter	How our audit addressed the key audit matter
Outstanding claims provision The outstanding claims provision of R62.4 million at year-end as described in Note 8 to the financial statements, is a provision recognised for the estimated cost of healthcare benefits that have been incurred prior to year-end but that were only reported to the Scheme after year-end. The outstanding claims provision is calculated by the Scheme's actuaries and administrator which is reviewed by management and the Audit and Risk Committee and recommended to the Board of Trustees for approval. The Scheme's actuaries use an actuarial model, based on the Scheme's actual claim development patterns throughout the year, to project the year-end provision. This model applies the Basic Chain Ladder ("BCL") method. The claim service date, processing date and amount are used to derive claim development patterns. These historical patterns are then used to estimate the outstanding claims provision	We obtained an understanding from the Scheme's actuaries and administrator regarding the process to calculate the outstanding claims provision. The actuarial method applied by the Scheme is one that is generally applied within the medical scheme industry. We obtained the actual claims data from the member administration system covering the year ended 31 December 2018. For a sample of actual claims received by the Scheme in the 31 December 2018 financial year, we tested the accuracy of the service and process dates. No material inconsistencies were noted. We substantively tested a sample of claims against the relevant Scheme rules and assessed completeness of the claims data.

We identified this to be a matter of most significance to the audit because of the uncertainty in the projected claims pattern. A change in the projected claims pattern can cause a material change to the amount of the provision.	The claims data that was included in the Scheme's actuarial model was agreed to the above actual claims data with no material inconsistencies noted. To assess the reasonableness of the Scheme actuaries' estimation process, we compared the actual claim results in the current year to the prior year provision. Based on our assessment, the estimation process was considered reasonable. We have evaluated management's experts by assessing their competence, capability, and objectivity and noted no aspects requiring further consideration. We also obtained the outstanding claims provision report from the Scheme's actuaries and assessed whether the inputs, assumptions, methodology and findings per the report were consistent with our testing above. Based on the results of our assessment we accepted the inputs, assumptions, methodology and findings as reasonable. We obtained the actual claims run-off report up to 31 March 2019 from the Scheme's management. For a sample of claims from the report, we tested the occurrence and accuracy of the claims as well as the accuracy of the related service dates and we identified no material inconsistencies. We enquired from the Scheme's management whether there were delays in processing claims at year-end that could possibly impact the claims run-off pattern subsequent to year-end. Management confirmed that there were no such delays. We obtained the treatment pre-authorisations approved prior to year-end from management and selected a sample to assess if any of the selected claims were excluded from the actual claims run-off report up to 31 March 2019. No material inconsistencies were noted.

Other Information

The Scheme's trustees are responsible for the other information. The other information comprises the information included in the *Profmed Annual Integrated Report 2018*. The other information does not include the financial statements and our auditor's report thereon.

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

In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit, or otherwise appears to be materially misstated. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact. We have nothing to report in this regard.

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

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

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

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

- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, design and perform audit procedures responsive to those risks, and obtain audit evidence that is sufficient and appropriate to provide a basis for our opinion. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control.
- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Scheme's internal control.
- Evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by the Scheme's trustees.
- Conclude on the appropriateness of the Scheme's trustees' use of the going concern basis of accounting and based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the Scheme's ability to continue as a going concern. If we conclude that a material uncertainty exists, we are required to draw attention in our auditor's report to the related disclosures in the financial statements or, if such disclosures are inadequate, to modify our opinion. Our conclusions are based on the audit evidence obtained up to the date of our auditor's report. However, future events or conditions may cause the Scheme to cease to continue as a going concern.
- Evaluate the overall presentation, structure and content of the financial statements, including the disclosures, and whether the financial statements represent the underlying transactions and events in a manner that achieves fair presentation.

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

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

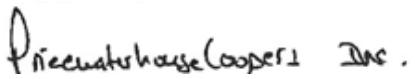
Independent auditor's report to the members of Profmed *(continued)*

Report on Other Legal and Regulatory Requirements

Non-compliance with the Medical Schemes Act of South Africa
As required by the Council for Medical Schemes, we report the following material instances of non-compliance with the requirements of the Medical Schemes Act of South Africa, as amended, that have come to our attention during the course of our audit:

Section 33(2)(b) of the Medical Schemes Act of South Africa: Certain benefit options were not self-supporting in terms of financial performance, as disclosed in note 26 of the financial statements.

Audit Tenure
As required by the Council for Medical Schemes' Circular 38 of 2018, Audit Tenure, we report that PricewaterhouseCoopers Inc. has been the auditor of Profmed for 22 years.
The engagement partner, Corlia Volschenk, has been responsible for Profmed's audit for 2 years.



PricewaterhouseCoopers Inc.
Director: C Volschenk
Registered Auditor
Johannesburg
26 April 2019

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Statement of financial position
As at 31 December 2018

	Notes	2018 R'000	2017 R'000
ASSETS			
Non-current assets		**793 498**	816 068
Property, plant and equipment	**2**	**21 946**	21 099
Available-for-sale financial assets	**4**	**-**	794 969
Financial assets at fair value through profit and loss	**4**	**771 552**	-
Current assets		**128 978**	153 008
Available-for-sale financial assets	**4**	**-**	142 791
Financial assets at fair value through profit and loss	**4**	**113 566**	-
Financial assets at amortised cost	**4**	**6 875**	-
Accounts receivable	**5**	**2 807**	3 555
Cash and cash equivalents	**6**	**5 730**	6 662
Total assets		**922 476**	969 076
LIABILITIES			
Current liabilities		**92 505**	104 097
Accounts payable	**7**	**30 109**	53 269
Outstanding claims provision	**8**	**62 396**	50 828
Total liabilities		**92 505**	104 097
Total net assets		**829 971**	864 979
Members' funds and reserves		**829 971**	864 979
Accumulated funds		**829 971**	804 069
Revaluation reserve		**-**	60 910
Members' funds and reserves		**829 971**	864 979

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Statement of comprehensive income
For the year ended 31 December 2018

	Notes	2018 R'000	2017 R'000
Risk contribution income		**1 668 455**	1 532 948
Relevant healthcare expenditure	**9**	**(1 499 250)**	(1 393 186)
Risk claims incurred		**(1 474 008)**	(1 369 625)
Risk claims incurred		**(1 475 089)**	(1 371 421)
Third-party claim recoveries	**9**	**1 081**	1 796
Accredited managed healthcare services	**10**	**(26 345)**	(23 242)
Net recovery/(expense) on the risk transfer arrangement	**9**	**1 103**	(319)
Risk transfer arrangement fees		**(4 563)**	(4 232)
Claims paid		**5 666**	3 913
Gross healthcare result		**169 205**	139 762
Administration and other operational expenditure	**11**	**(192 546)**	(174 375)
Broker service fees	**12**	**(10 616)**	(10 068)
Net impairment losses on healthcare receivables		**(46)**	107
Net healthcare result		**(34 003)**	(44 574)
Other income		**6 144**	73 772
Investment income	**13**	**6 083**	73 723
Sundry income	**14**	**61**	49
Other expenditure		**(7 149)**	(6 931)
Asset management fees	**15**	**(7 149)**	(6 931)
Net (deficit)/surplus for the year		**(35 008)**	22 267
Other comprehensive income			
Items that may be reclassified into surplus or loss		**-**	37 743
Realised gains on financial assets	**4**	**-**	(15 339)
Unrealised (loss)/gain on available-for-sale financial assets		**-**	53 082
Movement in financial assets at fair value through profit and loss		**-**	-
Total comprehensive income for the year		**-**	60 010

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Statement of changes in funds and reserves
For the year ended 31 December 2018

	Accumulated funds R'000	Revaluation reserve for available-for-sale financial assets R'000	Total members' funds and reserves R'000
Balance at 1 January 2017	781 802	23 167	804 969
Total comprehensive income for the year	22 267	37 743	60 010
Surplus for the year	22 267	-	22 267
Other comprehensive income	-	37 743	37 743
Balance at 31 December 2017	804 069	60 910	864 979
Change in accounting policy	60 910	(60 910)	-
Re-stated accumulated funds at the beginning of the year	864 979	-	864 979
Total comprehensive income for the year	**(35 008)**	**-**	**(35 008)**
(Deficit) for the year	**(35 008)**	**-**	**(35 008)**
Balance at 31 December 2018	**829 971**	**-**	**829 971**

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Statement of cash flows
For the year ended 31 December 2018

	Notes	**2018 R'000**	2017 R'000
Cash flow from operating activities			
Cash (utilised) from operations	**17**	**(43 714)**	(32 208)
Cash flow from investing activities			
Acquisition of property, plant and equipment	**2**	**(1 886)**	(1 138)
Proceeds on disposal of property, plant and equipment		**1**	12
Funds transferred to the asset manager	**4**	**(23 000)**	(25 000)
Funds withdrawn from the asset manager	**4**	**62 000**	54 000
Interest: Call and current bank accounts	**13**	**3 642**	3 368
Net rental income	**13**	**2 025**	1 345
Net cash generated from investing activities		**42 782**	32 587
Net (decrease)/increase in cash and cash equivalents		**(932)**	379
Cash and cash equivalents at beginning of year		**6 662**	6 283
Cash and cash equivalents at end of year	**6**	**5 730**	6 662

1. Summary of accounting policies

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

1.1 Basis of preparation

The financial statements of the Scheme are prepared in accordance with International Financial Reporting Standards (IFRS) and the manner required by the Medical Schemes Act of South Africa. The financial statements are prepared under the historical cost convention, as modified by the revaluation of available-for-sale financial assets to fair values.

The preparation of financial statements in conformity with IFRS requires the use of certain critical accounting estimates. It also requires the Scheme's management to exercise judgement in the process of applying the Scheme's accounting policies. The areas involving a higher degree of judgement or complexity, or areas where assumptions and estimates are significant to the financial statements, are disclosed in Note 8 and Note 23.

1.2 Changes to accounting policy and disclosures

New and amended standards or interpretations relevant to the Scheme and amendments to relevant standards where the amendment is not early adopted or relevant to the Scheme:

Standard/Interpretation	Effective date	Expected impact
IFRS 9 -Financial Instruments	1 January 2018	Material: 1.2.1
IFRS 15 – Revenue from contracts with customers	1 January 2019	Immaterial
IFRS 16 – Leases	1 January 2019	Immaterial

1.2.1 IFRS 9 Financial Instruments

(a) Equity instruments previously classified as available-for-sale
The Scheme previously elected to present changes in the fair value of available-for-sale financial assets in Other comprehensive income as these investments are held as a long-term strategic investment that is not expected to be sold in the short to medium term. As a result, Available-for-sale financial assets were reclassified to Financial assets at fair value through profit and loss.

(b) Available-for-sale debt instruments classified as fair value through profit and loss
Debt instruments were reclassified from available-for-sale to fair value through profit and loss as the Scheme's business model is achieved both by collecting contractual cash flows and selling of these assets. The contractual cash flows of these investments were solely principal and interest. As a result, listed and unlisted bonds were reclassified from Available-for-sale financial assets to Financial assets at fair value through profit and loss.

(c) Reclassification of financial instruments on the adoption of IFRS 9
On date of application, 1 January 2018, the financial instruments of the Scheme were as follows with the reclassification noted:

Financial instrument	Original IAS39	New IFRS 9
Equity securities	Available-for-sale	Fair value through profit and loss
Bonds and cash instruments	Available-for-sale	Fair value through profit and loss
Money market	Available-for-sale	Amortised cost*

* Cash instruments which were previously classified as available-for sale and are now measured at amortised cost had no difference in value as the amortised cost in the previous financial year approximated the fair value.

1.3 Property, plant and equipment

Land and buildings comprise an office building which is partly owner-occupied and stated at historical cost less the accumulated depreciation of the building. Land is not depreciated. Other property, plant and equipment is stated at historical cost less accumulated depreciation and accumulated impairment losses. Historical cost includes expenditure that is directly attributable to the acquisition of the items. Subsequent costs are included in the carrying amount when it is probable that future economic benefits associated with the asset will flow to the Scheme and the cost of the item can be measured reliably. Repairs and maintenance are charged to the Statement of Comprehensive Income during the financial period in which they are incurred.

Depreciation on buildings, furniture and equipment is calculated using the straight-line method to allocate their cost over their estimated useful lives.

The estimated maximum useful lives of the assets are:

Buildings	30 years
Office furniture	10 years
Office equipment	3 years
Vehicles	5 years.

The assets' residual values and useful lives are reviewed, and adjusted if material. Gains and losses on disposals are determined by comparing realisable proceeds with carrying amounts. These are included in the Statement of Comprehensive Income as Sundry income.

Where components of an item of furniture and equipment have different useful lives, they are accounted for as separate items. There were no changes in the useful lives from prior years.

1.4 Financial instruments

Financial assets and liabilities are recognised when the Scheme becomes party to the contractual provisions of the instrument (the trade date). The Scheme classifies its financial assets into categories, namely, Accounts receivable and Financial assets at fair value through profit and loss and at amortised cost. The classification depends on the purpose for which the financial assets were acquired. The Scheme determines the classification of its financial assets at initial recognition.

Initial recognition of financial instruments

All financial instruments are initially recognised at fair value, which represents the consideration receivable or given, plus direct transaction costs. Regular purchases and sales of financial instruments are recognised on trade date, which is the date on which the Scheme commits to purchase or sell the instruments. Subsequent to initial recognition, financial instruments are measured as set out in the paragraphs below.

Accounts receivable

Accounts receivable are non-derivative financial assets that arise from transactions with members and suppliers, and have fixed or determinable payments that are not quoted in an active market. Subsequent to initial recognition, they are measured at amortised cost, using the effective interest-rate method. A provision for impairment is raised when there is objective evidence that the Scheme will not be able to collect all amounts due according to the original terms of receivables.

Accounts receivable from the Road Accident Fund

The timing and monetary value of recoveries from the Road Accident Fund are considered to be uncertain and therefore debtors are not raised for amounts receivable at year-end. Amounts received during the year are deducted from relevant healthcare expenditure (Note 9) as part of Third-party claim recoveries.

Available-for-sale financial assets: 2017
Available-for-sale financial assets are non-derivative financial assets that are either designated in this category or not classified in any of the other categories. They are included in Non-current assets unless the Scheme intends to dispose of them within twelve months of the Statement of Financial Position date. Subsequent to initial recognition, available-for-sale financial assets are carried at fair values. Changes in the fair values of financial assets classified as available-for-sale are recognised directly in the Scheme's Revaluation reserve. When securities classified as available-for-sale are sold or impaired, the accumulated fair value adjustments previously recognised in Revaluation reserve are transferred to the Statement of Comprehensive Income and disclosed as realised gains on disposal of available-for-sale investments. Interest on available-for-sale financial assets, calculated using the effective interest-rate method, is recognised as Investment income in the Statement of Comprehensive Income. Dividends on available-for-sale equity instruments are recognised as Investment income in the Statement of Comprehensive Income when the Scheme's right to receive payments is established.

The fair values of quoted financial assets are based on bid prices at Statement of Financial Position date as quoted daily on a regulated exchange. Investments in collective investment schemes are valued at the unit price at year-end. If the market for a financial asset is not active, the Scheme establishes fair value by using valuation techniques. The Scheme did not have any financial assets that did not trade in an active market for the period under review.

For financial assets carried at fair value, the allocation of fair value measurements into the fair value hierarchy is reflective of the significant inputs used in making the measurements. The fair value hierarchy is based on the following levels:

Level 1: Where inputs are determined directly by reference to published price quotations (unadjusted) in an active market for identical instruments;
Level 2: Where inputs other than published price quotations included in Level 1 that are observable for assets, either directly (i.e. as prices) or indirectly (i.e. derived from prices), are used;
Level 3: Where the fair values are determined using a valuation technique based on assumptions that are not supported by observable market data.

Financial assets at fair value through profit and loss and financial assets held at amortised cost

(i) Classification
From 1 January 2018, the Scheme classifies its financial assets in the following measurement categories:
- those to be measured subsequently at fair value; and
- those to be measured at amortised cost.

The classification depends on the entity's business model for managing the financial assets and the contractual terms of the cash flows. For assets measured at fair value, gains and losses will either be recorded in profit or loss. For investments in equity instruments that are not held for trading, this will depend on whether the Scheme has made an irrevocable election at the time of initial recognition to account for the equity investment at fair value through other comprehensive income (FVOCI).

The Scheme reclassifies debt investments when, and only when, its business model for managing those assets changes.

(ii) Recognition and derecognition
Regular way purchases and sales of financial assets are recognised on trade-date, the date on which the Scheme commits to purchase or sell the asset. Financial assets are derecognised when the rights to receive cash flows from the financial assets have expired or have been transferred and the Scheme has transferred substantially all the risks and rewards of ownership.

(iii) Measurement
At initial recognition, the Scheme measures a financial asset at its fair value plus, in the case of a financial asset not at fair value through profit or loss (FVPL), transaction costs that are directly attributable to the acquisition of the financial asset. Transaction costs of financial assets carried at FVPL are expensed in profit or loss.

Debt instruments
Subsequent measurement of debt instruments depends on the Scheme's business model for managing the asset and the cash flow characteristics of the asset. There are three measurement categories into which the Scheme classifies its debt instruments:

- Amortised cost: Assets that are held for collection of contractual cash flows where those cash flows represent solely payments of principal and interest, are measured at amortised cost. Interest income from these financial assets is included in Interest income using the effective interest-rate method. Any gain or loss arising on derecognition is recognised directly in profit or loss and presented in other gains/(losses). Impairment losses are presented as a separate line item in the Statement of Comprehensive Income.

- FVPL: Assets that do not meet the criteria for amortised cost or FVOCI are measured at FVPL. A gain or loss on a debt investment that is subsequently measured at FVPL is recognised in profit or loss and presented net within other gains/(losses) in the period in which it arises.

Equity instruments
The Scheme subsequently measures all equity investments at fair value. Dividends from such investments continue to be recognised in profit or loss as Other income when the Scheme's right to receive payments is established. Changes in the fair value of financial assets at FVPL are recognised in other gains/(losses) in the Statement of Comprehensive Income as applicable.

1.5 Structured entities
IFRS 12 describes a structured entity as an entity that has been designed so that voting or similar rights are not the dominant factor in deciding who controls the entity, such as when any voting rights relate to administrative tasks only, and the relevant activities are directed by means of contractual arrangements. A structured entity often has some or all of the following features or attributes:
(a) restricted activities;
(b) a narrow and well-defined objective, such as to provide investment opportunities for investors by passing on risks and rewards associated with the assets of the structured entity to investors;
(c) insufficient equity to permit the structured entity to finance its activities without subordinated financial support;
(d) financing in the form of multiple contractually-linked instruments to investors that create concentrations of credit or other risks (tranches).

The Scheme has certain of its investments in other funds (investee funds), which are investments in unconsolidated structured entities. The Scheme invests in investee funds whose objectives range from achieving medium- to long-term capital growth. The investee funds are managed by unrelated asset managers and apply various investment strategies to accomplish their respective investment objectives.

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

An asset is impaired if its carrying amount is greater than its recoverable amount. The recoverable amount of all assets is the greater of the selling price and value in use. 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.

Impairment of receivables and other financial assets carried at amortised cost
Objective evidence that a financial asset (or group of financial assets) carried at amortised cost is impaired includes observable data that comes to the attention of the Scheme regarding the following loss events:

- Significant difficulty of service provider or member debtors;
- Breach of contract, such as non-payment of member contributions when due and if these remain unpaid for extended periods;
- Default or delinquency in payments due by service providers and other debtors;
- The absence of an active market for that financial asset due to financial difficulties;
- Observable data indicating that there is a measurable decrease in the estimated future cash flows from other Scheme assets since the initial recognition of those assets, although the decrease cannot yet be identified with the individual financial assets in the Scheme;
- Adverse changes in the payment status of members of the Scheme;
- National or local economic conditions that correlate with non-payment of debtor contributions.

If there is objective evidence that an impairment loss on receivables carried at amortised cost has been incurred, the amount of the loss is measured as the difference between the carrying amount and the present value of estimated cash flows, discounted at the asset's effective interest rate. The carrying amount of the asset is reduced through the use of an allowance account, and the amount of the loss is recognised in the Statement of Comprehensive Income within Net impairment losses on receivables.

Impairment of assets
Goodwill and intangible assets that have an indefinite useful life are not subject to amortisation and are tested annually for impairment, or more frequently if events or changes in circumstances indicate that they might be impaired. Other assets are tested for impairment whenever events or changes in circumstances indicate that the carrying amount may not be recoverable. An impairment loss is recognised for the amount by which the asset's carrying amount exceeds its recoverable amount. The recoverable amount is the higher of an asset's fair value less costs of disposal and value in use. For the purposes of assessing impairment, assets are grouped at the lowest levels for which there are separately identifiable cash inflows, which are largely independent of the cash inflows from other assets or groups of assets (cash-generating units). Non-financial assets other than goodwill that suffered an impairment are reviewed for possible reversal of the impairment at the end of each reporting period.

Reversal of impairment
Impairment losses are reversed when there has been a change in the estimates used to determine the recoverable amount. An impairment loss is reversed only to the extent that the asset's carrying amount does not exceed the carrying amount that would have been determined, net of depreciation or amortisation, if no impairment loss had been recognised. Subsequent recoveries of receivables previously impaired are recognised through the Statement of Comprehensive Income.

1.7 Derecognition of financial instruments
Financial assets are derecognised when the rights to receive cash flows from the financial assets have expired or have been transferred or when, on transfer, the Scheme retains the contractual rights to receive the cash flows of the financial asset, but assumes a corresponding liability to transfer these contractual rights to another party and consequently transfers substantially all the risks and benefits associated with the asset.

Where the Scheme retains substantially all the risks and rewards of ownership of the financial asset, the Scheme continues to recognise the financial asset.

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. In this case:

(i) 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;
(ii) if the Scheme has retained control, it continues to recognise the financial asset to the extent of its continuing involvement in the financial asset.

Financial liabilities are derecognised when the contractual obligations are discharged or cancelled or expire.

1.8 Offsetting of financial instruments

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

1.9 Cash and cash equivalents

Cash and cash equivalents include cash in hand, deposits held on call with banks, and other short-term highly liquid investments with original maturities of three months or less which are readily convertible to a known amount of cash and are subject to insignificant risk of change in value.

1.10 Provisions

Provisions are recognised when the Scheme has a present legal or constructive obligation and, as a result of past events, it is more likely than not that an outflow of resources embodying economic benefits will be required to settle the obligation, and a reliable estimate of the amount of the obligation can be made.

Provisions are measured at the present value of the Scheme's best estimate of the cash flows to settle the present obligation for claims (excluding claims from members and providers) and other expenses incurred and notified to the Scheme as at the Statement of Financial Position date.

Where there are a number of similar obligations, the likelihood that an outflow will be required in settlement is determined by considering the class of obligations as a whole. A provision is recognised even if the likelihood of an outflow with respect to any one item included in the same class of obligations may be small.

Provisions are measured at the present value of expenditure expected to be required to settle the obligation using a pre-tax rate that reflects current market assessments of the time value of money and the risks specific to the obligation. The increase in the provision due to passage of time is recognised as an interest expense.

Outstanding claims provision

The outstanding claims provision comprises provisions for the Scheme's best estimate of the ultimate cost of settling all claims incurred but not yet reported as at the Statement of Financial Position date. Claims outstanding are determined as accurately as possible based on a number of factors, which include previous experience in claims patterns, claims settlement patterns, changes in the nature and number of members according to trends in claims frequency, changes in the claims processing cycle and variations in the nature and average cost incurred per claim.

Estimated co-payments 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.

1.11 Member insurance contracts

Contracts under which the Scheme accepts significant insurance risk from members 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.

1.12 Contribution income

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

1.13 Relevant healthcare expenditure

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

Risk claims incurred comprise:

- claims submitted and accrued for services rendered during the year;
- over- or under-provisions relating to prior year claims accruals;
- amounts paid or to be paid under service provider contracts for services rendered to members;
- claims incurred but not yet reported;
- claims settled in terms of risk transfer arrangements.

Net of:

- recoveries from members for co-payments;
- recoveries from third parties;
- discount received from service providers.

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

1.14 Expenses for the acquisition of member insurance contracts

These expenses comprise commissions or fees paid to brokers on new member insurance contracts as well as renewal commissions and any other expenses related thereto. These expenses are accounted for on an accrual basis when they become due and payable.

1.15 Investment income

Investment income comprises dividends and interest on cash and cash equivalents and other financial assets at fair value through profit and loss. Interest income is recognised using the effective interest-rate method, taking into account the principal amount outstanding and the effective rate over the period to maturity, when it is determined that such income will accrue to the Scheme.

Dividend income on investments is recognised when the right to receive payment has been established. This is the ex-dividend date for equity securities. Where dividend income accrues to the Scheme through unitised instruments, dividend and interest income is recognised after the units are sold and the income realised. Capitalisation shares received in terms of a capitalisation issue from reserves, other than share premium or a reduction in share capital, are treated as dividend income.

1.16 Retirement benefits

Defined contribution plan

The Scheme's employees belong to a defined contribution retirement fund, governed by the Pensions Fund Act, where the Scheme pays employee contributions to the fund. Once the contributions have been paid, the Scheme has no legal or constructive obligations to pay further contributions if the pension fund does not hold sufficient assets to pay all employees their entitlement. The pension contributions are recognised as staff remuneration when they are due and payable.

1.17 Unallocated funds

Unallocated funds arise on the receipt of unidentified deposits in favour of the Scheme. Unallocated funds that have legally prescribed, that is funds older than three years, are written back and included in the Statement of Comprehensive Income.

1.18 Liabilities and related assets under the liability adequacy test

The liability for insurance contracts is tested for adequacy by discounting current estimates of all future contractual cash flows, and comparing this amount to the carrying value of the liability net of any related assets (i.e. the value of business acquired). Where a shortfall is identified, an additional provision is made and the Scheme recognises the deficiency in Income for the year.

1.19 Allocation of income and expenditure to benefit options

The following items are directly allocated to benefit options:
• Risk contribution income
• Relevant healthcare expenditure
• Broker service fees.

The remaining items are apportioned based on the number of principal members on each option:
• Accredited manged healthcare services
• Administration and other operational expenditure
• Other income
• Other expenditure.

1.20 Leases

Leases are categorised as operating leases. Income arising from leases is disclosed as Net rental income over a straight-line basis over the period of the lease term. The leased property is included in the Statement of Financial Position according to its nature.

1.21 Administration expenses

Administration expenses include administration fees, non-accredited managed care fees, Scheme expenses, Board and committee expenses, marketing, communication, broker consultancy expenses and other expenses. These costs are expensed as incurred.

1.22 Accredited managed healthcare fees

Accredited managed healthcare fees comprise amounts paid or payable to a third party for managing the utilisation, costs and quality of healthcare services provided to the members of the Scheme. Accredited managed healthcare fees are expensed as incurred and are categorised into fees for accredited managed healthcare services based on the accreditation by the Council for Medical Schemes of the managed healthcare service provider.

2. Property, plant and equipment

	Land and buildings R'000	Office equipment & software R'000	Office furniture R'000	Total R'000
31 December 2018				
Opening carrying amount	19 802	661	636	21 099
Acquisitions during the year	1 430	456	-	1 886
Disposals: Cost	-	(156)	-	(156)
Disposals: Accumulated depreciation	-	152	-	152
Depreciation charge	(547)	(396)	(92)	(1 035)
Closing carrying amount	20 685	717	544	21 946
Cost or valuation	23 677	2 168	1 187	27 032
Accumulated depreciation	(2 992)	(1 451)	(643)	(5 086)
Carrying amount	20 685	717	544	21 946
31 December 2017				
Opening carrying amount	19 637	575	683	20 895
Acquisitions during the year	697	392	49	1 138
Trade-in: Motor vehicle	-	86	-	86
Disposals: Cost	-	(219)	-	(219)
Disposals: Accumulated depreciation	-	170	-	170
Depreciation charge	(532)	(343)	(96)	(971)
Closing carrying amount	19 802	661	636	21 099
Cost or valuation	22 247	1 867	1 187	25 301
Accumulated depreciation	(2 445)	(1 206)	(551)	(4 202)
Carrying amount	19 802	661	636	21 099

No items of property, plant and equipment have been pledged as security.

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

	2018 R'000	2017 R'000
Financial assets		
Non-current	**771 552**	794 969
Current	**113 566**	142 791
Amortised cost	**6 875**	-
Cash and cash equivalents	**5 730**	6 662
Accounts receivable		
Loans and receivables	**540**	725
Insurance receivables	**2 267**	2 830
Current liabilities		
Financial liabilities measured at amortised cost	**2 136**	4 664
Insurance payables	**80 738**	99 433

4. Financial assets

4.1 Movement in financial assets

	Notes	2018 R'000	2017 R'000
Beginning of the year		**937 760**	866 938
Capital contribution		**23 000**	25 000
Withdrawals		**(62 000)**	(54 000)
Total (loss)/gain		**(58 700)**	53 082
Net realised (loss)/gain on financial assets	13	**(4 258)**	15 339
Unrealised fair value (losses)		**(54 442)**	37 743
Asset management fees	15	**(7 149)**	(6 931)
Interest		**43 310**	40 222
Dividends	13	**15 772**	13 449
Fair value at the end of the year		**891 993**	937 760
Less current portion		**(120 441)**	(142 791)
Non-current portion at year-end		**771 552**	794 696

4.2 Financial assets at fair value through profit or loss

	Notes	2018 R'000	2017 R'000
Non-current			
Equity securities		**391 979**	-
Bonds and cash instruments		**379 573**	-
Total non-current	3	**771 552**	-
Current			
Money market		**94 694**	-
Bonds and cash instruments		**18 782**	-
Total current	3	**113 566**	-

4.3 Financial assets held at amortised cost

	Notes	2018 R'000	2017 R'000
Current			
Cash instruments	3	**6 875**	-

4.4 Financial assets previously classified as available-for-sale

	Notes	2018 R'000	2017 R'000
Non-current			
Equity securities		**-**	396 701
Bonds and cash instruments		**-**	398 268
Total non-current	**3**	**-**	794 969
Current			
Money market		**-**	125 330
Bonds and cash instruments		**-**	17 461
Total current	**3**	**-**	142 791

Financial assets at fair value are denominated in RSA Rand. Money market instruments redeemable in three months or less are classified as financial assets at fair value through profit and loss and financial assets at amortised costs. None of the financial assets at fair value are past due.

5. Accounts receivable

	2018 R'000	2017 R'000
Insurance receivables	**2 267**	2 830
Financial receivables	**488**	610
Accrued interest	**52**	115
Sub-total: Accounts receivable	**2 807**	3 555
Impairment provision	**-**	-
Total accounts receivable	**2 807**	3 555

As at 31 December 2018, the carrying amounts of accounts receivable approximated their fair value. Interest is not charged on overdue balances.

6. Cash and cash equivalents

	2018 R'000	2017 R'000
Cash at bank and on hand	**5 366**	3 962
Short-term bank deposits	**364**	2 700
Total cash and cash equivalents	**5 730**	6 662

The weighted average effective interest rate was 6.35% (2017: 6.55%) on call account balances.

7. Accounts payable

	2018 R'000	2017 R'000
Insurance liabilities		
Risk contributions received in advance	**2 421**	3 270
Reported claims not yet paid	**22 376**	43 194
Member and provider credit balances	**3 177**	2 141
Total liabilities arising from insurance contracts	**27 974**	48 605
Financial liabilities		
Sundry accounts payable	**2 135**	4 664
Total arising from financial liabilities	**2 135**	4 664
Total accounts payable	**30 109**	53 269

As at 31 December 2018, the carrying amounts of accounts payable approximated their fair value because of the short-term maturities of these liabilities.

8. Outstanding claims provision

	Notes	2018 R'000	2017 R'000
Analysis of movements in outstanding claims			
Balance at beginning of year		**50 828**	46 792
Payments in respect of prior year	**9**	**(47 816)**	(46 213)
Overprovision written back		**(3 012)**	-
Prior year over-provision	**9**	**-**	579
Adjustment for current year	**9**	**62 396**	50 249
Balance of the provision at year-end		**62 396**	50 828

Analysis of movements in provision arising from liability adequacy test
The liability adequacy test was performed and no additional provision was required. There are some sources of uncertainty that need to be considered in the estimate of the liability that the Scheme will ultimately pay for claims made under insurance contracts. Initial estimates are made relating to the best calculations on reported claims and reviewed as the claims process develops. All estimates are revised and adjusted at year-end by management.

Process used to determine the assumptions
The process used to determine the assumptions is intended to result in realistic estimates of the most likely or expected outcomes. The sources of data used as inputs for the assumptions are internal, using detailed studies of historical claiming patterns to establish a "claims run-off" period per discipline. More emphasis is placed on recent information, particularly where current claims do not appear to follow prior year trends. Where, in prior years, there is insufficient information to make a reliable best estimate of claims development, prudent assumptions are used.

Notified claims are assessed with due regard to the claim circumstances, medical discipline, anticipated development, and expected seasonal fluctuations. The provisions are best estimates, based on the most recent information available, and may be affected by the different claims run-off periods of the various medical disciplines. The process of estimation differs by category of claims, such as in-hospital, chronic and day-to-day benefits, due to differences in the underlying insurance contracts, claim complexity, the volume of claims, individual severity of claims and reporting lags.

The cost of outstanding claims is estimated using the chain-ladder method. This model extrapolates the development of incurred claims for each option and each discipline based upon observed historical development. Run-off triangles are used in situations where it takes time after the treatment date for the full extent of the claims to become known. It is assumed that payments will emerge in a similar way in each service month. The proportional increase in known cumulative payments from one development month to the next can then be used to calculate payments for future development months.

The actual method or blend of methods used varies by benefit year being considered, categories of claims and observed historical claims development. To the extent that historical claims development information is used, it is assumed that the historical 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 and recording of claims paid and incurred;
- changes in composition of members and their dependants;
- random fluctuations, including the impact of large losses;
- legislative changes, e.g. expansion of the definition of a prescribed minimum benefit (PMB)/Chronic Disease List (CDL).

Assumptions

The outstanding claims provision is calculated based on claims processing patterns over the previous twenty-four months. Due to the large size of the Scheme membership base, no adjustment to the data is made for large claims. The assumptions that have the greatest effect on the measurement of the outstanding claims provision are the claims run-off periods for the most recent benefit years (split by discipline) for the in-hospital, chronic and day-to-day categories of claims. The run-off factor relates to the emergence and settlement patterns of claims and is expressed as the percentage of claims settled in respect of total claims expected to emerge in a specific service month. This factor is then used to project the remainder of the outstanding claims relating to the specified service month. These are used for assessing the outstanding claims provision for the 2015 benefit year. Due to the fact that 72% of claims are paid within three months of the date of service, no allowance for discounting of claims costs is made.

Changes in assumptions and sensitivities to changes in key variables

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

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

An analysis of sensitivity around various scenarios for the general medical insurance business provides an indication of the adequacy of the Scheme's estimation process. The Scheme believes that the liability for claims reported in the Statement of Financial Position is adequate. However, it recognises that the process of estimation is based upon certain variables and assumptions which could differ when claims arise. Consequently, if the estimates of the outstanding portion of claims costs for the year were, for example, 1% inaccurate, the impact on the provision would be as follows:

	Change in variable	**Change in liability**	
		2018 R'000	**2017 R'000**
Hospitalisation	1%	**4 805**	4 629
Chronic medication	1%	**701**	670

This analysis has been prepared for a change in run-off factors with other assumptions remaining constant. The change in liability also represents the absolute change in surplus or deficit for the period. It should be noted that an increase in liabilities will result in a decrease in surpluses and *vice versa*. These reasonable possible changes in key variables do not result in any changes directly to reserves.

9. Relevant healthcare expenditure

	Notes	2018 R'000	2017 R'000
Current year claims paid		**1 463 521**	1 367 385
Movement in outstanding claims provision		**11 568**	4 036
Payments in respect of prior year	**8**	**(47 816)**	(46 213)
(Over) provision in prior year	**8**	**(3 012)**	(579)
Adjustment for current year	**8**	**62 396**	50 828
Claims incurred		**1 475 089**	1 371 421
Less: Third-party claim recoveries		**(1 081)**	(1 796)
Accredited managed healthcare services	**10**	**26 345**	23 242
Risk transfer arrangement (recovery)/expense		**(1 103)**	319
		1 499 250	1 393 186

Risk transfer arrangement
The Scheme has a risk transfer arrangement with Netcare 911 for claims relating to emergency transport services. The fee for the arrangement remained unchanged until the end of 2018. The Scheme closely monitors the services to ensure cost-effectiveness and value for members and the Scheme.

10. Accredited managed healthcare services

	2018 R'000	2017 R'000
Dental benefit management	**1 724**	1 668
Hospital pre-authorisation and case management	**19 712**	18 091
Pharmacy benefit and clinical risk management	**3 663**	3 374
Trauma benefit management	**90**	109
Doctors procedure and consultation claims review	**414**	-
Provider profiling	**742**	-
	26 345	23 242

11. Administration and other operational expenditure

	Notes	2018 R'000	2017 R'000
Actuarial fees		**870**	818
Association fees		**556**	525
Bank charges		**1 267**	1 143
Computer expenses		**518**	474
Council for Medical Schemes expenses		**1 185**	1 085
Depreciation		**1 035**	971
External audit fees		**1 042**	949
Fees paid to the administrator		**116 434**	106 805
Internal audit fees		**86**	46
Internal new business consultants' remuneration and expenses		**14 023**	13 299
Legal fees		**889**	455
Marketing and communication expenses		**22 511**	18 095
Multiply Wellness Programme		**4 658**	4 422
Managed healthcare services not accredited by the CMS		**8 885**	8 453
Office rental		**424**	402
Principal Officer remuneration		**3 661**	3 269
Printing and stationery		**661**	662
Professional fees		**553**	461
Professional indemnity insurance premiums		**559**	547
Staff cost		**7 575**	6 605
Telephone and postage		**76**	334
Travel, accommodation and conferences		**113**	76
Trustee remuneration and considerations	**16**	**4 736**	4 288
Other expenses		**229**	191
		192 546	174 375

12. Broker service fees

	2018 R'000	2017 R'000
Broker fees	**10 616**	10 068

No distributions other than broker fees were paid to brokers.

13. Investment income

	2018 R'000	2017 R'000
Dividend income on assets held at fair value through profit and loss	**15 772**	-
Available-for-sale dividend income	**-**	13 449
Interest income	**46 952**	43 590
Assets held at fair value through profit and loss	**42 306**	-
Assets held at fair value at amortised cost	**1 004**	-
Available-for-sale financial assets	**-**	40 222
Call and current bank accounts	**3 642**	3 368
Net realised gains on available-for-sale financial assets	**-**	15 339
Net realised losses on assets held at fair value through profit and loss	**(4 258)**	-
Net unrealised losses on assets held at fair value through profit and loss	**(54 408)**	-
Net rental income	**2 025**	1 345
	6 083	73 723

14. Sundry income

	2018 R'000	2017 R'000
Prescribed amounts written to income	**64**	-
(Loss)/Profit on disposal of equipment	**(3)**	49
	61	49

15. Asset management fees

	2018 R'000	2017 R'000
Management fees	**7 149**	6 931

This expense is charged as a percentage of the total value of investments managed by the asset management company.

16. Trustee and committee member remuneration

The following table records the remuneration paid to, and considerations paid for, trustees and other committee members during 2018:

	Remuneration paid to trustees/committee members			Other considerations paid					
31 December 2018	**Fees for meeting attendance R**	**Fees for holding of office R**	**Fees for consultancy services R**	**Training R**	**Travel and accommodation R**	**Travel and accommodation-flights/hotels R**	**Other disburse-ments and reimburse-ments R**	**VAT paid R**	**Total R**
Mr DC Arnold*	58 425				764				**59 189**
Dr AD Behrman	143 350				1 827	17 795			**162 972**
Mr HP du Toit	356 350				5 164	52 105			**413 619**
Mr JS Gardner*	34 950				334				**35 284**
Ms MM Geringer	254 400				2 544				**256 944**
Prof WM Gumede	171 600				836	11 087			**183 523**
Mr GS Harvey	257 400				7 199	60 265			**324 864**
Mr M Jeena	367 050				1 452				**368 502**
Mr PL Marais*	34 950								**34 950**
Mr KG Mockler*	92 663		84 900		3 893				**181 456**
Dr BH Modi	345 525							**51 258**	**396 783**
Dr AP Newell	179 350								**179 350**
Dr Y Omar Carrim*	61 775				1 926				**63 701**
Mr J Prinsloo*	61 775				2 684				**64 459**
Adv HB Smalberger	401 650				7 425	75 030		**60 692**	**544 797**
Dr RD Shuttleworth	149 725	443 333			6 362	68 936	**1 320**		**669 676**
Mr RN Theunissen	30 000	307 868			249	12 404	**230**	**48 934**	**399 685**
Dr SJ Velzeboer	388 750			5 818	1 585				**396 153**
Total	**3 389 688**	**751 201**	**84 900**	**5 818**	**44 244**	**297 622**	**1 550**	**160 884**	**4 735 907**

*Independent Board committee members

Trustee appointment, election and resignation dates are disclosed in the Corporate Governance report.

SARS issued two Binding General Rulings, numbers 40 and 41, during 2017 to the effect that non-executive directors are not employees but are conducting an enterprise and are liable to charge and account for VAT on their fees if they are registered or obliged to register as VAT vendors. The rulings became effective 1 June 2017. The same principle is applicable to trustees of medical schemes and Profmed consequently became obliged to pay VAT on the fees of three trustees. The VAT payments are reflected in the table above. Medical schemes may not register for VAT and the Scheme consequently cannot claim a VAT refund from SARS.

The following table records the remuneration paid to, and considerations paid for, trustees and other committee members during 2017:

	Remuneration paid to trustees/committee members			Other considerations paid				
31 December 2017	**Fees for meeting attendance R**	**Fees for holding of office R**	**Fees for consultancy services R**	**Training R**	**Travel and accommodation R**	**Travel and accommodation- flights/hotels R**	**VAT Paid**	**Total R**
Mr DC Arnold*	54 925				750			**55 675**
Dr AD Behrman	303 535				3 394	21 102		**328 031**
Dr MM Bhikhoo		303 811					**1 824**	**305 635**
Mr HP du Toit	289 41				2 443	30 468		**322 321**
Mr JS Gardner	32 850				334			**33 184**
Ms MM Geringer	74 200					8 119		**82 319**
Prof WM Gumede	294 885				955			**295 840**
Mr M Jeena	222 610			1 367	1 117			**225 095**
Mr PL Marais*	32 850				303			**33 153**
Mr KG Mockler*	108 875		55 107		2 547			**166 529**
Dr BH Modi	222 580						**31 161**	**253 741**
Dr AP Newell	286 485			1 368				**287 853**
Dr E Nkosi	100 700				1 364			**102 064**
Dr Y Omar Carrim*	58 100				1 704			**59 804**
Mr J Prinsloo	66 050				3 517			**69 567**
Adv HB Smalberger	333 385				6 179	52 279	**34 353**	**426 196**
Dr RD Shuttleworth	367 910				7 457	30 460		**405 827**
Mr RN Theunissen	151 400	402 363		1 368	3 107	15 101	**61 954**	**635 293**
Dr SJ Velzeboer	197 185			1 368	963			**199 516**
Total	**3 197 935**	**706 174**	**55 107**	**5 472**	**36 134**	**157 529**	**129 292**	**4 287 643**

* Independent Board committee members

Trustee appointment, election and resignation dates are disclosed in the Corporate Governance report.

17. Cash generated from operations per the Statement of Cash Flows

	Notes	2018 R'000	2017 R'000
Net (deficit)/surplus for the year		**(35 008)**	22 267
Adjustments for:			
Depreciation	**2**	**1 035**	971
Interest received	**13**	**(46 952)**	(43 590)
Dividend income	**13**	**(15 772)**	(13 449)
Realised gain on disposal of available-for-sale financial assets	**13**	**-**	(15 339)
Realised loss on disposal of financial assets held at fair value through profit and loss	**13**	**4 258**	-
Asset management fees	**15**	**7 149**	6 931
Net rental income	**13**	**(2 025)**	(1 345)
Unrealised losses on assets held at fair value through profit and loss	**4**	**54 442**	-
Loss/(Profit) on disposal of equipment	**14**	**3**	(49)
Increase in outstanding claims provision	**9**	**11 568**	4 036
Cash flows from operations before working capital changes		**(21 302)**	(39 567)
Changes in working capital		**(22 412)**	7 359
Decrease/(Increase) in accounts receivable	**5**	**748**	(410)
(Decrease)/Increase in accounts payable	**7**	**(23 160)**	7 769
Cash (utilised) in operations		**(43 714)**	(32 208)

18. Surplus/(deficit) from operations per benefit option

The Scheme offered five benefit options in 2018. The principal features of each option are explained in the Business Model on page 11.

The benefit options performed as follows:

	ProPinnacle R'000	ProSecure Plus R'000	ProSecure R'000	ProActive Plus R'000	ProActive R'000	Total R'000
2018						
Risk contribution income	211 493	181 752	526 992	300 640	447 578	1 668 455
Relevant healthcare expenditure	(238 601)	(169 651)	(505 275)	(235 332)	(350 391)	(1 499 250)
Claims incurred	(237 856)	(167 960)	(499 368)	(229 503)	(340 402)	(1 475 089)
Accredited managed healthcare services	(1 311)	(1 810)	(6 165)	(6 225)	(10 834)	(26 345)
Third-party claim recoveries	511	44	-	135	391	1 081
Risk transfer arrangement expense	55	75	258	261	454	1 103
Gross healthcare result	(27 108)	12 101	21 717	65 308	97 187	169 205
Administration and other operational expenditure	(9 582)	(13 227)	(45 060)	(45 497)	(79 180)	(192 546)
Broker service fees	(528)	(729)	(2 484)	(2 509)	(4 366)	(10 616)
Net impairment losses on healthcare receivables	(2)	(3)	(11)	(11)	(19)	(46)
Net healthcare result	**(37 220)**	**(1 858)**	**(25 838)**	**17 291**	**13 622**	**(34 003)**
Average number of members during the year	1 653	2 282	7 774	7 850	13 661	33 221

18. Surplus/(deficit) from operations per benefit option *(continued)*

	ProPinnacle R'000	ProSecure Plus R'000	ProSecure R'000	ProActive Plus R'000	ProActive R'000	Total R'000
2017						
Risk contribution income	204 104	174 853	502 388	250 182	401 421	1 532 948
Relevant healthcare expenditure	(223 597)	(195 813)	(483 572)	(189 641)	(300 563)	(1 393 186)
Claims incurred	(223 146)	(194 316)	(478 292)	(184 484)	(291 183)	(1 371 421)
Accredited managed healthcare services	(1 230)	(1 707)	(5 7 68)	(5 116)	(9 421)	(23 242)
Third-party claim recoveries	796	234	567	29	170	1 796
Risk transfer arrangement expense	(17)	(24)	(79)	(70)	(129)	(319)
Gross healthcare result	(19 493)	(20 960)	18 816	60 541	100 858	139 762
Administration and other operational expenditure	(9 230)	(12 804)	(43 271)	(38 386)	(70 684)	(174 375)
Broker service fees	(533)	(739)	(2 499)	(2 216)	(4 081)	(10 068)
Net impairment losses on healthcare receivables	5	8	27	24	43	107
Net healthcare result	(29 251)	(34 495)	(26 927)	19 963	26 136	(44 574)
Average number of members during the year	1 729	2 399	8 106	7 191	13 241	32 665

The allocation of the non-healthcare expenses across the options is based on the average number of principal members per option during the year.

19. Related party transactions

Administration agreement

Administration fees were paid to the administrator, PPS Healthcare Administrators (Pty) Ltd, a wholly-owned subsidiary of PPS Insurance Company Limited. Administration fees were charged in line with market-related rates. The administrator is deemed to form part of key management personnel of the Scheme as it participates in financial and operating policy decisions, but does not control the Scheme. A division of the administrator also provides accredited managed healthcare services.

Transactions with related parties

	Notes	2018 R'000	2017 R'000
Statement of Comprehensive Income			
PPS Healthcare Administrators			
Administration fees	**11**	**116 434**	106 805
Managed care fees	**10**	**19 712**	18 091
Statement of Financial Position			
Balance to PPS Healthcare Administrators		-	-

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

The administration agreement is in terms of the Rules of the Scheme and in accordance with instructions given by the Board. The agreement is automatically renewed each year unless notification of termination is received or following the cancellation of the administrator's accreditation or the issue of a lawful directive to this effect by the Council for Medical Schemes in terms of the Medical Schemes Act 131 of 1998, as amended.

Key management personnel and their close family members

The Scheme is controlled by the Board, fifty percent of whom are elected by the members of the Scheme and fifty percent are appointed by the Board.

Key management personnel are those persons having authority and responsibility for planning, directing and controlling the activities of the Scheme. Key management personnel include the trustees and the Principal Officer. The disclosure deals with full-time personnel that are compensated on a salary basis (Principal Officer) and part-time personnel that are compensated on a fee basis (trustees). Close family members include close family members of the trustees and the Principal Officer.

Transactions with key personnel (trustees and Principal Officer) and their close family members

	2018 R'000	2017 R'000
Statement of Comprehensive Income		
Remuneration	**8 397**	7 557
Contributions received	**811**	810
Claims incurred	**(687)**	(2 091)
Statement of Financial Position		
Contribution debtors	-	-
Claims reported not yet paid	-	-

The terms and conditions of the transactions with related parties, other than the administrator, were as follows:

Transaction	Nature of transactions and terms and conditions thereof
Contributions received	These are the contributions paid by the related parties as members of the Scheme in their individual capacities. All contributions were on the same terms as applicable to other members.
Claims incurred	These are amounts claimed by the related parties as members of the Scheme in their individual capacities. All claims were paid out in terms of the Rules of the Scheme, as applicable to other members.
Contribution debtor	These are outstanding contributions receivable. The amounts are due immediately. No impairment provisions have been raised on these amounts.
Claims reported not yet paid	These are claims that have been reported but not yet paid due to the fact that the Scheme's year-end fell between the claims payment runs. All claims are settled within 30 days of being received, as applicable to third parties or other members.

20. Commitments

The Scheme had not made any commitments for future capital or lease payments as at year-end.

21. Subsequent events

There have been no adjusting or non-adjusting events that have occurred between the accounting date and the date of this Report that affected the 2018 results.

22. Financial risk management

22.1 Financial risk factors

The Scheme's activities expose it to a variety of financial risks, including the effects of changes in the equity market price, credit risk and interest rates. In particular, the key financial risk is that the proceeds from its financial assets are not sufficient to fund the obligations arising from its insurance contracts. The most important components of this financial risk are liquidity risk, credit risk, interest rate risk and market 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, which the Scheme holds to meet its obligations to its members.

Risk management and investment decisions are carried out by the Investment Committee, under the policies approved by it. The Committee identifies and evaluates financial risks associated with the Scheme's investment portfolio.

The Board provides written principles for overall risk management, as well as written policies covering specific areas, such as interest rate risk, credit risk, use of derivative financial instruments and investing excess liquidity. The Board approves all of these written policies.

22.2 Market risk

a) Interest rate risk

Interest rate risk is the Scheme's exposure to changes in interest rates. The main exposure to the Scheme would be a reduction in interest income on investments if interest rates were to decrease.

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

The table below summarises the Scheme's exposure to interest rate risk. Included in the table are the Scheme's money market securities, fixed deposits, deposits on call and current bank accounts at carrying amounts, categorised by the earlier of contractual repricing or maturity dates.

	Up to 3 months R'000	4 – 12 months R'000	1 – 5 years R'000	Total R'000
2018				
Total exposure	71 946	54 226	379 573	505 745
2017				
Total exposure	109 560	39 893	398 268	547 721

The above amounts are classified as follows:

	Notes	2018 R'000	2017 R'000
Financial assets			
- Non-current	**4**	379 573	398 268
- Current	**4**	113 566	142 791
- Amortised cost	**4**	6 875	-
- Cash and cash equivalents	**6**	5 730	6 662
		505 745	547 721

Interest rate risk sensitivity analysis
A change of 100 basis points in interest rates at the reporting date would have increased/(decreased) accumulated funds and the surplus by the amounts shown below. The analysis assumes that all other variables remain constant.

	Surplus or deficit (R'000)		Accumulated funds (R'000)	
	100bp increase	100bp decrease	100bp increase	100bp decrease
2018	(22 685)	(22 265)	889 347	872 877
2017	14 429	14 162	868 395	852 313

b) Currency risk
All of the Scheme's investments and benefits are Rand-denominated and therefore do not have significant net currency risk. The Scheme is exposed to currency risk related to drugs and appliances being imported. The weakening of the Rand will have an adverse effect on the claims experience of the Scheme.

c) Price risk
The Scheme is exposed to equity securities price risk because of investments held by the Scheme and classified in the Statement of Financial Position as Financial assets at fair value through profit and loss. The Scheme is not exposed to commodity risk. To manage the price risk arising from investment in equity securities, the Scheme diversifies its portfolio within the limits prescribed by the Medical Schemes Act and Regulations.

The table below summarises the Scheme's exposure to equity securities price risk:

	Up to 1 month R'000	1 – 3 months R'000	4 – 12 months R'000	1 – 5 years R'000	Total R'000
2018					
Total exposure	-	-	-	391 979	391 979
2017					
Total exposure	-	-	-	396 701	396 701

22.3 Credit risk

Credit risk is the risk of loss arising from the inability of a third party to service its debt obligations. The Scheme's principal financial assets are cash and cash equivalents, accounts receivable and investments. The Scheme's credit risk relates primarily to its accounts receivable and exposure to bond instruments.

The receivables are in respect of:
- contributions due from members;
- amounts recoverable from service providers; and
- accrued interest.

The Scheme manages credit risk by:
- actively pursuing all contributions not received after three days of becoming due, as required by Section 26(7) of the Medical Schemes Act 131 of 1998, as amended;
- suspending benefits on all member accounts when contributions have not been received for 30 days;
- terminating benefits on all member accounts when contributions have not been received for 60 days;
- ageing and pursuing unpaid accounts on a monthly basis.

The amounts presented in the Statement of Financial Position are net of provision for impairment, estimated by the Scheme's management, based on prior experience and the current economic environment.

All of the Scheme's debt investments at amortised cost and FVPL are considered to have low credit risk, and the loss allowance recognised during the period was therefore limited to 12 months expected losses. Management consider 'low credit risk' for listed bonds to be an investment grade credit rating with at least one major rating agency. Other instruments are considered to be low credit risk when they have a low risk of default and the issuer has a strong capacity to meet its contractual cash flow obligations in the near term.

The credit risk on liquid funds is limited because the counter-parties are banks with high credit ratings assigned by international credit rating agencies. There is no significant concentration of credit risk with respect to receivables as the Scheme has a large number of members who are nationally dispersed.

The Scheme only dealt with financial institutions with National Long Term ratings of B and higher. At year-end the major financial institutions that the Scheme contracted with had the following credit ratings:

ABSA Bank	BA1
FirstRand Holdings	B+
Investec Ltd	BB+
Nedbank	BB+
Standard Bank	BA1

Exposure to credit risk

For the disclosure of the maximum exposure to credit risk on Accounts receivable, financial assets and Cash and cash equivalents, please refer to Note 3.

Accounts receivable that are less than sixty days past due are not considered impaired. The ageing analysis of these receivables is as follows:

	Notes	2018 R'000	2017 R'000
Fully performing		**540**	724
Past due: 4 – 30 days		**1 435**	1 772
Past due: 31 days and older		**832**	1 059
Total accounts receivable	**5**	**2 807**	3 555

Investec Asset Managers' (IAM) credit investment process comprises three distinct yet interrelated aspects:

- Bottom-up fundamental credit analysis
  Potential investment is deal-screened, which entails a high-level review of quantitative (business financials) and qualitative (market positioning, competition and quality of management) factors. A full review entails a detailed fundamental analysis of the investment and the submission of a credit report to the Credit Investment Committee for consideration and approval. Investments approved become part of the potential investible universe and they are continually monitored.

- Top-down macro-economic
  Systematically evaluates and scores each macroeconomic factor that may have an impact on the portfolio. Also influences the overall exposure of the funds, strongly influencing both buy and sell decisions.

- Market factor analysis and portfolio construction (which incorporates risk management)
  Investment decisions are made within a defined risk framework. Given the downside risk inherent in credit, it is critically important to limit exposure to vulnerable sectors that are more defensive or positioned to strengthen.

22.4 Liquidity risk

The Scheme manages liquidity risk by monitoring cash flows. The Scheme is exposed to daily calls on its available cash resources, mainly from claims. Liquidity risk is the risk that cash may not be available to pay obligations when they are due, at a reasonable cost.
The availability of funding through liquid-holding cash positions with various financial institutions ensures that the Scheme has the ability to fund the day-to-day operations of the Scheme. The financial liabilities outlined in the table below have maturity dates of less than twelve months after year-end.

	Total R'000
Cash and cash equivalents	5 730
Trade and other receivables	2 807
Current portion of financial assets	113 566
Financial assets held at amortised cost	6 875
Total liabilities	**(92 505)**

Maturities of financial liabilities	**1 – 3 months R'000**	**4 – 12 months R'000**	**Total R'000**
Accounts payable	27 735	374	30 109
Outstanding claims provision	59 979	2 417	62 396

22.5 Capital management

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

The risk is that there could be insufficient reserves to provide for adverse variations on actual and future experience. The MSA requires a minimum ratio of accumulated funds expressed as a percentage of gross premiums to be 25%. The Scheme's accumulated funds ratio was 49.4% as at 31 December 2018 (2017: 52.5%).

The accumulated funds ratio is calculated as follows:

	2018 R'000	2017 R'000
Total members' funds per Statement of Financial Position	**829 971**	864 979
Less: Reserve for unrealised investment gains	**-**	(60 910)
Less: Financial assets at fair value through profit and loss	**(6 502)**	-
Accumulated funds per Regulation 29 of the Regulations to the MSA	**823 469**	804 069
Annual contribution income per Statement of Comprehensive Income	**1 668 455**	1 532 948
Accumulated funds ratio calculated as the ratio of accumulated funds/gross annual contributions x 100	**49.4%**	52.5%

22.6 Investment risk

Investment risk is the risk that the investment returns on accumulated assets will not be sufficient to cover future liabilities. Continuous monitoring takes place to ensure that appropriate assets are held where the Scheme's liabilities are dependent upon the performance of the investment portfolio and that a suitable match of assets exists for all liabilities.

The performance of this portfolio is measured against the JSE All Share Index. The table below indicates the sensitivity of the surplus/(deficit) of the Scheme to movement in the JSE All Share Index, assuming that the movement of the market is realised:

	Surplus (R'000)					
	Increase in market			Decrease in market		
	30%	15%	5%	5%	15%	30%
2018						
Equity portfolio	-9,802.1	-11,902.6	-13,302.9	-14,703.2	-16,103.5	-18,203.9
2017						
Equity portfolio	11 580	10 240	9 350	8 460	7 570	6 230

The fair values of financial assets by hierarchy level are:

	Level 1 R'000	Level 2 R'000	Level 3 R'000	Re-classification
2018				
Financial assets at fair value through profit and loss	553 837	318 808	-	-
2017				
Available-for-sale financial assets	627 265	295 731	-	-

For financial assets carried at fair value, the allocation of fair value measurements into the fair value hierarchy is reflective of the significant inputs used in making the measurements. The cash component of the available-for-sale financial assets has been excluded from the fair value hierarchy. The fair value hierarchy is based on the following levels:

Level 1: Where inputs are determined directly by reference to published price quotations (unadjusted) in an active market for identified instruments;

Level 2: Where inputs other than published price quotations included in Level 1 that are observable for assets, either directly (i.e. as prices) or indirectly (i.e. derived from prices), are used;

Level 3: Where the fair values are determined using a valuation technique based on assumptions that are not supported by observable market data.

22.7 Structured entities

The Scheme's investments in investee funds are subject to the terms and conditions of the respective investee fund's offering documentation and are susceptible to market price risk arising from uncertainties about future values of those investee funds. The investment manager makes investment decisions after extensive due diligence of the underlying fund, its strategy and the overall quality of the underlying fund's manager. All of the investee funds in the investment portfolio are managed by portfolio managers who are compensated by the respective investee funds for their services. Such compensation generally consists of an asset-based fee and a performance-based incentive fee and is reflected in the valuation of the fund's investment in each of the investee funds. These investments are included in financial assets at fair value as available-for-sale in the Statement of Financial Position.

The exposure to investments in investee funds at fair value is disclosed in the following table:

Investee fund	Net asset value of investee fund	Fair value of Scheme's share of net asset of investee fund	% of Scheme's share of investee fund's net assets
Prudential Life Core Equity Fund	R1 208 million	R189 million	15.65%
Taquanta Asset Managers	R145 636 million	R47 million	0.03%

The strategy of the investee funds is to protect the capital of investors in an absolute sense, whilst providing income in excess of short-term bank deposit rates. The Scheme is not exposed to any further risks of financial loss beyond the fair value of its share in the investee funds as outlined in the table above.

23. Critical accounting judgements and areas of key sources of estimation uncertainty

The Scheme makes estimates and assumptions that affect the reported amounts of assets and liabilities within the next financial year. Estimates and judgements are continually evaluated and are based on historical experience and other factors, including expectations of future events that are believed to be reasonable under the circumstances.

Key assumptions concerning the future and other key sources of estimation uncertainty at the Statement of Financial Position date that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities in the next financial year, are discussed below.

Outstanding claims provision

The outstanding claims provision is a provision made for the estimated cost of healthcare benefits that had occurred before the year-end, but that had not been reported to the Scheme by that date. This provision is 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 trends in claims frequency, changes in the claims processing cycle, and variations in the nature and average cost incurred per claim. Refer to Note 8.

24. Insurance risk management

The primary insurance activity carried out by the Scheme is assuming the risk of loss from members and their dependants as a result of claims that are directly subject to the risk. These risks relate to the insured healthcare events of the Scheme's members. As such the Scheme is exposed to the uncertainty surrounding the timing and severity of claims under the contracts. The Scheme also has exposure to market risk through its insurance and investment activities.

The Board has developed and approved a documented policy for the acceptance and management of insurance risk to which the Scheme is exposed. Reference has also been made to the requirements of the MSA in compiling the insurance risk management policy. This policy is reviewed annually and the benefit options available to the members are structured to fall within the acceptable insurance risk levels specified. The annual business plan is structured around the insurance risk management policy.

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, protocols as well as the monitoring of emerging legislative, environmental and actuarial issues.

The Scheme uses several methods to assess and monitor insurance risk exposure, both for individual types of risks insured and overall risks. These methods include internal risk measurement models, regular comparison of budgeted versus actual claims, sensitivity analyses, scenario analyses and stress testing. The theory of probability is applied to the pricing and provisioning for a portfolio of insurance contracts, using established actuarial principles. 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.

The table below summarises the concentration of insurance risk, with reference to the carrying amount of the insurance claims incurred, by age group and in relation to the type of risk covered and benefits provided.

Concentration of insurance risk
Claims incurred for the 2018 service year were as follows:

Age grouping (in years)	In-hospital R'000	Chronic R'000	Day-to-day R'000	Other R'000	Total R'000
< 26	125 280	7 912	18 863	15 003	**167 058**
26 – 34	77 327	8 497	10 181	10 779	**106 784**
35 – 49	104 876	19 287	17 770	22 318	**164 251**
50 – 64	228 611	47 660	43 407	52 587	**372 265**
> 65	412 853	99 565	59 278	76 785	**648 481**
Total	**948 947**	**182 921**	**149 499**	**177 472**	**1 458 839**

Movement in the outstanding claims provision	11 568
Accredited managed healthcare services	26 345
Rectified benefits	(220)
Claims refunds	(1 081)
Other adjustments	3 799
Relevant healthcare expenditure (Note 9)	**1 499 250**

Claims incurred for the 2017 service year were as follows:

Age grouping (in years)	In-hospital R'000	Chronic R'000	Day-to-day R'000	Other R'000	Total R'000
< 26	108 319	7 557	18 208	14 003	**148 087**
26 – 34	67 497	8 125	9 542	9 913	**95 077**
35 – 49	103 985	20 972	16 781	19 978	**161 716**
50 – 64	222 673	51 655	42 381	51 146	**367 855**
> 65	374 903	94 150	53 526	68 534	**591 113**
Total	**877 377**	**182 459**	**140 438**	**163 574**	**1 363 848**

Movement in the outstanding claims provision	4 036
Accredited managed healthcare services	23 242
Rectified benefits	(221)
Claims refunds	(1 796)
Other adjustments	4 077
Relevant healthcare expenditure (Note 9)	**1 393 186**

In-hospital benefits cover all costs incurred by members while they are in hospital to receive pre-authorised treatment for medical conditions.

Chronic benefits cover the cost of certain prescribed conditions or medicines consumed by members for chronic conditions/diseases, such as high blood pressure, cholesterol and asthma.

Day-to-day benefits provide cover for out-of-hospital medical attention, such as visits to general practitioners and dentists, and prescribed acute medicines.

The Scheme's strategy seeks diversity to ensure a balanced portfolio and is based on a large portfolio of similar risks over a number of years and, as such, it is believed that the variability of the outcome is reduced. The strategy is set out in the annual business plan, which specifies the benefits to be provided by each option, the preferred target market and demographic split of this market.

All the 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 and claims ratios by option, target market and demographic split, is reviewed monthly. There is also an underwriting review programme that reviews a sample of contracts on a quarterly basis to ensure adherence to the Scheme's objectives.
The table below indicates how sensitive the Scheme's results are to changes in the claims experience:

	Change in variable	2018 R'000	2017 R'000
Actual surplus		(35 008)	22 267
Surplus after change in claims experience	1% lower	(50 001)	8 335
Surplus after change in claims experience	1% higher	(20 015)	36 199

Risk transfer arrangements
The Scheme has a risk transfer arrangement in respect of management services for its local emergency transport benefit. Please refer to Note 9 in this regard.

Claims development
Claims development tables have not been presented as the uncertainty regarding the amounts and timing of claims payments is typically resolved within a year. In the majority of cases, claims are resolved within four months from the time they are reported to the Scheme. At year-end, a provision is made for those claims outstanding that have not yet been reported. Details on the subsequent development in respect thereof for the last two years are shown in Note 8.

25. Contingent asset
The Scheme grants assistance to its members in defraying expenditure incurred in connection with the rendering of any relevant health service. Such expenditure may be in connection with a claim that is also made to the Road Accident Fund (RAF), administered in terms of the Road Accident Fund Act No. 56 of 1996. If the member is reimbursed by the RAF, the member is obliged contractually to cede that payment to the Scheme to the extent that they have already been compensated. The outstanding claims at year-end amount to R15 073 209 (2018: R26 199 634).

26. Non-compliance matters
In terms of Section 26(7) of the Medical Schemes Act 131 of 1998, contribution income shall be received within three days of becoming due. There were instances where the Scheme did not receive all contributions within three days of becoming due.

In terms of Section 33(2) of the Medical Schemes Act 131 of 1998, each benefit option shall be self-supporting in terms of membership and financial performance, and be financially sound. At the end of the year, three of the options had deficits.

In terms of Section 59(2) of the Medical Schemes Act 131 of 1998, a valid claim submitted to the Scheme should be paid within 30 days after the day on which the claim was received. Some claims were paid after 30 days.

In terms of Section 35(8) of the Medical Schemes Act 131 of 1998, a medical scheme shall not invest any of its assets in a medical scheme administrator. The Scheme, through one of its unit trust investments, had investments in a medical scheme administrator. The Scheme was granted exemption from this requirement.

In terms of Regulation 30 of the Regulations to the MSA, read with Annexure B, medical schemes may invest only 40% of reserves in equities. The CMS granted exemption to Profmed to invest up to 50% of its reserves in South African equities.

In terms of Regulation 30 of the Regulations to the MSA, read with Annexure B, medical schemes may not hold credit-linked instruments which were retrospectively reclassified into category 7 (restricted category) of Annexure B by the CMS. The Scheme has exposure to these instruments, which caused the Scheme to become retrospectively non-compliant at year-end.

PROFMED

Scheme information

1. Registered address and third-party service provider details

1.1 Registered office address and postal address

Profmed Place
15 Eton Road
Parktown
Johannesburg

P.O. Box 1004
Houghton
2041.

1.2 Administrator

PPS Healthcare Administrators Proprietary Limited
(Accreditation no. Admin 37)
PPS Centurion Square
1262 Heuwel Avenue
Centurion

Private Bag X1031
Lyttelton
0140.

1.3 Auditors

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Waterfall City
Jukskei View

Private Bag X36
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2157.

1.4 Investment advisors

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(Financial Service Provider no. 8905)
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Sandown
Sandton

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Sandton
2146.

1.5 Actuaries

Insight Actuaries & Consultants
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1685.

1.6 Attorneys

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PROFMED

Notice of annual general meeting

Notice to members
Notice is hereby given that the 48th Annual General Meeting of the members of Profmed will be held at Profmed Place, 15 Eton Road, Parktown, Johannesburg, on Tuesday 4 June 2019 at 15:30.

Agenda

1. To receive and adopt the annual financial statements for the year ended 31 December 2018 (including the reports of the trustees, the Audit and Risk Committee and the auditor).

2. To re-appoint PricewaterhouseCoopers Inc. as the auditor of Profmed for 2019/20 in terms of rule 27 of the Rules of Profmed.

3. To accept the Profmed Remuneration Policy by means of a non-binding advisory vote.

4. To approve the remuneration of trustees for the 2019/20 year.

5. To announce the election of three (3) trustees in accordance with rule 20.1.2 of the Rules of Profmed.

6. To transact such other business as may be transacted at the Annual General Meeting (subject to the Rules of Profmed and in particular rule 28.1.6, and the provisions of the Medical Schemes Act No. 131 of 1998, as amended).

The Remuneration Policy, the trustee remuneration document, and the Form of Proxy are available at www.profmed.co.za.

By order of the Board of Trustees.

Craig W Comrie
Principal Officer and Chief Executive

14 May 2019