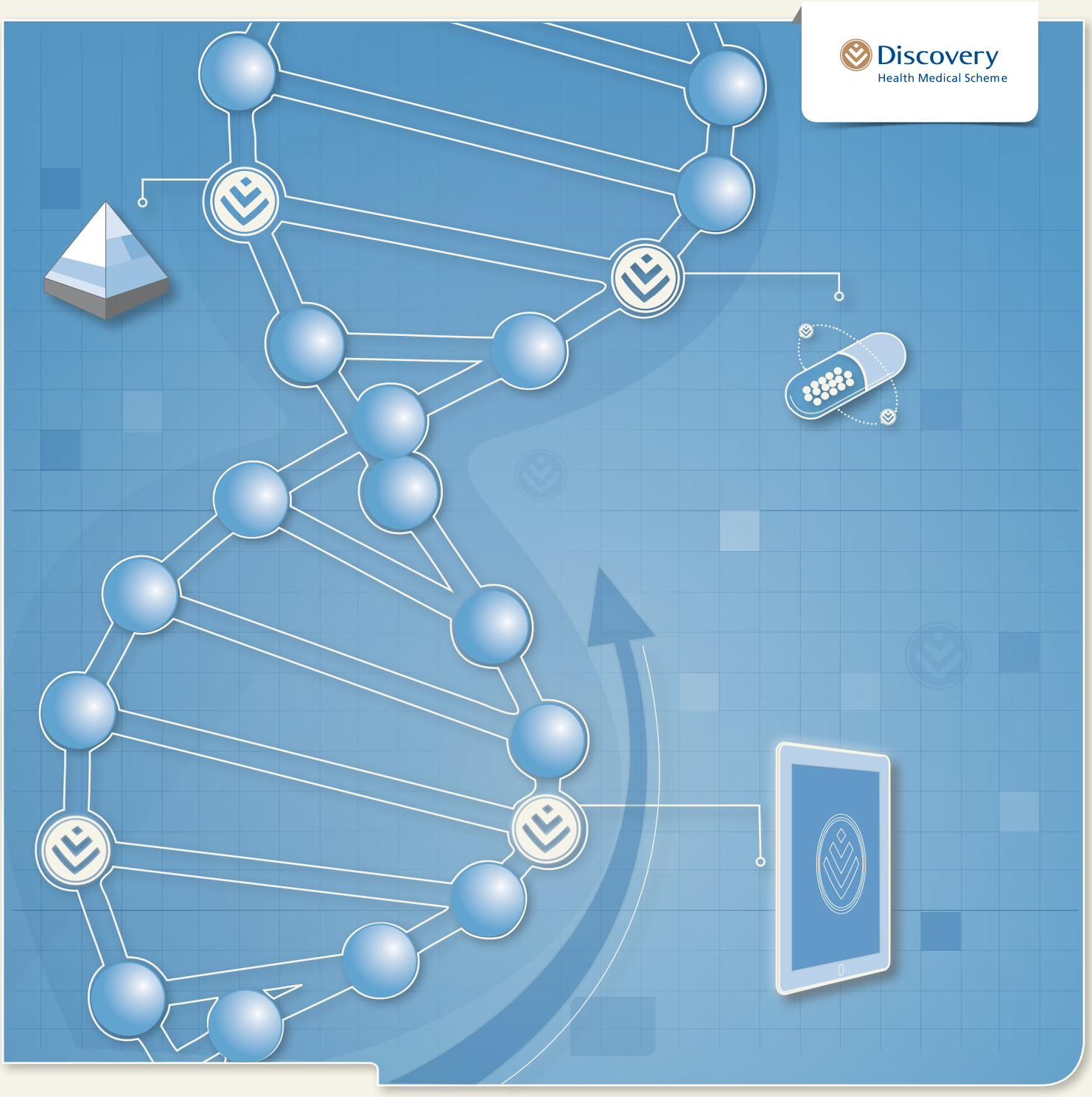

Discovery Health Medical Scheme

2011 Annual Report

Discovery Health Medical Scheme **Annual Report**

About this report

The aim of the Discovery Health Medical Scheme Annual Report for 2011 is to provide readers with information about the Discovery Health Medical Scheme's financial and operational performance for the period 1 January 2011 to 31 December 2011. This report also aims to provide stakeholders with greater insight into industry-specific matters impacting the Discovery Health Medical Scheme from a strategic and sustainability perspective.

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Adv Michael van der Nest

The Discovery Health Medical Scheme experienced another year of robust performance. The environment in which medical schemes operate is increasingly complex. Like elsewhere in the world, the role of medical schemes and private healthcare in general is continuously in the spotlight in South Africa. Medical schemes face many challenges, not least of which are medical price inflation, high-cost new medicines and medical technologies, an increased chronic disease burden, changes in the demographic profile of scheme members, a shortage of healthcare professionals in the private healthcare sector, fraud and benefit abuse, and medical schemes' solvency requirements.

Within this challenging environment, the goal of the Discovery Health Medical Scheme is to provide access to quality healthcare for its members while ensuring the sustainability of the Scheme. The reality is that healthcare funding is extremely complex and requires a significant amount of expertise to ensure that members' funds are managed appropriately. The success of the Discovery Health Medical Scheme in this regard is evident in the continued growth of the Scheme's membership. The Scheme also generated a net surplus of R570 million for 2011. The Discovery Health Medical Scheme enjoys substantial scale in the South African healthcare industry and has more than R7,4 billion in reserves.

The Board of Trustees of the Discovery Health Medical Scheme is responsible for the stewardship and best practice in corporate governance of the Scheme. The Trustees, who are all highly skilled, professional individuals, are the representatives of the Scheme's members and oversee and direct the strategy and management of the Scheme's activities performed by its Administrator, Discovery Health (Pty) Ltd.

The Board of Trustees believes that the Discovery Health Medical Scheme and Discovery Health (Pty) Ltd have managed the complex environment in which they operate most effectively over the past financial year. In light of this I would like to thank Discovery Health (Pty) Ltd for its continued innovation and world-class risk management expertise, which ensures Scheme members receive continuous value and have access to the best quality care, while at the same time ensuring appropriate cost control in the healthcare system.

The most important stakeholders of the Discovery Health Medical Scheme are the more than 2,3 million people to whom the Scheme provides healthcare cover. On behalf of the Board of Trustees I would like to thank the Scheme's members for their continued support.

The Board of Trustees will continuously focus on providing Scheme members with exceptional value and will strive to balance the needs of all healthcare stakeholders in a responsible way, thereby ensuring a sustainable healthcare delivery system.

Michael van der Nest
Chairperson

Principal Officer's report

Milton Streak

The 2011 financial year was a complex and challenging one, characterised by continuous economic uncertainty, escalating healthcare costs, and considerable public debate around healthcare issues. The Discovery Health Medical Scheme nonetheless achieved strong financial performance over the period. The Scheme's gross contribution income was higher than expected at R31,19 billion, with a net surplus of R570 million. The Scheme had another period of exceptionally strong membership growth, increasing total membership by 5.9% off an already high base. In total, 109,457 new members joined the Scheme, which ended the year with 2,354,351 million lives covered. The Scheme now has a 50% share in the open medical schemes market, enhancing its position as the largest open medical scheme in South Africa.

Non-healthcare expenses continue to reduce as a percentage of total annual contribution income and when considering the drivers of medical inflation over the past five years, administration expenditure is the only component of the Scheme's expenditure which has been reducing consistently in real terms. While medical inflation has averaged 10.5%, administration fees have had a deflationary effect of 4% for the past five years.

The significant membership growth of the Discovery Health Medical Scheme continues to put pressure on Scheme solvency, which is regulated at 25% of gross annual contribution income. Statutory solvency declined 1.16% to 23.5%. The Council for Medical Schemes has approved a business plan detailing the timeline over which the Scheme will increase solvency to 25%. The value of Scheme reserves has increased to R7,4 billion, which is significant and indicative of the financial strength of the Discovery Health Medical Scheme.

During the 2011 financial year, the Discovery Health Medical Scheme continued its efforts to rebalance benefit structures to eliminate waste and abuse, and to increase benefits in areas of critical care. This process led to public debate around the restructuring of the Allied Health and Therapeutic Benefit. However, the Scheme views it necessary to redirect spend towards coverage where the need is the highest. The Discovery Health Medical Scheme benefits are comparable to the best private health systems in the world, and provide access to superior quality healthcare. The Scheme's contribution increase of 8.9% for 2012 was one of the lowest in the industry, and within the guidelines set by the Council for Medical Schemes.

In addition to the strong growth achieved by the Scheme during 2011, the number of members leaving the Scheme (the lapse rate) reduced to 4.3% during the calendar year. This lapse rate is among the lowest in the industry. 98% of members opted to remain with their current benefit plans or bought up to higher benefit plans. This is indicative of a remarkably stable and sustainable system. Also supporting the strength and scale of the Scheme in the private healthcare industry is the AA+ credit rating of the Scheme by Global Credit Ratings Co – the highest possible rating for a medical scheme in South Africa.

The unique Discovery Health (Pty) Ltd operating model continues to ensure the competitive advantage of the Scheme in the private medical scheme industry. The strong focus of Discovery Health (Pty) Ltd on product and service innovation has ensured continuous service improvement and has enabled the Scheme to manage care and costs effectively, minimise abuse and fund the best quality healthcare for members. The scale of the operations of Discovery Health (Pty) Ltd is substantial, with over 200,000 member interactions a day, and claims volumes of 3,7 million a month. Independent industry surveys have verified that the services provided by Discovery Health (Pty) Ltd are the most highly rated in the industry.

Using its world-class risk management capabilities and provider partnerships, Discovery Health (Pty) Ltd has built a number of important healthcare provider assets within the healthcare system. This robust approach to health risk management, and the assets deployed in the healthcare system have brought down the cost of healthcare for both Scheme members and the industry, contributing to the continued sustainability of the Scheme.

The Discovery Health Medical Scheme remains acutely aware of its fundamental role in building a sustainable healthcare system, not only for its members, but for all South Africans. In this regard, the primary strategy of the Scheme and Discovery Health (Pty) Ltd have been to use the Scheme's scale and expertise to introduce a range of technological and service innovations aimed at improving the quality and efficiency of the healthcare system for the benefit of both its members and healthcare professionals.

Going forward, the Discovery Health Medical Scheme will focus on providing scheme members with continued healthcare value, ensuring that all stakeholder needs are balanced in a responsible fashion and that innovation in the delivery of healthcare remains a key strategic imperative. The Discovery Health Medical Scheme Board of Trustees and the Administrator, Discovery Health (Pty) Ltd, will continue to navigate the complex private healthcare system to ensure the continued provision of exceptional value for members.

Milton Streak
Principal Officer

Overview: Discovery Health Medical Scheme

Overview

Discovery Health Medical Scheme

Key facts and figures

5.9%
Net growth in membership of the Discovery Health Medical Scheme in 2011.

2,354,351
Number of lives the Discovery Health Medical Scheme covers.

R7,4 billion
Value of Discovery Health Medical Scheme members' reserves.

R570 million
The net surplus generated for the year under review.

23.5%
Discovery Health Medical Scheme solvency level. This is below the required level of 25%. The Scheme is implementing strategies to reach the required 25% solvency ratio over time, and the Council for Medical Schemes has approved its business plan in this regard.

AA+
International industry rating for the Discovery Health Medical Scheme from Global Credit Rating Co for claims paying and risk management ability. AA+ is the highest rating possible for a medical scheme in South Africa.

The Discovery Health Medical Scheme (the Scheme) is the largest open medical scheme in South Africa and provides cover to just over 2,3 million people. It is governed by the Medical Schemes Act, No 131 of 1998, and by the rules of the Discovery Health Medical Scheme. It is regulated by the Council for Medical Schemes (CMS).

The Discovery Health Medical Scheme is a not-for-profit entity as prescribed by the Medical Schemes Act. The Scheme belongs to its members. An independent Board of Trustees oversees and governs the business of the Scheme for and to the benefit of its members.

This overview provides detailed information about the performance of the Discovery Health Medical Scheme for the 2011 financial year. It explains how a medical scheme works, including the factors influencing the sustainability of medical schemes, and how members' contributions are spent. The overview shows how Scheme members are deriving significantly greater value from consistent benefit enhancements each year. It also sets out how the Scheme is administered. The overview highlights the key differentiators of the Discovery Health Medical Scheme, including how the Scheme curbs fraud and abuse, its continued engagement with its numerous stakeholders throughout the healthcare system, and the contribution of the Scheme and its Administrator, Discovery Health (Pty) Ltd, to the promotion and advancement of healthcare in South Africa. Lastly, the overview sets out the strategic objectives of the Scheme going forward.

Overview

How a medical scheme works

The members of the Discovery Health Medical Scheme pay contributions every month and in return, receive medical cover according to the rules of the Scheme and clinical best practice. Member contributions are paid directly into a pool of funds, from which members' medical claims are paid. Any money not paid out in claims, administration fees and other non-healthcare expenditure remains in this pool. Overseen by the Board of Trustees, this pool of funds belongs solely to the members and is used to build the reserves of the Scheme (compared to insurance companies where premiums not paid out in claims belong to the company).

Managing the complexities of a system based on cross-subsidisation

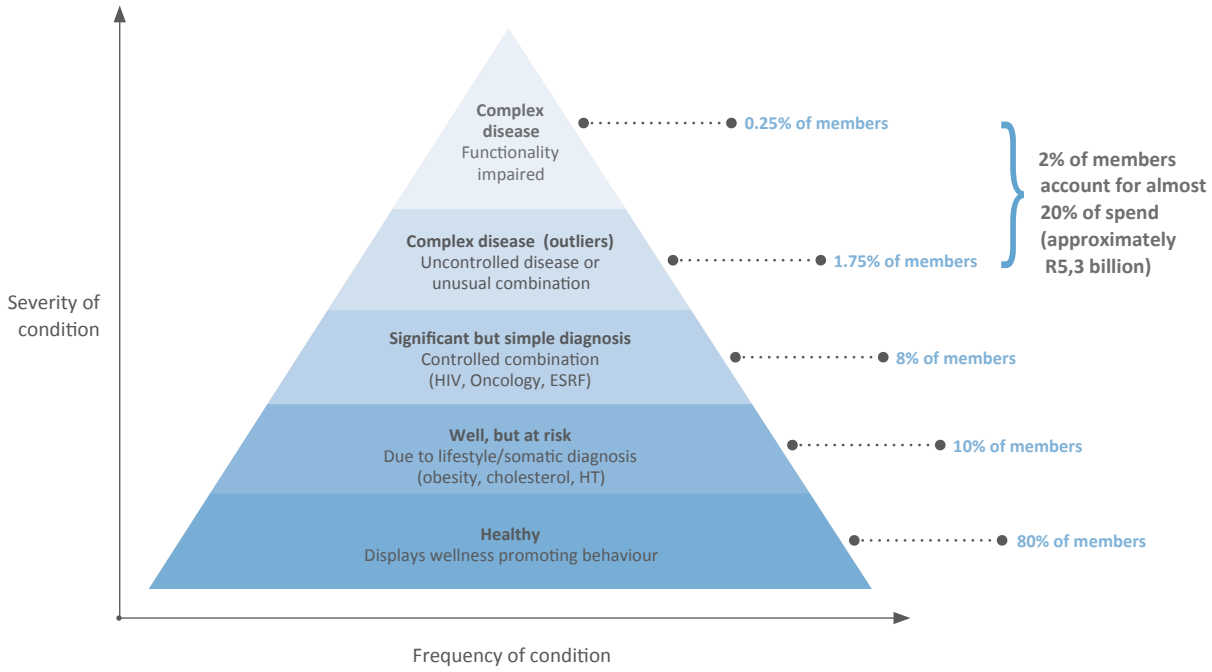
Medical schemes work on the philosophy of pooling of funds and cross-subsidisation. The money paid by members who are young and generally healthy and have a low claims level is used to pay for the claims of older, sicker members who have greater healthcare needs. By pooling everyone's money together, medical schemes help to make private healthcare cover accessible for everyone who can afford to pay the monthly contributions. It is vital to see health insurance as a lifetime process. Today's healthy young members who contribute more than they claim, will be tomorrow's older and sicker members who claim far more than they pay in at that stage.

According to the Medical Schemes Act, medical schemes:

- May not decline membership for any individual, and may only impose general waiting periods and time-limited waiting periods for previously diagnosed conditions. This important element of the law provides significant protection for the aged and those with serious health conditions. At the same time, it creates a risk of "anti-selection" for open medical schemes – members with greater healthcare needs join the scheme and healthier individuals tend to stay out of cover until they need it.
- Must calculate members' contributions so that members on the same plan pay the same contribution, regardless of how sick or healthy they are. This is different from conventional insurance, where contributions are closely related to the risk covered by the insurance company. Once again, this element of the law protects the vulnerable – the aged and the sick – but it also increases the complexity of balancing the books of the medical scheme.

These stipulations make the role of medical schemes in South Africa more complex than in other environments. Improving the health risk profile of their membership is a constant challenge for all medical schemes, as often, a small proportion of members consume the majority of benefits. The claims data of the Discovery Health Medical Scheme shows that the highest healthcare spend is incurred on behalf of a small minority of members – 2% of Scheme members account for almost 20% (approximately R5,3 billion in 2011) of the total claims spend. This is because of the low frequency but high severity and very high cost of serious healthcare conditions.

A small proportion of members consume the majority of benefits:



Source: Population Segmentation to Provide better Health Care for all: The "Bridges to Health" model. Joanne Lynn, Barry M Straube et al.

Healthier members traditionally perceive far less value in their medical scheme cover than sicker, higher-claiming members. Medical scheme cover is often seen as a "grudge" purchase with intangible value compared to, for example, home loan repayments, education and car repayments. There is also the perception that private healthcare is spiralling out of control and is unaffordable, and that medical scheme benefits are continually being reduced or limited.

For medical schemes to remain sustainable, they need to not only retain healthier members, but also increase the number of healthier members. Health plan benefits must be designed in such a way that healthier, lower-claiming members still perceive value in their cover, despite their lower use of healthcare services. At the same time, schemes need to ensure that sicker members are receiving appropriate and clinically effective treatment that is funded in a sustainable way. Medical schemes must find the right balance between these two member groups.

Balancing stakeholder interests in the healthcare system

The Discovery Health Medical Scheme has to balance the needs of various stakeholders with different and, in some cases, opposing interests in the healthcare environment. These stakeholders include healthcare professionals, hospitals, pharmaceutical providers and members (see diagram below). On the one hand, the Scheme has to collect members' contributions and increase them annually at a rate that will cover the cost of claims (taking into account the price of medical goods and services, reserve funding and solvency requirements, changes in the demographic profile of the Scheme's membership and any changes to benefits). At the same time, members want access to the latest healthcare treatment and technology at the lowest price. When designing benefits and limits, the Scheme must provide adequate benefits that address as many needs as possible, while still ensuring that contributions remain affordable. On the other hand, healthcare professionals, who provide scarce and valuable medical skills, resources and care, expect fair remuneration for their services.

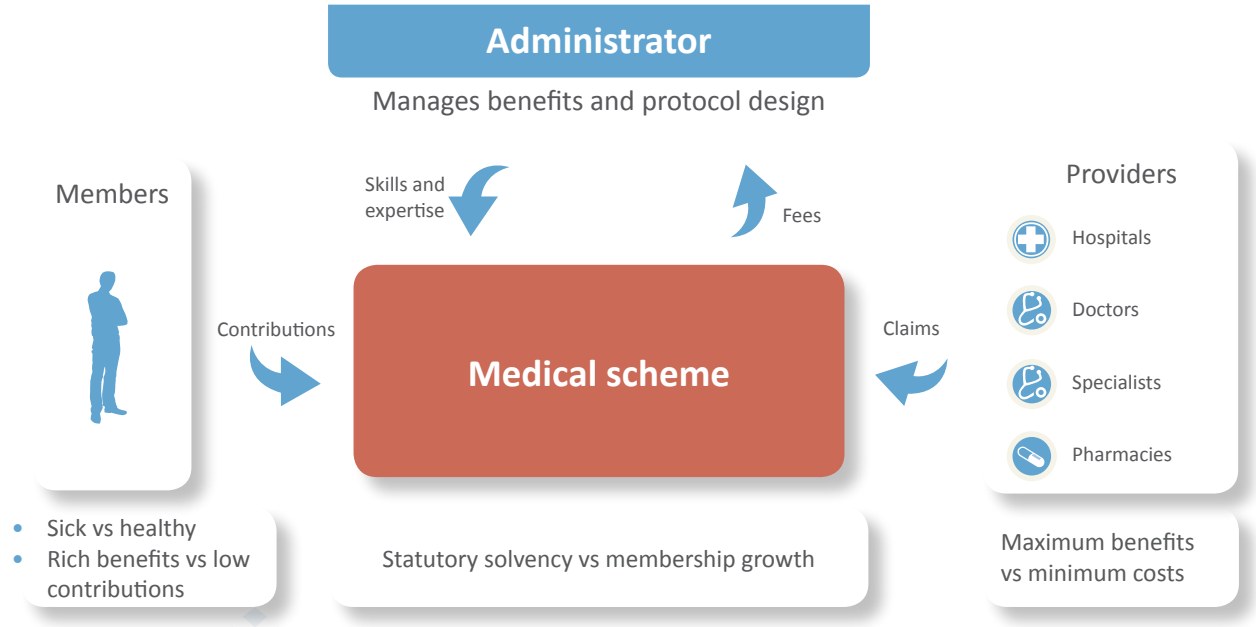
Overview

How a medical scheme works

Besides balancing the needs of Scheme members and various healthcare providers, the Scheme and its Administrator must also comply with the Medical Schemes Act and the regulations of the Council for Medical Schemes.

The Scheme has to manage all these needs and interests carefully, while still ensuring it remains sustainable over the long term. The challenges of managing a complex healthcare environment have led to more than 60 medical schemes closing or merging with larger schemes over the past 10 years. Over this period, the Discovery Health Medical Scheme has grown and thrived, adding 1,4 million beneficiaries and growing by 137%.

Medical schemes have to balance the needs of stakeholders with opposing interests:



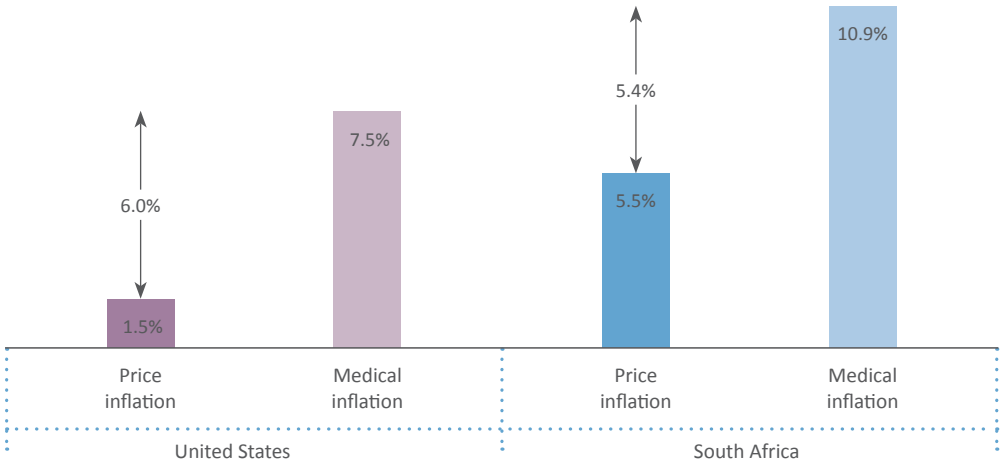
Factors influencing the sustainability of medical schemes

Healthcare funding in South Africa is extremely complex and requires expertise to ensure that medical scheme members' funds are managed appropriately. Medical schemes need to consider a number of factors to ensure that member contributions are increased in a manner sustainable to members while at the same time providing sustainable healthcare cover to members.

The price of medical goods and services

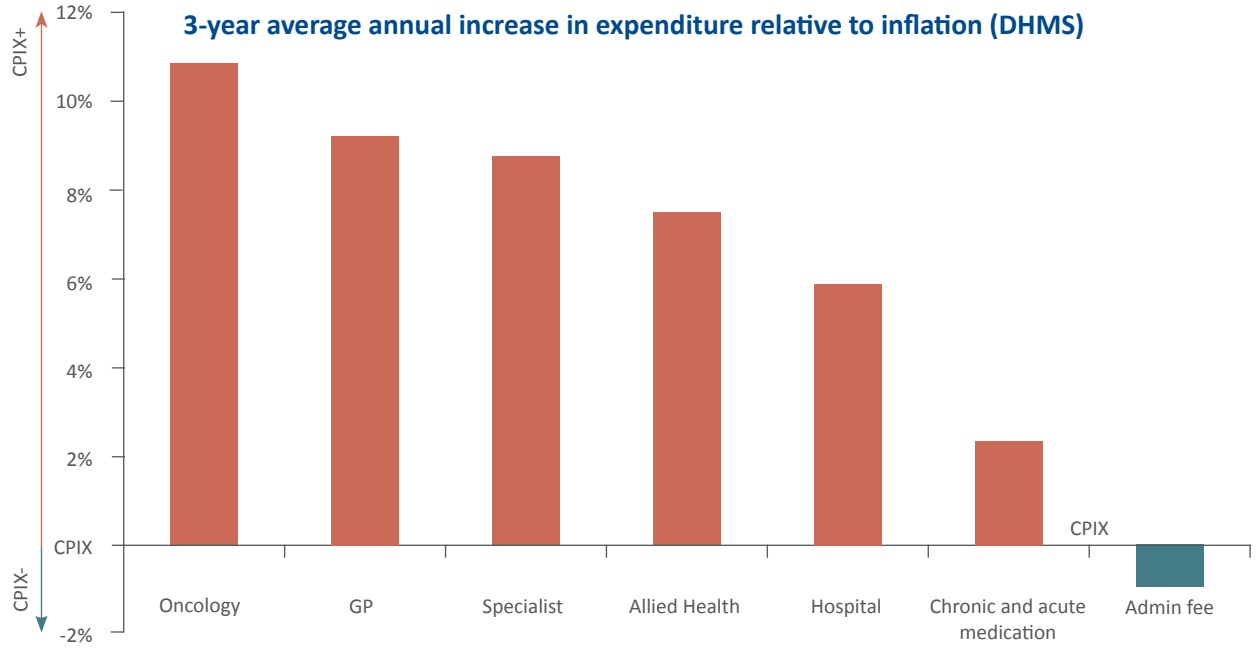
Medical price inflation depends on the increases in fees negotiated with specialists, hospitals and other healthcare providers, and any increases in medicine prices and pharmacy dispensing fees.

Medical inflation in South Africa is consistently higher than CPI. However, the gap between medical inflation and CPI is still lower in South Africa than it is in the United States (3-year average inflation rates):



New medicines and medical technologies, which are usually very expensive, have a significant impact on the cost of care for all medical schemes. Since they allow for earlier diagnosis and more aggressive treatment, people also live longer due to advances in medical science and treatment, driving up costs even further. The challenge for medical schemes is to find sustainable ways to fund these new medicines and medical technologies and to manage the inflationary impact. The medical inflation paradox that all medical schemes have to manage is that healthcare costs worldwide rise faster than consumer price inflation, but members want to be covered in full, and still expect contributions to increase at consumer price inflation or less.

Costs in various areas of healthcare have increased markedly above CPI over the past three years, compared to the Scheme's administration fees, which have had a deflationary effect:

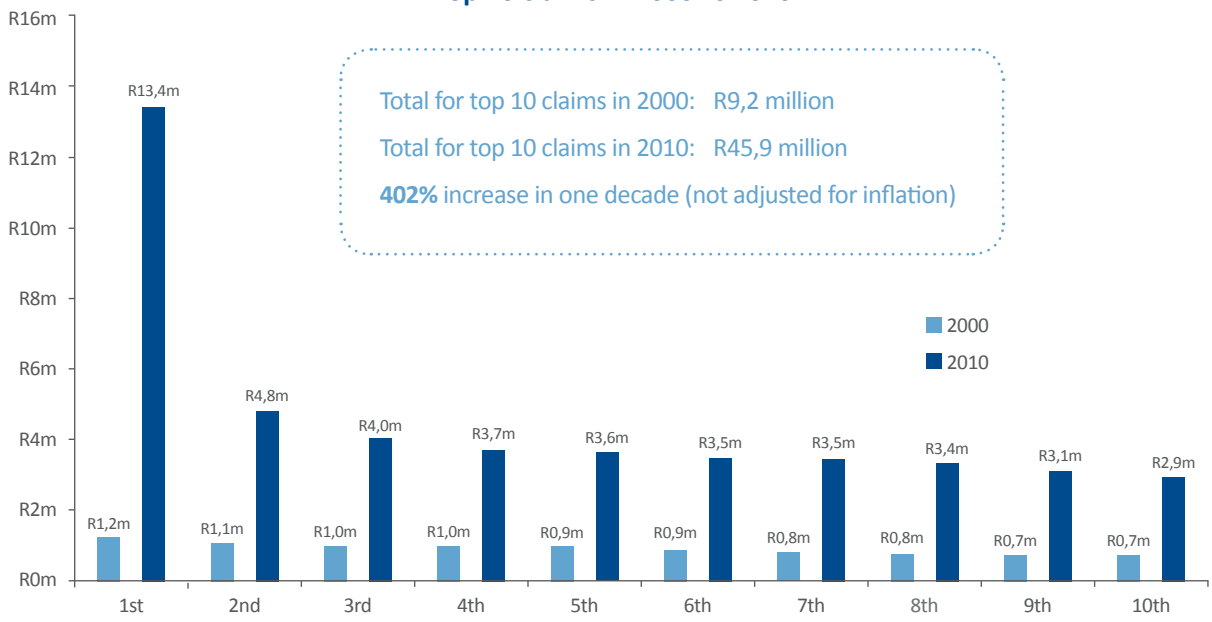


Overview

How a medical scheme works

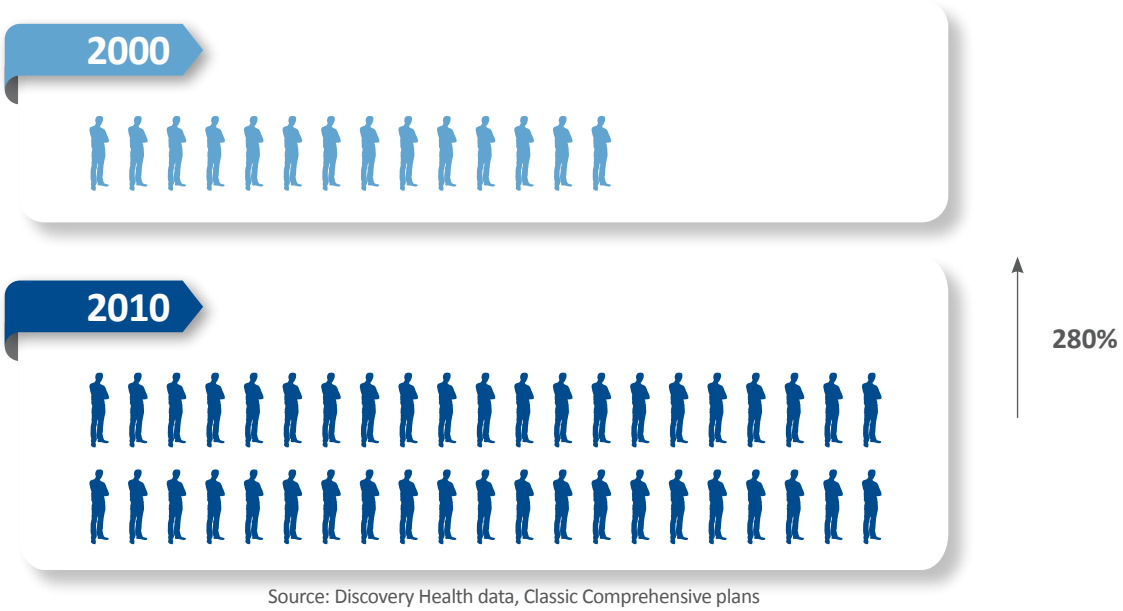
High-cost cases are more costly than before. The top 10 claims in 2010 cost the Discovery Health Medical Scheme 402% more than the top 10 claims in 2000 (not adjusted for inflation):

Top 10 claims in 2000 vs 2010



As a result of an increased chronic disease burden and increased benefit use by Scheme members, high-cost cases are more frequent than before. In 2010, the number of people per 10,000 claimants claiming more than R500,000 had increased by 280% from 2000:

Number of people per 10,000 claimants claiming more than R500,000 (2010 money terms)

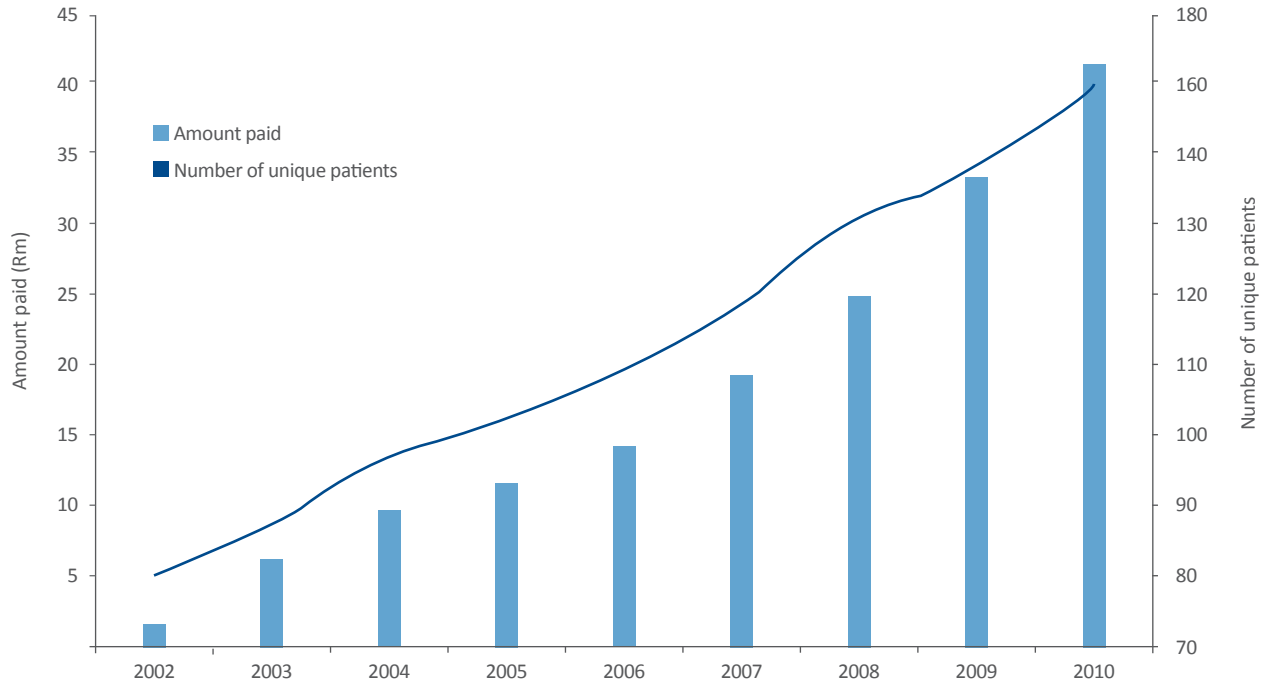


Source: Discovery Health data, Classic Comprehensive plans

For example, 25,000 members of the Discovery Health Medical Scheme received treatment for cancer during 2011, with R500 million spent from the Oncology Benefit for chemotherapy. This represents an increase in expenditure of 80% for chemotherapy over the last three years. A total of 99.8% of these oncology claims were covered in full. Advances in medical technology for the treatment of cancer have led to a dramatic increase in the cost of providing cover for such treatment. Many new treatments, medications and procedures come onto the market each year at significantly higher costs. To illustrate the scale of the cost of these advances: the total oncology spend by the Discovery Health Medical Scheme increased from R872 million in 2010 to just over R1 billion in 2011, representing a 17% increase in just one year.

The increase in spend by the Discovery Health Medical Scheme on oncology medication (mostly due to the increase in the use of biologics) is illustrated in the following diagram. In 2002, the Scheme had less than 10 members claiming for Gleevec® at a cost of less than R2 million. By 2010, this number had increased to more than 160 members with claims costing more than R40 million:

Gleevec®: Unique claimants and total expenditure



For medical schemes, the funding decision can be complicated: while many of these new treatments show great promise for improving patient outcomes, not all have been proven to be clinically and cost effective. Medical schemes have to weigh up the cost of providing access to these technologies against their clinical outcomes for members, and against their cost impact on the scheme membership as a whole.

Overview

How a medical scheme works

The number of healthy members the Scheme requires in order to sustainably fund high-cost cases:

Funding ability of 10,000 healthy members:

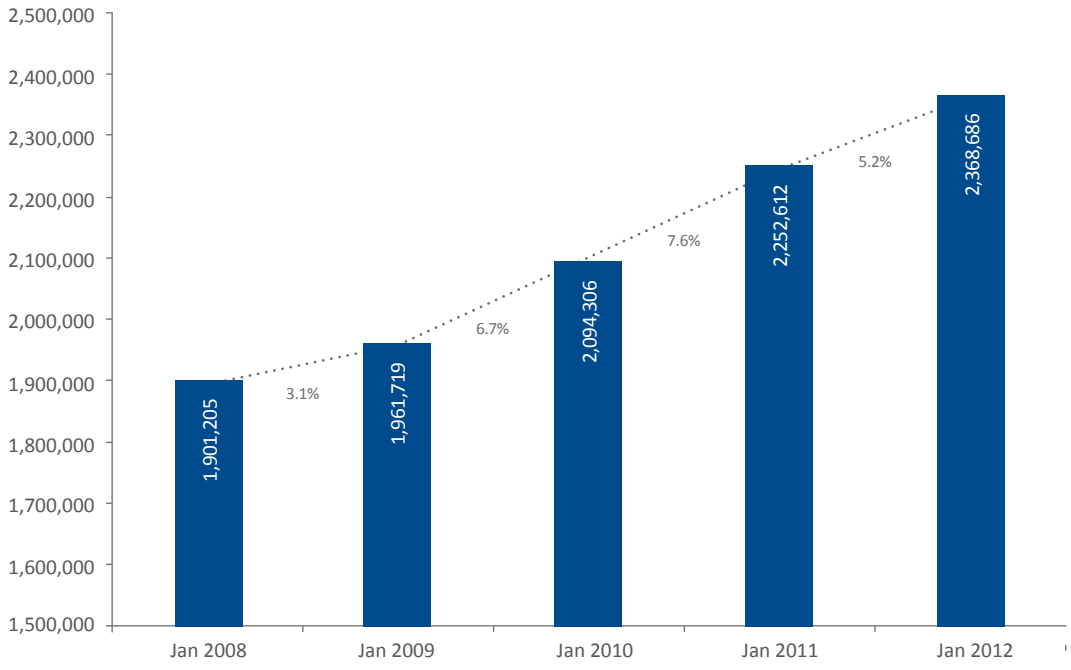
High allied benefit users	277 high allied benefit users for 1 year
Gleevec® treatment	234 cancer sufferers for 1 year

A scheme's solvency and funding needs

Membership growth is important to the sustainability of a medical scheme. However, as membership grows, schemes must allow for funding to meet the solvency level required by law for all medical schemes – 25% of the gross annual contributions they receive from members. The reserves are built up over time through the difference between what members pay into the scheme and what the scheme pays out for its members' claims. The money left over – the surplus – goes towards building the solvency level.

Other open medical schemes in South Africa have struggled to grow membership, with most growth coming through mergers between schemes. Mergers are not a sustainable source of growth, as they are often accompanied by an increase in individuals withdrawing their membership and deterioration in the scheme's demographic profile and claims experience.

The growth in the number of lives covered by the Discovery Health Medical Scheme over the past five years:



The Discovery Health Medical Scheme grew by almost 500,000 people in the last five years as indicated in the above diagram. During 2011, the number of members leaving the Scheme each year (the lapse rate) was 4.3%.

The marked reduction in administration fees brought about by the efficiencies of scale resulting from this significant growth in Scheme membership has also facilitated continued growth of the Scheme's reserves. The Scheme currently has over R7,4 billion in reserves.

Changes in the demographic profile of members and how people use benefits

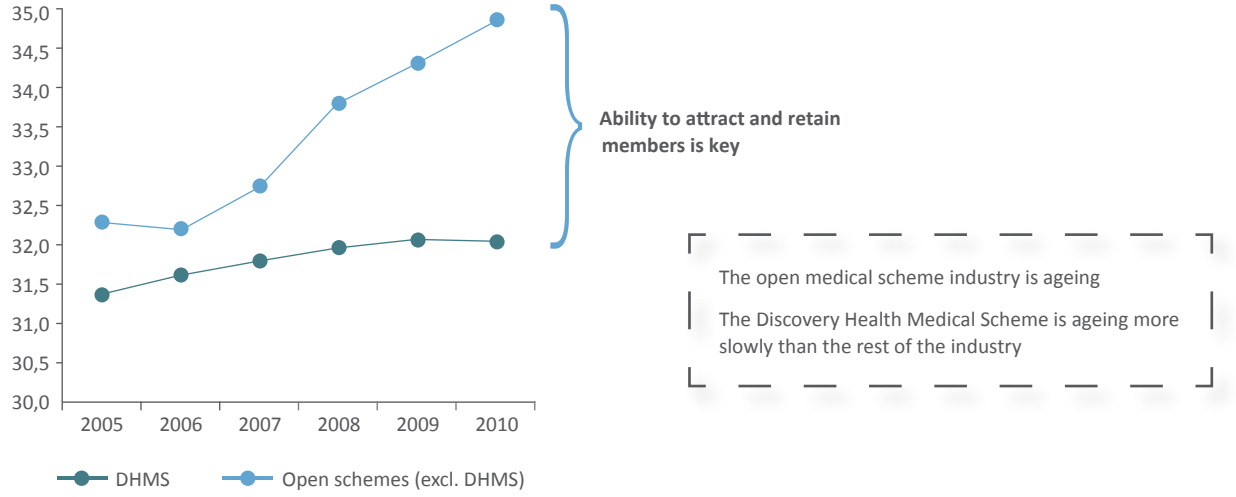
In addition to increases in prices of goods and services, increased use of benefits by members also results in the level of medical inflation being higher than CPI each year. Over time, the number of health services used by members increases as a result of:

- *Changes in the demographic profile and disease burden of medical schemes' membership*

An ageing medical scheme population and an increased disease burden are the main factors driving healthcare costs. However, strong membership growth has enabled the Discovery Health Medical Scheme to age slower than the rest of the industry.

The Discovery Health Medical Scheme is ageing more slowly than the rest of the open medical schemes industry, which illustrates the Scheme's ability to attract younger members:

Age profile comparison



- *An increase in lifestyle and chronic diseases*

Lifestyle and chronic diseases are on the increase worldwide. The total expenditure on medicines for chronic diseases by medical schemes has been relatively contained over the past 10 years, owing to the impact of Single Exit Price (SEP) legislation and the growing use of generic medicines. Despite these positive trends, medicine expenditure by medical schemes continues to grow each year and it remains one of the top three contributors to total healthcare expenditure by private medical schemes in South Africa.

For example, 363,525 Scheme members were registered on the Discovery Health Medical Scheme Chronic Illness Benefit in 2011. The average annual chronic medicine spend per member was R4,296, and the total annual chronic illness medicine spend was R1,5 billion in 2011. This represents a 6.3% per annum increase in spend on chronic illness medicine per member from 2008 to 2011. The increase in spend on biologic medicines in the treatment of chronic illness was 30.87% in 2011 alone.

Overview

How a medical scheme works

The Discovery Health Medical Scheme's 2012 contribution increase

The annual increase in members' contributions ensures that the Discovery Health Medical Scheme remains sustainable for its members over the long term, and enables the Scheme to maintain and improve benefits and reduce gaps in cover. All medical schemes' increases have to be approved by the Council for Medical Schemes before they can be implemented.

The Discovery Health Medical Scheme uses many methods to keep the increase in member contributions to a minimum. These include strategies such as:

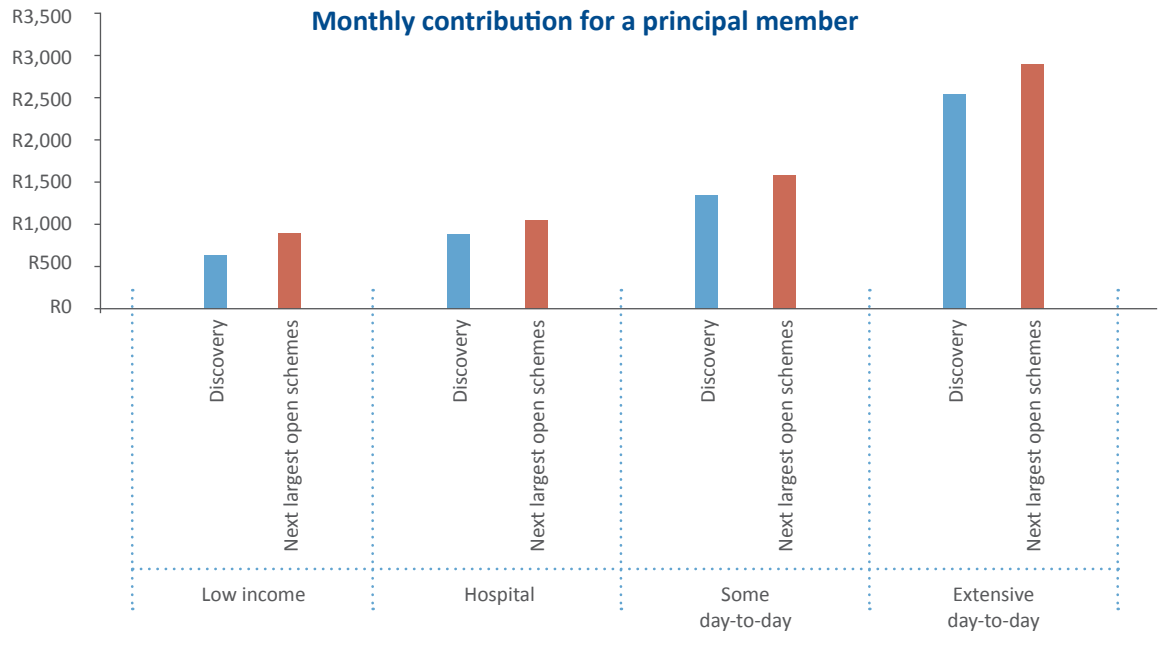
- Negotiating with suppliers such as hospitals and pharmacies to reduce overall costs
- Implementing plans that make use of network hospitals and specific medicine lists so the savings can be passed on directly to Scheme members
- Redesigning benefits, not only to increase benefits where new technologies or treatments become available, but also to target specific areas of abuse or overuse of services that are not clinically justified.

The Discovery Health Medical Scheme's contribution increase of 8.9% for 2012 was set to achieve the following key objectives:

- Maintain and enhance benefits for members
- Build member reserves in line with the Scheme's growth and solvency requirements
- Provide contribution stability with a uniform increase across all plans.

The Discovery Health Medical Scheme's contribution increase will ensure the Scheme maintains its significant pricing advantage over other open schemes in 2012. The Scheme's contributions are on average 16% below the market average on a plan-for-plan basis.

The Discovery Health Medical Scheme's contribution increase for 2012 across the Scheme's plan types compared to that of other open medical schemes:



How members' contributions are spent

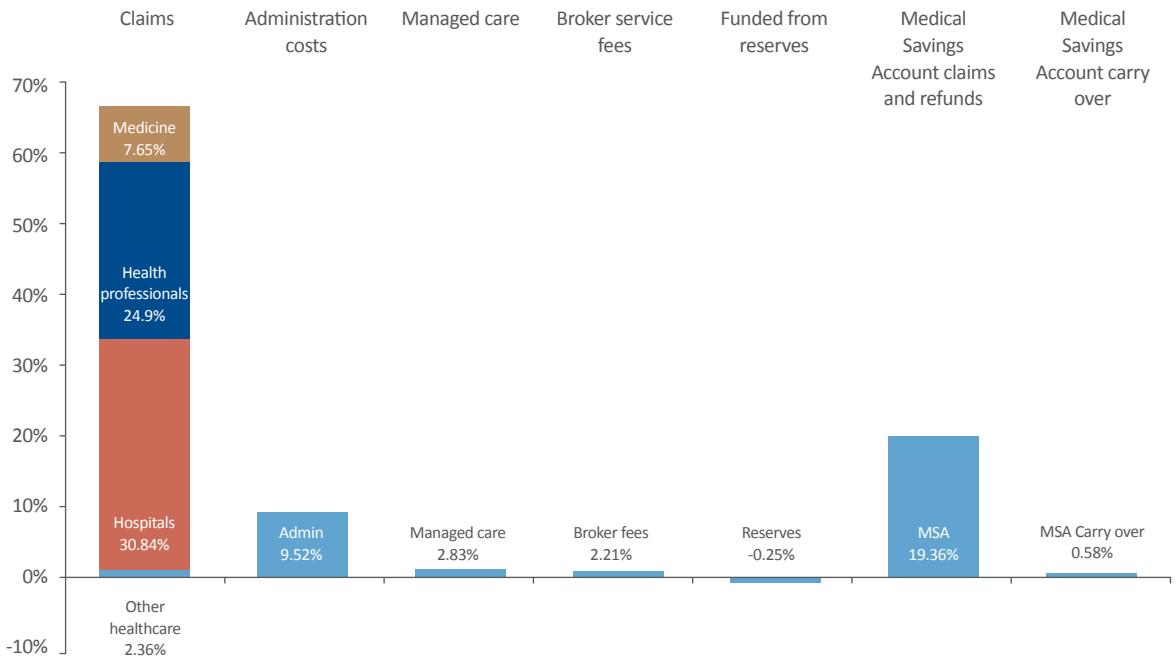
The allocation of members' monthly contributions

The total cost of healthcare for the Discovery Health Medical Scheme during 2011 was R20,6 billion. This can be broken down as follows:

- Hospital claims: R9,6 billion (30.8%)
- Claims by healthcare professionals: R7,8 billion (24.9%)
- Claims for medicines: R2,4 billion (7.7%)
- Other claims: R735 million (2.4%).

Administration expenses accounted for R3,0 billion (9.5%), managed care management services for R883 million (2.8%) and broker fees for R689 million (2.2%). Claims paid from members' Medical Savings Accounts claims and refunds came to R6,0 billion (19.4%). The Discovery Health Medical Scheme's Board of Trustees oversees the responsible management of the Scheme's funds.

How members' contributions were allocated during 2011:



Overview

How a medical scheme works

Benefits to optimise value for members

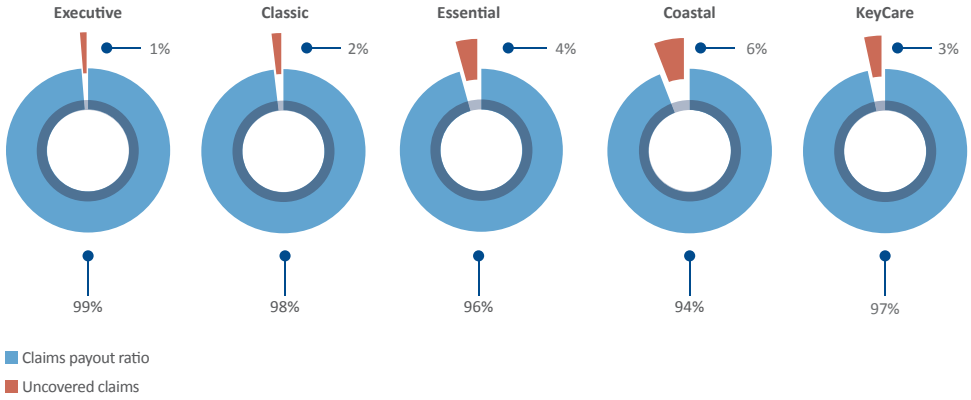
The Discovery Health Medical Scheme plans are structured to maximise cover on all plans. There are 14 different plans, which cater for all individuals' medical and financial needs, providing cover that ranges from the most comprehensive cover through the Executive Plan, to the KeyCare Series, the Scheme's plans for the lower-income market. At each plan level, healthcare benefits have been designed to address as many needs as possible while keeping contributions priced competitively to ensure long-term affordability and value for money.

The approach of the Discovery Health Medical Scheme has always been to provide, where possible, unlimited and comprehensive benefits when members have the greatest clinical need. High-cost events and conditions such as hospitalisation and cancer treatment can be financially catastrophic for families. The Discovery Health Medical Scheme is continuously enhancing its benefit structures in order to eliminate waste and benefit abuse, and to increase benefits in areas of critical care. This strategy has resulted in benefits that are comparable to the best private health systems in the world, yet at the same time provide access to superior healthcare when members are sick.

The largest portion of member contributions is used by the Discovery Health Medical Scheme for hospital claims. The Scheme's coverage level for in-hospital claims is significant – during 2011, Scheme members had 97% of all hospital claims paid out, translating to R9,6 billion.

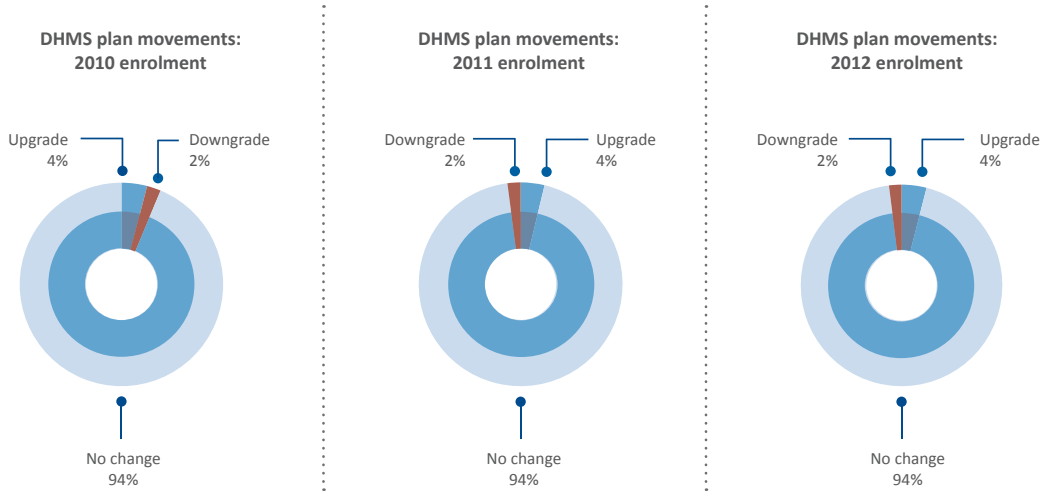
The breakdown of in-hospital claims payout across the Scheme's plans is as follows:

In-hospital claims payout ratios (including medical specialists)



The success of the Discovery Health Medical Scheme in achieving optimal benefit design while keeping member contributions affordable, is illustrated by the choices members make regarding their cover. During 2011, despite the expense of private healthcare, the number of members remaining with their current benefit plans or buying up to higher benefit plans measured 98%. This reflects a remarkably sustainable system.

The plan movements of Discovery Health Medical Scheme members:



Overview

How a medical scheme works

Over the past ten years, the benefits of the Discovery Health Medical Scheme have been enhanced across each key component of members' healthcare expenditure, resulting in broader access to expensive medical treatment, greater certainty of cover for members and a more efficient benefit design. These benefit enhancements include:

- **Specialised Medicine and Technology Benefit** – The Discovery Health Medical Scheme has taken the lead in the South African market by providing defined funding for high-cost medicines, and new medical technologies and procedures. This benefit is available on the Executive Plan and the Comprehensive Series.
- **Trauma Recovery Extender Benefit** – Certain traumatic events can result in extremely high costs after members leave the hospital. This benefit covers certain out-of-hospital costs related to a member's registered condition that would previously have been funded from the member's Medical Savings Account or their pocket. The benefit is available on all plan types except the Core Plans.
- **Insured Network Benefit** – This benefit provides extended cover for GP consultations and pathology tests at the Scheme's network providers, even when the funds in the Medical Savings Account have been exhausted. It is available on all plans except the Core and KeyCare Series.
- **Oncology Benefit** – The Scheme has a tailored Discovery*Care* Oncology Programme designed to ensure members with cancer get the most out of the Oncology Benefit, and to provide assistance and support after the initial diagnosis. Members on all plans (except the KeyCare Series) have cover for all approved treatments up to a benefit threshold depending on their plan type. After the threshold is reached, the Scheme pays 80% of the Discovery Health Rate, without any overall limits. All members, including those on KeyCare Plans, have access to the SA Oncology Consortium's Tier 1 cancer regimens in full, in line with members' Prescribed Minimum Benefits. The Scheme's Oncology Liaison Managers assist members with information on how best to use their cover.

For 2012, the Discovery Health Medical Scheme has continued its focus on correcting the balance between appropriate care and affordability of benefit structures for all members:

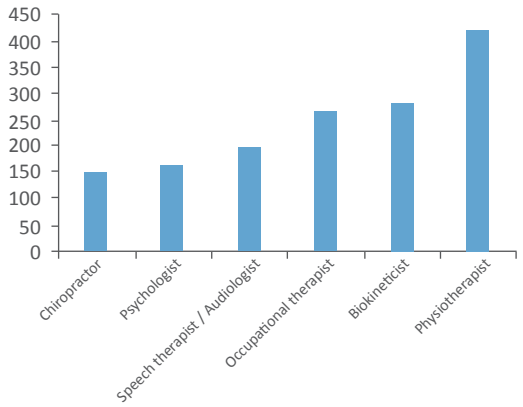
- **Allied and Therapeutic Benefit** – A key challenge facing all medical schemes is achieving the right balance between providing access to excellent, clinically appropriate healthcare benefits, and curtailing the abuse of scheme benefits. Such abuse results in the majority of members paying inappropriately for a small minority, and the financial impact on medical schemes is significant. Medical scheme plan benefit changes can be introduced to target specific areas of abuse or overuse of services.

  The Discovery Health Medical Scheme has identified an increasing trend towards abuse of certain day-to-day benefits, specifically in the areas of allied and therapeutic benefits. While these services are mostly being used appropriately for serious clinical conditions, the benefits were increasingly being exploited for services that are not clinically justified. Examples include the repeated use of biokineticists as personal trainers and occupational therapy to improve a child's "pencil grip".

A summary of spend on allied and therapeutic healthcare services:

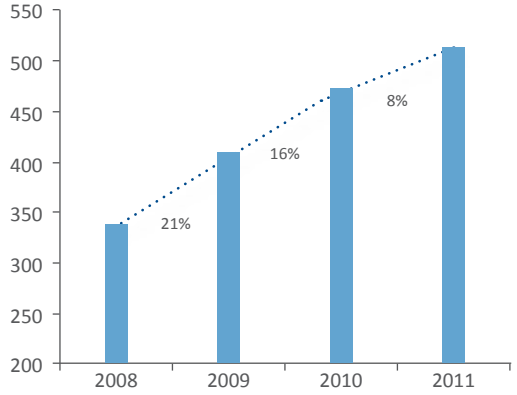
Top claimants per discipline

Highest claimant
(number of visits per person, 2011)



Overall benefit spend

Allied health spend
(Classic Comprehensive and Executive, Rm)



After evaluating various alternatives, the Discovery Health Medical Scheme has chosen an approach to allied and therapeutic benefits which focuses on curtailing abuse but still ensures that Scheme members with real clinical needs have access to benefits when they need them. Through a high limit, the benefit caters for all members where benefits are appropriately used (in-hospital and Prescribed Minimum Benefits remain unchanged). Rather than set a sub-limit for each area of care (for example, physiotherapy), the benefit now makes provision for a basket of care across a wide range of services, subject to an overall limit, that can be allocated to more than one area as services are required. The restructured benefit enhances cover in key areas: home nursing benefits have been increased and members needing psychiatry treatment will now have unlimited cover.

The benefit limit has been set to cater for more than 98% of Scheme members who claim for these benefits, based on current benefit usage patterns. If additional cover is required above these limits, an Allied and Therapeutic Extender Benefit automatically provides unlimited coverage for specified clinical conditions requiring extensive treatment. The benefit is also flexible enough that any member who does not automatically qualify for the Allied and Therapeutic Extender benefit can apply for additional benefits once they have used up their annual limit. The Scheme will submit all such applications to external clinical panels for adjudication, and will approve funding for additional services if so advised by these panels.

- **Consistent guidelines for members accessing chronic illness medication** – The Discovery Health Medical Scheme is committed to providing its members with extensive and flexible cover for medicine to treat chronic conditions. Members registered for medicine on the Chronic Illness Benefit have two options available when claiming. The preferred option is to claim for medicine that is on the Scheme's formulary. These medicines are funded in full at the Scheme's vast network of over 2,000 pharmacies, offering all members protection against possible co-payments. For medicines not on the formulary, the Scheme pays up to a set amount for medicines in a particular category, called the Chronic Drug Amount.

  The Discovery Health Medical Scheme continuously negotiates with the pharmaceutical industry to ensure the best medicine prices for Scheme members. As new medicines and more generic medicines become available, the prices of medicines continually change, and are in many cases reduced. In turn, the formulary and the Chronic Drug Amounts are updated.

Overview

How a medical scheme works

To ensure that the chronic illness benefits are applied in a fair manner to all Scheme members, a three-year process of ensuring that the chronic benefit rules are applied consistently to all members was recently completed. This means that some members may experience a co-payment this year when they did not do so previously. These changes were communicated extensively to all affected Scheme members as part of the year-end revision communication.

It is important to note that there has been no change to the Chronic Illness Benefit structure for 2012. The 2012 review of the formulary and Chronic Drug Amounts forms part of the annual revision based on the pricing movements in the markets. The current formulary and Chronic Drug Amounts were developed based on the best available scientific evidence and were reviewed by external experts to ensure that they provide comprehensive and clinically appropriate cover for Scheme members.

Covering the Prescribed Minimum Benefits

According to the Medical Schemes Act, all medical schemes have to cover the costs related to the diagnosis, treatment and care of any life-threatening emergency medical condition, a defined set of 270 diagnostic treatment pairs as well as 27 chronic conditions. These conditions and their treatments are known as the Prescribed Minimum Benefits (PMBs).

The Discovery Health Medical Scheme is fully committed to ensuring that members have access to the Prescribed Minimum Benefits as provided for in the Act. The Scheme played an active leadership role in working with the Council for Medical Schemes to develop the Prescribed Minimum Benefits Code of Conduct, and strongly endorses the Code and its requirements.

The Discovery Health Medical Scheme continuously enhances the process and communication with members around Prescribed Minimum Benefits. Over the last two years the Scheme has implemented the following:

- Using external plain-language consultants to review and simplify all material related to Prescribed Minimum Benefits
- Updating the Discovery website to include more information about Prescribed Minimum Benefits conditions and cover
- Introducing online tools and technologies making it easier for members to make informed choices about their healthcare cover (including giving members access to full-cover tools which allow them to find the Scheme's Designated Service Providers)
- Improving communication about Prescribed Minimum Benefits
- Messaging on Prescribed Minimum Benefits on the Scheme's telephonic system to inform members about cover provided
- Including more information on Prescribed Minimum Benefits on the Scheme's various application forms.

The Discovery Health Medical Scheme has put the necessary measures in place to ensure the most robust and comprehensive coverage for Prescribed Minimum Benefits in the industry. The Scheme is guided by the principle of full payment subject to the use of the Scheme's Designated Service Providers, formularies and baskets of care where appropriate.

Cover for most Prescribed Minimum Benefits does not require Scheme members to follow an application process, as the Scheme automatically recognises members' Prescribed Minimum Benefits entitlement. However, the Scheme supports the establishment of an accessible authorisation process for the payment of Prescribed Minimum Benefits in cases where this is necessary. This would be the case for certain chronic conditions where the Scheme requires specific clinical information before approving funding as part of a Prescribed Minimum Benefits condition.

In providing cover for the Prescribed Minimum Benefits, the Discovery Health Medical Scheme adheres to the following principles:

- Members should be able to obtain Prescribed Minimum Benefit cover from accessible Designated Service Providers and not face co-payments unless they voluntarily make use of service providers not nominated by the Scheme
- All members are treated fairly and consistently
- The Scheme has an established clinical appeals process, which is transparent and easily accessible
- The Scheme subscribes to the establishment of Designated Services Providers that give members cover, accessibility and choice
- The healthcare cover members purchase is appropriate to their monthly contributions, but they will always have access to the Prescribed Minimum Benefits, regardless of their plan
- The Scheme recognises that Prescribed Minimum Benefits cannot be identified through ICD (diagnosis) codes alone, and advocates the use of additional supporting information to establish a Prescribed Minimum Benefits diagnosis
- The Scheme has established appropriate baskets of care which define Prescribed Minimum Benefits entitlements. These baskets focus on providing minimum benefits in line with legislation and the Code of Conduct, and are not intended to cater for all situations. In most cases, members' benefits will exceed the baskets
- Members should be able to pay for benefits which are not Prescribed Minimum Benefits from their Medical Savings Accounts.

It is important to acknowledge that the very design of the Prescribed Minimum Benefits lends itself to complexity. This is evident in the difficulties all role-players have in understanding and implementing the requirements of the Act. However, the Discovery Health Medical Scheme realises and accepts the important responsibility of ensuring access to the prescribed cover is as simple as possible, while avoiding the inflationary risks of taking an unmanaged approach to providing cover for Prescribed Minimum Benefits.

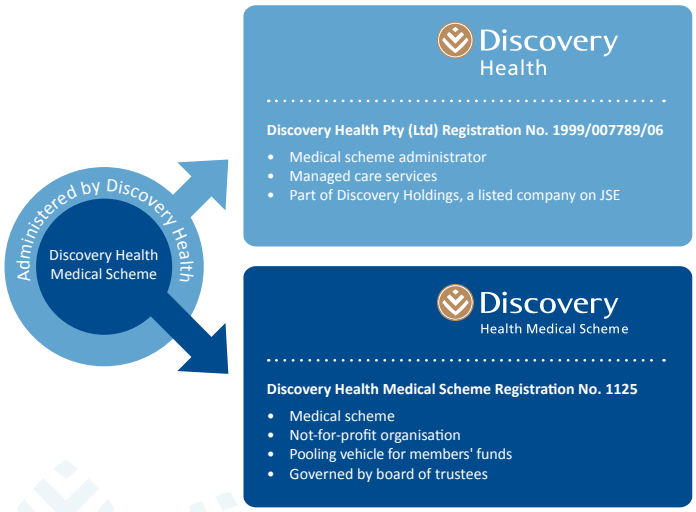
Overview

How a medical scheme works

How the Discovery Health Medical Scheme is administered

The Discovery Health Medical Scheme is administered by Discovery Health (Pty) Ltd, which is a for-profit subsidiary of the JSE-listed Discovery Holdings. Discovery Health (Pty) Ltd is accountable to the Scheme's independent Board of Trustees and the regulatory body, the Council for Medical Schemes. Discovery Health (Pty) Ltd is a dynamic, innovative and financially strong medical scheme administrator and health risk management organisation, which provides the highest quality administration and managed care services to the members of the Discovery Health Medical Scheme. Discovery Health (Pty) Ltd manages the key aspects of the operating environment for the Scheme, including the collection of contributions from members, and the contractual and claims payment relationships with healthcare professionals and providers of all healthcare services and products.

The relationship between the Discovery Health Medical Scheme and Discovery Health (Pty) Ltd, the Administrator:



Continuous innovation and investment in state-of-the-art risk management technology enables Discovery Health (Pty) Ltd to develop sophisticated actuarial, clinical and technological assets to ensure Scheme members have access to the best quality care while at the same time ensuring appropriate cost control in the healthcare system.

The Discovery Health (Pty) Ltd integrated operating model

Discovery Health (Pty) Ltd has invested a significant amount of expertise in developing an operating model to better manage healthcare funding for members of the Discovery Health Medical Scheme and the healthcare professionals responsible for their care. Inherent in the model is administration, risk management and operations management integration.

The integrated operating model has three distinct parts:

- **A consumer-engaged health plan benefit design**

  The Discovery Health Medical Scheme Plans all provide comprehensive insured benefits for lower-frequency, higher cost events like hospital admissions, and chronic medicine benefits ensure members have cover when they need it most. This differs from more traditional benefit models where higher costs were typically capped, leaving members exposed to major healthcare expenses. Medical Savings Accounts show members the cost of healthcare and engage them in managing their day-to-day medical expenditure. This assists in containing medical inflation and healthcare costs. Any unused funds in the Medical Savings Account get carried over to the next year, unlike traditional plans where unused cover is lost.

  If members require additional day-to-day cover over and above their Medical Savings Accounts, they can choose a plan that provides extended out-of-hospital protection, through the Above Threshold Benefit.

- **World-class clinical risk management expertise and systems**

  Discovery Health (Pty) Ltd augments the benefit construct with best-of-breed, pro-active risk management, which uses analytical and risk management tools to monitor and contain costs right across the healthcare value chain. Discovery Health (Pty) Ltd employs over 150 actuaries, health economists, analysts, doctors and other health professionals in its strategic risk management team. The team is led by some of South Africa's most respected experts in clinical risk adjustment, health economics policy as well as health actuarial science.

  This world-class risk management capability enables Discovery Health (Pty) Ltd to effectively manage the cost of care for the Discovery Health Medical Scheme, minimise abuse, and facilitate the ability of the Scheme to fund the latest medical technologies by applying sophisticated health economics modelling and developing funding protocols in collaboration with the health profession. This has resulted in significant savings for the Discovery Health Medical Scheme, which in turn are passed on to members through rich benefit cover, lower contribution increases and significant reserves.

- **Healthcare assets within the healthcare delivery system**

  The efficiencies resulting from these risk management processes have enabled the creation of a range of provider assets to save costs for members without compromising the quality of care. These assets include the Discovery Health GP network and direct payment arrangements with specialists, which now cover 87% and 88% of GP and specialist visits respectively for Discovery Health Medical Scheme members. The Delta Network, a dynamically managed network of hospitals, is another such asset, allowing for a 10% to 20% discount on member contributions on the Delta network options within some of the Scheme's major plan types. The KeyCare hospital and GP networks, which consist of 106 hospitals and over 2,000 GPs, enable the Discovery Health Medical Scheme to offer quality private healthcare access to lower-income earners, specifically to members who were previously uninsured.

The robust approach to risk management by Discovery Health (Pty) Ltd, and the assets built in the healthcare delivery system, allow the Discovery Health Medical Scheme to contain costs without compromising the quality of care and cover for members.

Overview

How a medical scheme works

A dedicated service infrastructure

To ensure that members of the Discovery Health Medical Scheme have access to exceptional service, Discovery Health (Pty) Ltd has developed a dedicated service infrastructure. This infrastructure supports high volumes and combines actuarial insight, operational expertise and technology to ensure high levels of service across every member interaction whilst maintaining personal interface with Scheme members. With over 200,000 member interactions per working day, ranging from new applications and call centre queries to emergency medical support, the scale of the operations of Discovery Health (Pty) Ltd is substantial.

Operational statistics:

Number of calls received per day	34,015
Percentage of calls answered within 20 seconds	83%
Percentage of calls abandoned	1.8%
Claims volumes a month	3,7 million
Percentage of claims submitted electronically	88%
Claims amounts paid for each working hour	R12 million
Percentage of Rands paid directly to healthcare professionals	94%
Claims error rate	0.9%
Average days from receipt to processed	0,21 days
Average days from receipt to paid (members)	1,81 days
Member satisfaction rate	9,37 out of 10

The member satisfaction rate is determined by the Discovery Health Client Research Centre, which receives 30,000 random email survey responses and conducts 3,000 telephonic surveys per month.

Industry surveys, such as the Private Healthcare Tracker, provide independent verification that the services provided by Discovery Health (Pty) Ltd are the most highly rated in the industry.

A range of value-added services to enhance member experience

The service offering by Discovery Health (Pty) Ltd is enhanced through a variety of exclusive value-added, additional services not offered by other administrators. Key initiatives rolled out during 2011 include:

- The **Discovery Integrated Care Unit** that ensures members with extensive medical needs receive holistic treatment from a team of medical experts, care coordinators and community-based care providers
- The **Discovery Trauma Support Service** that provides 24/7 access to a fleet of trauma support vehicles staffed by trained trauma counsellors
- **Discovery MedXpress**, a national medicine delivery service that provides members with home delivery of acute and chronic medicines at no charge
- The first **Discovery Health Member Lounge** at the Life Fourways Hospital in Gauteng where members and their families have access to facilities and support services during a hospital stay
- Extension of the **Discovery Health Member and Oncology Liaison Manager** service that provides personal support to members who are admitted into hospital or are facing cancer treatment.

Discovery Health (Pty) Ltd is committed to enhancing the quality of care Scheme members receive, controlling costs and improving members' experience in the healthcare system. A range of online support tools and technologies have been developed that help both members and healthcare professionals navigate the often complex healthcare system. These include:

- **Discovery HospitalXpress –** a range of services designed to facilitate rapid and efficient authorisation and admission of members to hospitals
- **HealthID –** a South African first; and iPad application which provides doctors treating Scheme members with access to members' health records, including past doctor and hospital visits, and current and past medications used. The treating doctor can also apply for chronic medicine and be provided with an immediate answer, and view pathology results
- **Online Advisor tools –** these help guide Scheme members through the healthcare system and identify when they can make full cover choices. Members can log on to the Discovery website to use these convenient and user-friendly self-service tools. They assist members in managing their hospital admissions by authorising admission online and calculating whether they can expect full cover for their chosen hospital and medical specialists. Members can also manage their day-to-day healthcare costs, check how they are covered for medicines and find healthcare providers who have an agreement with Discovery Health (Pty) Ltd
- **Discovery Member Application** – this application, available for iPhone and iPad, and coming soon for other mobile platforms, provides Scheme members with important and updated information regarding their Medical Savings Account balances, recent claims history, and membership card details.

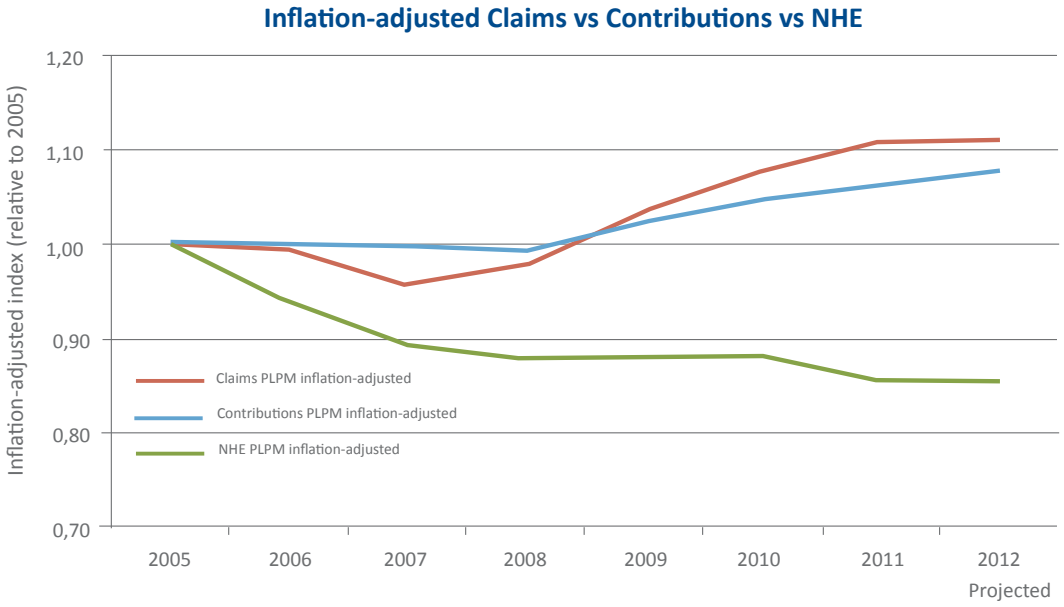
Non-healthcare expenditure has assisted in containing costs

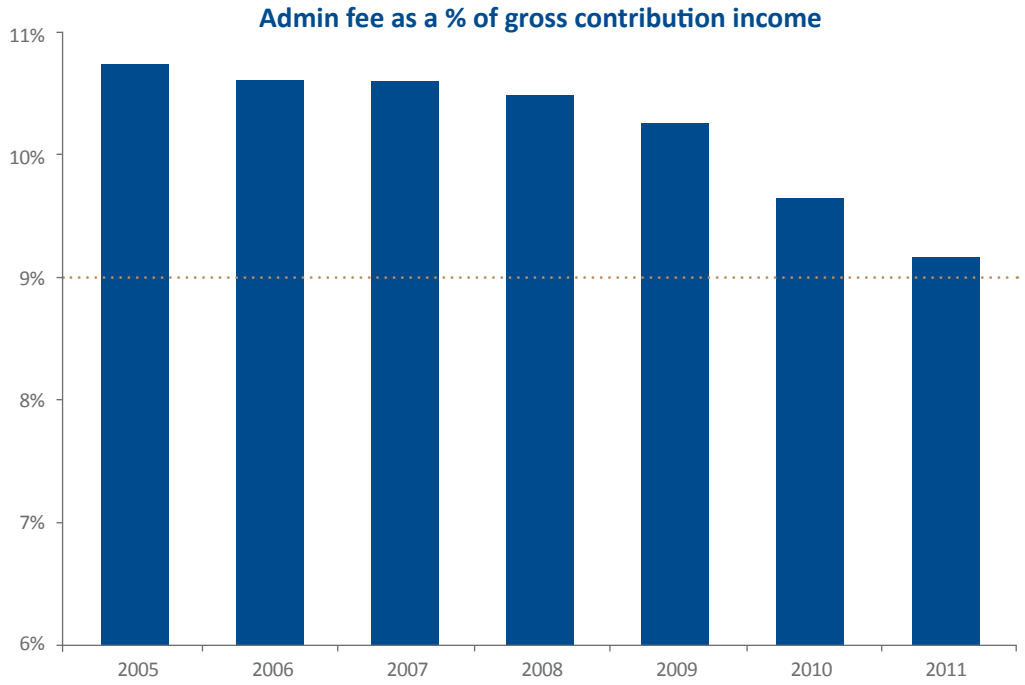
Non-healthcare expenditure (NHE) comprises of managed care: management services, broker service fees, administration fees and other operating expenses.

Discovery Health (Pty) Ltd is paid a fixed administration and managed care fee per member per month. The Board of Trustees of the Discovery Health Medical Scheme annually reviews and approves the administration and managed care fees to make sure that members receive continuous exceptional service and innovation. Non-healthcare expenditure is the only component of the Scheme's expenditure which has been decreasing consistently in real terms. For the period 2005 to 2011, as a percentage of gross contribution income, non-healthcare expenditure has reduced from 18.01% to 14.56%. This has been brought about by the significant growth of the Discovery Health Medical Scheme and the resulting efficiencies of scale. For the 2011 calendar year, there has been a further saving of R100 million in the administration fees paid by the Scheme to Discovery Health (Pty) Ltd. The deflationary effect of non-healthcare expenditure as demonstrated in the graph below has enabled the Scheme to allocate a greater portion of members' contributions to fund benefits.

Overview

How a medical scheme works





The profitability of Discovery Health (Pty) Ltd is based on the fixed administration and managed care fee it receives from the Discovery Health Medical Scheme and is unrelated to the payment of medical claims. In this sense, cover as provided by the Scheme differs completely from short-term insurance, where an insurer's profits are linked to whether they pay or deny claims. In the case of medical schemes, decisions on the payment of claims are based entirely on the rules of the medical scheme and the particular healthcare plan, and have nothing to do with the profits of the administrator.

Overview

Key differentiators of the Discovery Health Medical Scheme

Improving members' health through Vitality

Vitality is the Discovery Group's science-based wellness programme that harnesses the power of incentives to bring about behaviour change. The programme has been independently validated as a scientifically proven intervention that helps alleviate the risk related to chronic diseases of lifestyle.

Vitality HealthStyle (Pty) Ltd is a separate legal entity to the Discovery Health Medical Scheme, and the Scheme has contracted with Discovery Health (Pty) Ltd to offer membership of Vitality as a wellness programme to all Scheme members on a purely voluntary basis. Vitality complements the Discovery Health Medical Scheme, as the programme encourages members to be healthy and to lead an active lifestyle. The data proves that healthy and fit members experience lower healthcare costs and fewer and shorter hospital admissions. In turn, this improves the risk and claims profile of the Scheme.

The Vitality programme has been developed as a clinically and actuarially robust offering that combines clinical rigour with an understanding of how various activities impact on health and healthcare costs. Engagement with Vitality is built around three components:

- Clinical evaluation: giving members the tools to understand their health status
- Risk factor improvement: developing a personalised wellness solution for each member based on their unique health risk factors
- Behaviour change: using a rich offering of incentives and rewards to bring about the required health behaviour change.

Vitality aims to change simple and complex health behaviour, and covers the complete healthcare spectrum – ranging from lifestyle modification and preventive care to disease management.

Broad network of wellness and reward partners

Vitality has established several networks of wellness providers such as dietitians, biokineticists and pharmacies. Through these networks, members have access to a range of health services at a lower cost. These include health screenings, physical activity assessments and interventions, and nutritional assessments and interventions. A key differentiator of Vitality is its integration into food retailers. Through its proprietary HealthyFood™ benefit, Vitality provides rewards to members making healthier food choices as well as discounting of healthier food to its members. Travel and lifestyle rewards partners with significant market presence further incentivise members to engage in the programme.

Overview

Key differentiators of the Discovery Health Medical Scheme

The impact of Vitality

A fundamental measure of the success of Vitality is the level of engagement with the programme. It now has about 1,5 million members in South Africa. During 2011, engagement levels grew off an already positive base, with gym visits increasing to more than 20 million for the calendar year, kulula.com flights increasing from just over 500,000 flights in 2010 to over 750,000 flights for the 2011 calendar year, and South African participation in wellness activities increasing dramatically, with over 50% of the eligible population completing their Health Risk Assessments, over 50% having their glucose tested, and over 50% having their cholesterol assessed.

More importantly, Vitality has been proven to successfully reduce healthcare costs for the Discovery Health Medical Scheme. It has also enabled the Scheme to attract and retain younger and healthier members.

Research has revealed the significant impact of the programme on morbidity and mortality rates. Key findings from the Vitality Insured Persons studies, completed in collaboration with researchers from the universities of Cape Town, the Witwatersrand and Harvard, conclude that:

- Medical costs are on average 10% lower for highly-engaged Vitality members compared to members not on Vitality
- The total hospital costs for chronic conditions are 30% lower for highly-engaged members with multiple conditions, and 10% to 20% lower for conditions such as mental illness, cancer, hypertension and dyslipidemia
- Engagement with the physical activity components of the programme impacts on hospitalisation costs. Members who are highly engaged in fitness activities show a 10% lower hospital admittance rate, shorter length of stay (0,57 days shorter) and lower medical costs.

How the Discovery Health Medical Scheme curbs fraud and abuse

Fraud in the private healthcare industry is a major contributor to rising healthcare costs, decreased benefits and increased medical scheme contributions. Various estimates suggest that as much as 10% of funds paid out annually by medical schemes are lost due to fraud. It is therefore critical that the Discovery Health Medical Scheme identifies and prevents all possible instances of fraud, investigates suspected fraud, and recovers any funds inappropriately paid as a result of fraud.

The most common type of fraud the Scheme is exposed to by members is non-disclosure of prior ailments. Other fraudulent practices include members submitting multiple claims by changing procedure codes, service dates, service providers, amounts and dependent names. In many cases, fraud is committed with a paper trail – claims are usually faxed, so that the detail is unclear.

With regards to fraudulent activity by healthcare providers, code manipulation is the most common type of fraud investigated by the Scheme, followed by claims submitted and services not rendered. There is also a trend of certain healthcare professionals agreeing to treat non-scheme members and then submitting claims using the membership number of a scheme member.

How does the Discovery Health Medical Scheme detect fraud?

The Discovery Health Medical Scheme and its Administrator, Discovery Health (Pty) Ltd, have taken a strong stance against fraudulent practices by both Scheme members and healthcare professionals. Discovery Health (Pty) Ltd has a dedicated forensic investigative unit, comprising 30 full-time experienced investigators. Every suspected case is thoroughly investigated. Fraud and other inappropriate behaviour are detected in a number of ways:

- Through tip-offs by members, healthcare professionals and others using an anonymous fraud hotline
- Through data mining and data analysis using various specialist tools
- By using a unique fraud management system, which assists the Scheme in identifying trends and patterns
- Through the identification of identified warning signs of fraud as well as random audits.

The unique fraud management system of Discovery Health (Pty) Ltd combines clinical, actuarial, operational, legal and forensic expertise to help prevent fraud and save the Discovery Health Medical Scheme costs. An important element of the system is to use health claims and other data to cross-reference and integrate all data on a member. By having a single view of a member, and by filtering data, the Scheme is able to identify possible fraud.

All instances of suspected fraud are dealt with swiftly. The Discovery Health Medical Scheme is obligated in certain instances to report suspected fraud cases both to the South African Police Services and to the Health Professions Council of South Africa.

Members can report any suspected cases of fraud in the following ways:

- Toll-free hotline: 0800 004500
- SMS: 43477
- Toll-free fax: 0800 007788
- E-mail: discovery@tip-offs.com

Overview

Key differentiators of the Discovery Health Medical Scheme

Active engagement with the stakeholders of the Discovery Health Medical Scheme

The Discovery Health Medical Scheme has an impact on a range of stakeholders in South Africa. Relationships with these stakeholders, in turn, have an effect on the sustainability of the Scheme. These stakeholders are:

- **The members of the Discovery Health Medical Scheme:** The more than 2,3 million people to whom the Scheme provides healthcare cover are its most important stakeholders. Over the past five years, the Scheme has built structures in the healthcare system to improve members' cover. Through collaboration with healthcare providers, the Scheme has developed a series of benefit structures and payment agreements that offer members greater certainty and reduce gaps in cover. Today, all the Scheme's health plans offer members the choice of being covered in full for hospitalisation and chronic medicine. In addition, members on the Scheme's top plans have access to full cover for GP consultations through the Insured Network Benefit.

  The Scheme engages with members through its call centre and walk-in service centres, through electronic newsletters, claims statements, the Discovery website, social media, the Discovery magazine, year-end revision launches and communication, and regular product and benefit updates. Regular member surveys and research helps the Scheme to assess the level of service provided to members and to identify any areas in which service can be improved.
- **The Regulator (the Council for Medical Schemes):** The Regulator that governs the medical schemes industry is an important stakeholder to the Discovery Health Medical Scheme. The Scheme has regular meetings with the Council for Medical Schemes on Scheme matters as well as key industry issues.
- **National Department of Health:** The Scheme and its Administrator actively engage with the Department of Health on issues impacting healthcare in South Africa, and to contribute to strategic national development initiatives. One of these is the Government's National Health Insurance (NHI) policy. The Scheme believes that healthcare reform is needed to ensure a comprehensive healthcare system for all South Africans, and supports the roll-out of a NHI system. The Scheme will continue to be part of the engagement process in this regard.
- **The Administrator of the Scheme (Discovery Health (Pty) Ltd):** The Administrator provides administration and managed care services to the Scheme for a fixed monthly fee. It is accountable to the Scheme's Board of Trustees and to the Council for Medical Schemes. Economies of scale enable Discovery Health to provide Scheme members with highly valued, additional services not offered by other administrators.
- **The pharmaceutical industry:** The Discovery Health Medical Scheme engages with the pharmaceutical industry to get the best possible prices of medicines for Scheme members, thereby protecting the pool of funds from which members' claims are paid. Price negotiations with the pharmaceutical industry for lower market prices also benefit South Africans who are not members of the Scheme.

- **Healthcare professionals:** Healthcare professionals both in South Africa and globally are critical to the sustainability of private healthcare delivery. The Scheme's negotiated payment arrangements with GPs and specialists not only ensure certainty of cover for members, but also higher levels of funding for healthcare professionals. The Scheme further engages with healthcare professionals through regular thought leadership summits at which pertinent issues affecting healthcare in South Africa are examined, and also meets with representative bodies on specific industry issues. To assist healthcare professionals, an innovative tool, HealthID, is being rolled out this year, giving them access to a full health record of all members who give their consent to their doctors.
- **Healthcare intermediaries:** Around 7,000 independent and 400 Discovery advisers, supported by 250 business consultants countrywide, advise Scheme members on the best choice of healthcare plans to suit both their medical and financial needs. The Scheme's healthcare intermediaries play a very important role in providing necessary information to members. To assist them, Discovery Health (Pty) Ltd hosts the Discovery Insights Series, a series of regular workshops on relevant industry topics. These workshops are aimed at equipping them to provide high-quality advice and service on complex issues. Discovery Health (Pty) Ltd also provides a range of additional knowledge courses, training material and support, ongoing communication through electronic newsletters and website articles, supporting marketing material and tools, and product launches.

Contribution to healthcare in South Africa

The primary role of the Discovery Health Medical Scheme is to ensure that the more than 2,3 million people it provides healthcare cover to have access to quality healthcare on a sustainable basis. However, the scale and expertise of the Scheme also means the Scheme can play a fundamental role in building a sustainable healthcare system, not only for its members, but for all South Africans.

The broadest and deepest level of healthcare cover

The Discovery Health Medical Scheme now holds a 50% share of the open medical schemes market. This significant scale has enabled the Scheme to facilitate a healthcare infrastructure that ensures members enjoy the broadest and deepest level of healthcare cover available in the market, at the most competitive contribution rates and within a system that guarantees stability and consistency. This has also resulted in a positive ripple effect for the entire industry in terms of approach, costs and systems.

The evolution of the Scheme over the years has resulted in an institution of sophistication and significant financial strength. This has enabled the Scheme to build a robust and a comprehensive plan range for members, and provide comprehensive benefits and minimise gaps in cover for members. The Scheme is continuously enhancing the benefit structures on all its health plans to ensure members continue to have access to excellent quality of care and value in an increasing complex healthcare environment.

Managing the cost of healthcare

Through the ongoing engagement of the Scheme and its Administrator with stakeholders in the healthcare industry, it has built strategic assets in the Scheme's GP, specialist, hospital and pharmacy networks. These have brought down the cost of healthcare for both members and the industry, contributing to the continued sustainability of the Scheme. The benefits of these payment arrangements to healthcare professionals include improved cash flow, higher levels of remuneration and reduced administration, which may play a role in retaining them in South Africa's healthcare sector.

Overview

Key differentiators of the Discovery Health Medical Scheme

Increasing access to private healthcare

Given the disparity of healthcare resources and access to them in South Africa, one of the important priorities of the Discovery Health Medical Scheme has been to extend access to care to include more South Africans in the private healthcare market. In 2002, the Scheme launched the KeyCare series, offering quality private healthcare access to lower-income earners and members joining a medical scheme for the first time. Membership of KeyCare is now the equivalent of the third largest medical scheme in South Africa, and it is the fastest growing low-income plan option in the market.

Despite its lower cost, KeyCare Plans give members access to affordable healthcare cover through unlimited hospital cover, access to primary care as well as specialist care and cover for chronic medicines. KeyCare offers this quality cover while containing costs through a wide-ranging network of healthcare providers. During 2009, the KeyCare contribution rates were adjusted based on salary bands, enabling the lowest-income earners to benefit from the lowest contribution rates. With this new income-band structure for KeyCare, the Discovery Health Medical Scheme has been able to play an even greater role in improving access to private healthcare cover for lower-income earners, and in this way contributes to their wellbeing and wellness.

A force for good

Through Discovery Holdings, the Administrator of the Discovery Health Medical Scheme, Discovery Health (Pty) Ltd, plays an important role in supporting and strengthening the healthcare system in South Africa through corporate social investment. Between 2005 and 2015, R350 million will be invested through Discovery Holdings in a range of healthcare programmes and initiatives aimed at strengthening human resources for the healthcare system. This includes the training of medical specialists and other categories of health professionals, as well as the support of primary healthcare.

Over the past five years, considerable work has been done to support healthcare resources and skills as a national asset. Following from research in 2005 to understand the environmental challenges facing specialist medical training in South Africa, Discovery Holdings introduced the Discovery Foundation Awards. These annual awards are aimed at supporting specialist medical training and Academic Medicine in South Africa – a critical area of need for the sustainability of South Africa's healthcare sector in future. To date, financial support of R69 million has been provided for the training of 143 specialists and healthcare professionals in various medical disciplines where South Africa is in need of qualified doctors.

Discovery Holdings supports healthcare delivery in the public sector through public-private initiatives, aimed at meeting key national and provincial health priorities identified by the Department of Health. These include a partnership with the South African National Council for the Blind aimed at increasing the number of cataract surgeries in the public sector, and a training programme on antiretroviral treatment for nurses in partnership with the Lung Institute of the University of Cape Town.

The Discovery Fund, an independent trust through which Discovery Holdings funds sustainable public sector healthcare projects, is partnering with UNICEF over the next three years to support the Department of Health's national programme on immunisation. The pilot programme has been rolled out in two provinces – the Eastern Cape and KwaZulu-Natal. The Discovery Fund is contributing R5 million a year to the partnership, launched in 2011.

The Discovery Fund's investments centre on primary healthcare initiatives, including rural areas, HIV and AIDS programmes, and projects that deal with infectious diseases. For the 2010/2011 financial year, the Fund approved an amount of R11,370,371 for 32 community health projects.

Overview

Strategic objectives for the Discovery Health Medical Scheme

The Discovery Health Medical Scheme will focus on the following key strategic objectives during the 2012 benefit year:

- **Clinical risk** – Identifying and managing cost trends relating to the changing demographic profile and identifying and developing supply side interventions to reduce the impact of burden of disease
- **Benefit design** – Continuing efforts to rebalance benefit structures in order to eliminate waste and to ensure ongoing stability of the Scheme, increase cover for the most critical healthcare needs and to continuously enhance the member value proposition
- **Annual contribution increases** – Identifying areas to contain cost escalation and to ensure that members experience affordable contribution increases while ensuring the sustainability of the Scheme
- **Operations** – Further enhancing the member and service provider service experience as well as creating unique value-add differentiators for members and the Scheme
- **Stakeholders** – Creating a more robust stakeholder engagement strategy.

Corporate Governance

Corporate Governance

Corporate Governance

Board of Trustees

In the private healthcare industry, healthy partnerships between medical schemes, the organisations that administer them, and stakeholders within the broader healthcare environment in which medical schemes operate, are essential. The role of a medical scheme's board of trustees is to ensure that the needs of the scheme's members are met within the context of this broader environment.

The Discovery Health Medical Scheme's Board of Trustees consists of seven independent, highly skilled, professional individuals, each of them with distinctive and widely acknowledged expertise in either legal, medical, financial or actuarial disciplines. All the Trustees are non-executive officers, with no ties to either the Administrator or the executive officers of the Scheme. This degree of professional skill, independence and robust governance is essential for the proper management of any medical scheme.

As required by the Medical Schemes Act and the rules of the Discovery Health Medical Scheme, over 50% of the Scheme's trustees are elected by the Scheme's members in a transparent election process, assisted by a nomination committee appointed by the Scheme and overseen and audited by an independent auditing firm.

The focus of the Board of Trustees is on continuous improvement and innovation at all levels of strategy and business delivery while ensuring the sustainability of the Scheme. The Board of Trustees ensures that the services provided to the Discovery Health Medical Scheme by its Administrator are consistent with best practice, the highest service and operational standards, and the provisions stipulated in the administration agreement.

Trustees

Adv Michael van der Nest
BA (Law) LLB (Stellenbosch)
Chairperson

Dr Nozipho Sangweni
MBChB (Natal), DOH (Wits), DCAM (IATA)
Deputy Chairperson

Prof Zephne van der Spuy
MBChB (Stellenbosch), MRCOG (Royal College of Obstetricians and Gynaecologists), PhD (University of London, UK), FRCOG 1991 (Royal College of Obstetricians and Gynaecologists), FCOG (SA) (South African College of Obstetricians and Gynaecologists)

Giles Waugh
FIA (Fellow of the Institute of Actuaries UK), FASSA (Fellow of the Actuarial Society of South Africa)

Adv Noel Graves
BA LLB (UCT)

Puke Maserumule
BA (Law) LLB (UCT), Post-graduate Diploma in Labour Law (UJ)

Barry Stott
CTA (Wits), CA (SA)

Board of Trustees of the Discovery Health Medical Scheme

Adv Michael van der Nest
(appointed 16 August 2011)

Chairperson

(elected 16 August 2011)

BA (Law) LLB (Stellenbosch)

Occupation: Senior Counsel

Prof Zephne van der Spuy
(elected 24 June 2010)

Trustee

MBChB (Stellenbosch), MRCOG (Royal College of Obstetricians and Gynaecologists), PhD (University of London, UK), FRCOG 1991 (Royal College of Obstetricians and Gynaecologists), FCOG (SA) (South African College of Obstetricians and Gynaecologists)

Occupation: Professor of Obstetrics and Gynaecology, UCT

Adv Noel Graves
(elected 24 June 2010)

Trustee

BA LLB (UCT)

Occupation: Senior Counsel

Giles Waugh
(appointed 14 April 2011)

Trustee

FIA (Fellow of the Institute of Actuaries UK), FASSA (Fellow of the Actuarial Society of South Africa)

Occupation: Actuary

Puke Maserumule
(elected 24 June 2010)

Trustee

BA (Law) LLB (UCT), Post-graduate Diploma in Labour Law (UJ)

Occupation: Founder and Chairperson, Maserumule Incorporated Lawyers

Dr Nozipho Sangweni
(re-elected 24 June 2010)

Deputy Chairperson

(elected 15 November 2011)

MBChB (Natal), DOH (Wits), DCAM (IATA)

Occupation: SAA Chief Medical Officer

Barry Stott
(elected 24 June 2010)

Trustee

CTA (Wits), CA (SA)

Occupation: Non-executive company director, retired partner, PricewaterhouseCoopers Inc, responsible for financial services

Trustees who resigned during the year

Dr Dhesan Moodley
(resigned following relocation to the USA)

Chairperson

MBA (UCT), MSc Sports Medicine (UCT), MBChB (Natal)

Occupation: Group President, Alexander Proudfoot

Stephen Handler
(resigned following emigration)

Trustee

BCom, FFA, FASSA Trustee

Occupation: Non-executive Independent Director, Regent Insurance Group and Flagstone Reinsurance Company

Corporate Governance

Corporate Governance committees

Audit and Risk Committee

D Eriksson	–	Chairperson (Independent)
N Novick	–	Independent member
S Green	–	Independent member
B Stott	–	Trustee
G Waugh	–	Trustee

Investment Committee

P Maserumule	–	Chairperson (Trustee)
G Waugh	–	Trustee
S Handler	–	Independent member

Clinical Governance Committee

Dr N Sangweni	–	Chairperson (Trustee)
Prof Z van der Spuy	–	Trustee

Remuneration Committee

Adv M van der Nest	–	Chairperson (Trustee)
D Eriksson	–	Chairperson (Audit and Risk Committee)

Corporate Governance

Corporate Governance report

The Scheme is committed to principles of ethical leadership, good corporate citizenship and creating a positive impact in the communities within which it operates through the practice of fairness, transparency, integrity and accountability in all its dealings with its stakeholders.

The Scheme acknowledges its role within the medical scheme industry as well as its responsibilities to each individual beneficiary and the wider community. The Scheme recognises that sustainability can only be achieved through strong relationships with all stakeholders and responsible management of risk.

Transparency and ethics

The Scheme has adopted a stakeholder-inclusive approach to corporate governance and is bound by mandates and principles of treating members fairly. The Code of Conduct outlines the principles that guide the Scheme in a way that contributes to the welfare of the key stakeholders and helps balance the needs of all stakeholders in the system. The close stakeholder relationship and the appointment of the Board of Trustees by the members allow the Scheme to recognise the concerns and objectives of stakeholders in its decision-making process.

The Board of Trustees acknowledges that the perception of stakeholders will affect the reputation of the Scheme. Therefore, clear and open communication with stakeholders will enhance the reputation of the Scheme. It is the intention of the Trustees to produce a holistic and reliable integrated report in future to illustrate both the financial and non-financial performance of the Scheme.

The Board of Trustees and its committees

The Board of Trustees is responsible for the stewardship and governance of the Scheme. The Trustees are proposed and elected by the members of the Scheme and participating employers, according to the provisions of the Medical Schemes Act, No 131 of 1998, as amended, and the rules of the Scheme. The Trustees are representatives of the Scheme's members and are legally responsible for the management and strategic direction of the Scheme on behalf of the members.

During the year two Trustees resigned. Dr Dhesan Moodley resigned as Chairperson of the Board of Trustees and as a member of the Investment Committee following his relocation to the United States. Mr Stephen Handler emigrated and resigned as a member of the Board of Trustees and Audit and Risk Committee, but as at 31 December 2011 remained on the Investment Committee. In terms of the rules of the Scheme, the Board of Trustees may appoint Trustees to the Board should this be required. Following the two resignations the Trustees appointed Adv Michael van der Nest to the Board on 16 August 2011. Mr Giles Waugh's appointment on 14 April 2011 was ratified at the Scheme's Annual General Meeting on 23 June 2011. The Trustees elected Adv Michael van der Nest as Chairperson on 16 August 2011 and Dr Nozipho Sangweni as Deputy Chairperson on 15 November 2011.

The main role of the Board of Trustees is to:

- Act as the focal point for, and custodian of, corporate governance by managing its relationship with management, the members and other stakeholders of the Scheme along sound and best-practice corporate governance principles
- Appreciate that strategy, risk, performance and sustainability are inseparable
- Provide effective leadership on an ethical foundation
- Ensure that the Scheme is and is seen to be a responsible corporate citizen by having regard to not only the financial aspects of the business of the Scheme but also the impact that business operations have on the environment and the society within which it operates
- Ensure that the Scheme's ethics are managed effectively
- Ensure that the Scheme has an effective and independent audit committee
- Be responsible for the governance of risk
- Be responsible for information technology (IT) governance
- Ensure that the Scheme complies with applicable laws and considers adherence to non-binding rules and standards
- Ensure that there is an effective risk-based internal audit
- Appreciate that stakeholders' perceptions affect the Scheme's reputation
- Act in the best interests of the Scheme and its members.

The duties of the Board of Trustees are to:

- Appoint, evaluate and delegate functions to the Principal Officer
- Oversee and direct the management of the Scheme's activities performed by the Administrator
- Address key issues and ensure that discussion on policy, strategy and performance are treated as critical, informed and constructive
- Ensure that proper control systems are employed by or on behalf of the Scheme
- Ensure that the rules, operation and administration of the Scheme comply with the provisions of the Medical Schemes Act, No 131 of 1998, as amended, and all other applicable laws
- Take all reasonable steps to protect the confidentiality of medical records concerning the state of health of the Scheme's members
- Ensure that adequate and appropriate information is communicated to the members regarding their rights, benefits, contributions and duties in terms of the rules of the Scheme.

Corporate Governance

Corporate Governance report

Board of Trustees performance assessment

A collective board-effectiveness evaluation and peer review is performed annually. The Chairperson meets with individual Trustees on a one-to-one basis should the need arise.

Board of Trustees proceedings

The Board of Trustees met six times, including the strategy day, during the 2011 financial year. Additional meetings are convened as and when necessary. A separate strategy day is arranged each year where the Scheme's executive officers and representatives of the Administrator are invited to present and discuss strategy matters with the Trustees. The Trustees have full and unrestricted access to relevant information. All Trustees have access to the advice and services of the Principal Officer and, where appropriate, may seek independent advice at the expense of the Scheme to support them in their duties.

During the past financial year the attendance was as follows:

Name	10 Feb 2011	14 Apr 2011	15 Apr 2011	16 Aug 2011	6 Sep 2011	15 Nov 2011
M Van der Nest**	N/A	N/A	N/A	N/A	✓	✓
D Moodley***	✓	✓	✓	✗	N/A	N/A
N Graves*	✓	✓	✓	✓	✓	✓
P Maserumule*	✓	✓	✓	✓	✗	✓
N Sangweni*	✓	✓	✓	✗	✓	✓
B Stott*	✓	✓	✓	✓	✓	✓
Z Van der Spuy*	✓	✓	✓	✓	✓	✓
S Handler***	✗	✓	✓	✓	N/A	N/A
G Waugh****	N/A	N/A	N/A	✓	✓	✓

*= Elected on 24 June 2010. **= Appointed Chairperson on 16 August 2011. ***= Resigned on 16 August 2011. ****= Appointed on 23 June 2011.

Board of Trustees committees

Board committees constitute an important element of the governance process. Accordingly, specific committees have been established with clearly agreed reporting procedures and written scopes of authority. The establishment of committees does not exonerate the Board of Trustees from its legal responsibilities and the performance of these committees is considered by the Trustees annually.

The current committees of the Board of Trustees are:

Audit and Risk Committee

The Audit and Risk Committee performs a vital corporate governance role by safeguarding the integrity of the Scheme's reporting and internal financial controls and identifying and managing financial risk. The Committee reports to the Board of Trustees as to how the Committee has discharged its responsibilities.

The responsibilities of the Audit and Risk Committee are:

- To ensure that a combined assurance model is applied to provide a coordinated approach to all assurance activities
- To ensure that the finance function of the Scheme has sufficient expertise, resources and experience
- To assist in the execution of the Board of Trustees' role of accountability
- To ensure integrity, reliability and accuracy of accounting and financial reporting systems
- To have oversight of financial reporting risk, internal financial controls, fraud risk in relation to financial reporting and IT risks in relation to financial reporting
- To ensure that appropriate systems are in place for the monitoring of risk, control and compliance with laws, regulations and codes of conduct
- To evaluate the adequacy and effectiveness of the risk management, internal audit and compliance process
- To maintain a transparent and appropriate relationship with the external auditors and set the principles of recommending the use of external auditors for non-audit services
- To review the scope, quality and cost of the statutory audit and the independence of the auditors
- To examine and review the Scheme's financial statements prior to submission and approval by the Board of Trustees
- To oversee and review the performance of the internal audit function
- To provide independent and objective oversight of the financial, operational and strategic risks.

The Audit and Risk Committee had five members at 31 December 2011, two of whom are members of the Board of Trustees. In compliance with Section 36(11) of the Medical Schemes Act, No 131 of 1998, as amended, the majority of the members are not officers of the Scheme or of its Administrator.

Corporate Governance

Corporate Governance report

As at 31 December 2011, the Committee members were:

- D Eriksson (Independent member) CA (SA) – Chairperson
- N Novick (Independent member) CA (SA)
- S Green (Independent member) BSc (Hons)
- B Stott (Trustee member) CA (SA)
- G Waugh (Trustee member) FIA, FASSA.

The external auditors and the Principal Officer of the Scheme, as well as the internal auditors of the Administrator, attend all Audit and Risk Committee meetings and have unrestricted access to the Chairperson of the Audit and Risk Committee. The Audit and Risk Committee meets at least four times per year. It has additional meetings when they are required.

During the 2011 financial year, attendance at the Audit and Risk Committee meetings was as follows:

Name	17 Mar 2011	13 Apr 2011	7 Jul 2011	28 Sep 2011	3 Nov 2011
D Eriksson	✓	✓	✓	✓	✓
S Green	✓	✓	✓	✓	✓
S Handler***	✓	✓	N/A	N/A	N/A
N Novick	✓	✗	✓	✓	✓
B Stott	✓	✓	✓	✗	✓
G Waugh****	N/A	N/A	N/A	✓	✓

= Resigned on 16 August 2011. *= Appointed on 7 July 2011.

Investment Committee

The Investment Committee, established by the Board of Trustees, is mandated to invest excess funds in line with the Medical Schemes Act, No 131 of 1998, as amended, and the Scheme's approved Investment Policy. The Scheme's investment objectives are to maximise the return on investments on a long-term basis while exposing the investment to minimal risk, subject to any constraints imposed by legislation or the Trustees.

As at 31 December 2011, the Committee members were:

- P Maserumule BA Law, LLB – Chairperson
- S Handler BCom, FFA, FASSA
- G Waugh, FIA, FASSA.

During the 2011 financial year the attendance at Investment Committee meetings was as follows:

Name	10 Mar 2011	16 Aug 2011	3 Nov 2011
P Maserumule	✓	✓	✓
S Handler	✓	✓	✓
G Waugh****	N/A	✓	✓
D Moodley***	✓	N/A	N/A

****= Appointed on 16 August 2011. ***= Resigned on 16 August 2011.

Corporate Governance

Corporate Governance report

Clinical Governance Committee

The Scheme has a responsibility for overseeing clinical governance and associated risk. To assist with this objective the Scheme established the Clinical Governance Committee in terms of the Rules of the Scheme.

The responsibilities of the Clinical Governance Committee are:

- To ensure that the Scheme upholds the level of clinical care, as prescribed by the Medical Schemes Act and the rules of Discovery Health Medical Scheme
- To ensure that the Scheme complies with its mandate to offer members the highest level of appropriate affordable quality care, taking into account the balance between quality healthcare, effective clinical risk management and economic principles
- To ensure that all members of the Scheme experience an acceptable quality of care based on clinical best practice.

As at 31 December 2011, the Committee members were:

- Dr N Sangweni, MBChB (Natal), DOH (Wits), DCAM (IATA) – Chairperson
- Prof ZM van der Spuy, MBChB (Stellenbosch), MRCOG (Royal College of Obstetricians and Gynaecologists), PhD (University of London, UK), FRCOG 1991 (Royal College of Obstetricians and Gynaecologists), FCOG (SA) (South African College of Obstetricians and Gynaecologists).

During the 2011 financial year, attendance at the Clinical Governance Committee meetings was as follows:

Name	17 Mar 2011	14 Apr 2011	16 Aug 2011	15 Nov 2011
N Sangweni	✓	✓	✗	✓
ZM Van Der Spuy	✓	✓	✓	✓

Remuneration Committee

The main objective of the Remuneration Committee is to recommend to the Board of Trustees the remuneration principles and strategy of the Scheme. In order to achieve this, the Scheme has adopted the King 3 recommendations in respect of the remuneration of Trustees and has implemented a remuneration framework and policy. The policy and framework implemented by the Scheme provide for robust governance structures, which inform its remuneration strategy, policy and the levels of remuneration.

The Remuneration Committee is responsible for:

- Recommending remuneration for Trustees
- Reviewing the annual salary increase of all executive officers and employees of the Scheme.

The members of the Remuneration Committee are Adv M van der Nest (Board of Trustees Chairperson) and Mr D Eriksson (Audit and Risk Committee Chairperson). Mr M Streak (Principal Officer) is invited to attend the meetings of the Remuneration Committee. The Committee met once during the year on 31 October 2011 and all members were in attendance.

Trustee and committee remuneration

The Trustees and members of the committees have been remunerated for services to the Scheme. Remuneration is reviewed and recommended by the Remuneration Committee. It is based on the skills, expertise, time and commitment needed to serve as a Trustee or committee member of a large medical scheme, market-related trends and surveys on non-executive and committee remuneration, pension funds and insurance corporations of a similar size and nature to the Scheme, and recommendations of King 3.

The remuneration payable to the Audit and Risk Committee members and Trustees for the year ended 31 December 2011 is disclosed in Notes 16 and 19 respectively.

Events after the reporting period

The Trustees are not aware of any events that have occurred after the end of the financial period that would materially affect the Annual Financial Statements or that the Trustees consider necessary to report on.

Corporate Governance

Risk Management report

The Scheme is aware of the importance of sound risk management to enhance and protect its reputation, while ensuring that the Scheme's operations are sustainable.

The Scheme has a comprehensive risk management strategy and policy which sets the tone for risk management in the Scheme and defines the overall process used to manage risk. The Scheme recognises that the Board of Trustees is responsible for the governance of risk, and as such, the Board has established formal processes for the management of risk, which includes the system and process of risk management.

The risk management strategy and policy comprise the following key items:

- The overall strategic vision and mission of the Scheme
- The individuals responsible for achievement of strategic goals
- The continuous development and improvement of the risk management process
- A strategic plan communicated to all stakeholders to assist in more effective decision-making
- Safeguards and structures to ensure that risk is adequately managed
- Key areas of risk to which the Scheme is inherently exposed to as a result of its operations
- The risk appetite of the Scheme, with clear indication of risk tolerance
- The risk management process, which highlights the top-down and bottom-up approach to risk management
- The framework for risk management reporting
- The roles and responsibilities of all individuals involved in the risk management process.

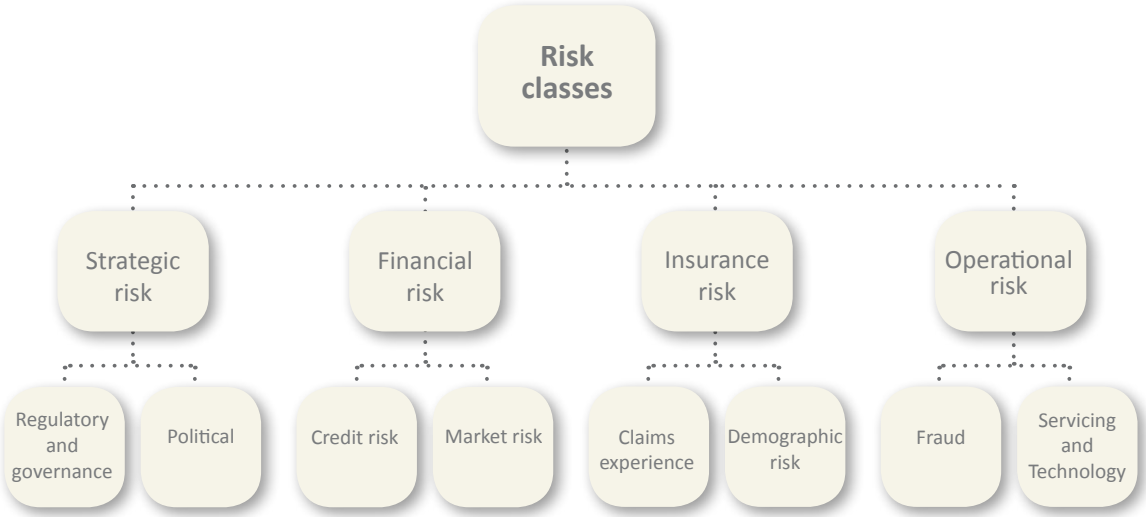
Risks are regularly reviewed and updated to ensure that the process is always relevant, while regular monitoring of risks is performed to ensure that risks are adequately addressed and categorised based on their urgency and importance to the sustainability of the Scheme.

Management regularly prepares a risk impact matrix, which categorises risks in terms of qualitative and quantitative factors as well as the possible impact on the Scheme and the likelihood that the risk will occur within the defined time horizon.

The Scheme continuously performs self-analysis of the risk management process and improves the methods to manage risk.

The risk management matrix, continuous improvement in the methodology and comprehensive risk management processes provide a systematic, disciplined approach to evaluate and improve the effectiveness of risk management, internal control, compliance and governance processes in the Scheme.

The Scheme categorises risks into four main risk classes. These classes are presented below and include some of the main risks identified under each risk class.



Strategic risk

Strategic risk refers to the risk arising internally from a poor choice of strategy or from the external environment acting to prevent the Scheme realising its strategy.

Financial risk

Financial risk is the risk that the Scheme will be unable to meet its financial obligations. This risk is primarily a function of credit, market, liquidity and non-healthcare expenses risk performance.

Insurance risk

Insurance risk refers to the inherent uncertainty as to the occurrence, amount and timing of insurance liabilities.

Operational risk

Operational risk is the risk of direct or indirect loss resulting from inadequate or failed internal processes, people and systems or from external events.

Corporate Governance

Compliance report

The Trustees of the Discovery Health Medical Scheme fully recognise their responsibilities to internal and external stakeholders in terms of the regulatory requirements applicable to all operations of the Scheme. The Scheme has implemented a coordinated compliance framework to ensure all operations are conducted in accordance with applicable legal, regulatory and supervisory requirements and guidelines. It also encourages the proactive and accountable management of regulatory compliance risks within the Scheme and ensures that all executives and managers understand their accountability.

The compliance function is independent of Scheme management, and its primary responsibility is to assist the Principal Officer and the Board to discharge their responsibilities and to ensure that operations:

- Are run with integrity
- Comply with all applicable legal and regulatory requirements
- Comply with international standards of best practice in terms of discharging its regulatory obligations
- Are conducted in an ethical manner.

The objectives of the compliance function can be summarised as follows:

- **Management of regulatory change:** Identification of changes in the regulatory environment and notification to relevant business operations to ensure that appropriate controls are implemented to address new requirements
- **Provision of general guidance and support to business:** Assistance of Scheme management with the implementation of appropriate controls to monitor compliance to relevant regulatory obligations, and with the management of incidences of non-compliance
- **Implementation of a compliance monitoring programme:** Implementation of a risk-based methodology to independently assess the appropriateness and efficiency of controls implemented to monitor and ensure compliance to regulatory obligations
- **Management of regulatory relationships:** Management of regulatory relationships with all applicable regulators, including implementation of controls to ensure:
  - A single point of entry for regulatory complaints and enquiries
  - That all regulatory returns are submitted on time
  - Regular and ongoing contact with the regulators in respect of regulatory and supervision developments that may impact the operations of the Scheme.

The Scheme's compliance function is authorised to:

- Have unrestricted access to relevant functions, business operations, records and personnel
- Allocate necessary skilled resources, set frequencies, select subjects, determine scope of work and apply techniques required to monitor the regulatory compliance risks within the operations as appropriate
- Have appropriate access to all relevant committees within the Scheme
- Obtain assistance from relevant operational areas to assist with monitoring reviews and/or investigations
- Access agendas and minutes of executive, management and board meetings
- Request any report, as appropriate, on a compliance-related matter.

Corporate Governance

Combined Assurance

A combined assurance model aims to optimise the assurance coverage obtained from management, and internal and external assurance providers on the risk areas affecting the Scheme. There are a number of assurance providers within the Scheme that either directly or indirectly provide the Board of Trustees and the Scheme's management with certain assurances of the effectiveness of the controls to mitigate the risks as identified during the risk assessment process. Collectively these providers are referred to as the combined assurance model.

During the financial year the following steps were taken to develop the combined assurance model:

Risk identification

The key risks facing the Scheme were identified, documented in the Scheme's risk register and rated. The risk register is regularly reviewed by the executive officers of the Scheme as well as representatives of the Administrator to ensure that the risks are still relevant to the Scheme and to identify additional risks.

The risk register is presented to and approved by the Audit and Risk Committee. The risk register is subsequently tabled and approved by the Board of Trustees.

Identification of controls

The controls that mitigate the identified risks were identified and documented. Certain assumptions were made based on a generic understanding of the processes. The controls were also assessed to ensure their relevance and effectiveness.

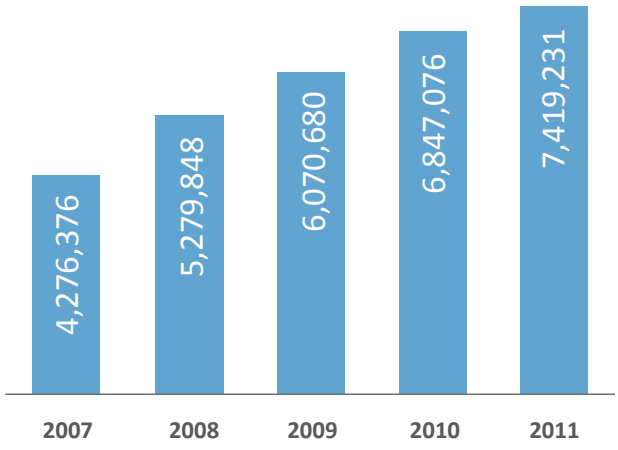
Performance Review for 2011: Report by the Board of Trustees

Performance Review

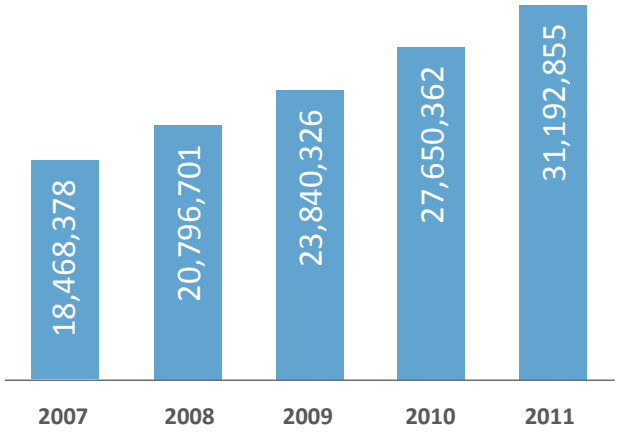
For the year ended 31 December 2011

Financial and performance highlights

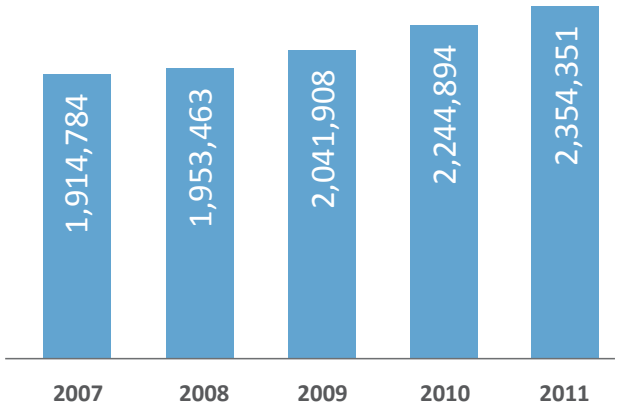
Growth in members' funds
R'000



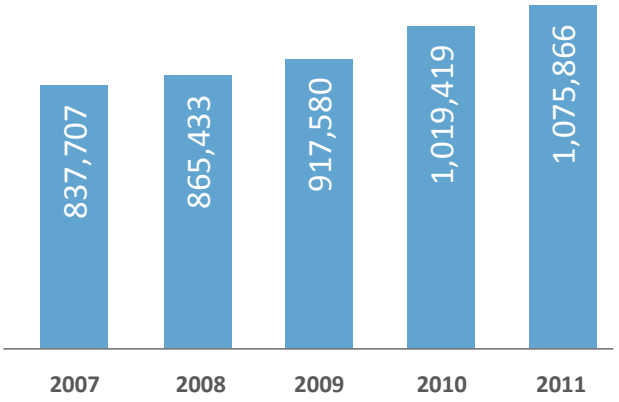
Increase in gross contributions
R'000



Increase in Scheme lives



Increase in Scheme principal members



23.5%	Statutory solvency level	12.8%	Increase in gross contributions
5.5%	Year-on-year growth in principal members	9.2%	Administration fees as % of gross contributions
4.3%	Annualised lapse rate	6.3%	Average return on investments
2,2	Average family size	AA+	Independent credit rating for claims paying ability

Performance Review

For the year ended 31 December 2011

Overview of financial performance

In a year characterised by turmoil in equity and capital markets around the globe, economic uncertainty and escalating healthcare costs, the Scheme experienced a year of robust performance. The membership base continued to increase during the 2011 financial year, with a 10.2% increase in new members, off an already substantial base. The rate of membership leaving the Scheme was only 4.3% resulting in a net membership growth of 5.9% for 2011. The Scheme now provides cover to over 2,3 million lives. This large and diverse membership base provides significant financial, risk and actuarial stability within the Scheme.

The Scheme's net surplus for the current year was R570 million, increasing members' funds to over R7,4 billion. The Scheme's total investments and cash exceeds R9 billion as at the end of the financial year. The Scheme's high level of financial strength and stability was once again confirmed by a credit rating of AA+, the highest possible rating in the industry, by independent credit rating agency Global Credit Rating Co.

The detailed results of the Scheme are set out in the financial statements on pages 78 to 153. The strong overall financial performance and position is attributable to sound governance, stewardship and effective risk management efforts. The Trustees continued their focus on member experience and ensuring that members have access to the highest quality of healthcare benefits.

In line with the Scheme's commitment to reduce administration costs, per member administration fees continue to be deflationary, rising at less than inflation. The Trustees were also able to reduce the 2011 administration fees by R100 million which will be carried forward in setting future administration fees.

The volatility in both local and global markets resulted in the Trustees implementing various strategies to move the Scheme's investment portfolios into defensive positions to reduce the risk of capital loss and a negative impact on solvency. These strategies included entering into forward exchange contracts to mitigate the risk of foreign currency fluctuations as well as a zero-cost short-fence to provide protection for the Scheme's equity portfolios. As at 31 December 2011 these transactions provided adequate protection at an overall portfolio level.

The Scheme continues to offer substantial member flexibility, well-priced plans and comprehensive and effective benefit design compared to its competitors. Stability in both contribution increases and benefit design has been of key importance in an environment characterised by volatile contributions and benefits in many other open medical schemes. As a result, the Scheme continues to grow and experience very low withdrawal rates.

At the end of 2011, the contribution increase was 8.9%. This was one of the lowest increases among South African open medical schemes.

Benefit plans

The Scheme offered 14 benefit plans to members of the public and employers for 2011. These were:

Series	Plan
Executive	Executive
Comprehensive (including the Delta network)	Classic Comprehensive
	Essential Comprehensive
Priority	Classic Priority
	Essential Priority
Saver (including the Delta network)	Classic Saver
	Essential Saver
	Coastal Saver
Core (including the Delta network)	Classic Core
	Essential Core
	Coastal Core
	Foundation Core*
KeyCare	KeyCare Plus
	KeyCare Core

* = The Trustees decided to discontinue the Foundation Core Plan with effect from 1 January 2012.

Performance Review

For the year ended 31 December 2011

Solvency and membership

The Scheme is required to maintain accumulated funds of 25% of gross annual contribution income for the accounting period under review in terms of Regulation 29(2) of the Medical Schemes Act, No 131 of 1998, as amended. As required by Regulation 29(4) of the Medical Schemes Act, the Scheme has informed the Council for Medical Schemes that the solvency level is below the required statutory solvency level of 25%. A business plan detailing the timeline over which the Scheme will increase solvency to 25% has been submitted. The business plan has been approved by the Council for Medical Schemes.

As at 31 December 2011, the Scheme's solvency margin was 23.5%.

Calculation of regulatory capital requirement

	2011 R'000	2010 R'000
Total members' funds per Statement of Financial Position	7,419,231	6,847,076
Less: cumulative unrealised net gain on remeasurement of investments to fair value	(90,436)	(29,739)
Accumulated funds per Regulation 29	7,328,795	6,817,337
Gross contribution income	31,192,855	27,650,362
Solvency margin = Accumulated funds / gross contribution income x 100	**23.50%**	**24.66%**

At 31 December 2011, the Scheme's regulatory capital was R469 million less than the capital requirement imposed by the Regulator.

Annual growth in membership

The Scheme membership continued to increase in 2011 despite tough economic conditions. The Scheme now covers over 2,3 million lives.

Total membership per benefit plan was as follows:

Benefit plan	31 December 2011 principal members	31 December 2011 total lives	31 December 2011 % of total lives	31 December 2010 total lives
Executive Plan	11,810	27,659	1.17	26,846
Classic Comprehensive	186,128	447,796	19.02	449,197
Classic Core	49,782	107,763	4.58	105,881
Classic Saver	185,048	404,702	17.19	364,319
Classic Priority	97,021	223,614	9.50	209,919
Essential Comprehensive	30,375	65,388	2.78	75,375
Essential Core	22,415	48,181	2.05	42,128
Essential Saver	63,756	140,870	5.98	134,636
Essential Priority	9,647	20,369	0.87	20,996
Coastal Saver	145,955	340,623	14.47	322,874
Coastal Core	70,459	157,061	6.67	150,625
Foundation Core	768	1,657	0.07	2,096
KeyCare Plus	187,279	343,811	14.60	313,112
KeyCare Core	15,423	24,857	1.06	26,890
Total	**1,075,866**	**2,354,351**	**100.00**	**2,244,894**

Market share

Membership growth was 5% from the previous year (2010: 11%). The growth was on the backdrop of lower than expected economic growth and hence growth in local employment. The Scheme's share of the open medical scheme market at the end of the current financial year, in terms of membership base, was at 50% (2010, 48%), reflecting its position as the largest and most stable open medical scheme in South Africa. Membership growth for 2012 is expected to be 5%.

Competitive contribution increase

The Scheme's average contribution increase for 2012 is 8.9% across all plans and family sizes. This is in line with or below the industry increase, supporting the Scheme's promise of continued growth, long-term affordability and sustainability.

To protect members from high contribution increases, the Scheme will, in conjunction with its Administrator, continue to develop, implement and measure various alternative reimbursement models with medical service providers. It will also develop and refine its risk management initiatives, whilst ensuring the competitiveness of its product offering and offering comprehensive cover for members' needs at different product price levels.

Performance Review

For the year ended 31 December 2011

Key financial and service metrics

	2011	2010
Members' funds	R7,4 billion	R6,8 billion
Solvency ratio	23.50%	24.66%
Membership (lives)	2,35 million	2,24 million
Gross contribution income	R31,19 billion	R27,65 billion
Risk contribution income	R24,97 billion	R22,12 billion
Average net contributions *per member per month (pmpm)*	R1,985	R1,876
Average net claims *per member per month (pmpm)*	R1,640	R1,527
Average accumulated funds per member at year end	R6,896	R6,970
Average return on investments as a percentage of investments	6.31%	7.49%
Number of hospital admissions	547,705	506,434

2011	New member applications	Customer service call centre	Claims processing	Hospital and walk-in centre visits
Volume	2,716 lives of new business applications are received per day	The Administrator received 34,015 calls per day	Average of 156,127 claims processed per working day	88,037 hospital patients were visited by member liaison managers 68,941 members visited the 4 walk-in centres
Average service delivery	On average applications are processed within 3 days	On average 83.12% of calls received are answered within 20 seconds	1,81 days from receipt to payment for members and 4,76 days for healthcare professionals 0.97% error rate	Average member-based research score out of 10 for member liaison managers increased to 9,37

Prudent financial management

The table below shows the high level of financial control achieved during the year.

Year ended	December 2011 R'000	December 2010 R'000	December 2009 R'000
Gross contributions	31,192,855	27,650,362	23,840,326
Total outstanding - excluding December contributions	8,304	15,315	9,482
% Outstanding	0.03%	0.06%	0.04%

Enhancing healthcare in a complex operating environment

Discovery Health (Pty) Ltd manages key aspects of the operating environment for the Discovery Health Medical Scheme, including the relationships with healthcare professionals and providers of all healthcare services and products. The Trustees of the Scheme monitor the outcomes of various initiatives, as well as the level of healthcare provided to members. The Trustees believe that the Administrator and the Scheme have managed the complex environment most effectively.

Through the Administrator's robust clinical risk management structures, the Scheme aims to balance access to high-quality, affordable healthcare for all members, with cost containment, thereby ensuring the sustainability of the Scheme.

Due application of the Scheme rules

The Trustees keep a constant check on appropriate and consistent application of Scheme rules in relation to beneficiary entitlement and healthcare provider reimbursements. This check is highly important given the large and diverse membership base of the Scheme.

Ensuring statutory and regulatory compliance

The Trustees are committed to ensuring statutory and regulatory compliance, viewing this as one of their most important responsibilities.

The Scheme's external auditors and Audit and Risk Committee, as well as the internal auditors and Compliance Officer, have an ongoing role in monitoring compliance to ensure the Scheme meets all the statutory regulatory requirements.

In addition, the Board of Trustees and the Council for Medical Schemes continue to monitor the Scheme's compliance within the broader regulatory framework.

Performance Review

For the year ended 31 December 2011

Matters of non-compliance for the year ended 31 December 2011

During the year the Scheme did not comply with the following sections and regulations of the Medical Schemes Act, No 131 of 1998, as amended:

Statutory Scheme solvency

In terms of Regulation 29(2) the Scheme must maintain accumulated funds expressed as a percentage of gross annual contributions for the accounting period under review which may be no less than 25%.

At 31 December 2011, the Scheme's accumulated funds expressed as a percentage of gross annual contributions was 23.5% (2010: 24.66%) which is less than the statutory requirement of 25%. The Scheme advised the Council for Medical Schemes during 2011 that one of the main reasons for this remains continuous high membership growth.

The Scheme has submitted a business plan to the Council for Medical Schemes in terms of Regulation 29(4) of the Medical Scheme Act, No 131 of 1998, as amended. The business plan provides that the Scheme will increase the statutory reserves to the required level of 25% by 31 December 2015. The business plan takes into account several assumptions such as membership growth, investment returns and medical inflation. The Council for Medical Schemes has approved the business plan.

Sustainability of benefit plans

In terms of Section 33(2) of the Medical Schemes Act, No 131 of 1998, as amended, each plan is required to be self-supporting in terms of membership and financial performance and be financially sound.

At 31 December 2011 the following benefit plans did not comply with Section 33(2):

Plan	Net underwriting deficit R'000	Net (deficit)/surplus R'000
Executive	(274,569)	(266,874)
Classic Comprehensive	(714,328)	(592,862)
Foundation Core	(2,364)	(1,896)
Coastal Saver	(23,930)	69,085
KeyCare Plus	(354,238)	(240,338)

The Trustees continue to monitor these plans with a view to improving their financial outcomes, and will evaluate different strategies to address the deficits in these plans. The different financial positions reflect the different disease burdens in each plan, among many other factors, and are due in large measure to the continued pattern of sicker members of the Scheme buying up to higher plans when they develop a serious illness. This is reflected in the much higher disease burden and risk profile of the top plans relative to the rest of the Scheme. The Scheme's strategy on the sustainability of plans has to balance short- and long-term financial considerations with considerations of fairness to both healthy and sick members, and with continued affordability of cover for members with different levels of income and different healthcare needs. While the Trustees are committed to complying wherever possible with the applicable legislation, the Scheme also focuses intensively on the overall stability and financial position of the Scheme as a whole and not only on individual benefit plan.

Investments in employer groups

Section 35(8)(a) of the Medical Schemes Act, No 131 of 1998, as amended, states that a medical scheme shall not invest any of its assets in the business of an employer who participates in or any administrator or any arrangement associated with a medical scheme. Due to the large number of the Scheme's employers being listed on the JSE, investments were made in certain of its employers listed on the JSE. The Council for Medical Schemes has granted the Scheme an exemption from this section of the Medical Schemes Act.

Contributions received after due date

Section 26(7) of the Medical Schemes Act, No 131 of 1998, as amended, states that all subscriptions or contributions shall be paid directly to a medical scheme not later than three days after payment thereof becoming due. There are instances where the Scheme received contributions after three days of becoming due. However, there are no contracts in place agreeing to this arrangement. The procedures that the Scheme follows regarding these contributions are set out in Note 31 to the Annual Financial Statements.

Ring-fenced reserves

Regulation 4(4) of the Medical Schemes Act, No 131 of 1998, as amended, prohibits ring-fencing. The funds transferred from the CNA Gallo Medical Scheme (Note 5) meets the definition of ring-fencing. The Scheme has submitted a request for exemption from this regulation to the Council for Medical Schemes. The balance remaining in these reserves at year end was R10 887 and will be fully utilised during the first half of 2012.

Broker fees paid before contributions are received

In terms of Regulation 28(5) of the Medical Schemes Act, No 131 of 1998, as amended, the Scheme broker fees must be paid monthly and on receipt by the Scheme of the relevant monthly contribution. In some instances brokers were compensated prior to receipt of the relevant monthly contribution. The Scheme has implemented additional controls to address this matter and continues to monitor the resulting instances where this requirement was contravened.

Performance Review

For the year ended 31 December 2011

Operational statistics

2011	Executive	Classic Comp	Classic Core	Classic Saver	Classic Priority	Essential Comp	Essential Core	Essential Saver
Number of members at the end of the accounting period	11,810	186,128	49,782	185,048	97,021	30,375	22,415	63,756
Number of beneficiaries at the end of the accounting period	27,659	447,796	107,763	404,702	223,614	65,388	48,181	140,870
Average number of members for the accounting period	11,889	187,683	48,581	179,653	96,053	30,773	20,672	61,111
Average number of beneficiaries for the accounting period	27,871	452,046	105,320	392,586	220,767	66,345	44,807	135,718
Average risk contributions per member per month (R')	4,191	3,371	1,958	1,863	2,259	2,985	1,601	1,644
Average risk contributions per beneficiary per month (R')	1,788	1,399	903	853	983	1,384	739	740
Average net claims incurred per member per month (R')	5,730	3,292	1,260	1,288	1,691	2,244	1,022	996
Average net claims incurred per beneficiary per month (R')	2,444	1,367	581	590	736	1,041	471	448
Average administration costs per member per month (R')	250	255	252	245	249	263	247	252
Average administration costs per beneficiary per month (R')	107	106	116	112	108	122	114	114
Average managed care: management services per beneficiary per month (R')	30	29	32	32	31	33	32	32
Beneficiaries per member at 31 December	2.34	2.41	2.17	2.19	2.30	2.16	2.17	2.22
Dependants per member at 31 December	1.34	1.41	1.17	1.19	1.30	1.16	1.17	1.22
Relevant healthcare expenditure as a percentage of risk contributions (%)	136	97	64	69	75	75	64	61
Non-healthcare expenditure as a percentage of risk contributions (%)	9	12	20	21	17	14	23	23

2011	Essential Priority	Coastal Saver	Coastal Core	Foundation Core	KeyCare Plus	KeyCare Core	Total
Number of members at the end of the accounting period	9,647	145,955	70,459	768	187,279	15,423	**1,075,866**
Number of beneficiaries at the end of the accounting period	20,369	340,623	157,061	1,657	343,811	24,857	**2,354,351**
Average number of members for the accounting period	9,403	143,590	68,234	798	175,488	14,576	**1,048,504**
Average number of beneficiaries for the accounting period	19,889	335,584	152,125	1,738	323,968	23,577	**2,302,341**
Average risk contributions per member per month (R')	2,040	1,546	1,473	1,421	976	845	**1,985**
Average risk contributions per beneficiary per month (R')	964	662	661	652	529	522	**904**
Average net claims incurred per member per month (R')	1,261	1,173	1,066	1,270	957	475	**1,641**
Average net claims incurred per beneficiary per month (R')	596	502	478	583	518	294	**747**
Average administration costs per member per month (R')	257	250	251	280	128	67	**228**
Average administration costs per beneficiary per month (R')	121	107	113	129	69	41	**104**
Average managed care: management services per beneficiary per month (R')	33	30	31	32	38	43	**32**
Beneficiaries per member at 31 December	2.12	2.34	2.23	2.18	1.85	1.62	**2.20**
Dependants per member at 31 December	1.12	1.34	1.23	1.18	0.85	0.62	**1.20**
Relevant healthcare expenditure as a percentage of risk contributions (%)	62	76	72	89	93	56	**82**
Non-healthcare expenditure as a percentage of risk contributions (%)	10	13	21	22	19	14	**24**

Performance Review

For the year ended 31 December 2011

Operational statistics (continued)

2010	Executive	Classic Comp	Classic Core	Classic Saver	Classic Priority	Essential Comp	Essential Core	Essential Saver
Number of members at the end of the accounting period	11,348	185,384	49,135	166,644	91,193	34,493	19,288	59,919
Number of beneficiaries at the end of the accounting period	26,846	449,197	105,881	364,319	209,919	75,375	42,128	134,636
Average number of members for the accounting period	11,376	185,363	47,699	160,432	89,518	33,231	18,074	57,936
Average number of beneficiaries for the accounting period	26,896	449,484	103,061	350,193	205,275	73,032	39,734	130,379
Average risk contributions per member per month (R')	3,892	3,139	1,819	1,739	2,092	2,798	1,525	1,559
Average risk contributions per beneficiary per month (R')	1,646	1,295	842	797	912	1,273	694	693
Average net claims incurred per member per month (R')	5,316	3,019	1,126	1,169	1,566	2,048	982	930
Average net claims incurred per beneficiary per month (R')	2,248	1,245	521	536	683	932	447	413
Average administration costs per member per month (R')	248	252	250	245	248	257	249	251
Average administration cost per beneficiary per month (R')	105	104	116	112	108	117	113	112
Average managed care: management services per beneficiary per month (R')	28	28	31	31	29	30	30	30
Beneficiaries per member at 31 December	2.37	2.42	2.15	2.19	2.30	2.19	2.18	2.25
Dependants per member at 31 December	1.37	1.42	1.15	1.19	1.30	1.19	1.18	1.25
Relevant healthcare expenditure as a percentage of risk contributions (%)	137	96	62	67	75	73	64	60
Non-healthcare expenditure as a percentage of risk contributions (%)	10	13	21	22	19	14	24	24

2010	Essential Priority	Coastal Saver	Coastal Core	Foundation Core	KeyCare Plus	KeyCare Core	TOTAL
Number of members at the end of the accounting period	9,862	137,813	67,910	947	169,067	16,416	**1,019,419**
Number of beneficiaries at the end of the accounting period	20,996	322,874	150,625	2,096	313,112	26,890	**2,244,894**
Average number of members for the accounting period	9,533	135,560	65,575	990	151,621	15,522	**982,431**
Average number of beneficiaries for the accounting period	20,298	317,479	145,597	2,193	281,083	25,313	**2,170,017**
Average risk contributions per member per month (R')	1,904	1,436	1,361	1,330	910	774	**1,876**
Average risk contributions per beneficiary per month (R')	894	613	613	600	491	474	**850**
Average net claims incurred per member per month (R')	1,213	1,059	960	892	875	449	**1,527**
Average net claims incurred per beneficiary per month (R')	570	452	432	403	472	275	**691**
Average administration costs per member per month (R')	253	250	250	265	116	60	**226**
Average administration cost per beneficiary per month (R')	119	107	112	120	63	37	**102**
Average managed care: management services per beneficiary per month (R')	31	29	30	30	36	41	**30**
Beneficiaries per member at 31 December	2.13	2.34	2.22	2.21	1.85	1.64	**2.20**
Dependants per member at 31 December	1.13	1.34	1.22	1.21	0.85	0.64	**1.20**
Relevant healthcare expenditure as a percentage of risk contributions (%)	64	74	71	67	93	58	**81**
Non-healthcare expenditure as a percentage of risk contributions (%)	20	26	27	29	24	21	**19**

Performance Review

For the year ended 31 December 2011

Reserve accounts

Movement in the reserves is set out in the Statement of Changes in Funds and Reserves.

Outstanding claims

Movements in the outstanding claims provision are set out in Note 6 to the Annual Financial Statements.

Medical Savings Account

The Medical Savings Account (MSA) empowers members to manage day-to-day expenses. Members pay an agreed sum of 15% or 25% of their gross contributions, depending on their plan choice, into this savings account. The full annual amount is available for use immediately, although members only contribute towards this monthly. The Medical Savings Account provides a variety of benefits to members for medical expenses outside of hospital, such as day-to-day medicines, visits to GPs and specialists, dental care and optometry.

The balance remaining in the Medical Savings Account at the end of each calendar year is carried over to the following year for the benefit of the member.

The Scheme's liability to members in respect of the savings account is reflected as a current liability in the Annual Financial Statements (Note 8) and is repayable in terms of Regulation 10 of the Medical Schemes Act, No 131 of 1998, as amended.

Going concern

The Board of Trustees is satisfied that the Scheme has adequate resources to continue its operations in the near future. The Scheme's financial statements have accordingly been prepared on the going-concern basis.

Auditor independence

The Scheme's financial statements have been audited by independent auditors PricewaterhouseCoopers Inc.
The Scheme believes that the external auditors have observed the highest level of business and professional ethics. It has no reason to believe that the external auditors have not at all times acted with unimpaired independence and the Audit and Risk Committee is satisfied that the auditor was independent of the Scheme.

Details of fees paid to the external auditors for audit services are included in the Annual Financial Statements.
The Scheme has accepted a policy governing non-audit service. The fees have also been disclosed and discussed with the Audit and Risk Committee.

The Trustees are responsible for the preparation, integrity and fair presentation of the Annual Financial Statements of the Discovery Health Medical Scheme (the Scheme). The Annual Financial Statements set out on pages 78 to 153 have been prepared in accordance with International Financial Reporting Standards and include amounts based on judgements and estimates made by management.

Annual Financial Statements

Annual Financial Statements

Statement of Responsibility by the Board of Trustees

For the year ended 31 December 2011

The Trustees are responsible for the preparation, integrity and fair presentation of the Annual Financial Statements of the Discovery Health Medical Scheme (the Scheme). The Annual Financial Statements set out on pages 78 to 153 have been prepared in accordance with International Financial Reporting Standards and include amounts based on judgements and estimates made by management.

The Trustees consider that in preparing the Annual Financial Statements they have used the most appropriate accounting policies, consistently applied, and that all applicable International Financial Reporting Standards 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 also reviewed the other information included in the Annual Report and are responsible for both its accuracy and its consistency with the Annual Financial Statements.

The Trustees are responsible for ensuring that accounting records are kept. The accounting records should disclose with reasonable accuracy the financial position of the Scheme to enable the Trustees to affirm that the financial statements comply with the relevant legislation.

The Scheme operated in a well-established control environment, which is well documented and regularly reviewed. This incorporates risk management and internal control procedures, which are designed to provide reasonable, but not absolute, assurance that assets are safeguarded and the risks facing the business are being controlled.

The going-concern basis has been adopted in preparing the Annual Financial Statements. The Trustees have no reason to believe that the Scheme will not be a going concern in the foreseeable future, based on forecasts and available cash resources. These financial statements support the viability of the Scheme.

The Code of Corporate Practices and Conduct has been adhered to. The Scheme's external auditors, PricewaterhouseCoopers Incorporated, audited the Annual Financial Statements, and their report is presented on pages 76 to 77.

The Annual Financial Statements were approved by the Board of Trustees on 17 April 2012 and are signed on its behalf by:



Adv M van der Nest Chairperson	**Dr N Sangweni** Deputy Chairperson	**M Streak** Principal Officer

Annual Financial Statements

Report of the Audit and Risk Committee

For the year ended 31 December 2011

We are pleased to present our report for the financial year ended 31 December 2011. The Audit and Risk Committee (the Committee) is an independent statutory committee. Duties are delegated to the Committee by the Board of Trustees.

Audit and Risk Committee terms of reference

The Committee has adopted formal terms of reference that have been approved by the Board of Trustees and are reviewed at least annually. The Committee has conducted its affairs in compliance with its terms of reference and has discharged the responsibilities contained therein.

Audit and Risk Committee members, meeting attendance and assessment

The Committee consists of three independent members and two Trustee members and meets at least four times a year.

The executive officers of the Scheme and representatives of the Administrator attend meetings or parts of meetings by invitation. Internal Audit and the external auditor attend meetings or parts of meetings by invitation and meet with the Committee after each meeting without the Administrator present.

The membership, qualifications and attendance of the members of the Committee are as follows:

Committee member	Qualifications	Number of meetings held during the financial year	Number of meetings attended
D Eriksson (Chairperson)	CA (SA)	5	5
N Novick	CA (SA)	5	4
S Green	BSc (Hons)	5	5
B Stott (Trustee)	CTA (Wits), CA (SA)	5	4
G Waugh (Trustee)****	FIA, FASSA	5	2
S Handler (Trustee)***	BCom, FFA, FASSA	5	2

= Resigned on 16 August 2011. *= Appointed on 7 July 2011.

The effectiveness of the Committee and its individual members has been assessed.

Role and responsibilities

Statutory duties

The Committee's role and responsibilities include statutory duties as per the Medical Schemes Act, No 131 of 1998, as amended, and further responsibilities assigned to it by the Board.

The Committee executed its duties in accordance with its terms of reference and applicable laws and regulations in force during the financial year.

External auditor appointment and independence

The Committee considered the matters set out in Section 36 of the Medical Schemes Act, No 131 of 1998, as amended, and nominated PricewaterhouseCoopers Inc for appointment as external auditor of the Scheme.

The Committee has satisfied itself that the external auditor is independent of the Scheme as set out in Section 36(3) of the Medical Schemes Act, No 131 of 1998, as amended. Requisite assurance was sought and provided by the auditor that internal governance processes within the audit firm support and demonstrate its claim to independence.

The Committee ensured that the appointment of the auditor at the Annual General Meeting complied with the Medical Schemes Act, No 131 of 1998, as amended, and any other legislation relating to the appointment of auditors.

The Committee, following consultation with the Scheme's executive officers, approved the engagement letter, terms, audit plan and budgeted audit fees for the year ended 31 December 2011.

There is a formal policy in respect of the provision of non-audit services by the external auditors of the Scheme, and a formal procedure governs the process whereby the auditor is appointed to provide any non-audit services. The Chairperson of the Committee approves the nature and extent of any non-audit services that the external auditor provides in terms of the agreed pre-approval policy. A schedule of approved non-audit services is reviewed annually by the Committee.

Financial statements and accounting practices

The Committee has reviewed the accounting policies and the Scheme's Annual Financial Statements and is satisfied that they are appropriate and comply with International Financial Reporting Standards.

Internal financial controls

The Committee is responsible for assessing the Scheme's system of internal financial and accounting control. In this regard the Committee has, inter alia, evaluated the adequacy and effectiveness of the Scheme's systems of internal control and made appropriate recommendations to the Board. This has included a formal documented review by the Internal Audit function of the design, implementation and effectiveness of the Administrator's system of internal financial controls pertaining to the Scheme. Based on the results of this review, it is the view of the Committee that High Assurance* can be placed on the adequacy and effectiveness of the Scheme's internal financial controls, relative to the fair presentation of the Annual Financial Statements.

**High Assurance = The existing control framework provides a high level of assurance that material risks are identified and well managed to ensure that business objectives will be achieved. No significant improvements are required.*

Annual Financial Statements

Report of the Audit and Risk Committee

For the year ended 31 December 2011

Evaluation of the expertise and experience of the Administrator's finance function pertaining to the Scheme

The Committee reviewed and satisfied itself of the appropriateness of the expertise, resources and experience of the Administrator's finance function pertaining to the Scheme.

Whistle-blowing

The Committee receives and deals with any concerns or complaints, whether from within or outside the Scheme, relating to the accounting practices and Internal Audit of the Scheme, the content or auditing of the Scheme's financial statements, the internal financial controls of the Scheme and related matters. The Administrator's forensics department assists the Committee in discharging this responsibility. No such concerns or complaints were received during the year.

Ethics and compliance

The Committee is responsible for reviewing any major breach of the relevant Scheme charters and codes, and relevant legal, regulatory and other obligations. The Committee is satisfied that there has been no material breach of these standards or material non-compliance with laws and regulations except for the following two matters of material non-compliance with the Medical Schemes Act:

- Note 33 of the Annual Financial Statements indicates that the Scheme did not comply with Regulation 29(2) of the Medical Schemes Act. The accumulated funds required of 25% of annual contributions had not been met at 31 December 2011. The ratio of accumulated funds expressed as a percentage of gross annual contributions was 23.50%. The Scheme has notified the Council for Medical Schemes and submitted a business plan detailing the period over which the Scheme will increase the reserves to meet the required solvency ratio of 25%. This business plan has been approved by the Council for Medical Schemes. The required solvency level as set out in the business plan at 31 December 2011 is 23.50%.
- Note 33 also details the disclosure in respect of five of the Scheme's 14 benefit plans which were not self-sustaining as at 31 December 2011 as required by Section 33(2) of the Medical Schemes Act.

Risk management

The Committee monitors the risk management processes and systems of internal control for the Scheme through review of reports from and discussions with the Scheme's internal and external auditors and the risk management function.

The Committee is satisfied that the system and process of risk management is effective.

Going concern

The Committee took note of the positive solvency and liquidity position of the Scheme. The Scheme's members' funds exceed R7,14 billion with cash and money market investments exceeding R7,5 billion.

After taking the above into consideration as well as the current net surplus and the budgeted results for the financial year ending 31 December 2012, the Audit and Risk committee considers that:

- The Scheme's assets currently exceed its liabilities
- The Scheme will be able, in the ordinary course of the Scheme's business to settle its liabilities as they arise for the foreseeable future

The Committee agreed that the Board of Trustees could be advised that based on the assessment conducted that there is no reason to believe that the Scheme will not be a going concern in the foreseeable future.

Opinion

Based on the information and explanations given by the Scheme's management, the Administrator and discussions with the independent external auditor regarding the results of their audit, the Committee is satisfied that there was no material breakdown in the internal accounting controls during the financial year under review.

The Committee has evaluated the Scheme's Annual Financial Statements for the year ended 31 December 2011 and, based on the information provided to the Committee, considers that the Scheme complies, in all material respects, with the requirements of the Medical Schemes Act, No 131 of 1998, as amended, and International Financial Reporting Standards.

The Committee has recommended the Annual Financial Statements to the Board for approval. The Board has subsequently approved the Annual Financial Statements which will be open for discussion at the forthcoming Annual General Meeting.

D Eriksson
Chairperson: Audit and Risk Committee

17 April 2012

Annual Financial Statements

Independent Auditor's report to the members of the Discovery Health Medical Scheme

For the year ended 31 December 2011

Report on the financial statements

We have audited the annual financial statements of the Discovery Health Medical Scheme which comprise the Statement of Financial Position as at 31 December 2011, Statement of Comprehensive Income, Statement of Changes in Funds and Reserves and Statement of Cash Flows for the year then ended, and a summary of significant accounting policies and other explanatory notes as set out on pages 78 to 153.

Trustees' responsibility for the financial statements

The Scheme's Trustees are responsible for the preparation and fair presentation of these financial statements in accordance with International Financial Reporting Standards and in the manner required by the Medical Schemes Act, No 131 of 1998, as amended, and for such internal control as the Trustees determine it necessary to enable the preparation of financial statements that are free from material misstatements, whether due to fraud or error.

Auditor's responsibility

Our responsibility is to express an opinion on these financial statements based on our audit. We conducted our audit in accordance with International Standards on Auditing. Those standards require that we comply with ethical requirements and plan and perform the audit to obtain reasonable assurance that the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgement, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal controls relevant to the entity's preparation and fair presentation of the financial statements 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 entity's internal control. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

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

Opinion

In our opinion, the financial statements present fairly, in all material respects, the financial position of the Discovery Health Medical Scheme as at 31 December 2011 and its financial performance and cash flows for the year then ended in accordance with International Financial Reporting Standards and in the manner required by the Medical Schemes Act, No 131 of 1998, as amended.

Report on other legal and regulatory requirements

As required by the Council for Medical Schemes, we report the following instances of non-compliance with the Medical Schemes Act, which we consider to be material:

Note 33 indicates that the Scheme did not comply with Regulation 29(2) of the Medical Schemes Act, No 131 of 1998, as amended. The accumulated funds required of 25% of annual contributions had not been met as at 31 December 2011. The ratio of accumulated funds, expressed as a percentage of gross annual contributions, was 23.50% as at 31 December 2011, short of the required minimum of 25%.

Furthermore we draw attention to the detailed disclosure in Note 33 with respect to five of the 14 benefit plans which were not self-sustaining during 2011 as required by Section 33(2) of the Medical Schemes Act, No 131 of 1998, as amended.

PricewaterhouseCoopers Inc
Director: V Muguto
Registered Auditor
2 Eglin Road, Sunninghill, Johannesburg
24 April 2012

Annual Financial Statements

Statement of Financial Position

As at 31 December 2011

	Notes	2011 R'000	2010 R'000
ASSETS			
Current assets		10,580,460	9,791,908
Financial assets at fair value through profit or loss	2	8,012,078	7,383,719
Derivative financial instruments	7	23,424	15
Trade and other receivables	3	1,318,307	1,135,271
Cash and cash equivalents	4	1,226,651	1,272,903
Total assets		**10,580,460**	**9,791,908**
FUNDS AND LIABILITIES			
Members' funds		7,419,231	6,847,076
Accumulated funds		7,419,231	6,847,076
Current liabilities		3,161,229	2,944,832
Outstanding claims provision	6	567,845	560,597
Derivative financial instruments	7	2,218	-
Members' savings accounts	8	1,930,591	1,718,442
Trade and other payables	9	660,564	665,443
Members' trust funds	5	11	350
Total funds and liabilities		**10,580,460**	**9,791,908**

Annual Financial Statements

Statement of Comprehensive Income

For the year ended 31 December 2011

	Notes	2011 R'000	2010 R'000
Net contribution income	10	**24,972,943**	**22,121,964**
Net claims incurred	11	(20,651,339)	(17,999,084)
Claims incurred		(20,777,150)	(18,089,129)
Third-party claim recoveries		125,811	90,045
Net income on risk transfer arrangements	12	142,036	48,924
Risk transfer arrangement fees		(229,132)	(169,965)
Recoveries from risk transfer arrangements		371,168	218,889
Relevant healthcare expenditure		**(20,509,303)**	**(17,950,160)**
Gross healthcare result		**4,463,640**	**4,171,804**
Managed care: management services	13	(882,883)	(787,872)
Broker service fees	14	(688,812)	(633,601)
Expenses for administration		(2,863,572)	(2,666,663)
Other operating expenses	15	(105,973)	(108,561)
Net healthcare result		**(77,600)**	**(24,893)**
Investment income	20	565,296	615,406
Net fair value gains / (losses) on financial assets at fair value through profit or loss	21	109,248	22,837
Sundry income	22	4,930	9,020
Other income		**679,474**	**647,263**
Expenses for asset management services rendered		(11,956)	(8,469)
Interest paid	23	(19,508)	(19,829)
Other expenditure		**(31,464)**	**(28,298)**
Net surplus for the year		**570,410**	**594,072**
Other comprehensive income		-	-
Total comprehensive income for the year		**570,410**	**594,072**

Annual Financial Statements

Statement of Changes in Funds and Reserves

For the year ended 31 December 2011

	Note	2011 R'000 Accumulated funds	2010 R'000 Accumulated funds
Balance at the beginning of the year		6,847,076	6,070,680
Total comprehensive income for the year		570,410	594,072
Reserves transferred from other medical schemes	24	1,745	182,324
Balance at the end of the year		**7,419,231**	**6,847,076**

Annual Financial Statements

Statement of Cash Flows

For the year ended 31 December 2011

	Notes	2011 R'000	2010 R'000
CASH FLOWS FROM OPERATING ACTIVITIES			
Cash flows from operations before working capital changes	28	(47,125)	13,151
Working capital changes			
Increase in trade and other receivables		(220,563)	(344,194)
Increase in outstanding claims provision		7,248	87,085
Increase in members' savings accounts		212,149	174,340
(Decrease) / increase in trade and other payables		(4,878)	156,474
Cash (utilised) / generated by operations		(53,169)	86,856
Purchases of financial instruments		(2,032,830)	(6,190,385)
Proceeds from sale of financial instruments		1,492,527	5,474,504
Interest received	28	554,426	609,240
Dividend income	20	10,896	6,457
Interest paid	23	(19,508)	(19,829)
Net cash flows from operating activities		**(47,658)**	**(33,157)**
CASH FLOWS FROM FINANCING ACTIVITIES			
Payments out of members' trust funds		(339)	(320)
Reserves transferred from other medical schemes	24	1,745	182,324
Net cash flows from financing activities		**1,406**	**182,004**
NET (DECREASE) / INCREASE IN CASH AND CASH EQUIVALENTS		(46,252)	148,847
Cash and cash equivalents at the beginning of the year		1,272,903	1,124,056
CASH AND CASH EQUIVALENTS AT THE END OF THE YEAR	4	**1,226,651**	**1,272,903**

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Accounting Policies

For the year ended 31 December 2011

GENERAL INFORMATION

The Discovery Health Medical Scheme (the Scheme) offers the insurance of hospital, chronic illness and day-to-day cover benefits and is administered by Discovery Health (Pty) Ltd, a wholly-owned subsidiary of Discovery Holdings Limited, listed in the insurance sector of the Johannesburg Stock Exchange (JSE).

The Scheme is an open medical scheme registered in terms of the Medical Schemes Act, No 131 of 1998, as amended, and is domiciled in South Africa. The Scheme was awarded AA+ for its claims-paying ability - the highest rating in the industry - by independent credit rating agency Global Credit Ratings Co for the eleventh consecutive year.

These Annual Financial Statements were authorised for issue by the Board of Trustees on 17 April 2012.

1 BASIS OF PREPARATION

The Annual Financial Statements have been prepared in accordance with International Financial Reporting Standards (IFRS), which are set by the International Accounting Standards Board (IASB). The Annual Financial Statements are also prepared in accordance with the Medical Schemes Act, No 131 of 1998, as amended, which requires additional disclosures for medical schemes.

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

The preparation of financial statements in conformity with IFRS requires the use of certain critical accounting estimates. It also requires management to exercise its judgment in the process of applying the Scheme's accounting policies. The areas involving a higher degree of judgment, or areas where estimates are significant to the Annual Financial Statements, are disclosed in Note 32.

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

- Financial instruments at fair value through profit or loss
- Derivative financial instruments carried at fair value through profit or loss.

All monetary information and figures presented in these financial statements are stated in thousands of Rand (R'000), unless otherwise indicated.

New standards, amendments and interpretations effective in 2011 and relevant to the Scheme:

- IAS 24 (amendment) – Related Party Disclosures (Amendments to the definition of related party which has not materially impacted the Scheme's related party disclosure. The amendment also modifies certain related party disclosures for government-related entities. However, this section is not relevant for the Scheme) – Effective 1 Jan 2011.
- IFRS 7 (amendment) – Financial Instruments (Disclosure – The amendment adds an explicit statement that qualitative disclosure should be made in the context of the quantitative disclosures to better enable users to evaluate an entity's exposure to risks arising from financial instruments) – Effective 1 Jan 2011.
- IFRS 7 (amendment) – Financial Instruments (Disclosure - Credit risk disclosure, the amendment clarifies disclosure for maximum exposure to credit risk, while enhancing the disclosure required for collateral held as security) – Effective 1 Jan 2011.

New standards, amendments and interpretations effective in 2011 but not relevant to the Scheme:

- IFRS 1 (amendment) – First-time Adoption of International Financial Reporting Standards – Effective 1 Jan 2011.
- IFRS 3 (amendment) – Business Combinations (Transition requirements for contingent consideration from a business combination that occurred before the effective date of the revised IFRS) – Effective 1 Jan 2011.
- IFRS 3 (amendment) – Business Combinations (Measurement of non-controlling interest) – Effective 1 Jan 2011.
- IFRS 3 (amendment) – Business Combinations (Un-replaced and voluntarily replaced share-based payment awards) – Effective 1 Jan 2011.
- IFRS 7 (amendment) – Disclosures – Transfers of financial assets – Effective 1 Jul 2011.
- IAS 1 (amendment) – Presentation of Financial Statements (Clarification that disaggregation of changes in each component of equity arising from transactions recognised in other comprehensive income is also required to be presented in either the Statement of Changes in Equity or in the notes) – Effective 1 Jan 2011.
- IAS 34 (amendment) – Interim Financial Reporting (Clarification of disclosure requirements around significant events and transactions including financial instruments. The Scheme does not prepare interim financial reports, therefore this amendment would not be relevant) – Effective 1 Jan 2011.
- IFRIC 13 (interpretation) – Customer Loyalty Programmes – Effective 1 Jan 2011.
- IFRIC 14 (amendment) – Pre-payments of a minimum funding requirement – Effective 1 Jan 2011.

Annual Financial Statements

Accounting Policies

For the year ended 31 December 2011

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

- IFRS 9 (new standard) – Financial Instruments (This is the first standard issued as part of a wider project to replace IAS 39. The standard simplifies the mixed measurement model and established two primary measurement categories for financial assets: amortised cost and fair value. The basis of classification depends on the entity's business model and the contractual cash-flow characteristics of the financial asset) – Effective 1 Jan 2015.
- IFRS 13 (new standard) – Fair Value Measurement (This standard replaces the fair value measurement guidance contained in individual IFRS with a single source of fair value measurement guidance. It defines fair value, establishes a framework for measuring fair value and sets out disclosure requirements for fair value measurement. It explains how to measure fair value when required or permitted by other IFRS) – Effective 1 Jan 2013.

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

- IFRS 1 (amendment) – Severe hyperinflation and removal of fixed dates for first-time adopters – Effective 1 Jan 2012.
- IFRS 10 (amendment) – Consolidated financial statements – Control - Effective 1 Jul 2013.
- IFRS 11 (amendment) – Joint arrangements – Joint ventures and joint operations – Effective 1 Jul 2013.
- IFRS 12 (amendment) – Disclosure of interest in other entities – Effective 1 Jul 2013.
- IAS 1 (amendment) – Presentation of items in other comprehensive income – Effective 1 Jul 2012.
- IAS 1 (amendment) – Employee benefits actuarial gains and losses – Effective 1 Jul 2013.
- IAS 12 (amendment) – Income taxes – Effective 1 Jan 2012.
- IAS 19 (amendment) – Employee benefits (Defined benefit pension) – Effective 1 Jan 2013.
- IAS 27 (amendment) – Consolidated and separate financial statements – Effective 1 Jan 2013.
- IAS 28 (amendment) – Investments in associates – Effective 1 Jul 2013.
- IFRIC 20 (interpretation) – Stripping costs in the production phase of surface mining – Effective 1 Jan 2013.

2 CLASSIFICATION, RECOGNITION, PRESENTATION AND DERECOGNITION OF FINANCIAL INSTRUMENTS

The Scheme recognises a financial instrument when, and only when, it becomes a party to the contractual provisions of the instrument. The Scheme classifies its financial instruments into the following categories: financial assets or financial liabilities at fair value through profit or loss and loans and receivables. The Scheme has grouped its financial instruments into the following classes of financial assets and financial liabilities:

Financial assets

- Listed equities
- Money market instruments
- Derivatives held for trading
- Trade and other receivables
- Cash and cash equivalents.

Financial liabilities

- Members' trust funds
- Trade and other payables
- Members' savings accounts.

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

Offsetting financial instruments

Where a legally enforceable right to set off exists, for recognised financial assets and financial liabilities; and there is an intention to realise the asset and settle the liability simultaneously or to settle on a net basis.

The Scheme will disclose the net asset or liability in the Statement of Financial Position or accompanying notes if the above conditions are met.

Derecognition of financial assets and liabilities

The Scheme derecognises a financial asset or part of a financial asset when:

- The contractual right to the cash flows from the asset expires
- The Scheme retains the contractual right to receive cash flows of the asset, but assumes the obligation to pay one or more third parties the cash flow without material delay
- The Scheme transfers the asset, while transferring substantially all the risks and rewards of ownership
- The Scheme neither transfers the financial asset nor retains significant risk and reward of ownership, but has transferred control of the financial asset.

The Scheme derecognises a financial liability when the obligation under the liability is discharged, cancelled or expires.

When an existing financial liability is replaced by another from the third party on substantially different terms or the terms of an existing liability are substantially modified, such exchange or modification is treated as a derecognition of the original liability and the recognition of a new liability, and the difference in the respective carrying amounts is recognised in the profit or loss section of the Statement of Comprehensive Income.

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Accounting Policies

For the year ended 31 December 2011

3 FINANCIAL ASSETS

Financial assets at fair value through profit or loss

The Scheme recognises a financial asset when any of the following conditions are met:

- The asset is acquired principally for the purpose of selling in the near term
- The portfolio of assets are traded for short-term profit
- A derivative that is not designated as an effective hedge
- Upon initial recognition the Scheme designated the asset as fair value through profit or loss.

Financial assets at fair value through profit or loss are initially recognised at fair value and the transaction costs are expensed in the profit or loss section of the Statement of Comprehensive Income.

Gains or losses arising from subsequent changes in fair value are recognised in the profit or loss section of the Statement of Comprehensive Income within the period in which they arise.

Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments that are not quoted in an active market, other than those the Scheme intends to sell in the short term.

Loans and receivables are initially recognised at fair value plus transaction costs and subsequently measured at amortised cost using the effective interest method, less provision for impairment. The Scheme's loans and receivables comprise trade and other receivables and cash and cash equivalents.

4 FOREIGN CURRENCY TRANSLATION

Functional and presentation currency

The functional and presentation currency of the Scheme is the South African Rand (R).

Transactions and balances

Foreign currency transactions are translated into the functional currency using the exchange rates prevailing at the dates of the transactions. Foreign exchange gains and losses resulting from the settlement of such transactions and from the translation at year-end exchange rates of monetary assets denominated in foreign currencies are recognised in the Statement of Comprehensive Income.

5 SCHEME AMALGAMATIONS

Scheme amalgamations are accounted for by applying the acquisition method.

The cost of an amalgamation is measured as the fair value of the assets transferred and liabilities incurred or assumed at the date of exchange, plus costs directly attributable to the acquisition.

When an entity is amalgamated into the Scheme, all identifiable assets, liabilities and members' funds are accounted for at their fair values at the acquisition date. No consideration is paid for these transactions and they are recognised as from the transaction date.

The Scheme recognises the net assets from amalgamated schemes as a direct addition to reserves in its Statement of Financial Position.

Section 63(14) of the Medical Schemes Act , No 131 of 1998, prescribes that assets and liabilities of the parties to amalgamations shall vest and become binding upon the party which the transfer effected.

No goodwill is recognised on the amalgamation of schemes.

6 CASH AND CASH EQUIVALENTS

In the Statement of Cash Flows, cash and cash equivalents comprise:

- Coins and bank notes
- Money on call and short notice
- Balances with banks.

Cash and cash equivalents only include items held for the purpose of meeting short-term cash commitments rather than for investing or other purposes. Cash and cash equivalents have a maturity of less than three months and insignificant risk of changes in fair value. Cash and cash equivalents are carried at cost which, due to their short-term nature, approximates fair value.

7 IMPAIRMENT OF FINANCIAL ASSETS

Financial assets carried at amortised cost

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

Objective evidence that a financial asset or group of financial assets is impaired includes observable data that comes to the attention of the Scheme regarding the following loss events:

- Significant financial difficulty of service provider or member debtors
- Breach of contract, such as non-payment of member contributions when due and if these remain unpaid for extended periods
- Default or delinquency in payments due by service providers and other debtors
- 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 attributed to 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.

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

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

When a receivable is uncollectable, it is written off against the related provision for impairment. Such receivables are written off after all the necessary procedures have been completed and the amount of the loss has been determined. Subsequent recoveries of amounts previously written off decrease the amount of the provision for impairment in the Statement of Comprehensive Income.

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

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For the year ended 31 December 2011

8 MEMBERS' FUNDS

The funds represent the accumulated funds of the medical scheme. The funds are mainly held as statutory reserves in lieu of the solvency requirements as stipulated by the Medical Schemes Act, No 131 of 1998.

9 FINANCIAL LIABILITIES

Financial liabilities are initially recognised at fair value net of transaction costs incurred. After initial recognition the financial liabilities are measured at amortised cost, using the effective interest rate method. In addition, the Scheme is not permitted to borrow, in terms of Section 35(6)(c) of the Medical Schemes Act, No 131 of 1998, as amended. The Scheme therefore has no long-term financial liabilities.

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

Trade payables

Trade payables are obligations to pay for goods or services that have been acquired in the ordinary course of business from suppliers. Trade payables are classified as current liabilities if payment is due within one year or less. If not, they are presented as non-current liabilities.

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

Members' savings accounts

Members' savings accounts mainly comprise savings plan contributions which are a deposit component of the insurance contracts. The deposit component has been unbundled since the Scheme can measure the deposit component separately and the Scheme's accounting policies do not otherwise require recognition of all obligations and rights arising from the deposit component.

Members' savings accounts represent a financial liability for funds held on behalf of members by the Scheme. The savings account facility assists members in managing cash flows for costs to be borne by them during the year and meeting provider service expenses not covered by the Scheme's approved benefits.

The savings accounts contain a demand feature and are initially measured at fair value plus transaction costs, which is the amount payable to a member on demand, discounted from the first date that the amount could be required to be paid. Subsequent to initial measurement, the liability is measured at amortised cost using the effective interest method. Savings account contributions are credited on the accrual basis and withdrawals are debited on a cash basis. No deduction is made for claims incurred but not reported at year-end.

Unspent savings at year-end are carried forward to meet future expenses for which the members are responsible. In terms of the Medical Schemes Act, No 131 of 1998, as amended, balances standing to the credit of members are refundable only in terms of Regulation 10 of the Act.

Interest payable on members' savings accounts is expensed when incurred.

10 PROVISIONS

The Scheme recognises a provision once the following conditions are met:

- It has a present legal or constructive obligation as a result of past events
- It is probable that an outflow of resources embodying economic benefits will be required to settle the obligation
- A reliable estimate of the amount of the obligation can be made.

Provisions are measured as the present value of management's best estimate of the expenditure required to settle the obligation at the reporting date. Where the effect of discounting to present value is material, provisions are adjusted to reflect the time value of money.

Outstanding claims provision

Claims outstanding comprise provisions for the Scheme's estimate of the ultimate cost of settling all claims incurred but not yet reported at the reporting date. Claims outstanding are determined as accurately as possible based on a number of factors. These include previous experience in claims patterns, claims settlement patterns, trends in claims frequency, changes in the claims processing cycle, and variations in the nature and average cost incurred per claim.

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

Estimated co-payments and payments from members' savings accounts are deducted in calculating the outstanding claims provision. The Scheme does not discount its provision for outstanding claims since the effect of the time value of money is not considered material.

11 CONTINGENT LIABILITY

The Scheme will disclose a contingent liability if one of the following conditions are met:

- A possible obligation arising from past events, the existence of which will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the Scheme
- A present obligation that arises from past events but is not recognised because:
  - It is not probable that an outflow of resources will be required to settle an obligation; and
  - The amount of the obligation cannot be measured with sufficient reliability.

12 MEMBER INSURANCE CONTRACTS

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

The contracts issued compensate the Scheme's members for healthcare expenses incurred and are detailed in Note 30.

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Accounting Policies

For the year ended 31 December 2011

13 CONTRIBUTION INCOME

Gross contributions comprise medical contributions and Medical Savings Account contributions.

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

14 RELEVANT HEALTHCARE EXPENDITURE

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

14.1 Claims incurred

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

Net risk claims incurred comprise:

- Claims submitted and accrued for services rendered during the year
- Payments under provider contracts for services rendered to members
- Over- or under-provisions relating to prior-year claims accruals
- Claims incurred but not yet reported
- Claims settled in terms of risk transfer arrangements.

Net of:

- Claims from members' savings accounts
- Recoveries from members for co-payments
- Recoveries from third parties
- Discount received from service providers.

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

14.2 Risk transfer arrangements

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

Risk transfer arrangement fees (including Managed care: healthcare services) are recognised as an expense over the indemnity period on a straight-line basis.

The claims incurred under member insurance contracts and the equivalent claims recoveries are presented in the Statement of Comprehensive Income on a gross basis. Amounts recoverable under such contracts are therefore recognised in the same year as related claims. The claims incurred liability under risk transfer arrangements and the equivalent receivable are also presented in the Statement of Financial Position on a gross basis.

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

Amounts recoverable under risk transfer arrangements are assessed for impairment at each reporting date. These assets are deemed impaired if there is objective evidence, as a result of an event that occurred after its initial recognition, that the Scheme may not recover all amounts due and that the event has a reliably measurable impact on the amounts that the Scheme will receive under the risk transfer arrangement. The Scheme gathers the objective evidence that a risk transfer arrangement asset is impaired using the same process adopted for financial assets held at amortised cost. The impairment loss is also calculated following the same method used for these financial assets. These processes are described in Accounting Policy Note 7.

15 LIABILITY ADEQUACY TEST

Liability adequacy tests are performed to ensure the adequacy of the member insurance contract liabilities as at the reporting date. In performing these tests, current estimates of future cash flows under the Scheme's insurance contracts are used. Any deficiency is immediately recognised in the Scheme's surplus or deficit.

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Accounting Policies

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16 MANAGED CARE: MANAGEMENT SERVICES FEES

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

17 BROKER SERVICE FEES

Broker service fees are expensed as incurred.

18 EXPENSES FOR ADMINISTRATION AND OTHER OPERATING EXPENSES

Expenses for administration and other operating expenses are expensed as incurred.

19 INVESTMENT INCOME

Investment income comprises dividends received and accrued on investments and interest on cash and cash equivalents.

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

20 REIMBURSEMENTS FROM THE ROAD ACCIDENT FUND

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, administered in terms of the Road Accident Fund Act, No 56 of 1996. If members are reimbursed by the Road Accident Fund, they are obliged contractually to cede that payment to the Scheme to the extent that they have already been compensated.

Due to the uncertainty around the confirmation and measurability of the Road Accident Fund amounts, the Scheme accounts for these amounts on a cash basis and recognises them as a reduction of net claims incurred.

21 UNALLOCATED FUNDS

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

Unallocated funds that have legally prescribed (funds older than three years) are written back and are included under sundry income on the face of the Statement of Comprehensive Income.

A liability for unallocated funds that have not legally prescribed is recognised and disclosed under trade and other payables. Initially the liability is measured at its fair value plus transaction costs. Subsequent to initial measurement, the liability is measured at amortised cost using the effective interest method.

22 EMPLOYEE BENEFITS

Pension obligations

All employees of the Scheme are members of defined contribution plans. A defined contribution plan is a pension plan under which the Scheme pays fixed contributions into a separate entity.

The Scheme has no legal or constructive obligations to pay further contributions if the fund does not hold sufficient assets to pay all employees the benefits relating to employee service in the current and prior periods. The Scheme has no further payment obligations once the contributions have been paid. Contributions to the defined contribution funds are recognised in the net surplus or deficit for the year in which they are incurred.

Other post-employment obligations

The Scheme has no liability for the post-retirement medical benefits of employees.

Leave pay accrual

The Scheme recognises in full employees' rights to annual leave entitlement in respect of past service.

Bonuses

Management and staff bonuses are recognised as an expense in staff costs as incurred.

23 INCOME TAX

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

Annual Financial Statements

Accounting Policies

For the year ended 31 December 2011

24 ALLOCATION OF INCOME AND EXPENDITURE TO BENEFIT PLANS

The following items are directly allocated to benefit plans:

- Contribution income
- Claims incurred
- Risk transfer arrangement fees
- Managed care: management services fees
- Expenses for administration
- Broker service fees.

The remaining items are allocated as detailed below:

- For contributions that are not directly allocated to benefit plans these amounts are apportioned based on a percentage of net contribution income per plan
- For claims that are not directly allocated to benefit plans these amounts are apportioned based on a percentage of net claims incurred per plan
- Other operating expenditure is apportioned based on the number of members per benefit plan
- Investment income is apportioned based on the number of members per benefit plan
- Net fair value gains / (losses) on financial assets at fair value through profit or loss are apportioned based on the number of members per benefit plan
- Other income is apportioned based on the number of members per benefit plan
- Expenses for asset management services rendered are apportioned based on the number of members per benefit plan
- Interest paid is apportioned based on the number of members per benefit plan.

25 COMPARATIVE FIGURES

Where necessary, comparative figures have been adjusted for disclosure purposes in order to conform to International Financial Reporting Standards.

Notes to the Annual Financial Statements

For the year ended 31 December 2011

1 ACCOUNTING POLICIES

The accounting policies of the Scheme are set out on pages 82 to 94.

2 FINANCIAL ASSETS AT FAIR VALUE THROUGH PROFIT OR LOSS

	2011 R'000	2010 R'000
The Scheme's financial assets are summarised by measurement category as follows:		
Financial assets at fair value through profit or loss	8,012,078	7,383,719
Loans and receivables (Note 3)	146,682	72,644
Total financial assets	**8,158,760**	**7,456,364**
The details of the assets in each of the categories are detailed below:		
Financial assets held at fair value through profit or loss		
Held for trading:		
Current assets	8,012,078	7,383,719
– Offshore bond portfolio	528,352	331,377
– Listed equities	377,102	422,757
– Yield-enhanced bond portfolios	741,992	328,031
– Money market portfolios	6,364,632	6,301,554
	8,012,078	**7,383,719**
Reconciliation of the balance at the beginning of the year to the balance at the end of the year:		
At the beginning of the year	7,383,719	6,645,016
Acquisitions	2,032,830	6,190,385
Disposals	(1,490,825)	(5,473,892)
Gain on revaluation of investments to fair value	86,354	22,210
At the end of the year	**8,012,078**	**7,383,719**

A register of investments is available for inspection at the registered office of the Scheme.

Section 35(8)(a) of the Medical Schemes Act, No 131 of 1998, as amended, states that a medical scheme shall not invest any of its assets in the business of an employer who participates in or any administrator or any arrangement associated with a medical scheme. Owing to the large number of the Scheme's employers being listed on the JSE, investments were made in certain of its employers listed on the JSE. The Council for Medical Schemes has granted the Scheme an exemption from this section of the Medical Schemes Act.

		2011 R'000	2010 R'000
3	**TRADE AND OTHER RECEIVABLES**		
	Insurance receivables		
	Contribution receivables	1,039,209	963,717
	Contributions outstanding	1,045,331	971,876
	Less: Provision for impairment	(6,122)	(8,159)
	Member and service provider claims receivables	59,823	52,373
	Amount due	200,132	185,107
	Less: Provision for impairment	(140,309)	(132,734)
	Other risk transfer arrangements	3,501	348
	Recoveries due from other risk transfer arrangements	64	27
	Share of outstanding claims provision (Note 6)	3,437	321
	Broker fee receivables	96	444
	Amounts due from brokers	389	803
	Less: Provision for impairment	(293)	(359)
	Other insurance receivables	68,996	45,745
	Total receivables arising from insurance contracts	**1,171,625**	**1,062,627**
	Loans and receivables		
	Balance due by related party	15,000	50,000
	Discovery Third Party Recovery Services (Pty) Ltd	15,000	50,000
	Sundry accounts receivable	129,596	20,587
	Interest receivable	2,086	2,057
	Total receivables arising from loans and receivables	**146,682**	**72,644**
		1,318,307	**1,135,271**

At 31 December 2011 the carrying amounts of trade and other receivables approximate their fair values due to the short-term maturities of these assets. Interest is not charged on overdue balances. The estimated future cash flow receipts have not been discounted as the effect would be immaterial.

Section 26(7) of the Medical Schemes Act, No 131 of 1998, as amended, states that all subscriptions or contributions shall be paid directly to a medical scheme not later than three days after payment thereof becoming due. There are instances where the Scheme received contributions after three days of becoming due. However, there are no contracts in place agreeing to this arrangement. The procedures the Scheme follows regarding these contributions are set out in Note 31.

The Scheme's Administrator has guaranteed the recoverability of certain member claims receivables to the value of R10,879,364 as well as certain forensic claims recoveries to the value of R100 million. The forensic claims recoveries are included under sundry accounts receivable. The guarantees are payable on 31 December 2012 and provide certainty as to the recoverability of these receivables.

Notes to the Annual Financial Statements

For the year ended 31 December 2011

		2011 R'000	2010 R'000
4	**CASH AND CASH EQUIVALENTS**		
	Call accounts	580,000	653,506
	Current accounts	389,128	355,268
	Money market instruments	257,523	264,129
		1,226,651	**1,272,903**

At 31 December 2011 the carrying amounts of cash and cash equivalents approximate their fair values due to the short-term maturities of these assets.

As per the agreement with CNA Gallo Medical Scheme (Mega), included above are the following amounts held in separate bank accounts:

Call account	-	307
Current account	11	43
	11	**350**

5	**MEMBERS' TRUST FUNDS**		
	Mega reserves	11	350
	Less:		
	Current portion included in current liabilities	(11)	(350)
		-	-

These funds were transferred to the Discovery Health Medical Scheme in 1999 from the CNA Gallo Medical Scheme, in terms of Section 20(c) of the Medical Schemes Act of 1967. The funds may only be used to subsidise the pensioner contributions and ex gratia payments of those scheme members. Regulation 4(4) of the Medical Schemes Act, No 131 of 1998, as amended, prohibits ring-fencing. This arrangement meets the definition of ring-fencing. The Scheme has submitted a request for exemption from this regulation to the Council for Medical Schemes. The balance remaining in these reserves at year-end was R10,887 and will be fully utilised during the first half of 2012.

As agreed with the CNA Gallo Medical Scheme, the Mega reserves are held in separate bank accounts and are included under cash and cash equivalents (Note 4) and interest accrues directly to these reserves.

		2011 R'000	2010 R'000
6	**OUTSTANDING CLAIMS PROVISION**		
	Outstanding claims provision – not covered by risk transfer arrangements	564,408	560,276
	Outstanding claims provision – covered by risk transfer arrangements	3,437	321
	Provision arising from liability adequacy test	-	-
		567,845	**560,597**
	Analysis of movement in outstanding claims		
	Balance at the beginning of the year	560,597	473,512
	Payments in respect of prior year	(545,737)	(506,143)
	Over / (under) provision in prior year	14,860	(32,631)
	Adjustment for current year	552,985	593,228
	Covered by risk transfer arrangements	3,437	321
	Not covered by risk transfer arrangements	549,548	592,907
	Balance at the end of the year	**567,845**	**560,597**
	Analysis of outstanding claims provision		
	Estimated gross claims	589,743	580,873
	Less:		
	Estimated recoveries from savings plan accounts (Note 8)	(21,898)	(20,276)
	Balance at the end of the year	**567,845**	**560,597**

Notes to the Annual Financial Statements

For the year ended 31 December 2011

	2011 R'000	2010 R'000
7 DERIVATIVE FINANCIAL INSTRUMENTS		
Financial assets held at fair value through profit or loss		
Current assets		
– Derivative financial instruments held for trading	23,424	15
	23,424	**15**
Financial liabilities held at fair value through profit or loss		
Current liabilities		
– Derivative financial instruments held for trading	(2,218)	-
	(2,218)	**-**
Derivative financial asset at the end of the year	**21,206**	**15**
Reconciliation of the balance at the beginning of the year to the balance at the end of the year:		
Derivative financial asset / (liability) at the beginning of the year	15	-
Realised (gain) / loss on derivative financial instruments transferred to:	**(1,702)**	**(612)**
Realised gain on revaluation of derivative financial instruments to fair value	(3,349)	(612)
– Equity portfolio derivatives	(1,620)	(612)
– Bond portfolio derivative	(1,729)	-
Realised loss on revaluation of derivative financial instruments to fair value	1,647	-
– Equity portfolio derivatives	1,399	-
– Bond portfolio derivatives	248	-
Net gain / (loss) on revaluation of derivative financial instruments to fair value:	**22,893**	**627**
Gain on revaluation of derivative financial instruments to fair value	24,905	1,942
– Zero-cost short-fence	3,931	1,942
– Forward exchange contract	16,659	-
– Bond portfolio derivatives	4,315	-
Loss on revaluation of derivative financial instruments to fair value	(2,012)	(1,315)
– Equity portfolio derivatives	(2,012)	(1,315)
Derivative financial asset at the end of the year	**21,206**	**15**

Derivative instruments

The Trustees approved a strategy to protect the value of the Scheme's investments by entering into a zero-cost short-fence, which protects the Scheme's equity portfolios. The Trustees also entered into a forward exchange contract to reduce the effect of currency fluctuations on the offshore bond portfolio.

The Scheme's equity managers entered into All Share Index (ALSI) futures contracts to generate an equity-related return on cash held in the equity portfolios.

One of the Scheme's bond managers entered into bond futures to hedge the bond portfolio and provide protection against market risk.

Details of the Scheme's derivatives and the impact of these instruments on investment return are set out in the Financial Risk Note (Note 31).

		2011 R'000	2010 R'000
8	**MEMBERS' SAVINGS ACCOUNTS**		
	Balance on savings accounts at the beginning of the year	1,718,442	1,544,102
	Add:		
	Savings account contributions received or receivable	6,219,912	5,528,398
	For the current year (Note 10)	6,219,912	5,528,398
	Interest paid to members on savings accounts (Note 23)	19,507	19,829
	Transfers received from other medical schemes	11,659	24,724
	Less:		
	Claims paid to or on behalf of members (Note 11)	(5,911,391)	(5,272,433)
	Refunds on death or resignation	(127,538)	(126,178)
		1,930,591	**1,718,442**

It is estimated that claims to be paid out of members' savings accounts in respect of claims incurred in 2011 but not recorded will amount to approximately R21,898,422 (2010: R20,276,024) (Note 6).

As at 31 December 2011 the carrying amount of the members' savings accounts were deemed to be equal to their fair values, which is the amount payable on demand. The amounts were not discounted, due to the demand feature.

Interest is paid on these savings plan balances monthly at predetermined rates on an accrual basis. The Scheme does not charge interest on savings plan balances.

Notes to the Annual Financial Statements

For the year ended 31 December 2011

		2011 R'000	2010 R'000
9	**TRADE AND OTHER PAYABLES**		
	Insurance liabilities		
	Contributions received in advance	46,409	33,572
	Premium refunds due to employers	212	331
	Reported claims not yet paid		
	Balance at the beginning of the year	271,403	219,660
	Movement for the year	47,862	51,743
	Balance at the end of the year	319,265	271,403
	Broker fee creditors	61,654	53,284
	Accredited brokers	61,654	53,284
	Other insurance liabilities	21	47
	Total liabilities arising from insurance contracts	**427,561**	**358,637**
	Financial liabilities		
	Balance due to related parties	220,673	297,536
	Discovery Health (Pty) Ltd	220,673	297,536
	Unallocated funds	3,567	4,804
	Total accruals	8,763	4,464
	General accruals	8,657	4,367
	Leave pay provision	106	99
	Total arising from financial liabilities	**233,003**	**306,806**
		660,564	**665,443**

At 31 December 2011 the carrying amounts of insurance and other payables approximate their fair values due to the short-term maturities of these liabilities.

		2011 R'000	2010 R'000
10	**NET CONTRIBUTION INCOME**		
	Gross contributions	31,192,855	27,650,362
	Risk contributions	24,972,943	22,121,964
	Members' savings account contributions (Note 8)	6,219,912	5,528,398
	LESS:		
	Members' savings account contributions (Note 8)	(6,219,912)	(5,528,398)
		24,972,943	**22,121,964**
11	**NET CLAIMS INCURRED**		
	Current year claims	26,681,293	23,274,477
	Claims not covered by risk transfer arrangements	26,310,125	23,055,588
	Claims covered by risk transfer arrangements	371,168	218,889
	Movement in outstanding claims provision	7,248	87,085
	(Over) / Under provision in prior year (Note 6)	(14,860)	32,631
	Adjustment for current year	22,108	54,454
		26,688,541	23,361,562
	Less:		
	Claims charged to members' savings accounts (Note 8)	(5,911,391)	(5,272,433)
	Claims incurred	**20,777,150**	**18,089,129**
	Third party claim recoveries	(125,811)	(90,045)
		20,651,339	**17,999,084**

Risk transfer arrangements

During 2011 the Scheme had four risk transfer arrangements in place. The methodologies used to determine the claims covered by these arrangements are set out below:

1. Risk transfer arrangement covering in-hospital and out-of-hospital benefits for certain members on the KeyCare Plus plan.

   The claims experience for members on the KeyCare Plus plan for the 2011 benefit year was used as the basis for determining the claims under this arrangement. These claim amounts are adjusted to include a provision for outstanding claims and then converted to a Per Life Per Month (PLPM) rate using the membership on the KeyCare Plus plan.

   In order to determine the value of claims under this arrangement, the average 2011 PLPM rate is multiplied by the lives exposure for this arrangement's membership and reduced by the actual claims that the Scheme has paid under this arrangement.

2. Risk transfer arrangement providing optometry services to members on the KeyCare Plus plan.

   An analysis as to the expected costs of optometry benefits using the experience from other Scheme plans was conducted. These claim amounts are adjusted to include a provision for outstanding claims and converted to a PLPM rate. Generally, the claims experience on KeyCare Plus is different to that of other Scheme plans as KeyCare Plus is aimed at a specific target market and the benefits are restricted. To allow for this the overall PLPM is adjusted by the ratio of KeyCare Plus claims experience to the other plans offered by the Scheme. The value of claims under this arrangement is determined by multiplying the PLPM rate by the lives exposure for KeyCare Plus.

   The method used to determine the estimated claims for the current year was amended as described above as this method is believed to represent a more reliable estimate of the claims under this arrangement. The method used to determine the 2010 estimated claims is set out below.

   The utilisation experience for these members is obtained from the service provider. The average cost to the Scheme for consultations, lenses, frames and contact lenses is calculated and applied to the utilisation experience to estimate the claims under this arrangement.

Notes to the Annual Financial Statements

For the year ended 31 December 2011

11 NET CLAIMS INCURRED (CONTINUED)

3. Risk transfer arrangement providing dentistry services to members on the KeyCare Plus plan.

   The cost of the dental group of procedure codes was isolated. Using claims data linked to this group the overall PLPM cost of dental services on all plans excluding KeyCare Plus was estimated. These claim amounts are adjusted to include a provision for outstanding claims. Generally the claims experience on KeyCare Plus is different to that of other Scheme plans as KeyCare Plus is aimed at a specific target market and the benefits are restricted. To allow for this the overall PLPM is adjusted by the ratio of KeyCare Plus claims experience to the other benefit plans offered by the Scheme.

   The value of claims under this arrangement is determined by multiplying the PLPM rate by the lives exposure for KeyCare Plus.

4. Risk transfer arrangement covering treatment for Executive and Comprehensive Plan members diagnosed with diabetes (type I and II).

   Members have a choice of using this managed care organisation for their diabetes-related treatment or not. As the risk profile of the two groups of members are similar, the claims experience of the Executive and Comprehensive Plan members who have not elected to use this provider, was used to estimate the members' fee-for-service cost for those who have elected to use this provider.

   As no underlying fee-for-service data is available, the cost of providing the capitated services was estimated as follows:

   - Per Life Per Month estimates were calculated for consultations, procedures, medication and hospital admissions to the extent that these services were covered under this risk transfer arrangement for the Executive and Comprehensive Plan members who have not elected this provider.
   - The expected fee-for-service cost was calculated by multiplying the calculated Per Life Per Month costs by the number of members exposed for the period on this programme.

12 NET INCOME ON RISK TRANSFER ARRANGEMENTS

	2011 R'000	2010 R'000
Other risk transfer arrangements:		
Capitation fees paid	(229,132)	(169,965)
Recoveries under risk transfer arrangements	371,168	218,889
Claims incurred in respect of related risk transfer arrangements	305,925	191,640
Recoveries received	65,243	27,249
	142,036	**48,924**

	2011 R'000	2010 R'000

13 MANAGED CARE: MANAGEMENT SERVICES

The Managed care: management services have been grouped into the following categories of services:

Discovery Health (Pty) Ltd		
Clinical protocols	22,072	19,697
Disease management	132,432	118,181
Hospital management	459,099	409,693
Pharmaceutical benefit management	132,433	118,181
Provider networks	136,847	122,120
	882,883	**787,872**

The Managed care: management services have been grouped into the above categories of services. The comparative figures have been regrouped in order to align with the revised categories of services.

14 BROKER SERVICE FEES

Brokers' fees	688,812	633,601
	688,812	**633,601**

In terms of Regulation 28(5) of the Medical Schemes Act, No 131 of 1998, as amended, the Scheme broker fees shall be paid on a monthly basis and upon receipt by the Scheme of the relevant monthly contribution. In some instances brokers were compensated prior to receipt of the relevant monthly contribution. The Scheme has implemented additional controls to address this matter and continues to monitor the resulting instances where this requirement was contravened.

15 OTHER OPERATING EXPENSES

Association fees	5,342	6
Audit fees	3,289	3,892
Audit services for the year ended 2009	-	1,900
Audit services for the year ended 2010	1,658	1,673
Audit services for the year ended 2011	1,581	-
Other services	50	319
Audit and Risk Committee fees (Note 16)	650	560
Audit and Risk Committee training	5	-
Bank charges	8,625	8,042
Clinical governance projects	-	3
Council for Medical Schemes	21,641	16,796
Custodian fees	438	190
Debt collecting fees	1,470	1,356
Dispute Committee fees	128	30
Electronic checking fees	-	21,024
General meeting costs	297	448
Investment Committee fees	25	266
Legal fees	461	865
Net impairment losses (Note 17)	37,452	37,828
Other expenses	9,536	5,287
Principal Officer fees	3,782	2,899
Principal Officer office costs	618	481
Printing, postage and stationery	21	20
Professional fees	1,158	1,771
Specialist referral fees	7,311	3,579
Staff costs (Note 18)	1,386	1,605
Sundry amounts written off	28	60
Trustees' remuneration and consideration expenses (Note 19)	2,310	1,552
	105,973	**108,561**

Notes to the Annual Financial Statements

For the year ended 31 December 2011

		2011 R'000	2010 R'000
16	**AUDIT AND RISK COMMITTEE FEES**		
	D Eriksson – Chairperson	358	285
	N Novick – member	142	149
	S Green – member	150	126
		650	**560**

These are payments to independent members of the Audit and Risk Committee. These members are not Trustees of the Scheme and the amounts paid to Trustee members of this Committee are disclosed in Note 19.

17	**NET IMPAIRMENT LOSSES**		
	Insurance and other receivables		
	Contributions that are not collectible	(2,037)	3,362
	Movement in provision	(2,037)	3,362
	Members' and service providers' portions that are not recoverable	39,630	34,569
	Movement in provision	39,630	34,569
	Amounts due by brokers that are not recoverable	(66)	(147)
	Movement in provision	(66)	(147)
	Receivables written off	103	96
	Less:		
	Previously written off receivables recovered	(178)	(52)
		37,452	**37,828**

18	**STAFF COSTS**		
	Salaries and bonuses	1,276	1,599
	Pension costs – defined contribution plans	55	68
	Medical and other benefits	23	32
	Increase / (decrease) in leave pay accrual	32	(93)
		1,386	**1,606**

Notes to the Annual Financial Statements

For the year ended 31 December 2011

19 TRUSTEES' REMUNERATION AND CONSIDERATION EXPENSES

The following table records the remuneration and consideration paid to Trustees during the year:

31 December 2011		Sub-committee fees					
	Services as Trustee	Audit and Risk Committee	Investment Committee	Clinical Governance Committee	Training	Trustee travel	Total
	R'000	R'000	R'000	R'000	R'000	R'000	R'000
M van der Nest (Chairperson)*	115	-	-	-	12	-	127
D MoodleyΔ	187	-	47	-	-	-	234
P Maserumule	192	-	135	-	-	-	327
S HandlerΔ	113	58	65	-	-	-	236
N Sangweni	183	-	-	135	13	-	331
B Stott	193	100	-	-	1	-	294
N Graves	192	-	-	-	-	-	192
Z van der Spuy	193	-	-	105	2	67	367
G Waugh*	102	50	50	-	-	-	202
Total	**1,470**	**208**	**297**	**240**	**28**	**67**	**2,310**

31 December 2010		Sub-committee fees					
	Services as Trustee	Audit and Risk Committee	Investment Committee	Clinical Governance Committee	Training	Trustee travel	Total
	R'000	R'000	R'000	R'000	R'000	R'000	R'000
M van der Nest**	219	-	-	-	-	-	219
D Moodley (Chairperson)	79	-	56	-	5	-	140
P Maserumule	50	-	56	-	-	-	106
S Handler	164	46	46	-	-	-	256
D Cohen**	141	46	72	-	-	-	259
N Sangweni	167	-	-	66	-	-	233
B Jacobson**	70	-	-	-	-	-	70
B Stott	50	69	-	-	-	-	119
N Graves	49	-	-	-	-	-	49
Z van der Spuy	50	-	-	46	5	-	101
Total	**1,039**	**161**	**230**	**112**	**10**	**-**	**1,552**

Δ = Resigned
* = New appointment
** = Term of office expired

Notes to the Annual Financial Statements

For the year ended 31 December 2011

		2011 R'000	2010 R'000
20	**INVESTMENT INCOME**		
	Financial assets at fair value through profit or loss:	499,483	529,732
	Dividend income	10,896	6,457
	Interest income	488,587	523,275
	Cash and cash equivalents interest income	65,813	85,674
	Investment income per Statement of Comprehensive Income	**565,296**	**615,406**
	The Scheme's total interest income is summarised below.		
	Financial assets not at fair value through profit or loss:		
	Loans and receivables	65,839	85,965
	Interest received from Administrator (Note 22)	26	291
	Cash and cash equivalents interest income	65,813	85,674
	Financial assets at fair value through profit or loss:		
	Interest income	488,587	523,275
	Total interest income	**554,426**	**609,240**
21	**NET GAINS / (LOSSES) ON FINANCIAL ASSETS AT FAIR VALUE THROUGH PROFIT OR LOSS**		
	Net foreign exchange losses on financial assets at fair value through profit or loss:	(5,214)	(28,734)
	– Offshore bonds	(5,214)	(28,734)
	Net fair value gains on financial assets at fair value through profit or loss including derivatives:	125,363	61,102
	– Equity securities	-	48,089
	– Derivatives held for trading	24,905	627
	– Money market	10,597	12,386
	– Offshore bonds	84,188	-
	– Local bonds	5,673	-
	Net fair value losses on financial assets at fair value through profit or loss including derivatives:	(10,901)	(9,531)
	– Equity securities	(8,796)	(9,531)
	– Derivatives held for trading	(2,012)	-
	– Local bonds	(93)	-
		109,248	**22,837**
22	**SUNDRY INCOME**		
	Interest received from Administrator	26	291
	Prescribed amounts written back	1,851	6,043
	Stale cheques written back	3,053	2,686
		4,930	**9,020**
23	**INTEREST PAID**		
	Financial assets not at fair value through profit or loss:		
	Interest paid on members' savings accounts (Note 8)	19,507	19,829
	Interest paid to Administrator	1	-
		19,508	**19,829**
24	**RESERVES TRANSFERRED FROM OTHER MEDICAL SCHEMES**		
	Reserves transferred from other schemes		
	Umed Medical Scheme	1,792	163,035
	Afrisam Medical Scheme	(47)	19,289
		1,745	**182,324**

25 AMALGAMATIONS

An amalgamation between the Scheme and the Edcon Medical Scheme ("Edcon") has been approved during the year under review and is effective from 1 January 2012.

The effective date of the amalgamation is post the reporting date of the Scheme, but before the financial statements are authorised for issue.

IFRS 3 (Business combinations) requires that information relating to this amalgamation be disclosed in the current reporting period and these disclosures are provided below.

Edcon Medical Scheme

Edcon is a not-for-profit restricted medical scheme registered in terms of the Medical Schemes Act, No 131 of 1998, as amended. Membership of the Scheme is open to all current and retired employees of Edcon (Pty) Ltd, its subsidiaries and associates. Retired employees of subsidiaries and associates, which have been disposed of, may continue their membership if they so elect.

In terms of the Medical Schemes Act, No 131 of 1998, as amended, medical schemes do not have equity. Therefore, the Scheme did not acquire any voting equity interest.

The members of the Scheme and Edcon voted that the amalgamation of Edcon with the Scheme would be in the best interest of Edcon members.

The Scheme obtained control of Edcon by means of the exposition requirements as set out in Section 63 of the Medical Schemes Act, No 131 of 1998, as amended. No goodwill will be recognised as a result of this transaction.

The acquisition date fair value of the total consideration transferred and the acquisition date fair value of each major class of assets and liabilities was:

	R'000	R'000
Consideration effectively transferred: (Acquisition date fair value of Edcon members' interest)		34,145
Net recognised values of Edcon's identifiable assets and liabilities:		34,145
Current assets	44,991	
Cash and cash equivalents	43,886	
Contribution receivables	832	
Member and service provider claims receivables	104	
Interest receivable	146	
Other accounts receivable	23	
Current liabilities	(10,846)	
Outstanding claims provision	(1,240)	
Reported claims not yet paid	(1,317)	
Unallocated funds	(25)	
General accruals	(2,136)	
Members' savings accounts	(6,128)	
Goodwill		-

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For the year ended 31 December 2011

25 AMALGAMATIONS (CONTINUED)

Edcon Medical Scheme (continued)

As a result of the amalgamation, the Scheme acquired the following receivables, information of which is set out below.

	R'000
Fair value of receivables acquired:	**1,105**
Insurance receivables	959
Contribution debtors	832
Members' claim debtors	129
Service provider claim debtors	182
Other accounts receivable	23
Provision for impairment	(207)
Loans and receivables	146
Interest receivable	146
Gross contractual amounts receivable:	**1,312**
Insurance receivables	1,166
Member claim debtors	129
Service provider claim debtors	182
Other accounts receivable	23
Loans and receivables	146
Interest receivable	146
Best estimate at the acquisition date of the contractual cash flows not expected to be collected are:	
Insurance receivables	(207)
Member and service provider claim debtors	(94)
Hospital network discount debtors	(113)

The amounts recognised as of the acquisition date for each major class of assets acquired and liabilities assumed.

Current assets	**44,991**
Cash and cash equivalents	43,886
Contribution debtors	832
Member claim debtors	35
Service provider claim debtors	69
Interest receivable	146
Other accounts receivable	23
Current liabilities	**(10,846)**
Outstanding claims provision	(1,240)
Reported claims not yet paid	(1,317)
Unallocated funds	(25)
General accruals	(2,136)
Members' savings accounts	(6,128)
	34,145

25 AMALGAMATIONS (CONTINUED)

Edcon Medical Scheme (continued)

There are no contingent consideration arrangements, indemnification assets, contingent liabilities or intangible assets arising from this amalgamation.

No goodwill has arisen from this amalgamation.

In terms of Section 10(1)(d) of the Income Tax Act, No 58 of 1962, as amended, receipts and accruals of a benefit fund are exempt from normal tax. A medical scheme is included in the definition of a benefit fund and consequently the Scheme is exempt from income tax. Therefore should goodwill arise due to an amalgamation there would be no tax consequences.

The Scheme and Edcon had no pre-existing relationship or other arrangements prior to commencing negotiations for the amalgamation, therefore there are no transactions recognised separately from those identified as a result of the amalgamation.

Prior year amalgamations

The Scheme amalgamated with two restricted medical schemes during the prior financial year. The details of the amalgamations are set out below.

AfriSam South Africa Medical Scheme

The AfriSam South Africa Medical Scheme (AfriSam) is a not-for-profit restricted medical scheme registered in terms of the Medical Schemes Act, No 131 of 1998, as amended. Membership of the Scheme is open to all current and retired employees of AfriSam South Africa (Pty) Ltd, its subsidiaries and associates. Retired employees of subsidiaries and associates, which have been disposed of, may continue their membership if they so elect.

The effective date of this amalgamation was 1 June 2010.

In terms of the Medical Schemes Act, No 131 of 1998, as amended, medical schemes do not have equity, therefore the Scheme did not acquire any voting equity interest.

The members of the Scheme and AfriSam voted that the amalgamation of AfriSam with the Scheme would be in the best interest of AfriSam's members.

The Scheme obtained control of AfriSam by means of the exposition requirements as set out in Section 63 of the Medical Schemes Act, No 131 of 1998, as amended.

No goodwill has been recognised as a result of this transaction.

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For the year ended 31 December 2011

25 AMALGAMATIONS (CONTINUED)

AfriSam South Africa Medical Scheme (continued)

The acquisition date fair value of the total consideration transferred and the acquisition date fair value of each major class of assets and liabilities was:

	R'000	R'000
Consideration effectively transferred: (Acquisition date fair value of AfriSam's members' interest)		19,237
Net recognised values of AfriSam's identifiable assets and liabilities:		19,237
Non-current assets	252	
Available-for-sale financial assets	252	
Current assets	27,850	
Cash and cash equivalents	27,037	
Contribution receivables	23	
Member and service provider claims receivables	647	
Interest receivable	136	
Other accounts receivable	7	
Available-for-sale reserves	(200)	
Current liabilities	(8,665)	
Outstanding claims provision	(1,245)	
Contributions received in advance	(32)	
Reported claims not yet paid	(840)	
Unallocated funds	(177)	
General accruals	(683)	
Members' savings accounts	(5,688)	
Goodwill		-

25 AMALGAMATIONS (CONTINUED)

AfriSam South Africa Medical Scheme (continued)

As a result of the amalgamation, the Scheme acquired the following receivables, information of which is set out below.

	R'000
Fair value of receivables acquired:	**813**
Insurance receivables	677
Contribution debtors	23
Member claim debtors	600
Service provider claim debtors	47
Other accounts receivable	7
Provision for impairment	-
Loans and receivables	136
Interest receivable	136
Gross contractual amounts receivable:	**813**
Insurance receivables	677
Contribution debtors	23
Member claim debtors	600
Service provider claim debtors	47
Other accounts receivable	7
Loans and receivables	136
Interest receivable	136
Best estimate at the acquisition date of the contractual cash flows not expected to be collected are:	
Insurance receivables	-
Contribution debtors	-
Member and service provider claim debtors	-
Hospital network discount debtors	-

The amounts recognised as of the acquisition date for each major class of assets acquired and liabilities assumed.

Non-current assets	**252**
Available-for-sale financial assets	252
Current assets	**27,850**
Cash and cash equivalents	27,037
Contribution debtors	23
Member claim debtors	600
Service provider claim debtors	47
Interest receivable	136
Other accounts receivable	7
Available-for-sale reserves	**(200)**
Current liabilities	**(8,665)**
Outstanding claims provision	(1,245)
Contributions received in advance	(32)
Reported claims not yet paid	(840)
Unallocated funds	(177)
General accruals	(683)
Members' savings accounts	(5,688)
	19,237

There are no contingent consideration arrangements, indemnification assets, contingent liabilities or intangible assets arising from this amalgamation.

No goodwill has arisen from this amalgamation.

In terms of Section 10(1)(d) of the Income Tax Act, No 58 of 1962, as amended, receipts and accruals of a benefit fund are exempt from normal tax. A medical scheme is included in the definition of a benefit fund and consequently the Scheme is exempt from income tax. Therefore, should goodwill arise due to an amalgamation, there would be no tax consequences.

The Scheme and AfriSam had no pre-existing relationship or other arrangements prior to commencing negotiations for the amalgamation, therefore there are no transactions recognised separately from those identified as a result of the amalgamation.

Notes to the Annual Financial Statements

For the year ended 31 December 2011

25 AMALGAMATIONS (CONTINUED)

AfriSam South Africa Medical Scheme (continued)

An estimate of contributions and surplus or deficit for the combined schemes for the period prior to the acquisition date has not been disclosed, as the Scheme could not objectively estimate a reliable measure of the amounts. Data for the period prior to the amalgamation has not been collected in a way that allows the Scheme to reliably measure these amounts. The benefits offered by Afrisam and the Scheme differed significantly, and estimating the contributions and surplus or deficit would require considerable assumptions on amongst others, utilisation, seasonality and benefit option choice and is not expected to provide a reliable estimate.

UMED Medical Scheme

The UMED Medical Scheme (UMED) is a not-for-profit restricted medical scheme registered in terms of the Medical Schemes Act, No 131 of 1998, as amended. UMED was established in 1973 as a restricted membership medical scheme for Armscor and Denel employees and qualifying ex-employees.

The effective date of this amalgamation was 1 August 2010.

In terms of the Medical Schemes Act, No 131 of 1998, as amended, medical schemes do not have equity. Therefore, the Scheme did not acquire any voting equity interest.

The members of the Scheme and UMED voted that the amalgamation of UMED with the Scheme would be in the best interest of UMED's members.

The Scheme obtained control of UMED by means of the exposition requirements as set out in Section 63 of the Medical Schemes Act, No 131 of 1998, as amended.

No goodwill has been recognised as a result of this transaction.

The acquisition date fair value of the total consideration transferred and the acquisition date fair value of each major class of assets and liabilities was:

UMED Medical Scheme

	R'000	R'000
Consideration effectively transferred: (Acquisition date fair value of UMED's members' interest)		120,308
Net recognised values of UMED's identifiable assets and liabilities:		120,308
Non-current assets	8,700	
Financial assets at fair value through profit or loss	8,700	
Current assets	134,143	
Cash and cash equivalents	121,275	
Contribution debtors	6,558	
Interest receivable	5,706	
Other accounts receivable	604	
Current liabilities	(22,535)	
Outstanding claims provision	(11,200)	
Contributions in advance/credit balances	(136)	
Members' balances in respect of claims	(694)	
Suppliers' balances in respect of claims	(5,348)	
Stale cheques	(854)	
Accruals	(4,062)	
Unallocated receipts	(241)	
Goodwill		-

25 AMALGAMATIONS (CONTINUED)

UMED Medical Scheme (continued)

As a result of the amalgamation, the Scheme acquired the following receivables, information of which is set out below:

	R'000
Fair value of receivables acquired:	12,868
Insurance receivables	7,162
Contribution debtors	6,558
Other accounts receivable	604
Loans and receivables	5,706
Interest receivable	5,706
Gross contractual amounts receivable:	12,868
Insurance receivables	7,162
Contribution debtors	6,558
Other accounts receivable	604
Loans and receivables	5,706
Interest receivable	5,706
Best estimate at the acquisition date of the contractual cash flows not expected to be collected are:	
Insurance receivables	-
Contribution debtors	-

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For the year ended 31 December 2011

25 AMALGAMATIONS (CONTINUED)

UMED Medical Scheme (continued)

The amounts recognised as of the acquisition date for each major class of assets acquired and liabilities assumed.

	R'000
Non-current assets	**8,700**
Financial assets at fair value through profit or loss	8,700
Current assets	**134,143**
Cash and cash equivalents	121,275
Contribution debtors	6,558
Interest receivable	5,706
Other accounts receivable	604
Current liabilities	**(22,535)**
Outstanding claims provision	(11,200)
Contributions in advance/credit balances	(136)
Members' balances in respect of claims	(694)
Suppliers' balances in respect of claims	(5,348)
Stale cheques	(854)
Accruals	(4,062)
Unallocated receipts	(241)
	120,308

There are no contingent consideration arrangements, indemnification assets, contingent liabilities or intangible assets arising from this amalgamation.

No goodwill has arisen from this amalgamation.

In terms of Section 10(1)(d) of the Income Tax Act, No 58 of 1962, as amended, receipts and accruals of a benefit fund are exempt from normal tax. A medical scheme is included in the definition of a benefit fund and consequently the Scheme is exempt from income tax. Therefore, should goodwill arise due to an amalgamation, there would be no tax consequences.

The Scheme and UMED had no pre-existing relationship or other arrangements prior to commencing negotiations for the amalgamation, therefore there are no transactions recognised separately from those identified as a result of the amalgamation.

An estimate of contributions and surplus or deficit for the combined schemes for the period prior to the acquisition date has not been disclosed, as the Scheme could not objectively estimate a reliable measure of the amounts. Data for the period prior to the amalgamation has not been collected in a way that allows the Scheme to reliably measure these amounts. The benefits offered by UMED and the Scheme differed significantly, and estimating the contributions and surplus or deficit would require considerable assumptions on amongst others, utilisation, seasonality and benefit option choice and is not expected to provide a reliable estimate.

The Scheme has therefore determined that it is not practicable to disclose the contributions and surplus or deficit of the combined schemes as of the beginning of the prior reporting period.

26 RELATED PARTY TRANSACTIONS

The Scheme is controlled by the Board of Trustees, who are elected by the members of the Scheme.

Parties with significant influence over the Scheme

Administrator:

Discovery Health (Pty) Ltd has significant influence over the Scheme, as Discovery Health (Pty) Ltd participates in the Scheme's financial and operating policy decisions, but does not control the Scheme. Discovery Health (Pty) Ltd provides administration, managed care services and third party collection services via Discovery Third Party Recovery Services (Pty) Ltd, a wholly-owned subsidiary of Discovery Health (Pty) Ltd.

Key management personnel and their close family members

Key management personnel are those persons having authority and responsibility for planning, directing and controlling the activities of the Scheme. Key management personnel include the Board of Trustees and the executive officers of the Scheme. The disclosure deals with full-time personnel who are compensated on a salary basis, and part-time personnel who are compensated on a fee basis (Board of Trustees).

Close family members include close family members of the Board of Trustees and executive officers of the Scheme.

Transactions with related parties

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

Transactions with key management personnel and their close family members

	2011 R'000	2010 R'000
Statement of Comprehensive Income transactions		
Compensation		
Short-term employee benefits	(6,820)	(5,804)
Contributions and claims		
Gross contributions received	418	341
Claims paid from the Scheme	(108)	(89)
Claims paid from the Medical Savings Account	(88)	(51)
Healthcare provider fees paid	-	(36)
Statement of Financial Position transactions		
Contribution debtors	6	14
Amounts due to executive officers	-	(3)
Medical Savings Account balances	35	(18)
Trustee remuneration payable	-	-

Notes to the Annual Financial Statements

For the year ended 31 December 2011

26 RELATED PARTY TRANSACTIONS (CONTINUED)

Transactions with key management personnel and their close family members (continued)

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

Transactions	Nature of transactions and their terms and conditions
Contributions received	This constitutes the contributions paid by the related party as a member of the Scheme, in their individual capacity. All contributions were on the same terms as applicable to other members.
Claims incurred	This constitutes amounts claimed by the related parties, in their individual capacity as members of the Scheme. All claims were paid out in terms of the rules of the Scheme, as applicable to other members.
Contribution debtors	This constitutes outstanding contributions receivable. The amounts are due immediately. No impairment provisions have been raised on these amounts.
Amounts due to executive officers	These are amounts due to the Scheme's executive officers in terms of their cellphone expenditure.
Medical Savings Account balances	The amounts owing to the related parties relate to Medical Savings Account balances to which the parties have a right. In line with the terms applied to third parties, the balances earn interest monthly at predetermined interest rates, on an accrual basis. The amounts are all current, and would need to be payable on demand should an appropriate claim be issued, or should the member resign from the Scheme, as applicable to other members.
Healthcare provider fees paid/payable	These constitute fees paid to healthcare providers (medical practitioners). Fees are paid on the same basis as applicable to third parties.

Transactions with entities that have significant influence over the Scheme

	2011 R'000	2010 R'000
Discovery Health (Pty) Ltd – Administrator		
Statement of Comprehensive Income transactions		
Administration fees paid	(2,863,572)	(2,666,663)
Interest received on monthly balances (Note 22)	26	291
Interest paid on monthly balances (Note 23)	(1)	-
Statement of Financial Position transactions		
Balance due to Discovery Health (Pty) Ltd at year-end (Note 9)	(145,456)	(229,788)
Discovery Health (Pty) Ltd - Managed care organisation		
Statement of Comprehensive Income transactions		
Managed care fees paid	(882,883)	(787,872)
Managed care: management services	(882,883)	(787,872)
Statement of Financial Position transactions		
Balance due to Discovery Health (Pty) Ltd at year-end (Note 9)	(75,216)	(67,748)
Discovery Third Party Recovery Services (Pty) Ltd		
Statement of Comprehensive Income transactions		
Third party collection fees	(9,418)	(5,212)
Statement of Financial Position transactions		
Balance due to the Scheme at year-end (Note 3)	15,000	50,000

As disclosed in Note 3, the Scheme obtained guarantees from Discovery Health (Pty) Ltd for the recoverability of certain claims debtors and identified forensic claims recoveries. The aggregate value of the guarantees amounts to R110 million and falls due on 31 December 2012.

26 RELATED PARTY TRANSACTIONS (CONTINUED)

Transactions with entities that have significant influence over the Scheme (continued)

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

Administration agreement

The administration agreement is in terms of the Rules of the Scheme and in accordance with instructions given by the Board of Trustees. 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, No 131 of 1998, as amended. The Scheme and the Administrator shall be entitled to terminate the agreement by giving notice in writing of not less than 90 days and not more than 180 days. The outstanding balance bears interest at prime less 4.5% and is due within 30 days.

Administration fees are calculated on a per-member-per-month basis. The total expense for administration cost increases in line with membership growth. However, the per-member-per-month fee has increased at a rate lower than inflation for a number of years.

Managed care agreements

Managed care means the management of member healthcare benefit entitlements by providing, and/or assessing, and/or facilitating the appropriateness and cost effectiveness of relevant healthcare services to members and their dependants, including accepted clinical practices and treatment protocols. This process can be categorised into two expenditure classifications, namely Managed care: healthcare services, and Managed care: management services. The Scheme did not have any Managed care: healthcare services arrangements with Discovery Health (Pty) Ltd during the year under review and the prior year.

Managed care: management services

Managed care: management services is the cost of managing healthcare expenditure, such as bill review, specialist and hospital referrals, case management, disease management (where healthcare benefits are not included in the contract), peer review, claims audits and statistical analysis, but does not include the cost of any relevant healthcare services.

The managed care agreement is in accordance with instructions given by the Board of Trustees. The agreement is automatically renewed each year, unless notification of termination is received or following the cancellation of Discovery Health (Pty) Ltd's accreditation or the issue of a lawful directive to this effect by the Council for Medical Schemes in terms of the Medical Schemes Act, No 131 of 1998, as amended. The Scheme and Discovery Health (Pty) Ltd shall be entitled to terminate the agreement by giving notice in writing of not less than 90 days and not more than 180 days. The outstanding balance bears interest at prime less 4.5% and is due within 30 days.

Notes to the Annual Financial Statements

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26 RELATED PARTY TRANSACTIONS (CONTINUED)

Transactions with entities that have significant influence over the Scheme (continued)
Managed care: management services (continued)

The services provided by the managed care organisation include:

- Managed healthcare services as defined in the Medical Schemes Act, No 131 of 1998, as amended, and the rules of the Scheme
- Pharmacy benefit management services
- Prospective review services, including pre-authorisation and ensuring benefit availability
- Concurrent case management services, including managing each beneficiary's medical event on an individual case basis
- Acute case management services, including managing each beneficiary's treatment for severe medical conditions on at least a daily basis
- On-site case management services, including managing each beneficiary's medical treatment at the site where the treatment is provided in appropriate circumstances, and auditing of clinical notes to assess coding accuracy
- Disease case management services, including managing each disease for which the Scheme provides benefits by determining the cost and incidence of each disease and suggesting appropriate measures to reduce the cost of treating the disease
- Auditing and reviewing accounts received from service providers in respect of treatment provided to members and beneficiaries
- Continually analysing and reporting on data, including data on a case mixed adjusted basis in order to monitor both cost and utilisation of Scheme benefits with a view to identifying areas for intervention
- Managing all contracts with service providers to the Scheme with the aim of reducing costs while maintaining and/or improving quality of service
- Implementing, managing and reviewing reimbursement models and making recommendations on alternative reimbursement models
- Auditing and reviewing provider servicing behaviour with the aim of reducing costs while maintaining and/or improving the provision of appropriate levels of care.

Third party collection services

The Scheme has contracted with Discovery Third Party Recovery Services (Pty) Ltd, a wholly-owned subsidiary of Discovery Health (Pty) Ltd, to manage the identification and collection of third party recoveries from the Road Accident Fund and the Compensation for Occupational Injuries and Diseases. The Scheme has sold all Road Accident Fund claims incurred by the Scheme during the period 1 January 2011 and 31 December 2011 for the amount of R15 million.

Guarantees

Discovery Health (Pty) Ltd has guaranteed the recoverability of certain member claims receivables to the value of R10,879,364 as well as certain forensic claims recoveries to the value of R100 million. The guarantees are payable on 31 December 2012 and provide certainty as to the recoverability of these receivables.

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27 SURPLUS / (DEFICIT) FROM OPERATIONS PER BENEFIT PLAN

2011	Executive R'000	Classic Comp R'000	Classic Core R'000	Classic Saver R'000	Classic Priority R'000	Essential Comp R'000	Essential Core R'000	Essential Saver R'000
Net contribution income	**597,963**	**7,591,106**	**1,141,213**	**4,017,376**	**2,603,388**	**1,102,238**	**397,262**	**1,205,377**
Net claims incurred	(817,528)	(7,415,085)	(734,397)	(2,777,521)	(1,948,750)	(828,618)	(253,414)	(730,073)
Claims incurred	(822,366)	(7,461,294)	(738,841)	(2,794,381)	(1,960,509)	(833,670)	(254,875)	(734,412)
Third-party claim recoveries	4,838	46,209	4,444	16,860	11,759	5,052	1,461	4,339
Net income on risk transfer arrangements	2,130	24,243	-	-	-	2,403	-	-
Risk transfer arrangement fees	(6,498)	(85,208)	-	-	-	(9,417)	-	-
Recoveries from risk transfer arrangements	8,628	109,451	-	-	-	11,820	-	-
Relevant healthcare expenditure	**(815,398)**	**(7,390,842)**	**(734,397)**	**(2,777,521)**	**(1,948,750)**	**(826,215)**	**(253,414)**	**(730,073)**
Gross healthcare result	**(217,435)**	**200,264**	**406,816**	**1,239,855**	**654,638**	**276,023**	**143,848**	**475,304**
Managed care: management services	(10,011)	(158,037)	(40,907)	(151,275)	(80,881)	(25,912)	(17,407)	(51,457)
Broker service fees	(10,017)	(159,826)	(30,263)	(130,278)	(75,443)	(25,518)	(11,276)	(38,781)
Expenses for administration	(35,624)	(573,335)	(147,128)	(527,684)	(286,635)	(97,013)	(61,303)	(184,972)
Other operating expenses	(1,126)	(17,778)	(4,573)	(16,891)	(9,066)	(2,917)	(2,522)	(5,130)
Net healthcare result	**(274,213)**	**(708,712)**	**183,945**	**413,727**	**202,613**	**124,663**	**51,340**	**194,964**
Investment income	6,409	101,164	26,192	96,862	51,781	16,586	14,600	29,501
Net fair value gains on financial assets at fair value through profit or loss	1,230	19,418	5,058	18,740	9,978	3,181	2,851	5,723
Sundry income	56	884	228	844	453	145	127	257
Other income	**7,695**	**121,466**	**31,478**	**116,446**	**62,212**	**19,912**	**17,578**	**35,481**
Expenses for asset management services rendered	(135)	(2,126)	(554)	(2,051)	(1,091)	(348)	(312)	(626)
Interest paid	(221)	(3,490)	(904)	(3,343)	(1,787)	(572)	(504)	(1,018)
Other expenditure	**(356)**	**(5,616)**	**(1,458)**	**(5,394)**	**(2,878)**	**(920)**	**(816)**	**(1,644)**
Net surplus/(deficit) for the year	**(266,874)**	**(592,862)**	**213,965**	**524,779**	**261,947**	**143,655**	**68,102**	**228,801**

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27 SURPLUS / (DEFICIT) FROM OPERATIONS PER BENEFIT PLAN (CONTINUED)

2011	Essential Priority R'000	Coastal Saver R'000	Coastal Core R'000	Foundation Core R'000	KeyCare Plus R'000	KeyCare Core R'000		Total R'000
Net contribution income	**230,166**	**2,664,697**	**1,205,826**	**13,605**	**2,054,977**	**147,749**		**24,972,943**
Net claims incurred	(142,339)	(2,020,910)	(872,967)	(12,166)	(2,014,418)	(83,153)		(20,651,339)
Claims incurred	(143,211)	(2,033,131)	(878,198)	(12,240)	(2,026,399)	(83,623)		(20,777,150)
Third party claim recoveries	872	12,221	5,231	74	11,981	470		125,811
Net income on risk transfer arrangements	-	-	-	-	113,260	-		142,036
Risk transfer arrangement fees	-	-	-	-	(128,009)	-		(229,132)
Recoveries from risk transfer arrangements	-	-	-	-	241,269	-		371,168
Relevant healthcare expenditure	**(142,339)**	**(2,020,910)**	**(872,967)**	**(12,166)**	**(1,901,158)**	**(83,153)**		**(20,509,303)**
Gross healthcare result	**87,827**	**643,787**	**332,859**	**1,439**	**153,819**	**64,596**		**4,463,640**
Managed care: management services	(7,918)	(120,908)	(57,456)	(672)	(147,768)	(12,274)		(882,883)
Broker service fees	(6,642)	(97,643)	(36,276)	(395)	(61,972)	(4,482)		(688,812)
Expenses for administration	(28,976)	(431,320)	(205,417)	(2,684)	(269,844)	(11,637)		(2,863,572)
Other operating expenses	(885)	(13,540)	(6,414)	(76)	(23,190)	(1,865)		(105,973)
Net healthcare result	**43,406**	**(19,624)**	**27,296**	**(2,388)**	**(348,955)**	**34,338**		**(77,600)**
Investment income	5,070	77,410	36,790	430	94,640	7,861		565,296
Net fair value gains on financial assets at fair value through profit or loss	980	14,930	7,115	82	18,436	1,526		109,248
Sundry income	44	675	321	4	824	68		4,930
Other income	**6,094**	**93,015**	**44,226**	**516**	**113,900**	**9,455**		**679,474**
Expenses for asset management services rendered	(107)	(1,635)	(779)	(9)	(2,016)	(167)		(11,956)
Interest paid	(175)	(2,671)	(1,270)	(15)	(3,267)	(271)		(19,508)
Other expenditure	**(282)**	**(4,306)**	**(2,049)**	**(24)**	**(5,283)**	**(438)**		**(31,464)**
Net surplus/(deficit) for the year	**49,218**	**69,085**	**69,473**	**(1,896)**	**(240,338)**	**43,355**		**570,410**

27 SURPLUS / (DEFICIT) FROM OPERATIONS PER BENEFIT PLAN (CONTINUED)

2010	Executive R'000	Classic Comp R'000	Classic Core R'000	Classic Saver R'000	Classic Priority R'000	Essential Comp R'000	Essential Core R'000	Essential Saver R'000
Net contribution income	**531,296**	**6,982,284**	**1,041,097**	**3,348,594**	**2,247,314**	**1,115,772**	**330,855**	**1,083,704**
Net claims incurred	(725,679)	(6,715,644)	(644,485)	(2,250,916)	(1,682,411)	(816,789)	(213,085)	(646,679)
Claims incurred	(729,560)	(6,751,554)	(647,565)	(2,261,011)	(1,690,856)	(821,028)	(214,078)	(649,667)
Third-party claim recoveries	3,881	35,910	3,080	10,095	8,445	4,239	993	2,988
Net (expense) on risk transfer arrangements	(408)	(7,061)	-	-	-	(1,153)	-	-
Risk transfer arrangement fees	(5,535)	(73,809)	-	-	-	(8,973)	-	-
Recoveries from risk transfer arrangements	5,127	66,748	-	-	-	7,820	-	-
Relevant healthcare expenditure	**(726,087)**	**(6,722,705)**	**(644,485)**	**(2,250,916)**	**(1,682,411)**	**(817,942)**	**(213,085)**	**(646,679)**
Gross healthcare result	**(194,791)**	**259,579**	**396,612**	**1,097,678**	**564,903**	**297,830**	**117,770**	**437,025**
Managed care: management services	(9,123)	(148,656)	(38,253)	(128,660)	(71,790)	(26,650)	(14,494)	(46,462)
Broker service fees	(9,638)	(157,611)	(28,485)	(113,707)	(68,805)	(27,055)	(9,473)	(35,498)
Expenses for administration	(33,923)	(561,213)	(143,281)	(472,617)	(266,759)	(102,289)	(53,966)	(174,826)
Other operating expenses	(1,228)	(20,027)	(5,108)	(17,135)	(9,611)	(3,572)	(1,922)	(6,198)
Net healthcare result	**(248,703)**	**(627,928)**	**181,485**	**365,559**	**147,938**	**138,264**	**37,915**	**174,041**
Investment income	7,140	116,330	29,896	100,501	56,127	20,813	11,312	36,302
Net fair value gains on financial assets at fair value through profit or loss	257	4,195	1,100	3,723	2,055	783	423	1,341
Sundry income	105	1,710	438	1,472	823	309	165	532
Other income	**7,502**	**122,235**	**31,434**	**105,696**	**59,005**	**21,905**	**11,900**	**38,175**
Expenses for asset management services rendered	(98)	(1,596)	(411)	(1,383)	(772)	(287)	(156)	(500)
Interest paid	(230)	(3,749)	(964)	(3,239)	(1,809)	(670)	(364)	(1,170)
Other expenditure	**(328)**	**(5,345)**	**(1,375)**	**(4,622)**	**(2,581)**	**(957)**	**(520)**	**(1,670)**
Net surplus/(deficit) for the year	**(241,529)**	**(511,038)**	**211,544**	**466,633**	**204,362**	**159,212**	**49,295**	**210,546**

Notes to the Annual Financial Statements

For the year ended 31 December 2011

27 SURPLUS / (DEFICIT) FROM OPERATIONS PER BENEFIT PLAN (CONTINUED)

2010	Essential Priority R'000	Coastal Saver R'000	Coastal Core R'000	Foundation Core R'000	KeyCare Plus R'000	KeyCare Core R'000		Total R'000
Net contribution income	**217,859**	**2,335,694**	**1,071,196**	**15,796**	**1,656,393**	**144,110**		**22,121,964**
Net claims incurred	(138,795)	(1,722,870)	(755,516)	(10,596)	(1,592,027)	(83,592)		(17,999,084)
Claims incurred	(139,483)	(1,730,774)	(759,223)	(10,664)	(1,599,686)	(83,980)		(18,089,129)
Third-party claim recoveries	688	7,904	3,707	68	7,659	388		90,045
Net income on risk transfer arrangements	-	-	-	-	57,546	-		48,924
Risk transfer arrangement fees	-	-	-	-	(81,648)	-		(169,965)
Recoveries from risk transfer arrangements	-	-	-	-	139,194	-		218,889
Relevant healthcare expenditure	**(138,795)**	**(1,722,870)**	**(755,516)**	**(10,596)**	**(1,534,481)**	**(83,592)**		**(17,950,160)**
Gross healthcare result	**79,064**	**612,824**	**315,680**	**5,200**	**121,912**	**60,518**		**4,171,804**
Managed care: management services	(7,645)	(108,714)	(52,589)	(794)	(121,594)	(12,448)		(787,872)
Broker service fees	(6,485)	(88,776)	(32,499)	(455)	(50,740)	(4,374)		(633,601)
Expenses for administration	(28,999)	(406,050)	(196,377)	(3,150)	(211,948)	(11,265)		(2,666,663)
Other operating expenses	(1,019)	(14,557)	(7,016)	(108)	(19,311)	(1,749)		(108,561)
Net healthcare result	**34,916**	**(5,273)**	**27,199**	**693**	**(281,681)**	**30,682**		**(24,893)**
Investment income	5,970	85,007	41,092	622	94,578	9,716		615,406
Net fair value gains on financial assets at fair value through profit or loss	223	3,101	1,514	22	3,736	364		22,837
Sundry income	88	1,246	601	9	1,380	142		9,020
Other income	**6,281**	**89,354**	**43,207**	**653**	**99,694**	**10,222**		**647,263**
Expenses for asset management services rendered	(82)	(1,169)	(565)	(8)	(1,308)	(134)		(8,469)
Interest paid	(192)	(2,740)	(1,324)	(20)	(3,045)	(313)		(19,829)
Other expenditure	**(274)**	**(3,909)**	**(1,889)**	**(28)**	**(4,353)**	**(447)**		**(28,298)**
Net surplus/(deficit) for the year	**40,923**	**80,172**	**68,517**	**1,318**	**(186,340)**	**40,457**		**594,072**

		2011 R'000	2010 R'000
28	**CASH FLOWS FROM OPERATIONS BEFORE WORKING CAPITAL CHANGES**		
	Net surplus for the year	570,410	594,072
	Adjustments for:		
	Impairment losses	37,527	37,784
	Interest received	(554,426)	(609,240)
	Dividend income	(10,896)	(6,457)
	Interest paid	19,508	19,829
	Net gains on financial assets at fair value through profit or loss	(109,248)	(22,837)
		(47,125)	**13,151**

29 EVENTS AFTER THE REPORTING PERIOD

No significant events occurred between the reporting date and the date the financial statements were authorised for issue.

Notes to the Annual Financial Statements

For the year ended 31 December 2011

30 INSURANCE RISK MANAGEMENT REPORT

Nature and extent of risks arising from insurance contracts

The Scheme issues contracts that transfer insurance risk. The primary insurance activity carried out by the Scheme indemnifies covered members and their dependants against the risk of loss arising as a result of the occurrence of a health event (ie. an event relating to the health of the Scheme's beneficiary), in accordance with the Rules of the Scheme and the requirements of legislation.

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

Insurance risk

The risk under any insurance contract is the possibility that the insured event occurs and the uncertainty of the amount of the resulting claim. Insurance events are, by nature, random and the actual number and size of events during any one year may vary from those estimated using established techniques. As such, the Scheme is exposed to the uncertainty surrounding the timing and severity of claims under the contract.

For a portfolio of insurance contracts where the theory of probability is applied to pricing and provisioning, the principal risk that the Scheme faces under its insurance contracts is that the actual claim payments exceed the carrying amount of the insurance liabilities. This could occur because the frequency and severity of claims are greater than estimated. As insurance events are random, the actual number and amount of claims will vary from year to year from the level established using statistical techniques.

Experience shows that the larger the portfolio of similar insurance contracts, the smaller the relative variability about the expected outcome will be. In addition, a more diversified portfolio is less likely to be affected by a change in any subset of the portfolio.

Factors that aggravate insurance risk include changes in membership distribution and major unanticipated demographic movements, adverse experience due to an unexpected epidemic, unexpected changes in members' disease profile, unexpected price increases and the cost of new technologies or drugs.

The Scheme offers members a range of benefit plans reflecting the Scheme's underlying philosophy to offer choice, make members healthier, and enhance and protect their lives. The main types of benefits offered by the Scheme in return for monthly contributions are indicated below:

- **Hospital benefits**

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

- **Chronic Illness Benefit**

  The Chronic Illness Benefit (CIB) covers approved medication and treatment for up to 61 listed conditions, including the 27 Prescribed Minimum Benefit chronic conditions which include HIV and AIDS. These include conditions such as high blood pressure, cholesterol and asthma.

- **Day-to-day benefits**

  The day-to-day benefits include both the Medical Savings Account (MSA) and an insurance risk element – the Above Threshold Benefit. Day-to-day benefits cover the cost of out-of-hospital healthcare services, such as visits to general practitioners and dentists as well as prescribed non-chronic medicines.

The risks associated with the types of benefits offered to members are addressed below:

- **Hospital benefit risk**

  Frequency and severity of claims

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

  The introduction of new hospital technologies could also increase variability of claims. In some instances, the new technology has a beneficial impact on costs, whether in-hospital or consequent costs. In other instances the new technologies will increase costs.

30 INSURANCE RISK MANAGEMENT REPORT (CONTINUED)

Insurance risk (continued)
Hospital benefit risk (continued)

Initiatives used by the Scheme to manage the risk associated with admission rate include:

- The development of protocols around various high-cost conditions, such as lower back surgery
- The "See Your Doctor First" initiative, which requires members to see their doctor prior to an elective admission
- The amendment to the pre-authorisation length-of-stay benchmarks
- The work of the Clinical Policy Unit, which evaluates the effectiveness of new technologies and recommends whether the Scheme should cover these technologies or not
- Increased statistical and actuarial investigations and techniques to detect, manage and prevent fraud and over-servicing.
- The establishment of a unit to focus on reducing surgical consumable spend
- The profiling of statistically significant outlier doctors on admission rate and generated costs as well as peer reviewing them
- The establishment of the Coordinated Care Programme (CCP). This is a dedicated unit to ensure direct coordination of care from medical providers to beneficiaries that are exposed to conditions that would generate multiple admissions if not managed
- The establishment of a new disease management unit dedicated to managing high-risk beneficiaries with complex diseases.

Other factors that impact on admission rates are changes in the disease profile of the Scheme and shifts in membership distribution between plans.

The actions that the Scheme can take are limited by the legislative requirement of open enrolment. Nevertheless, the Scheme has developed advanced risk attribution models that quantify the likely cost impact of demographic movements, and advanced tools to monitor changes in disease profile. These models and tools help the Scheme to take corrective action shortly after such trends emerge by, for instance, implementing new managed care policies where appropriate.

Notes to the Annual Financial Statements

For the year ended 31 December 2011

30 INSURANCE RISK MANAGEMENT REPORT (CONTINUED)

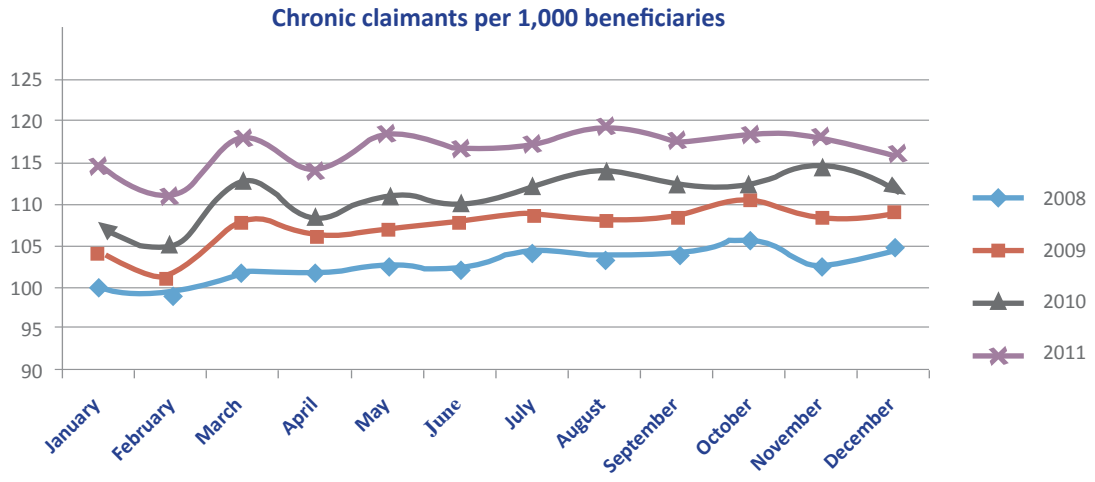
Insurance risk (continued)

- **Chronic Illness Benefit (CIB) risk**

  Frequency and severity of claims

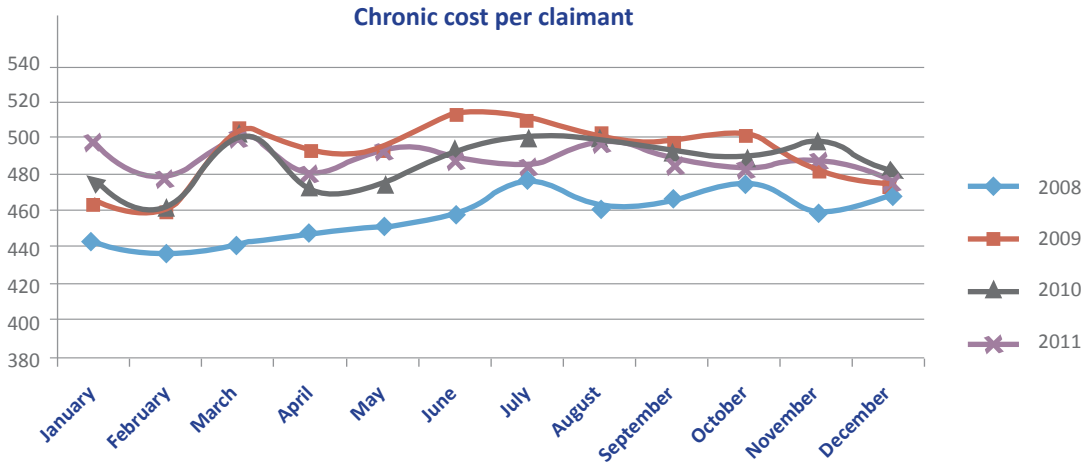
  The main factors impacting the frequency and severity of chronic claims are the number of claimants and the cost per claimant. An increase in the cost of claims results from an increase in the frequency and/or severity of claims. Higher increases in claimants are often linked to increases in the number of beneficiaries at older ages. The timing of increases in the Single Exit Price regulations for medication also has an impact on costs per claim. Any changes in the rules or regulations relating to Prescribed Minimum Benefits for chronic conditions would also impact either positively or negatively on the costs. Increases in the number of items per claimant drive up the cost of chronic claims per claimant.

  The following graphs indicate the change in the number of claimants over the past four years as well as the impact on the cost per claimant. These graphs are indexed to a value of 100 as at January 2008.



30 INSURANCE RISK MANAGEMENT REPORT (CONTINUED)

Insurance risk (continued)
Chronic Illness Benefit (CIB) risk (continued)



The Scheme manages and mitigates the risks associated with chronic illness benefits through an extensive managed care programme, involving detailed drug policy interventions, medicine protocols and benefit rules, all of which comply with the Regulations on Prescribed Minimum Benefits. Much of the work of the Clinical Policy Unit mentioned above also focuses on new drugs.

The mix between the various chronic conditions impacts the frequency and severity of claims.

Notes to the Annual Financial Statements

For the year ended 31 December 2011

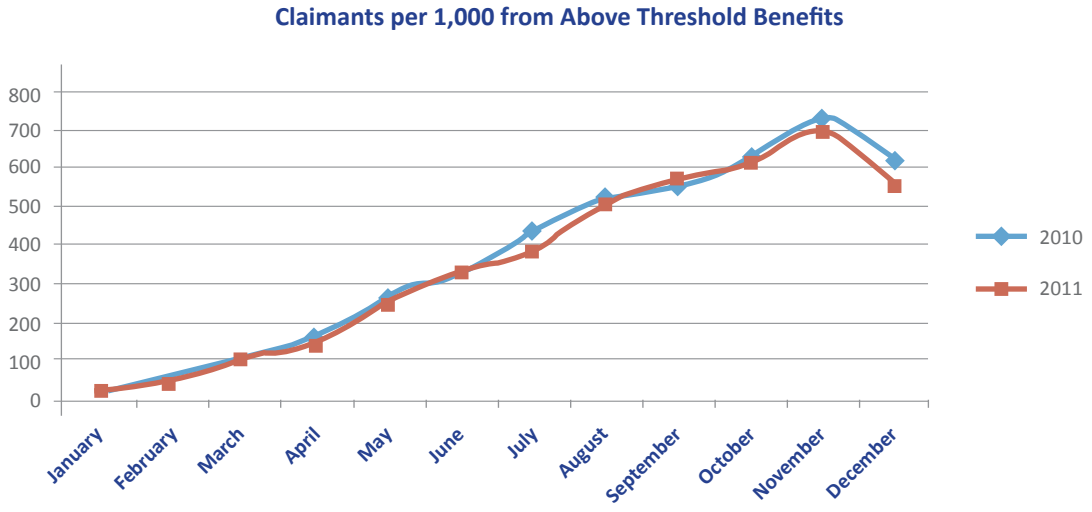
30 INSURANCE RISK MANAGEMENT REPORT (CONTINUED)

Insurance risk (continued)

- **Day-to-day benefit risk**

  Frequency and severity of claims

  The Above Threshold Benefit component of the day-to-day benefit results in the most variable component of the risk to the Scheme. The frequency and severity of claims are driven by the number of claimants and the distribution of membership per benefit plan.



Concentration of insurance risk

As the largest medical scheme in South Africa, the Scheme is not subject to a significant degree of concentration risk. The Scheme offers a wide range of benefit plans which meet a variety of members' needs. This results in the Scheme being representative of the medical scheme market and, as such, it is believed that this reduces the variability of the outcome.

The strategy is set out in the annual actuarial valuation, which specifies the benefits to be provided and the expected demographic profile for each benefit plan.

All contracts are negotiated and renewed annually. The Scheme has the right to change the terms and conditions of each contract at renewal. Contracts can be terminated at any time during the year, subject to three months' written notice.

30 INSURANCE RISK MANAGEMENT REPORT (CONTINUED)

Risk transfer arrangements

The Scheme has four risk transfer agreements with service providers to cover specific risks. The first risk transfer arrangement covers in-hospital and out-of-hospital benefits for certain members on the KeyCare Plus plan. There are two arrangements providing optometry and dentistry services to members on the KeyCare Plus plan. The fourth arrangement covers the treatment for Executive and Comprehensive Plan members diagnosed with diabetes (type I and II).

Risk in terms of risk transfer arrangements

According to the terms of the agreements, the suppliers provide certain minimum benefits to Scheme members, as and when required by the members. The Scheme does, however, remain liable to its members if any supplier fails to meet the obligations it assumes.

When selecting a supplier, the Scheme considers their ability to provide the relevant service. The Scheme also monitors the performance of the suppliers, checks the quality of care provided and has access to data on the underlying fee-for-service claims which are included in the arrangement.

Claims development

Detailed claims development tables are not presented as the uncertainty regarding the amount and timing of claim payments is typically resolved within one year and in the majority of cases within four months. At year-end, a provision is made for those claims outstanding that are not yet reported at that date.

Liquidity risk

The Scheme has not presented a maturity analysis showing the remaining contractual maturities of its insurance contracts. The Scheme presents information around the estimated timing of its insurance liabilities recognised at year-end.

The main component of the Scheme's insurance liabilities is the outstanding claims provision. Approximately 95% of this provision is settled within three months after the claim was incurred and the balance is settled within six months. The remaining insurance liabilities are generally settled within 30 days.

Risk management objectives and policies for mitigating insurance risk

The Scheme manages its insurance risk through benefit limits and sub-limits, application of clinical protocols, approval procedures for transactions that exceed set limits, pricing guidelines, preauthorisation and case management, service provider profiling, and the regular monitoring of demographic and claims trends through advanced actuarial and clinical risk models.

The Scheme uses several methods to assess and monitor insurance risk exposures both for individual types of risks insured and overall risks. These methods include internal risk measurement models, sensitivity analyses, scenario analyses and stress testing, as well as statistical techniques such as generalised linear modelling, bootstrapping, cluster analysis and decision trees. The theory of probability and best actuarial practice is applied to the pricing and provisioning for a portfolio of insurance contracts. The principal risk is that the frequency and/or severity of claims is greater than expected.

The following factors affect the frequency and severity of claims:

- Fee-for-service provider reimbursement combined with a third-party payer creates the incentive for overservicing of members. The Scheme uses alternative reimbursement arrangements to mitigate this risk and also peer review of service providers, network arrangements and statistical trend analyses
- The demographic profile of the membership base, ie. older, sicker members require more frequent and more intense treatment than younger, healthier members. This risk is managed through the regular updating of internal risk management models which assess the impact of any changes to the Scheme's demographic profile
- Technological advances in healthcare generally increase the cost of treatment. This may be due to either the increased price of the new technology or the increased quantity of treatment. This risk is mitigated through a rigorous health technology assessment process in the Clinical Policy Unit, which determines whether the technology is cost-effective and whether it should be funded
- The price of covered services affects the severity of claims. This risk is mitigated by the Scheme's rules, which specify the maximum rate at which each treatment is funded. The Scheme also manages this risk through annual tariff agreements with most provider groups.

Notes to the Annual Financial Statements

For the year ended 31 December 2011

30 INSURANCE RISK MANAGEMENT REPORT (CONTINUED)

Outstanding claims provision

The methodology followed in setting the outstanding claims provision is the generally accepted actuarial methodology of chain ladder estimation. This methodology is the most objective, but the accuracy of the estimate is sensitive to changes in the average time from treatment to payment of claims.

There are some sources of uncertainty that need to be considered in the estimate of the liability that the Scheme will ultimately have for claims made under insurance contracts prior to the effective date of the financial statements.

The estimation of the December 2011 outstanding claims provision was made in accordance with Professional Guidance Note 304 of the Actuarial Society. In accordance with this guidance note, we also checked whether the following factors would have any impact on the outstanding claims provision estimate:

- The homogeneity of claims data
- The credibility of claims data
- Changes in emergence and settlement patterns
- The impact of seasonality
- The impact of reopened or adjusted claims
- The impact of benefit limits and benefit changes
- External influences
- The demographic profile of the Scheme.

It was found that all of the above factors are adequately taken into account in the calculation methodology.

Based on the processing patterns and claims development up to the end of February 2012 in respect of treatment dates during 2011, the recommended provision for outstanding claims as at December 2011 is R568 million.

Assumptions and the process used to determine the assumptions

The risks associated with the Scheme's insurance contracts are complex and subject to a number of variables that complicate quantitative sensitivity analysis.

The process used to determine the assumptions is intended to result in best estimates of the most likely or expected outcome. However, ultimate liabilities will vary as a result of subsequent developments. The sources of data used as inputs for the assumptions are internal, using detailed studies that are carried out monthly. There is emphasis on current trends, and where there is insufficient information to make a reliable best estimate of claims development, assumptions are used.

The claims provision is based on information currently available. The cost of outstanding claims is estimated using the chain ladder method. Run-off triangles are used as it takes time after the treatment date until the full extent of the claims to be paid is known. This method extrapolates the development of paid and incurred claims for each benefit month based on observed development of earlier months, ie. the method assumes that the recent historic claims development pattern will occur again over the run-off period. The outstanding claims provision is calculated based on claim processing patterns over the previous months. Owing to differences in reporting lags and claim processing patterns (caused by differences in the underlying insurance contracts, claim complexity, the volume of claims, the different rates of claim submission, the individual severity of claims and claim reporting lags), risk claims are grouped into in-hospital, chronic, above threshold benefits and out-of-hospital claim categories, and the claims development pattern is assessed separately for each category.

The reasonableness of the outstanding claims provision is reviewed at the time of its calculation. Using current and historic development factors, the provision is back tested to ensure that it is reasonable and adequate. Any significant deviations provide an indication that the provision may need to be increased or decreased accordingly.

30 INSURANCE RISK MANAGEMENT REPORT (CONTINUED)

Assumptions and the process used to determine the assumptions (continued)

A run-off triangle is constructed showing, for each treatment month, the cumulative claims paid in each development month. The percentage increase in the cumulative claims paid from one development month to the next, ie. the claims development factors, can then be used to calculate claims payments for future development months.

The calculation methodology assumes that the claim processing patterns will remain unchanged from month to month. The chain ladder estimate of outstanding claims is adjusted inter alia for the following factors:

- Known changes to the claims development pattern, for example as a result of changes in the method of submission (manual/ electronic), are allowed for by adjusting the claim development factors on the basis of patterns evident from the most recent processing months
- Known changes to the hospital admission rate are allowed for by adjusting the claim development factors on the basis of changes in the proportion of members obtaining a hospital authorisation
- The seasonality of the claims experience
- External influences, for example the potential impact of medicine pricing legislation.

The number of hospital admissions authorised through the pre-authorisation process and the expected increase in the per-life-per month cost for the most recent benefit years for the “in-hospital”, “chronic” and “above threshold” categories of claims are also considered. Since approximately 95% of claims are paid within three months of the date of service, no allowance for discounting of claims costs is made.

Outstanding claims provisions are estimated at a gross level and an adjustment made to cater for risk transfer arrangements by reducing the outstanding claims provision by the amount of the expected claims incurred under these risk transfer arrangements.

Changes in assumptions and sensitivities to changes in key variables

There has been no material change in the assumptions or the calculation methodology over the period.

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

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

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

Notes to the Annual Financial Statements

For the year ended 31 December 2011

30 INSURANCE RISK MANAGEMENT REPORT (CONTINUED)

Changes in assumptions and sensitivities to changes in key variables (continued)

The total estimate of incurred claims and the provision for outstanding claims is as follows:

	2011 R'000	2010 R'000
Total estimate of incurred claims		
In-hospital claims incurred	14,246,218	12,306,208
Chronic claims incurred	1,567,473	1,406,098
Out-of-hospital risk claims incurred	4,792,298	4,271,693

Impact on the outstanding claims provision and reported profits caused by changes in key variables:

	Change in variable %	Impact on outstanding claims provision 2011 R'000	Impact on outstanding claims provision 2010 R'000
In-hospital claims incurred	1% increase in claims costs	142,462	123,081
Chronic claims incurred	1% increase in claims costs	15,675	14,061
Out-of-hospital risk claims incurred	1% increase in claims costs	47,923	42,720

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

Underwriting risk

Underwriting risk is the risk that the actual exposure of the Scheme in respect of outstanding claims will exceed the prudent estimates of such outstanding claims. Actuaries have been consulted in setting these estimates at year-end, including the estimate for those claims outstanding at year-end, which had not yet been reported.

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

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

One of the sensitivity tests performed in arriving at the estimate is to calculate the chain ladder on treatment-to-paid run-off patterns over the last 12 months and compare it to the number of treatment-to-paid patterns scenarios. These include the treatment-to-paid patterns over the last three, the last six, and the last nine months. Other reasonability checks are also performed, namely checks against the expected loss ratio taking into account the seasonality of claims, checks of pre-authorisation statistics relating to hospital admissions, as well as known hospital admission rates and consideration of the number of working days in recent months.

31 FINANCIAL RISK MANAGEMENT REPORT

Overview

The Scheme is exposed to financial risk through its financial assets, financial liabilities and insurance liabilities. In particular the financial risk is that the proceeds for any reason from its financial assets and member contributions are not sufficient to fund the obligations arising from its insurance contracts.

The most important components of financial risk include credit risk, liquidity risk, interest rate risk and market risk. The Scheme's overall risk management programme focuses on the optimal return given the unpredictability of financial markets and seeks to minimise potential adverse effects on the Scheme's statutory solvency requirement.

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

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

The Scheme manages the financial risks as follows:

- The Investment Committee is a sub-committee of the Board of Trustees and determines, recommends, implements and maintains investment policies and procedures. The Investment Committee advises the Board of Trustees on the strategic and operating matters in respect of the investment of Scheme funds and meets at least quarterly
- The Scheme has appointed reputable external asset managers to manage its investments and their performance is constantly monitored
- An external asset consulting company has been appointed to assist in formulating fund strategy and to provide ongoing reporting and monitoring of the asset managers
- An external legal adviser is used to review asset management agreements to ensure they are concluded in the best interest of the Scheme's members.

The Scheme enhanced the process of managing key financial risks during the current reporting period, as a result of instability in the equity and currency markets caused by the global debt crisis. The aim of the enhancements to the risk management process is to ensure that short-term asset returns are protected to reduce the potential adverse effects on the statutory solvency requirement.

Information on the enhancements to the risk management process is provided under the price and currency risk sections below.

Credit risk

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

Key areas where the Scheme is exposed to credit risk are:

- Trade and other receivables comprising of insurance receivables, and loans and receivables. The main components of insurance receivables are in respect of contributions due from members and amounts recoverable from members in respect of claims debt. The Scheme does have exposure from its loans and receivables. The management of this risk is discussed on page 135.
- Financial assets at fair value through profit or loss, comprising money market, equity and bond instruments are entered into to fund the obligations arising from its insurance contracts as well as the investing of surplus funds to maintain the statutory solvency requirement. The Scheme is exposed to the issuer's credit standing on these instruments. Exposure to credit risk is monitored and minimum credit ratings for these investments are set. Reputable asset managers with prior expertise have been appointed to manage these instruments. Information regarding the aggregated credit risk exposure is provided on page 141.
- Cash and cash equivalents comprise cash deposits in financial institutions. The risks associated with these deposits are managed by monitoring the Scheme's exposure to external financial institutions against approved deposit limits per institution. Information regarding the credit quality of cash and cash equivalents is provided on page 141.

Notes to the Annual Financial Statements

For the year ended 31 December 2011

31 FINANCIAL RISK MANAGEMENT REPORT (CONTINUED)

Credit risk (continued)

Trade and other receivables

The Scheme's trade and other receivables at 31 December comprise:

	Note	2011 R'000	2010 R'000
Insurance receivables	3	1,171,625	1,062,627
Contribution receivables [1]		1,045,331	971,876
Less provision for impairment		(6,122)	(8,159)
Member and service provider claims receivables [2]		200,132	185,107
Less provision for impairment		(140,309)	(132,734)
Recoveries due from other risk transfer arrangements		64	27
Share of outstanding claims provision (Note 6)		3,437	321
Broker fee receivables		389	803
Less provision for impairment		(293)	(359)
Other insurance receivables		68,996	45,745
Loans and receivables	3	146,682	72,644
Balance due by related parties		15,000	50,000
Sundry accounts receivable [3]		129,596	20,587
Interest receivable		2,086	2,057
Total		**1,318,307**	**1,135,271**

1 *Contribution receivables are not credit rated by the Scheme as exposure to any single member is insignificant. Contribution receivables comprise amounts receivable from individuals and corporates and are collected by means of debit orders or cash payments. They are actively pursued if not received within three days of becoming due. Benefits are suspended on member accounts when contributions have not been received for 30 days and benefits are terminated when contributions have not been received for 60 days.*

2 *Member and service provider claim receivables are amounts recoverable in respect of claims debt. They are not credit rated by the Scheme as exposure to any single party is insignificant. Member and service provider claims receivable that are past due are handled by a specialist area within the Administrator. Member claims receivables are separated between active and withdrawn members. Where amounts due by withdrawn members remain uncollected for more than 150 days, the debtors are handed to specialist debt collection agencies.*

3 *As set out in Notes 3 and 26, the Scheme obtained guarantees for the recoverability of certain member claims receivables and forensic claims recoveries from Discovery Health (Pty) Ltd.*

31 FINANCIAL RISK MANAGEMENT REPORT (CONTINUED)

Credit risk (continued)
Trade and other receivables (continued)

Exposure to credit risk

The carrying amount of trade and other receivables represents the maximum credit exposure.

The Scheme ages and pursues unpaid accounts on a monthly basis. The tables below highlight insurance receivables within trade and other receivables which are due, past due (by number of days) and impaired.

Contribution debtors	Gross 2011 R'000	Impairment 2011 R'000	Gross 2010 R'000	Impairment 2010 R'000
Not past due	824,172	-	804,552	-
Past due 4 - 30 days not impaired	214,913	-	167,336	-
Past due 31 - 60 days not impaired	3,888	-	(13,628)	-
Past due 61 - 90 days not impaired	2,445	-	13,659	-
91 days to more than one year	(218)	(6,122)	(43)	(8,159)
Total	**1,045,200**	**(6,122)**	**971,876**	**(8,159)**

Total member and service provider claims debtors	Gross 2011 R'000	Impairment 2011 R'000	Gross 2010 R'000	Impairment 2010 R'000
Not past due	-	-	-	-
Past due 0 - 30 days not impaired	21,091	-	26,922	-
Past due 31 - 60 days not impaired	529	-	1,098	-
Past due 61 - 90 days not impaired	6,082	-	7,813	-
Past due 91 - 120 days not impaired	11,186	-	9,613	-
Past due 121 - 150 days not impaired	7,686	-	3,092	-
151 days to more than one year	153,557	(140,309)	136,569	(132,734)
Total	**200,131**	**(140,309)**	**185,107**	**(132,734)**

Active member claims debtors	Gross 2011 R'000	Impairment 2011 R'000	Gross 2010 R'000	Impairment 2010 R'000
Not past due	-	-	-	-
Past due 0 - 30 days not impaired	2,735	-	10,830	-
Past due 31 - 60 days not impaired	1,526	-	699	-
Past due 61 - 90 days not impaired	1,370	-	1,389	-
Past due 91 - 120 days not impaired	1,443	-	1,521	-
Past due 121 - 150 days not impaired	1,146	-	1,038	-
151 days to more than one year	27,974	(15,397)	24,575	(22,917)
Total	**36,194**	**(15,397)**	**40,052**	**(22,917)**

Withdrawn member claims debtors	Gross 2011 R'000	Impairment 2011 R'000	Gross 2010 R'000	Impairment 2010 R'000
Not past due	-	-	-	-
Past due 0 - 30 days not impaired	7,390	-	10,226	-
Past due 31 - 60 days not impaired	4,347	-	2,819	-
Past due 61 - 90 days not impaired	5,641	-	6,657	-
Past due 91 - 120 days not impaired	6,563	-	5,163	-
Past due 121 - 150 days not impaired	8,886	-	4,346	-
151 days to more than one year	120,971	(116,689)	110,713	(106,946)
Total	**153,798**	**(116,689)**	**139,924**	**(106,946)**

Notes to the Annual Financial Statements

For the year ended 31 December 2011

31 FINANCIAL RISK MANAGEMENT REPORT (CONTINUED)

Credit risk (continued)
Trade and other receivables (continued)
Exposure to credit risk (continued)

Service provider claims debtors	Gross 2011 R'000	Impairment 2011 R'000	Gross 2010 R'000	Impairment 2010 R'000
Not past due	-	-	-	-
Past due 0 - 30 days not impaired	10,966	-	5,866	-
Past due 31 - 60 days not impaired	(5,344)	-	(2,420)	-
Past due 61 - 90 days not impaired	(927)	-	(233)	-
Past due 91 - 120 days not impaired	3,179	-	2,929	-
Past due 121 - 150 days not impaired	(2,346)	-	(2,292)	-
151 days to more than one year	4,613	(8,223)	1,281	(2,870)
Total	**10,141**	**(8,223)**	**5,131**	**(2,870)**

Other risk transfer arrangements	Gross 2011 R'000	Impairment 2011 R'000	Gross 2010 R'000	Impairment 2010 R'000
Not past due	9,815	-	2,554	-
Past due 0 - 30 days not impaired	-	-	-	-
Past due 31 - 60 days not impaired	-	-	-	-
Past due 61 - 90 days not impaired	-	-	-	-
Past due 91 - 120 days not impaired	-	-	-	-
Past due 121 - 150 days not impaired	-	-	-	-
151 days to more than one year	-	-	-	-
Total	**9,815**	**-**	**2,554**	**-**

Broker fee debtors	Gross 2011 R'000	Impairment 2011 R'000	Gross 2010 R'000	Impairment 2010 R'000
Not past due	-	-	-	-
Past due 0 - 30 days not impaired	363	-	14,026	-
Past due 31 - 60 days not impaired	21	-	(1,373)	-
Past due 61 - 90 days not impaired	(181)	-	192	-
Past due 91 - 120 days not impaired	(7)	-	1,321	-
Past due 121 - 150 days not impaired	15	-	(1,457)	-
151 days to more than one year	178	(293)	(11,905)	**(359)**
Total	**389**	**(293)**	**803**	**(359)**

31 FINANCIAL RISK MANAGEMENT REPORT (CONTINUED)

Credit risk (continued)
Trade and other receivables (continued)
Exposure to credit risk (continued)

Provision for impairment

The Scheme establishes an allowance for impairment that represents its estimate of incurred losses in respect of trade and other receivables. The provision is based on the expected difference between the current carrying amount and the amount recoverable from the counterparty.

The main components of this provision are:

- A specific loss component that relates to individually significant exposures
- A collective loss component established for groups of similar assets in respect of losses that have been incurred but not yet identified. The collective loss allowance is determined based on historical data of payment statistics for similar financial assets.

The movement in the provision for impairment, for each component of trade and other receivables, during the year ended 31 December:

	Trade and other receivables				
	Insurance receivables				
	Contribution debtors	Member and service provider claims debtors	Other risk transfer arrangements	Broker fee debtors	**Total**
	R'000	**R'000**	**R'000**	**R'000**	**R'000**
Balance as at 1 January 2010	**4,797**	**132,330**	**18,265**	**506**	**155,898**
Increase/(decrease) in provision for impairment	3,362	34,569	-	(147)	37,784
Amounts utilised during the year	-	(34,165)	(18,265)	-	(52,430)
Balance as at 31 December 2010	**8,159**	**132,734**	**-**	**359**	**141,252**
Balance as at 1 January 2011	**8,159**	**132,734**	**-**	**359**	**141,252**
Increase/(decrease) in provision for impairment	(2,037)	39,630	-	(66)	37,527
Amounts utilised during the year	-	(32,055)	-	-	(32,055)
Balance as at 31 December 2011	**6,122**	**140,309**	**-**	**293**	**146,724**

Notes to the Annual Financial Statements

For the year ended 31 December 2011

31 FINANCIAL RISK MANAGEMENT REPORT (CONTINUED)

Credit risk (continued)
Trade and other receivables (continued)
Exposure to credit risk (continued)

Based on past experience, the Scheme believes that no provision for impairment is required in respect of contribution debtors that are past due and outstanding for less than 90 days. For member and service provider claims debtors and broker fee debtors that are past due and outstanding for less than 180 days, past experience has indicated that no provision is required. The Scheme has not renegotiated the terms of receivables and does not hold any collateral or guarantees as security.

Credit quality

The credit quality of trade and other receivables that are neither past due nor impaired can be assessed by reference to historical information about counterparty default:

	2011 R'000	2010 R'000
Insurance receivables		
Counterparties without external credit rating net of provision for impairment:		
Contribution debtors	1,039,209	963,717
Member and service provider claim debtors	59,823	52,373
Active member claim debtors	20,796	17,135
Withdrawn member claim debtors	37,109	32,977
Service provider claim debtors	1,918	2,261
Broker fee debtors	96	444
Other insurance receivables	68,996	45,745
	1,168,124	**1,062,279**

Contribution debtors

The Scheme collected over 97% (2010: 99%) of outstanding debt in January 2012. Therefore we can reasonably establish that the credit quality of contribution debtors is high. Consequently no additional disclosure of the credit quality is provided.

Active member claims debtors

These debtors are current members of the Scheme and are expected to have similar credit quality to the contribution debtors. The debt notification and collection procedures continued to be improved during the year under review. A provision for impairment covering 43% (2010: 78%) of the debtors has been raised. The percentage covered by the impairment increases to 61% after taking into account the guarantee of R10,879,364 provided by Discovery Health (Pty) Ltd. The Trustees are satisfied that the provision is adequate and that no additional provision needs to be raised.

Withdrawn member claims debtors

These amounts are due from members that have withdrawn from the Scheme. A provision for impairment covering 76% (2010 – 78%) of the total amount due has been raised and the Trustees are satisfied that this is adequate.

31 FINANCIAL RISK MANAGEMENT REPORT (CONTINUED)

Credit risk (continued)

Other insurance receivables

Other insurance debtors mainly comprise of amounts due by hospitals, which are inherently of high quality. As agreed with the providers the majority of these receivables are recovered by reducing future provider payments providing a high certainty of recoverability and no further analysis will be performed on these receivables.

Financial assets held at fair value through profit or loss

The Scheme's financial assets held at fair value through profit or loss as at 31 December comprise:

	2011 R'000	2010 R'000
Financial assets held at fair value through profit or loss		
Current assets	528,352	331,377
– Offshore bond portfolio	377,102	422,757
– Listed equities	741,992	328,031
– Yield enhanced bond portfolios	23,424	15
– Derivative financial instruments held for trading	6,364,632	6,301,554
– Money market portfolios		
	8,035,502	**7,383,734**

The fair value of the listed equities has been determined by reference to quoted stock exchanges.

The Scheme has assessed whether any of the financial assets are impaired. Based on the risk management measures undertaken by the Scheme, there is no objective evidence that any financial assets are impaired below the fair market value stated above.

Exposure to credit risk

Derivative counterparties and cash transactions are limited to high credit quality financial institutions. The Scheme has a policy of limiting the amount of credit exposure to any one financial institution.

The Scheme manages credit risk through the appointment of reputable and appropriate asset managers, extensive diversification and ongoing monitoring and management of credit risk exposures and portfolio holdings.

Annexure B of the Regulations to the Medical Schemes Act, No 131 of 1998, as amended, prescribes the credit limits per institution, which reduces the individual risk per institution. For institutions with lower credit ratings the Scheme has set specific exposure limits. The utilisation of credit limits is regularly monitored.

Notes to the Annual Financial Statements

For the year ended 31 December 2011

31 FINANCIAL RISK MANAGEMENT REPORT (CONTINUED)

Credit risk (continued)

Credit quality

R'000	Total	Govt	F1+	F1	AAA	AA+ to AA-	A+ to A-	B to BBB	CCC to CCC+	Not rated
2011										
At fair value through profit or loss:	7,634,976	321,351	876,923	112,809	1,704,934	3,283,786	976,377	199,633	9,165	149,998
- Offshore bond portfolio	528,352	144,758	-	-	44,905	3,372	30,927	172,496	9,165	122,729
- Yield enhanced bond portfolios	741,992	176,593	-	-	51,588	271,306	188,099	27,137	-	27,269
- Money market portfolios	6,364,632	-	876,923	112,809	1,608,442	3,009,108	757,350	-	-	-
Cash and cash equivalents	1,226,651	-	870,508	112,000	7,549	140,809	-	-	-	95,785
	8,861,627	**321,351**	**1,747,431**	**224,809**	**1,712,484**	**3,424,595**	**976,376**	**199,633**	**9,165**	**245,783**
2010										
At fair value through profit or loss:	6,960,962	-	956,219	169,861	1,605,600	3,363,375	624,123	162,763	-	79,021
- Offshore bond portfolio	331,377	-	-	-	35,925	4,179	55,831	162,763	-	72,679
- Yield enhanced bond portfolio	328,031	-	119,724	-	45,509	55,402	101,054	-	-	6,342
- Money market portfolios	6,301,554	-	836,495	169,861	1,524,166	3,303,794	467,238	-	-	-
Cash and cash equivalents	1,272,903	-	1,183,381	-	85,220	4,123	-	-	-	179
	8,233,865	**-**	**2,139,600**	**169,861**	**1,690,820**	**3,367,498**	**624,123**	**162,763**	**-**	**79,200**

At the reporting date the credit ratings shown are the most conservative of Moody's, Fitch and S&P and have been provided in a Fitch format.

31 FINANCIAL RISK MANAGEMENT REPORT (CONTINUED)

Credit risk (continued)
Credit quality (continued)

Credit rating scales

Credit ratings provide an opinion on the relative ability of an entity to meet its financial commitments, such as interest, dividends or the repayment of capital invested. They are used as indications of the likelihood of receiving the amounts owed in accordance with the terms on which they were invested.

Definitions of the symbols are presented below.

Short-term rating scales

F1: Highest short-term credit quality

F1 indicates the strongest intrinsic capacity for timely payment of financial commitments. They may have an added "+" to denote any exceptionally strong credit feature.

Long-term rating scales

AAA: Highest credit quality

AAA ratings denote the lowest expectation of default risk and are assigned only in cases of exceptionally strong capacity for payment of financial commitments. This capacity is highly unlikely to be adversely affected by foreseeable events.

AA: Very high credit quality

AA ratings denote expectations of very low default risk and indicate very strong capacity for payment of financial commitments. This capacity is not significantly vulnerable to foreseeable events.

A: High credit quality

A ratings denote expectations of low default risk. The capacity for payment of financial commitments is considered strong. This capacity may, nevertheless, be more vulnerable to adverse business or economic conditions than is the case for higher ratings.

B to B1 comprise BBB, BB and B symbols and these are defined below:

BBB: Good credit quality

BBB ratings indicate that expectations of default risk are currently low. The capacity for payment of financial commitments is considered adequate but adverse business or economic conditions are more likely to impair this capacity. In 2011 1.0% (2010: 0.9%) of the Scheme's financial assets at fair value through profit or loss were invested in instruments with this credit rating.

BB: Speculative

BB ratings indicate an elevated vulnerability to default risk, particularly in the event of adverse changes in business or economic conditions over time. However, business or financial flexibility exists, which supports the servicing of financial commitments. In 2011 0.7% (2010: 0.3%) of the Scheme's financial assets at fair value through profit or loss were invested in instruments with this credit rating.

B: Highly speculative

B ratings indicate that material default risk is present, but a limited margin of safety remains. Financial commitments are currently being met. However, capacity for continued payment is vulnerable to deterioration in the business and economic environment. In 2011 0.5% (2010: 1.1%) of the Scheme's financial assets at fair value through profit or loss were invested in instruments with this credit rating.

CCC: Possibility of default

Obligations for which there is a current perceived possibility of default. Timely repayment of principal and interest is dependent on favourable business economic or financial conditions.

Notes to the Annual Financial Statements

For the year ended 31 December 2011

31 FINANCIAL RISK MANAGEMENT REPORT (CONTINUED)

Liquidity risk

Liquidity risk is the risk that the Scheme will not have sufficient liquid funds available to settle financial obligations as they fall due.

The Scheme's approach to managing liquidity is to ensure, with significant conservative margin, that it will always have sufficient liquidity to meet its liabilities when due, under both normal and stressed conditions, without incurring unacceptable losses or risking damage to the Scheme's reputation. In order to meet the conflicting objective of enhancing returns while also providing high liquidity, the combined Scheme portfolios have explicit constraints that guarantee liquidity of at least 20% of the Scheme assets within a period of one week.

The Scheme has complied with the requirements regarding the nature and categories of assets as prescribed by Section 35 and Regulation 30 of the Medical Schemes Act, No 131 of 1998, as amended.

Over 95% of the Scheme's insurance claim liabilities are settled within three months after the claim was incurred and the balance of the claims liability is settled within six months. The Scheme's remaining insurance liabilities are generally settled within 30 days.

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

As at 31 December 2011	Less than 1 year R'000	Between 1 and 2 years R'000	Between 2 and 5 years R'000
Members' trust funds	11	-	-
Members' savings accounts	1,930,591	-	-
Insurance and other payables (Note 9)	233,003	-	-

As at 31 December 2010	Less than 1 year R'000	Between 1 and 2 years R'000	Between 2 and 5 years R'000
Members' trust funds	350	-	-
Members' savings accounts	1,718,442	-	-
Insurance and other payables (Note 9)	306,806	-	-

Market risk

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

The Scheme's insurance liabilities are settled within one year. The Scheme does not discount insurance liabilities and consequently changes in market interest rates would not affect the Scheme's surplus or deficit.

Currency risk

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

For the purpose of seeking international diversification, the Scheme initially invested less than 5% of its assets offshore during the prior financial year. At 31 December 2011 this equates to R528 million (2010: R332 million), which represents 5.7% of the Scheme's investments and cash.

Derivative financial instruments

During the 2011 financial year the Scheme opted for the use of derivative financial instruments to manage its exposure to fluctuations in the Rand/Dollar exchange.

Forward exchange contract (currency forward)

The Scheme purchased a currency forward during the 2011 financial year. The purpose of the currency forward was to limit the economic impact resulting from a strong South African Rand.

The currency forward has not been designated as a hedging instrument, resulting in no hedge accounting being applied.

The fair value of the currency forward as at 31 December 2011 is R16,7 million.

31 FINANCIAL RISK MANAGEMENT REPORT (CONTINUED)

Currency risk (continued)

Currency risk sensitivity analysis

The sensitivity analysis is based on the Rand/Dollar spot rate as at 31 December 2011, with all other remaining variables constant.

A 5% increase or decrease in the value of the Rand against the Dollar will result in a R26,4 million profit and a R26,4 million loss respectively without the currency forward. As a result of purchasing the currency forward the respective profit or loss as a result of a 5% increase or decrease in the Rand/Dollar exchange rate will be a R12,9 million profit and a R5,9 million loss.

Price risk

The Scheme is exposed to equity securities price risk due to equity investments held by the Scheme that are classified as fair value through profit and loss. The Scheme is indirectly exposed to commodity risk through its investments in listed equities.

The Scheme manages the price risk arising from investments in equity securities, through the diversification of its investment portfolios. Diversification of the portfolios is performed by asset managers in accordance with the mandates set by the Scheme.

The Scheme purchased a derivative financial instrument to protect the solvency of the Scheme as a result of fluctuations in the equity market. This is mainly due to the global market instability resulting in local and international economic concerns.

Zero-cost short-fence (collar)

The collar is not designated as a hedging instrument and hedge accounting will not be applicable to the collar. The collar is categorised as at fair value through profit or loss.

The collar affords the Scheme limited downside protection resulting from a fall in the market price of equities. To achieve this, the Scheme has agreed to forego upside benefit above a predetermined level. The Scheme has over 4.5% of its overall portfolio invested in local equity.

The fair value of the collar as at 31 December 2011 is R3,9 million.

Sensitivity analysis – equity price risk

The sensitivity analysis is based on the contractual terms of the collar.

A 10% decrease in the price of listed equities within the equity portfolio will result in a loss of R37,7 million. The unrealised loss would be recognised as a fair value movement and disclosed in the Statement of Comprehensive Income.

The collar will effectively reduce the above loss by R16,4 million in the Statement of Comprehensive Income. In the event that stock markets perform particularly well during 2012, the equity hedge collar will dampen the increase on the instruments in the portfolios. The Scheme may not therefore experience the full market escalation – this is the cost of the downside protection.

Notes to the Annual Financial Statements

For the year ended 31 December 2011

31 FINANCIAL RISK MANAGEMENT REPORT (CONTINUED)

Interest rate risk

The Scheme is exposed to interest rate risk as it places funds in short maturity investments, money market accounts and bonds. The risk is managed by maintaining an appropriate mix between fixed and floating rate investments within the Scheme's money market investment portfolios as well as additional fixed and call deposit investments.

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

As at 31 December 2011	0 - 3 months R'000	3 - 12 months R'000	> 12 months R'000	Total R'000
Cash and cash equivalents	1,226,651	-	-	1,226,651
Money market instruments carried at fair value through profit or loss	-	6,364,632	-	6,364,632
Yield enhanced bond instruments carried at fair value through profit or loss	-	741,992	-	741,992
Offshore bond instruments carried at fair value through profit or loss	-	-	528,352	528,352

As at 31 December 2010	0 - 3 months R'000	3 - 12 months R'000	> 12 months R'000	Total R'000
Cash and cash equivalents	1,272,903	-	-	1,272,903
Money market instruments carried at fair value through profit or loss	-	6,301,554	-	6,301,554
Yield enhanced bond instruments carried at fair value through profit or loss	-	328,031	-	328,031
Offshore bond instruments carried at fair value through profit or loss	-	-	331,377	331,377

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

	2011 %	2010 %
Money market instruments carried at fair value through profit or loss	7.11%	7.97%
Cash and cash equivalents	5.27%	5.75%

The weighted average effective interest rate on short-term bank deposits (namely call account deposits) was 5.24% (2010: 6.17%). These deposits have an average maturity of 15 days (2010: 15 days).

Cash flow sensitivity analysis

In preparing the sensitivity analysis for the various portfolios expected future returns were obtained and reviewed. The prevailing market conditions including various risk factors were considered to determine a risk adjusted expected future return.

Equity portfolios

The expected return for the 12 months to December 2012 is expected to be 12.5%. The value at risk is expected to be 21.61% due to heightened risk caused by the global debt crisis. On the upside the Scheme's surplus and accumulated funds could increase by R47,3 million, based on December 2011 market values. On the downside the Scheme's surplus and accumulated funds could decrease by R34,5 million.

Portfolio equity derivatives

In order to generate an equity-related return on the cash balances held in both of the Scheme's equity portfolios, the Scheme's asset managers purchased futures and option contracts.

These contracts provide the Scheme with an exposure to the FTSE/JSE Top 40 Index. These instruments are traded on SAFEX and settled daily.

As at 31 December 2011 the following instruments with their respective market values were in use:

- FTSE/JSE Top 40 Index futures with a market value loss of R703,358
- ALSI Long Futures and options with a market value loss of R1,514,682.

31 FINANCIAL RISK MANAGEMENT REPORT (CONTINUED)

Offshore portfolios

The expected return for the 12 months to December 2012 before taking into account exposure to foreign currency is expected to be between 6.33% and negative 5%. On the upside the Scheme's surplus and accumulated funds could increase by US$4,15 million (R33,47 million) based on December 2011 market values, and decrease by US$3,27 million (R26,43 million) on the downside.

After taking into account exposure to foreign currency the return in South African Rand is expected to be 7.33% which increases the Scheme's surplus and accumulated funds by R38,75 million, with an annualised risk of 16.5%. The expected negative return is estimated to be 12% which could decrease the Scheme's surplus and accumulated funds by R63,55 million.

Cash flow sensitivity analysis

Money market portfolios

The expected return for the 12 months to December 2012 is estimated to be 7.27%, based on an analysis of the economic environment. The actual return is expected to be between 6.36% and 7.88%. The Scheme's surplus and accumulated funds could increase by a minimum of R427 million and a maximum of R530 million, based on market values at 31 December 2011.

In preparing the sensitivity analysis for 2012, a review of the movement of previous years' prime rates as well as the fixed deposit rates for the following 12 months was performed. The profile of the Scheme's investments at the reporting date as well as the prevailing market conditions at the time of preparing the financial statements was also considered.

Due to the short duration of these instruments and current economic factors we expect a possible change in interest rates by 50 basis points, decline or increase, for the third and fourth quarter of 2012. The effect of the increase or decrease in interest rates will result in a respective increase or decrease in the Scheme's surplus and accumulated funds by R15 million. This analysis assumed that all other variables remained constant. The main reason for changing the method used to determine the effect on the Scheme's results in 2012 is that this method provides a more objective measure and is expected to improve accuracy and comparability for future reporting periods.

Yield enhanced bond portfolios

The expected return for the 12 months to December 2012 is estimated to be 7,75% based on the expected performance of the bond markets for 2012. On the upside the Scheme's surplus and accumulated funds could increase by 9%, amounting to R73,8 million or decrease by 5%, which amounts to R41,3 million on the downside.

The Scheme's portfolio managers purchased bond futures to reduced the sensitivity of these portfolios to changes in the level of medium- and long-term interest rate level. The market value of the future as at 31 December 2011 is a gain of R2,834,120.

Legal risk

Legal risk is the risk that the Scheme will be exposed to contractual obligations which have not been provided for. At 31 December 2011 the Scheme did not consider there to be any significant concentration of legal risk that had not been provided for.

Notes to the Annual Financial Statements

For the year ended 31 December 2011

31 FINANCIAL RISK MANAGEMENT REPORT (CONTINUED)

Capital management

The Scheme is subject to the capital requirement imposed by Regulation 29(2) to the Medical Schemes Act, No 131 of 1998, as amended, which requires a minimum solvency ratio of accumulated funds expressed as a percentage of gross contributions to be 25%.

The Scheme's objectives when managing capital are to maintain the capital requirements of the Medical Schemes Act, No 131 of 1998, as amended, and to safeguard the Scheme's ability to continue as a going concern in order to provide benefits for its stakeholders.

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

	2011 R'000	2010 R'000
Total members' funds per Statement of Financial Position	7,419,231	6,847,076
Less: cumulative unrealised net gain on remeasurement of investments to fair value	(90,436)	(29,739)
Accumulated funds per Regulation 29	7,328,795	6,817,337
Gross contribution income	31,192,855	27,650,362
Solvency margin = Accumulated funds / gross contribution income x 100	**23.50%**	**24.66%**

At 31 December 2011, the Scheme's regulatory capital was R469 million less than the capital requirement imposed by the Regulator.

The Scheme has submitted a business plan to the Council for Medical Schemes in terms of Regulation 29(4) of the Medical Schemes Act, No 131 of 1998, as amended. The business plan provides that the Scheme will increase the statutory reserves to the required level of 25% by 31 December 2015. The business plan takes into account several assumptions such as membership growth, investment returns and medical inflation. The Council for Medical Schemes has approved the business plan.

Fair value estimation

The fair value of financial instruments traded in active markets is based on quoted market prices at the reporting date. The quoted market price used for financial assets held by the Scheme is the current bid price.

The carrying value less impairment provision of trade receivables and payables are assumed to approximate their fair values due to their short-term nature.

The members' savings accounts contain a demand feature. In terms of Regulation 10 of the Medical Schemes Act, No 131 of 1998, as amended, any credit balance on a member's savings account must be taken as a cash benefit when the member terminates his or her membership of the Scheme or benefit plan, and enrolls in another benefit plan or medical scheme without a savings account or does not enroll in another medical scheme. Therefore the carrying values of the members' savings accounts are deemed to be equal to their fair values, which is the amount payable on demand.

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 Scheme's Investment Committee invests excess funds in line with the Medical Schemes Act, No 131 of 1998, as amended.

The Scheme's investment objectives are to maximise the return on its investments on a long-term basis at minimal risk, subject to any constraints imposed by legislation or the Board of Trustees. The Scheme diversifies its investment portfolio by investing in short-term deposits, bond, money market and equity portfolios managed by reputable asset managers.

The Investment Committee monitors the performance of the Scheme's asset managers to ensure that the Scheme receives the benefit of top performing asset managers.

To assist the Regulator in monitoring the Scheme's compliance with Annexure B of the Medical Schemes Act, No 131 of 1998, as amended, the Scheme submits monthly detailed investment schedules to the Council for Medical Schemes, supplemented by the Scheme's asset manager's reports on a quarterly basis.

31 FINANCIAL RISK MANAGEMENT REPORT (CONTINUED)

Investment risk (continued)

Breakdown of investments

The investments managed by the Investment Committee are split between the following in the Annual Financial Statements:

- Investments carried at fair value through profit or loss
- Cash and cash equivalents.

Money market portfolios:

Local portfolios:

The two local money market portfolios are each managed by an independent asset manager. The investment mandate is for an actively managed portfolio of financial products aimed at achieving our performance of the targeted return.

The investment mandate is subject to the provisions of the Medical Schemes Act, No 131 of 1998, as amended.

For the first portfolio, the weighted modified duration of the portfolio shall not exceed 180 days. The weighted term to maturing of the portfolio shall not exceed two years. The term of each individual instrument is also limited.

The second portfolio has a number of liquidity restrictions ranging from a minimum of 20% of the assets under administration being available within 24 hours to an average portfolio duration of 180 days.

The performance of the first portfolio is measured against the Short Term Fixed Income (STeFI) Composite Index only. Approximately 30% of the second portfolio is measured against the STeFI Call Index and the remainder of the portfolio against the STeFI Composite Index.

The local money market portfolios comprise approximately 80% of the Scheme's financial assets at fair value through profit or loss.

Yield-enhanced bond portfolios:

Local portfolios:

The Scheme has two local and one offshore bond portfolios.

One asset manager manages a segregated credit income portfolio. The portfolio invests in a broad spectrum of listed and unlisted fixed-income instruments. The instruments are typically investment grade and include but are not limited to asset types such as listed bonds, credit-linked notes, floating rate notes, interest rate swaps and bond futures.

The investment mandate is subject to the provisions of the Medical Schemes Act, No 131 of 1998, as amended. In addition to the provisions in the Medical Schemes Act, the mandate sets specific exposure limits depending on the credit rating of the individual counterparty and has restricted exposure to unrated investments to 25% of the portfolio.

The benchmark for this portfolio is the Johannesburg Interbank Agreed Rate (JIBAR) over a period of one year.

This portfolio comprises approximately 5% of the Scheme's financial assets at fair value through profit or loss.

During the year the Board of Trustees further diversified the Scheme's investments by appointing an additional independent asset manager to manage a segregated yield enhanced bond portfolio. The portfolio has moderate risk limits seeking diversity, reasonable yield enhancement, moderate liquidity and relatively low volatility due to constrained interest rate positions.

The benchmark for this portfolio is the BEASSA All Bond Index ("ALBI") and comprises approximately 5% of the Scheme's financial assets at fair value through profit or loss.

Offshore portfolio:

The Scheme has one offshore portfolio managed by an independent asset manager. The primary objective of the investment portfolio is the generation of a high level of current income by means of investments in high-yielding fixed or floating rate securities of varying maturities denominated in a spread of currencies.

The investment mandate is subject to any applicable exchange control regulations and the provisions of the Medical Schemes Act, No 131 of 1998, as amended. The portfolio complies with the requirements of the Luxembourg law of 20 December 2002 relating to collective investment undertakings.

The benchmark for this portfolio is a Composite Global Strategic Income Bond Index, comprising of the different areas in which the manager may invest.

This portfolio comprises approximately 7% of the Scheme's financial assets at fair value through profit or loss.

Notes to the Annual Financial Statements

For the year ended 31 December 2011

31 FINANCIAL RISK MANAGEMENT REPORT (CONTINUED)

Investment risk (continued)
Breakdown of investments (continued)

Equity portfolios:

The Scheme has two local equity portfolios, each managed by an independent asset manager.

The primary goal of these mandates is to maximise long-term investment performance with due regard to the relevant risks, including volatility of returns, risk of capital loss and liquidity. The portfolios are managed on a moderate risk basis.

The portfolios may only be invested in South African equities and are subject to a maximum cash allocation of 5%. The portfolios are prohibited from investing in Discovery Holdings Limited or its subsidiaries and must comply with the Medical Schemes Act, No 131 of 1998, as amended.

The performance for the portfolios is the FTSE/JSE Shareholder Weighted Index (SWIX).

These portfolios comprise approximately 5% of the Scheme's financial assets at fair value through profit or loss.

To understand the risks associated with these investments better, the following disclosure is presented under each category.

Investments carried at fair value through profit or loss

Investments carried at fair value through profit or loss are made up of the following:

	As at 31 December 2011 R'000	As at 31 December 2010 R'000
Offshore bond portfolio	528,352	331,377
Local equity portfolios	377,102	422,757
Local yield enhanced bond portfolios	741,992	328,031
Local money market portfolios	6,364,632	6,301,554
Derivatives	21,206	15
Total	**8,033,284**	**7,383,734**

Cash and cash equivalents

Cash and cash equivalents are made up of the following:

	As at 31 December 2011 R'000	As at 31 December 2010 R'000
Deposits on call	580,000	653,506
Overnight deposits with financial institutions	389,128	355,268
Money market portfolios	257,523	264,129
Total	**1,226,651**	**1,272,903**

31 FINANCIAL RISK MANAGEMENT REPORT (CONTINUED)

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

	Financial assets and liabilities at fair value through profit and loss		Loans and receivables	Insurance receivables and (payables)	Financial liabilities at amortised cost	Total carrying amount	Fair value amount
	Designated upon initial recognition	Classified as held for trading					
	R'000	R'000	R'000	R'000	R'000	R'000	R'000
For the year ended 31 December 2011							
Investments							
– Offshore bond portfolio	-	528,352	-	-	-	**528,352**	**528,352**
– Listed equities	-	377,102	-	-	-	**377,102**	**377,102**
– Yield enhanced bond portfolios	-	741,992	-	-	-	**741,992**	**741,992**
– Money market portfolios	-	6,364,632	-	-	-	**6,364,632**	**6,364,632**
Cash and cash equivalents	-	-	1,226,651	-	-	**1,226,651**	**1,226,651**
Trade and other receivables	-	-	146,682	1,171,625	-	**1,318,307**	**1,318,307**
Members' savings accounts	-	-	-	(1,930,591)	-	**(1,930,591)**	**(1,930,591)**
Trade and other payables	-	-	-	(427,561)	(233,003)	**(660,564)**	**(660,564)**
Members' trust funds							
– Non-current portion	-	-	-	-	-	**-**	**-**
– Current portion	-	-	-	(11)	-	**(11)**	**(11)**
Derivatives held for trading							
– Forward exchange contract	-	16,659	-	-	-	**16,659**	**16,659**
– Collar	-	3,931	-	-	-	**3,931**	**3,931**
– Other	-	616	-	-	-	**616**	**616**
	-	**8,033,284**	**1,373,333**	**(1,186,538)**	**(233,003)**	**7,987,076**	**7,987,076**

Notes to the Annual Financial Statements

For the year ended 31 December 2011

31 FINANCIAL RISK MANAGEMENT REPORT (CONTINUED)

The following table compares the fair value and carrying amounts of financial assets and liabilities per class of assets and liabilities:

	Financial assets and liabilities at fair value through profit and loss		Loans and receivables	Insurance receivables and (payables)	Financial liabilities at amortised cost	Total carrying amount	Fair value amount
	Designated upon initial recognition	Classified as held for trading					
	R'000	R'000	R'000	R'000	R'000	R'000	R'000
For the year ended 31 December 2010							
Investments							
– Offshore bond portfolio	-	331,377	-	-	-	**331,377**	**331,377**
– Listed equities	-	422,757	-	-	-	**422,757**	**422,757**
– Yield enhanced bond portfolio	-	328,031	-	-	-	**328,031**	**328,031**
– Money market portfolios	-	6,301,554	-	-	-	**6,301,554**	**6,301,554**
Cash and cash equivalents	-	-	1,272,903	-	-	**1,272,903**	**1,272,903**
Trade and other receivables	-	-	72,644	1,062,627	-	**1,135,271**	**1,135,271**
Members' savings accounts	-	-	-	(1,718,442)	-	**(1,718,442)**	**(1,718,442)**
Trade and other payables	-	-	-	(358,637)	(306,806)	**(665,443)**	**(665,443)**
Members' trust funds							
– Non-current portion	-	-	-	-	-	-	-
– Current portion	-	-	-	(350)	-	**(350)**	**(350)**
Derivatives held for trading							
– Forward exchange contract	-	-	-	-	-	-	-
– Collar	-	-	-	-	-	-	-
– Other	-	15	-	-	-	**15**	**15**
	-	**7,383,734**	**1,345,547**	**(1,014,801)**	**(306,806)**	**7,407,673**	**7,407,673**

31 FINANCIAL RISK MANAGEMENT REPORT (CONTINUED)

Fair value hierarchy for financial assets measured at fair value

Assets measured at fair value

2011	Fair value measurement at end of the year using:		
	R'000	Level 1 R'000	Level 2 R'000
Financial assets at fair value through profit or loss:			
Equity instruments	**377,102**	377,102	-
Government bonds	**144,758**	144,758	-
Corporate bonds	**1,042,850**	-	1,042,850
Other investments	**6,468,574**	-	6,468,574
	8,033,284	**521,860**	**7,511,424**

2010	Fair value measurement at end of the year using:		
	R'000	Level 1 R'000	Level 2 R'000
Financial assets at fair value through profit or loss:			
Equity instruments	**422,757**	422,757	-
Government bonds	**-**	-	-
Corporate bonds	**2,765,957**	-	2,765,957
Other investments	**4,195,005**	-	4,195,005
	7,383,719	**422,757**	**6,960,962**

The fair value assets are classified using a fair value hierarchy that reflects the significance of the inputs used in determining the measurements.

The fair value hierarchy has the following levels:

Level 1 – These are assets measured using quoted prices in an active market

Level 2 – These are assets measured using inputs other than quoted prices included within Level 1 that are either directly or indirectly observable

Level 3 – These are assets measured using inputs that are not based on observable market data.

The Scheme does not have any assets falling under Level 3.

32 CRITICAL ACCOUNTING ESTIMATES AND JUDGEMENTS

Critical accounting estimates and assumptions

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.

Outstanding claims provision

The critical estimates and judgements relating to the outstanding claims provision are set out under Note 30.

Other risk transfer arrangements

The critical estimates and judgements relating to other risk transfer arrangements are set out under Note 11.

Impairment of assets

The critical estimates made by the Scheme are set out under Note 31 and judgements relating to the impairment of assets are set out under Note 7 of the Accounting Policies.

Notes to the Annual Financial Statements

For the year ended 31 December 2011

33 MATERIAL NON-COMPLIANCE MATTERS

Statutory Scheme solvency

In terms of Regulation 29(2) of the Medical Schemes Act, No 131 of 1998, as amended, the Scheme must maintain accumulated funds expressed as a percentage of gross annual contributions for the accounting period under review which may be no less than 25%.

At 31 December 2011, the Scheme's accumulated funds expressed as a percentage of gross annual contributions was 23.5% (2010: 24.66%) which is less than the statutory requirement of 25%. The Scheme advised the Council for Medical Schemes during 2011 that one of the main reasons for this remains continuous high membership growth.

The Scheme has submitted a business plan to the Council for Medical Schemes in terms of Regulation 29(4) of the Medical Schemes Act, No 131 of 1998, as amended. The business plan provides that the Scheme will increase the statutory reserves to the required level of 25% by 31 December 2015. The business plan takes into account several assumptions such as membership growth, investment returns and medical inflation. The Council for Medical Schemes has approved the business plan.

Sustainability of benefit plans

In terms of Section 33(2) of the Medical Schemes Act, No 131 of 1998, as amended, each plan is required to be self-supporting in terms of membership and financial performance and be financially sound.

At 31 December 2011 the following plans did not comply with Section 33(2):

Plan	Net underwriting deficit R'000	Net (deficit)/ surplus R'000
Executive	(274,569)	(266,874)
Classic Comprehensive	(714,328)	(592,862)
Foundation Core	(2,364)	(1,896)
Coastal Saver	(23,930)	69,085
KeyCare Plus	(354,238)	(240,338)

The Trustees continue to monitor these plans with a view to improving their financial outcomes, and will evaluate different strategies to address the deficits in these plans. The different financial positions reflect the different disease burdens in each plan, among many other factors, and are due in large measure to the continued pattern of sicker members of the Scheme buying up to higher plans when they develop a serious illness. This is reflected in the much higher disease burden and risk profile of the top plans relative to the rest of the Scheme. The Scheme's strategy on the sustainability of plans has to balance short- and long-term financial considerations with considerations of fairness to both healthy and sick members, and with continued affordability of cover for members with different levels of income and different healthcare needs. While the Trustees are committed to complying wherever possible with the applicable legislation, we also focus intensively on the overall stability and financial position of the Scheme as a whole and not only on individual benefit plans.

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