# Discovery Health Medical Scheme
# Integrated Annual Report 2012

# Your Discovery Health Medical Scheme **Integrated Annual Report**

## About this report

The aim of the Discovery Health Medical Scheme Integrated Annual Report for 2012 is to provide readers with information about the Discovery Health Medical Scheme's financial and operational performance for the period 1 January 2012 to 31 December 2012. 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.

## Contact us

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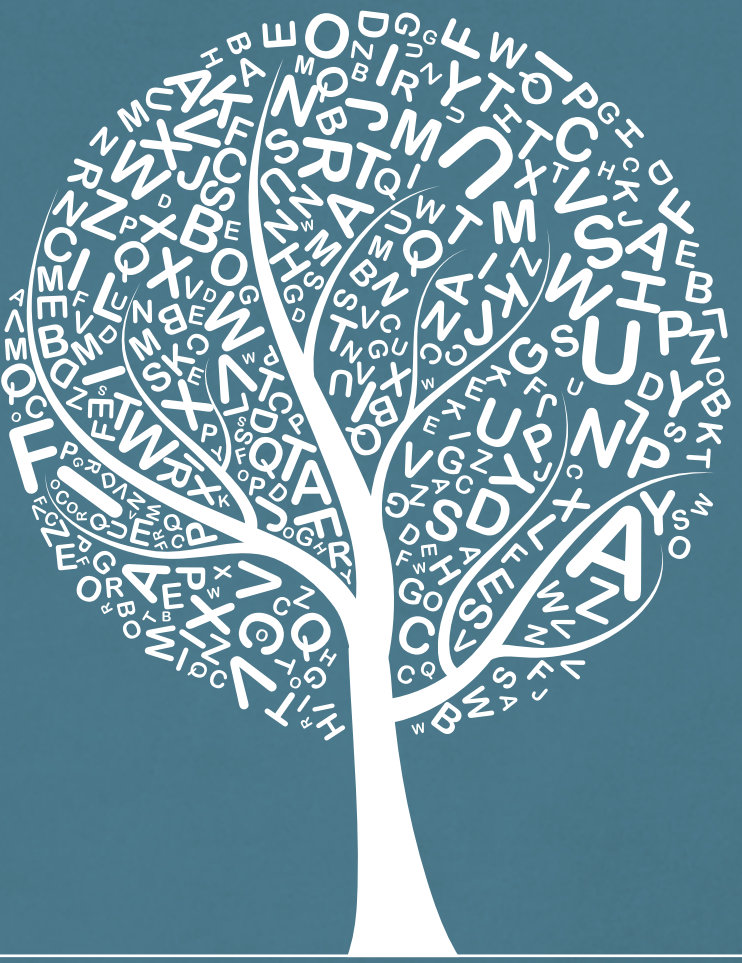


**Executive** reports

# Chairperson's report

Adv Michael van der Nest

The Discovery Health Medical Scheme experienced another year of robust performance.

In an environment where the majority of medical schemes in South Africa are shrinking, the Discovery Health Medical Scheme continues to go from strength to strength. It remains the scheme which attracts most new members, with the highest growth rate, offering continuity, financial stability and predictability for members. The Scheme has grown by more than 100 000 lives each year since 2008, to 2 469 023 lives at the end of 2012. It also experienced another year of strong financial performance, generating a net surplus of R789 million for the period under review. This will go towards building the Scheme's reserves, which now stand at a significant R8.2 billion.

The Discovery Health Medical Scheme's strong financial performance is evidence of its sound financial management, continuous best practice governance and effective risk management, which underpin the performance of the Scheme and ensure its long-term sustainability.

The Board of Trustees of the Discovery Health Medical Scheme is responsible for the stewardship of the Scheme by focusing on continuous best practice governance output. The Trustees, who are all highly skilled, professional individuals, are the representatives of the Scheme's members. A main focus of the Trustees is to drive continuous innovation at all levels of strategy and operations, ensuring that members receive maximum value for the contributions they pay. One of the most important functions of the Trustees is to continually evaluate the performance of the Administrator and Managed Healthcare Provider, Discovery Health (Pty) Ltd, based on global best practice outsourcing principles. At a Board meeting in November 2011, the Trustees resolved to commission an independent governance review, including an in-depth assessment of the value for money obtained by the Scheme and its members from Discovery Health (Pty) Ltd. This review was recently completed by the consulting firm Deloitte Consulting (Pty) Ltd, and the findings will be presented at the 2013 Annual General Meeting of the Scheme.

The more than 2.4 million lives to whom the Discovery Health Medical Scheme provides healthcare cover are the Scheme's most important stakeholders. On behalf of the Board of Trustees, I would like to thank the Scheme's members for their continued support, evidenced by the very low lapse rates experienced by the Scheme.

As the benchmark open medical scheme in South Africa, the Discovery Health Medical Scheme regularly engages with the Council for Medical Schemes, the National Department of Health and relevant industry bodies on issues impacting healthcare in South Africa. The private healthcare system in South Africa is a national asset and the Scheme supports all efforts by Discovery Health (Pty) Ltd and other stakeholders in building a better healthcare system for not only Scheme members but all South Africans.

Going forward, the Board of Trustees will continue to focus on providing Scheme members with excellent value and strive to balance the needs of all healthcare stakeholders in a responsible way, thereby ensuring a sustainable and thriving private healthcare system.

Adv M van der Nest
*Chairperson*

# **Principal Officer's** report

Milton Streak

The 2012 financial year was another challenging one for all medical schemes. Ongoing economic uncertainty, rising healthcare costs due to utilisation changes and increased disease burden, and intense media and public debate around healthcare issues continued to impact the healthcare industry. In the face of these complexities, the Discovery Health Medical Scheme continued to deliver on its core purpose of funding quality, cost-effective healthcare cover for all its members, and achieved a positive operating result for the period under review. The Scheme's gross contribution income was R35.19 billion, with a net surplus (including investment income) of R789 million.

The Scheme again experienced substantial membership growth, increasing principal membership by 6% off an already high base. Overall, the Scheme added 64 224 new principal members, and ended the year with 2 469 023 million lives covered. The Scheme now covers 51% of the lives in the open medical scheme industry and 30% of the total medical scheme industry, enhancing its position as the benchmark open medical scheme in South Africa. In a community-rated regulatory environment, continuous and steady membership growth is vital for the sustainability of medical schemes.

When considering the drivers of medical inflation over the past five years, non-healthcare expenditure has been the Scheme's only cost component that has been reducing consistently in real terms. The Board of Trustees has set a combined administration and managed healthcare fees target of 10% of total annual contribution income, to be achieved by 2014. While claims have increased by 17.5% over and above consumer price inflation over the past five years, administration and managed healthcare fees have had a deflationary effect of 4.6% over the same period.

The Discovery Health Medical Scheme's substantial membership growth continues to create solvency pressures on the Scheme, which is required to maintain accumulated funds of 25% of annual contribution income. The Scheme's solvency ratio is now at 23.41%, in line with the solvency trajectory agreed with the Council for Medical Schemes. The Council has approved the Scheme's business plan detailing the timeline over which the Scheme will increase solvency to 25%. It is estimated that this solvency level will be reached by 2015. In increasing solvency, annual contribution increases and building the Scheme's reserves must be carefully and responsibly balanced without increasing the financial burden on members. The value of Scheme reserves has increased to R8.2 billion, which is indicative of the significant financial strength and scale of the Discovery Health Medical Scheme in the private healthcare industry.

During the 2012 financial year, the Discovery Health Medical Scheme continued its commitment to providing rich benefits and the widest plan choices to all Scheme members, while at the same time expanding access to more affordable healthcare cover to a broader base of the lower income market. The Scheme's contribution increases for 2013 ranged between 9.8% and 11.8%, and were set to recognise the difference in demand-side effects between different plans, ensure sustainability of cover for low-income members, and continue to build solvency while growing membership. The Discovery Health Medical Scheme remains the most affordable medical scheme choice across the entire spectrum of healthcare needs.

The confidence in the Discovery Health Medical Scheme and its ability to retain members is demonstrated by the extremely low number of members leaving the Scheme (the lapse rate). During 2012, the lapse rate reduced even further to 4.1% (2011: 4.3%), and remains the lowest in the open medical schemes market by a

significant margin. The position of the Scheme in the private healthcare industry has again been validated by the AA+ credit rating of the Scheme by independent credit rating agency Global Credit Ratings – the highest rating an open medical scheme in South Africa can receive. The Scheme has maintained this rating for 12 consecutive years.

Over the past 20 years, the unique and successful health risk management operating model employed by Discovery Health (Pty) Ltd has continued to ensure the cost-effective management of healthcare funding and the sustainability of the Discovery Health Medical Scheme. The efficiency of this integrated model, which is built on innovation, collaboration, good corporate governance, transparency and member engagement, has been demonstrated by the success of the Scheme relative to all its competitors, on every performance metric. The scale of the operations of Discovery Health (Pty) Ltd is unparalleled in the industry, with over 35 300 calls answered each day and claims volumes of 3.9 million a month. Independent industry surveys have confirmed that the services provided by Discovery Health (Pty) Ltd are among the most highly rated in the industry. In 2012, the Administrator and Managed Healthcare Provider achieved an all-time high client satisfaction score of 8.96 (out of 10).

The Scheme and Discovery Health (Pty) Ltd have leveraged the Scheme's scale to develop a range of technological and service innovations aimed at ensuring quality of care for members, greater control of costs, and the improvement of members' experience in the healthcare system. These revolutionary innovations include smartphone and iPad applications for both healthcare professionals and members, telemetry and other devices, and iPad applications for healthcare advisers. HealthID was launched in 2012 – it is a groundbreaking iPad application for healthcare professionals and a first in the private healthcare industry in South Africa. It provides a platform for sharing clinical information to facilitate better coordination of care, improve efficiency and patient outcomes and streamline doctors' administration.

Discovery Health (Pty) Ltd has invested significantly in a wide range of benefit and risk management assets and tools. These include a number of important healthcare provider assets within the healthcare system. These capabilities and assets have succeeded in "bending the cost curve" for the Discovery Health Medical Scheme and lowering the cost of healthcare for both Scheme members and the industry.

The Discovery Health Medical Scheme will focus on ensuring continuous best practice governance, a continued focus on innovation in risk management and alternative reimbursement strategies, and enhanced stakeholder engagement and relationship strategies. Innovation in product design to maintain and enhance the Scheme's competitive and product leadership positions also remains a key strategic imperative. Through its commitment to best practice governance, the Discovery Health Medical Scheme Board of Trustees and the Administrator and Managed Healthcare Provider, Discovery Health (Pty) Ltd, will continue to navigate the complex private healthcare system optimally to ensure continuous excellent value for members.

Milton Streak
*Principal Officer*

**Overview:**
Discovery Health Medical Scheme

# Key facts and figures

**6%**
Average increase in principal members of the Discovery Health Medical Scheme in 2012.

**2 469 023**
Number of lives the Discovery Health Medical Scheme covers.

**R8.2 billion**
Value of Discovery Health Medical Scheme members' reserves.

**R789 million**
The net surplus generated for the year under review.

**23.41%**
The Discovery Health Medical Scheme's solvency level. This is slightly below the required level of 25%. The Scheme is implementing strategies to reach the required 25% solvency ratio by 2015, 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 for claims paying ability. AA+ is the highest rating possible for an open medical scheme in South Africa, and has only been awarded to the Discovery Health Medical Scheme. The Scheme has kept this rating for 12 consecutive years.

The Discovery Health Medical Scheme (the Scheme) is the largest open medical scheme in South Africa and provides cover to more than 2.4 million people. It is a not-for-profit entity and is governed by the Medical Schemes Act, No 131 of 1998, as amended, and by the rules of the Discovery Health Medical Scheme. It is regulated by the Council for Medical Schemes.

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 2012 financial year. It explains how the Scheme is governed, including the responsibilities of the Board of Trustees and its various committees. The Discovery Health Medical Scheme has to balance the needs of various stakeholders in the healthcare environment, and the overview sets out how the Scheme interacts with these stakeholders throughout the year. It provides a short overview of the key strategic issues facing the private healthcare industry, including the factors influencing the sustainability of medical schemes, and highlights the key factors that differentiate the Discovery Health Medical Scheme from other open medical schemes. These include the status of the Scheme as the industry benchmark in South Africa, the strong and consistent pattern of membership growth and strong financial performance of the Scheme, how the Scheme balances cost, quality and sustainability, and the role of Vitality in bringing down costs for Scheme members. Lastly, the overview sets out the strategic objectives of the Scheme going forward, and highlights focus areas for 2013.

# **Governance** of the Discovery Health Medical Scheme

The Discovery Health Medical Scheme is governed on behalf of its members by an independent Board of Trustees. The 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 and Managed Healthcare Provider of the Scheme, Discovery Health (Pty) Ltd, or to 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, No 131 of 1998, as amended, 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 Trustees 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. One of the most important functions of the Board of Trustees is to ensure that the services provided to the Discovery Health Medical Scheme by its Administrator and Managed Healthcare Provider, Discovery Health (Pty) Ltd, are consistent with best practice, the highest service and operational standards, and the provisions stipulated in the Medical Schemes Act, No 131 of 1998, as amended, and administration and managed healthcare agreements.

The Discovery Health Medical Scheme adheres fully to all aspects of governance of the Scheme as required by the Medical Schemes Act, No 131 of 1998, as amended, and goes further in implementing the requirements of the King III Code on Corporate Governance in South Africa. The Board of Trustees has instituted periodic independent governance reviews to assess the effectiveness of the Board and its committees in terms of the correct skills and expertise represented. The Board and all its committees also perform annual peer and effectiveness reviews to address and strengthen governance processes.

This continued focus on governance best practice is evidenced by the fact that there has never been any instance of governance failures concerning the Discovery Health Medical Scheme.

The remuneration of the Discovery Health Medical Scheme Board of Trustees and its committees is benchmarked through independent review on a periodic basis. The Scheme's Remuneration Committee uses expert input and independent benchmarking surveys, based on remuneration structures for non-executive directors of large insurance and financial organisations in South Africa, as guidelines for its remuneration policy. The Board of Trustees takes on a high degree of fiduciary responsibility and risk in overseeing a scheme with an annual contribution income in excess of R35 billion, members' reserve funds in excess of R8.2 billion, and which operates in a highly regulated and complex environment. The fees paid to the Trustees are considered appropriate considering these levels of responsibility and the skills and experience required.

# Board of Trustees of the Discovery Health Medical Scheme

### Adv Michael van der Nest

BA (Law), LLB (Stellenbosch)
***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)

### Adv Noel Graves

BA, LLB (UCT)

### Dr Nozipho Sangweni

MBChB (Natal), DOH (Wits), DCAM (IATA), MBA (GIBS)
***Deputy Chairperson***

### Mr Giles Waugh

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

### Mr Barry Stott

CA (SA)

### Mr Puke Maserumule

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

**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, the Administrator and Managed Healthcare Provider, and other stakeholders of the Scheme along sound and best practice governance principles
- Appreciate that strategy, risk, performance and sustainability are inseparable
- Provide effective, ethical leadership
- 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 has an effective and independent audit committee
- Be responsible for the governance of risk and combined assurance
- 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:**

- Act with due care, diligence, skill and good faith
- Ensure the proper and sound management of the Scheme
- Appoint, evaluate and delegate functions to the Principal Officer
- Oversee and direct the management of the Scheme's activities performed by the Administrator and Managed Healthcare Provider
- Apply sound business principles and ensure the financial soundness of the Scheme
- Address key issues and ensure that discussions 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 members regarding their rights, benefits, contributions and duties in terms of the rules of the Scheme.

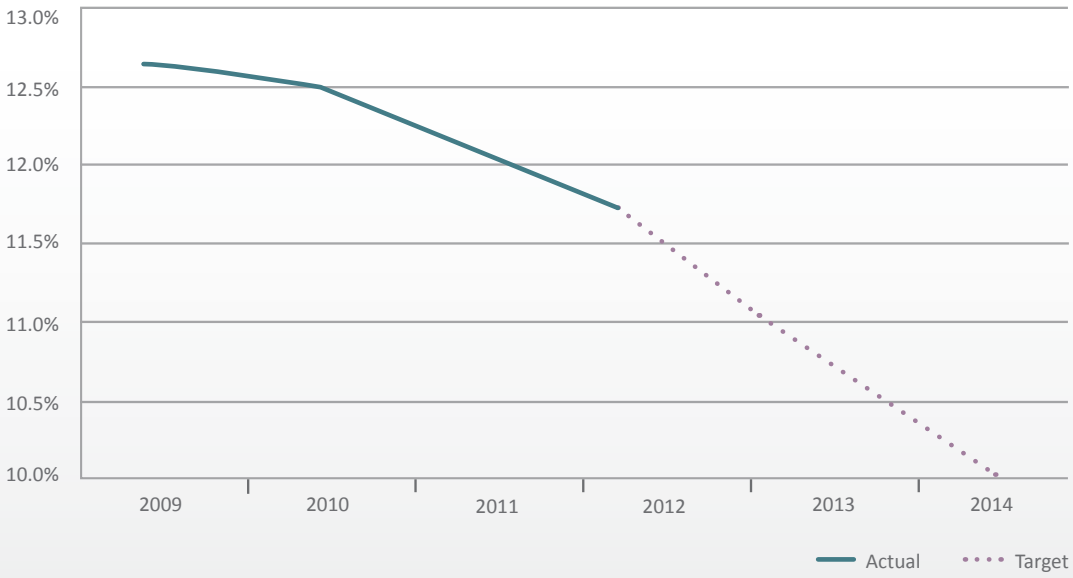
## Ensuring value for money for Discovery Health Medical Scheme members

The Board of Trustees of the Discovery Health Medical Scheme continually evaluates the performance of the Administrator and Managed Healthcare Provider, Discovery Health (Pty) Ltd, and the value for money provided to the Scheme and its members.

Discovery Health (Pty) Ltd is paid a fixed fee Per Member Per Month by the Scheme for the administration and managed healthcare services it provides to the Scheme. The fees paid by the Scheme to Discovery Health (Pty) Ltd are within the guidelines set by the Council for Medical Schemes and are governed by a formal contract, which is negotiated annually between the Board of Trustees and Discovery Health (Pty) Ltd. Each annual negotiation takes into account the Consumer Price Index, the range of services to be provided, as well as the growth in Scheme membership. The Scheme's Trustees review and approve the administration and managed healthcare fees every year.

When considering the drivers of medical inflation over the past five years, non-healthcare expenditure has been the Scheme's only cost component that has been reducing consistently in real terms. All other areas of claims cost continue to rise at a rate significantly higher than the Consumer Price Index. This is due to a combination of tariff inflation and increasing utilisation of healthcare services by members of the Scheme, as a result of increasing age, disease burden and the impact of new medical technologies. Over the past five years, claims have increased by 17.5% over and above consumer price inflation. Over the same period, the administration and managed healthcare fees paid by the Scheme to Discovery Health (Pty) Ltd have fallen by 4.6% in real terms. This is due to ongoing fee reductions which have been negotiated by the Trustees since 2008. The reduction in fees is expected to continue in line with ongoing growth of the Scheme. The Trustees have set a combined administration and managed healthcare fee target of 10% of total annual contribution income to be reached by the end of 2014.

**The historical trend and future trajectory of the Scheme's administration and managed healthcare fees as a percentage of gross contributions:**




At their Board meeting in November 2011, the Trustees decided to commission a detailed, independent review of the governance of the Scheme, and the value for money obtained by the Scheme and its members from Discovery Health (Pty) Ltd. This review was recently completed by the consulting firm Deloitte Consulting (Pty) Ltd. The results of the review will be made public at the Scheme's Annual General Meeting in June 2013. A report of the findings of this review will be included in the 2013 Discovery Health Medical Scheme Integrated Annual Report.

## Board of Trustees performance assessment and peer review

A collective board-effectiveness evaluation and peer review is performed annually. The Chairperson meets with individual Trustees on a one-to-one basis to assess and discuss performance and other related matters when necessary.

## Board of Trustees proceedings

The Board of Trustees met nine times during the 2012 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 discuss strategic focus areas with the Trustees. The Trustees have continuous, full and unrestricted access to all 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. Such independent advice is routinely obtained at each annual review of the Scheme's contribution and proposed benefit changes for the subsequent benefit year, and on other occasions when deemed appropriate.

**During the past financial year the Trustee meeting attendance was as follows:**

| Name | 9 February 2012 | 20 February 2012 | 21 February 2012 | 17 April 2012 | 12 June 2012 | 18 July 2012 | 16 August 2012 | 13 September 2012 | 13 November 2012 |
|---|---|---|---|---|---|---|---|---|---|
| Adv M van der Nest | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Mr P Maserumule | ✓ | ✓ | ✓ | x | ✓ | ✓ | x | ✓ | x |
| Dr N Sangweni | x | ✓ | ✓ | x | ✓ | ✓ | ✓ | ✓ | ✓ |
| Adv N Graves | ✓ | ✓ | ✓ | ✓ | x | ✓ | ✓ | ✓ | ✓ |
| Mr B Stott | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Prof Z van der Spuy | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | x | ✓ |
| Mr G Waugh | ✓ | ✓ | ✓ | ✓ | x | ✓ | ✓ | ✓ | ✓ |

# 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 charters. The establishment of committees does not exonerate the Board of Trustees from its fiduciary responsibilities. The performance of these committees is considered by the Trustees annually.

**During the year under review, the following two new permanent Board committees were established:**

- Non-healthcare Expense Committee
- Product Review Committee.

A Governance Review Steering Committee was also established in 2012 to oversee the independent governance review of the Scheme described above.

Each of the Board committees have terms of reference and conduct independent reviews annually. No major issues were noted for these committees in 2012.

**The committees of the Board of Trustees are:**

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

**Risk Committee**
Mr D Eriksson – Chairperson (Independent)
Mr N Novick – Independent member
Mr S Green – Independent member
Mr B Stott – Trustee
Mr G Waugh – Trustee
Mr M Streak – Principal Officer
Dr S Rich – Clinical Executive

**Clinical Governance Committee**
Dr N Sangweni – Chairperson (Trustee)
Prof Z van der Spuy – Trustee
Dr S Rich – Clinical Executive

**Investment Committee**
Mr P Maserumule – Chairperson (Trustee)
Mr B Stott – Trustee
Mr G Waugh – Trustee

**Remuneration Committee**
Adv M van der Nest – Board of Trustees Chairperson
Mr D Eriksson – Audit Committee and Risk Committee Chairperson

**Non-healthcare Expense Committee**
Mr B Stott – Trustee
Mr G Waugh – Trustee
Adv N Graves – Trustee

**Product Review Committee**
Dr N Sangweni – Trustee
Mr G Waugh – Trustee

## Audit Committee

The Audit Committee is a statutory committee established in terms of Sections 36(10) to (13) of the Medical Schemes Act, No 131 of 1998, as amended. The Audit Committee is mandated by the Board of Trustees by means of written terms of reference, which determine its membership, authority and duties. The main functions and responsibilities of the Audit Committee are to assist the Board of Trustees in discharging their responsibilities relating to the safeguarding of Scheme assets, the operation of adequate and effective systems and control processes, the preparation of fairly presented Annual Financial Statements in compliance with International Financial Reporting Standards and all applicable legal and regulatory requirements. The Audit Committee is satisfied that the Scheme has optimised the assurance coverage obtained from management, and internal and external assurance providers, in accordance with an appropriate combined assurance framework.

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

The report from the Audit Committee is set out on page 74 of this report.

### The responsibilities of the Audit Committee are to:

- Ensure that a combined assurance model is applied to provide a coordinated approach to all assurance activities for all significant risks facing the Scheme
- Ensure that the Finance function of the Scheme has sufficient expertise, resources and experience
- Assist in the execution of the Board of Trustees' role of accountability
- Ensure integrity, reliability and accuracy of accounting and financial reporting systems
- Have oversight of financial reporting risk, internal financial controls, fraud risk and IT risks in relation to financial reporting
- Ensure that appropriate systems are in place for the monitoring of risk, control and compliance with laws, regulations and codes of conduct
- Ensure that the significant risks facing the Scheme are adequately addressed
- 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
- Review the scope, quality and cost of the statutory audit and the independence of the auditors
- Examine and review the Scheme's Annual Financial Statements before submission and approval by the Board of Trustees
- Ensure that matters relating to the sustainability of the Scheme to the extent that they have an impact on the financial results, are addressed
- Oversee and review the performance of the internal audit function.

The Audit Committee is independent and the majority of members, including the Chairperson, are not officers of the Scheme, its Administrator, the controlling company of the Administrator or any subsidiary of its controlling company. The composition of the Audit Committee meets the statutory requirements of Section 36(11) of the Medical Schemes Act, No 131 of 1998, as amended.

The Audit Committee had five members at 31 December 2012, two of whom are members of the Board of Trustees.

### As at 31 December 2012, the Committee members were:

- Mr D Eriksson (Independent member), CA (SA) – Chairperson
- Mr N Novick (Independent member), CA (SA)
- Mr S Green (Independent member), BSc (Hons)
- Mr B Stott (Trustee member), CA (SA)
- Mr 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 and the heads of the outsourced administration functions, attend all Audit Committee meetings by invitation and have unrestricted access to the Chairperson of the Audit Committee. The Audit Committee meets at least four times per year and schedules additional meetings if necessary.

### During the 2012 financial year, attendance at the Audit Committee meetings was as follows:

| Name | 5 March 2012 | 15 March 2012 | 12 July 2012 | 14 August 2012 | 30 October 2012 |
|---|---|---|---|---|---|
| Mr D Eriksson | ✓ | ✓ | ✓ | ✓ | ✓ |
| Mr N Novick | ✓ | ✓ | ✓ | ✓ | ✓ |
| Mr S Green | ✓ | ✓ | ✓ | ✓ | ✓ |
| Mr B Stott | ✓ | ✓ | ✓ | ✓ | ✓ |
| Mr G Waugh | ✓ | ✓ | ✓ | ✓ | ✓ |

The external and internal auditors regularly meet separately with the Audit Committee without the presence of the Administrator's management. Management meets regularly with the Audit Committee without the presence of the auditors.

# Risk Committee

Although the Risk Committee is not mandated by the Medical Schemes Act, No 131 of 1998, as amended, the Board of Trustees has established the Committee to ensure best practice governance.

**In assisting the Board of Trustees in carrying out its risk responsibilities, the purpose and objectives of the Risk Committee, as described in the King III code, are to:**

- Consider the risk management strategy, policy and plans for recommendation to the Board of Trustees for approval
- Monitor the risk management process and effectiveness
- Ensure continuous risk monitoring by management
- Recommend the introduction of measures which the Committee believes may enhance the risk management process
- Monitor the appropriateness of the Scheme's combined assurance model
- Advise on any matter referred to the Committee by the Board of Trustees.

**The Scheme categorises risks into four main risk classes:**

| Risk class | Description | Examples of risks considered in 2012 |
|---|---|---|
| Strategic risk | • Business model – the risk of failing to meet the Scheme's strategic objectives arising from a poor choice of strategy<br>• External environment – the risk arising from the external environment acting to prevent the Scheme realising its strategy. | Plan and benefit design<br>Competitor and substitute risk |
| Financial risk | The risk that the Scheme will be unable to meet its financial obligations. This risk is primarily a function of credit, market and liquidity risks. | Contribution income |
| Insurance risk | The inherent uncertainty as to the occurrence, amount and timing of insurance liabilities of the Scheme. | Claims experience and demographic risk |
| Operational risk | Risk of direct or indirect loss resulting from inadequate or failed internal processes, people and systems, or from external events. | Statutory and regulatory compliance |

The Committee has identified National Health Insurance as an issue. However, owing to a lack of information, the level of risk posed to the Scheme cannot be adequately assessed.

The risk management processes of the Scheme are designed to cover all its activities and contribute to both the growth and protection of members and Scheme assets.

## Compliance management

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 pro-active and accountable management of regulatory compliance risks within the Scheme and ensures that management understands its accountability.

The Compliance function is independent of Scheme management, and its primary responsibility is to assist the Principal Officer and the Board of Trustees to discharge their responsibility.

### It must ensure that operations:

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

### 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
- **Providing general guidance and support to the Scheme:** Assisting Scheme management with the implementation of appropriate controls to monitor compliance to relevant regulatory obligations, to assist the Scheme with the management of any 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, Scheme 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 Scheme's operations as appropriate
- Have appropriate access to all relevant committees of the Scheme
- Obtain assistance from relevant operational functions 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.

## Combined Assurance

All risk classes are considered during the risk management process, which incorporates various assurance providers' input.

### The Scheme uses a combined assurance model based on three lines of defence:

- Management-based assurance, with management responsible for assessing, managing and monitoring risk
- Risk and compliance-based assurance, and other specialist functions
- Assurances provided by independent parties.

| First line of defence | Second line of defence | Third line of defence |
|---|---|---|
| Scheme management | Risk function | Internal audit |
| Administrator management | Compliance function | External audit |
| | Forensic function | Independent actuary |
| | Special projects / external consultants | Special projects / external consultants |

The combined assurance model is further enhanced with the assistance of independent Board committees.

### The Risk Committee:

- Ensures that the combined assurance received is appropriate to address all the significant risks facing the Scheme
- Monitors the relationship between the external assurance providers of the Scheme.

The Risk Committee had seven members at 31 December 2012, three of whom are independent, two are members of the Board of Trustees, and two are executives of the Scheme.

### As at 31 December 2012, the Committee members were:

- Mr D Eriksson (Independent member), CA (SA) – Chairperson
- Mr N Novick (Independent member), CA (SA)
- Mr S Green (Independent member), BSc (Hons)
- Mr B Stott (Trustee member), CA (SA)
- Mr G Waugh (Trustee member), FIA, FASSA
- Mr M Streak (Principal Officer), B Pharm, MM
- Dr S Rich (Clinical Executive), MBBCh.

The Risk Committee meets at least four times per year. It has additional meetings when they are required.

### During the 2012 financial year, attendance at the Risk Committee meetings was as follows:

| Name | 5 March 2012 | 15 March 2012 | 12 July 2012 | 14 August 2012 | 30 October 2012 |
|---|---|---|---|---|---|
| Mr D Eriksson | ✓ | ✓ | ✓ | ✓ | ✓ |
| Mr N Novick | ✓ | ✓ | ✓ | ✓ | ✓ |
| Mr S Green | ✓ | ✓ | ✓ | ✓ | ✓ |
| Mr B Stott | ✓ | ✓ | ✓ | ✓ | ✓ |
| Mr G Waugh | ✓ | ✓ | ✓ | ✓ | ✓ |
| Mr M Streak | ✓ | ✓ | ✓ | ✓ | ✓ |
| Dr S Rich | ✓ | ✓ | ✓ | ✓ | ✓ |

## Investment Committee

The Investment Committee, established by the Board of Trustees, is mandated to invest the Scheme's investable assets 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 investment returns on a long-term basis while exposing the investments to minimal risk, to ensure sufficient liquidity to meet its liabilities, subject to any constraints imposed by legislation or the Trustees. The Investment Committee is advised by an independent asset consultant, Riscura Consulting (Pty) Ltd, which assists the Committee in formulating and monitoring an appropriate investment strategy for the Scheme's assets.

**As at 31 December 2012, the Committee members were:**

- Mr P Maserumule, BA (Law), LLB – Chairperson
- Mr B Stott, CA (SA)
- Mr G Waugh, FIA, FASSA.

**During the 2012 financial year, attendance at Investment Committee meetings was as follows:**

| Name | 16 March 2012 | 12 July 2012 | 30 October 2012 |
|---|---|---|---|
| Mr P Maserumule | ✓ | ✓ | ✓ |
| Mr B Stott | ✓ | ✓ | ✓ |
| Mr G Waugh | ✓ | ✓ | ✓ |

## Clinical Governance Committee

Although the Clinical Governance Committee is not a statutory requirement, it does represent best practice governance, and the Board of Trustees has considered that there is a need for this Committee to ensure compliance with the Medical Schemes Act, No 131 of 1998, as amended, and its regulations.

Clinical governance forms a framework in terms of which the Discovery Health Medical Scheme develops effective oversight management on clinical matters, managed healthcare contracts and best clinical practice implemented by Discovery Health (Pty) Ltd, as mandated by the Trustees.

**The objectives of the Committee are to:**

- Ensure that the level of healthcare benefits, as prescribed by the Medical Schemes Act, No 131 of 1998, as amended, and the rules of the Discovery Health Medical Scheme, are upheld
- Ensure that the managed healthcare mandate of the Scheme to offer members the highest level of appropriate, affordable and quality care is complied with, taking into account the balance between cost-effective quality healthcare, effective clinical risk management and economic principles
- Ensure that all members of the Scheme enjoy an acceptable quality of care experience, in keeping with the philosophy of continued quality improvement and meeting member expectations and needs.

The Scheme measures the quality of care members receive by using various structural, process and outcome measures. The Scheme also subscribes to Health Quality Assessment (HQA), which assesses process measures on behalf of the Scheme, relative to the rest of the medical scheme industry. The Clinical Governance Committee oversees these measures and reports thereon.

The Committee oversees various clinical projects implemented in line with these measures, as well as their outcomes.

Furthermore, the Committee oversees clinical risk management for the Scheme, and monitors ex gratia requests, Council for Medical Scheme complaints, and disputes lodged by members or any other persons.

The Clinical Governance Committee serves as an assurance provider to the Board of Trustees, in their combined assurance model, for clinical risks, benefit compliance and clinical exceptions.

**As at 31 December 2012, the Committee members were:**

- Dr N Sangweni (Trustee member), MBChB, DOH, DCAM (IATA), MBA (GIBS) – Chairperson
- Prof Z van der Spuy (Trustee member), MBChB, MRCOG, PhD, FRCOG, FCOG (SA)
- Dr S Rich (Clinical Executive), MBBCh

**During the 2012 financial year, attendance at the Clinical Governance Committee meetings was as follows:**

| Name | 21 February 2012 | 17 April 2012 | 16 August 2012 | 13 November 2012 |
|---|---|---|---|---|
| Dr N Sangweni | ✓ | ✓ | ✓ | ✓ |
| Prof Z van der Spuy | ✓ | ✓ | ✓ | ✓ |
| Dr S Rich | ✓ | ✓ | ✓ | ✓ |

## Remuneration Committee

The main objectives of the Remuneration Committee are to govern the Scheme's remuneration process and to recommend to the Board of Trustees the Scheme's remuneration principles and strategy.

**As at 31 December 2012, the Committee members were:**

- Adv M van der Nest (Board of Trustees Chairperson), BA, LLB
- Mr D Eriksson (Audit Committee and Risk Committee Chairperson), CA (SA)

The Committee met once during the year on 31 October 2012 and all members were in attendance.

### Trustee and committee remuneration

As indicated in the report, the remuneration of Trustees and committee members are benchmarked periodically through independent review. The Scheme's Remuneration Committee uses independent experts and benchmarking surveys, based on remuneration structures of large insurance and financial services organisations in South Africa for comparative purposes. The Scheme's Board of Trustees' remuneration structure recognises the significant responsibilities and fiduciary risks borne by Trustees throughout the year, as well as the fact that all the Trustees are independent professionals who are required to give up substantial amounts of their time to serve the needs of the Scheme and its members. It is therefore essential that medical schemes remunerate Trustees appropriately to ensure that the appropriate skills are attracted and retained in a complex industry.

**The remuneration of the Trustees for the year ended 31 December 2012 was as follows:**

| 31 December 2012 | Sub-committee fees | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Services as Trustee | Audit and Risk Committees | Investment Committee | Clinical Governance Committee | Non-healthcare Expenditure Committee | Product Review Committee | Governance Review Committee | Training | Trustee travel | Total |
| | R'000 | R'000 | R'000 | R'000 | R'000 | R'000 | R'000 | R'000 | R'000 | R'000 |
| Adv M van der Nest (Chairperson) | 406 | - | - | - | - | - | 11 | - | - | 417 |
| Mr P Maserumule | 206 | - | 144 | - | - | - | - | - | - | 350 |
| Dr N Sangweni | 225 | - | - | 160 | - | 25 | - | - | - | 410 |
| Mr B Stott | 238 | 117 | 96 | - | 14 | - | 18 | - | - | 483 |
| Adv N Graves | 226 | - | - | - | 14 | - | 26 | - | - | 266 |
| Prof Z van der Spuy | 227 | - | - | 106 | - | - | - | - | 52 | 385 |
| Mr G Waugh | 228 | 117 | 96 | - | 14 | 25 | 26 | - | - | 506 |
| **Total** | **1 756** | **234** | **336** | **266** | **42** | **50** | **81** | **-** | **52** | **2 817** |

## Non-healthcare Expense Committee

The Board of Trustees has established the Non-healthcare Expense Committee in terms of the rules of the Scheme.

**The main responsibilities of the Non-healthcare Expense Committee are to:**

- Monitor the Scheme's non-healthcare expenses against agreed budgets and targets
- Negotiate the annual administration and managed healthcare fee adjustments with Discovery Health Pty (Ltd), the Scheme's Administrator
- Evaluate the performance of the Administrator based on agreed service levels
- Assess the value received by the Scheme and its members from the Administrator.

**As at 31 December 2012, the Committee members were:**

- Mr G Waugh (Trustee member), FIA, FASSA
- Mr B Stott (Trustee member), CA (SA)
- Adv N Graves (Trustee member), BA, LLB.

**During the 2012 financial year, attendance at Non-healthcare Expense Committee meetings was as follows:**

| Name | 25 June 2012 | 3 July 2012 | 17 July 2012 | 23 July 2012 |
|---|---|---|---|---|
| Mr G Waugh | ✓ | ✓ | ✓ | ✓ |
| Mr B Stott | ✓ | ✓ | ✓ | ✓ |
| Adv N Graves | ✓ | ✓ | ✓ | ✓ |

## Product Review Committee

An important responsibility of the Board of Trustees is to oversee the annual benefit design and contributions review processes. To assist with this objective, the Product Review Committee has been established in terms of the rules of the Scheme.

**The responsibilities of the Product Review Committee are to:**

- Evaluate and review the Scheme's benefit design on an annual basis
- Evaluate benefits based on clinical best practice and financial sustainability, as well as members' best interests (fairness principles) and communication best practice principles
- Recommend benefit amendments to the Board of Trustees.

**As at 31 December 2012, the Committee members were**:

- Dr N Sangweni (Trustee member), MBChB, DOH, DCAM (IATA), MBA (GIBS)
- Mr G Waugh (Trustee member), FIA, FASSA.

**During the 2012 financial year, attendance at Product Review Committee meetings was as follows:**

| Name | 29 May 2012 | 3 July 2012 | 17 July 2012 | 7 August 2012 | 7 September 2012 |
|---|---|---|---|---|---|
| Dr N Sangweni | ✓ | ✓ | ✓ | ✓ | ✓ |
| Mr G Waugh | ✓ | ✓ | ✓ | ✓ | ✓ |

# **Active engagement** with the stakeholders of the Discovery Health Medical Scheme

As the largest open medical scheme in South Africa, the Discovery Health Medical Scheme has both a direct and an indirect impact on a range of key stakeholders in South Africa and is in turn impacted by its relationships with these stakeholders. The Scheme is committed to continuous, transparent and effective engagement with its various stakeholders to establish and maintain meaningful, strong and mutually beneficial relationships with them. Engagement takes place through a number of channels, and across a wide range of issues.

**In engaging with stakeholders, the Scheme follows these principles:**

- Transparency and accountability
- Inclusivity and responsiveness
- Honesty and integrity
- Complete, timely, relevant, accurate and accessible information.

**Summary of the Scheme's key stakeholder groups and key engagements with these groups:**

## The members of the Discovery Health Medical Scheme

The most important stakeholders of the Scheme are the more than 2.4 million lives to whom the Scheme provides healthcare cover. The Scheme communicates with its members through several channels. The main forum for the Scheme to engage directly with its members is the Annual General Meeting, at which the Scheme's financial and operational performance during the preceding financial year is reported back to members. Members present also elect the Trustees of the Scheme for three-year terms in a transparent election process, and may vote on any motions submitted to the meeting.

**During the year, the Scheme engages intensively with members through the following channels:**

- **Call centres:** Discovery Health (Pty) Ltd operates four service teams across the country, offering call centre access 24 hours per day, seven days a week. The Discovery service teams receive around 35 300 calls per day from Scheme members and other stakeholders. Regular member surveys and research help the Scheme to assess the level of service provided to members and to identify any areas in which service can be improved. In 2012, the scores for member surveys continued on an upward trend and reached an all-time high of 8.96 out of 10.
- **Walk-in centres:** There are five walk-in service centres around the country, which provide members with personalised service during office hours. During 2012, more than 67 000 members accessed the Discovery Health (Pty) Ltd walk-in centres.
- **Digital communication:** The Scheme also communicates with members through frequent electronic newsletters, electronic and paper claims statements, SMS messaging and through the Discovery website, as well as a recently launched smartphone application which allows members to interact extensively with Discovery Health (Pty) Ltd without making a phone call. Members can also engage with the Scheme on social media such as Facebook and Twitter, and a dedicated social media team assists members through this channel.
- **Printed communication:** The Scheme interacts extensively with members throughout the year by means of the Discovery magazine, year-end benefit and plan materials, and regular communication regarding any changes to benefits.

# Regulators, industry bodies and government

The Regulator that governs the medical schemes industry is the Council for Medical Schemes. The Council is an important stakeholder of the Scheme, and regular meetings are held with the Council on Scheme matters as well as key industry issues. The Scheme and its Administrator also engage with the National Department of Health on issues impacting healthcare in South Africa, and to contribute to strategic national development initiatives. Active participation also takes place in relevant industry bodies and debates.

**Stakeholder engagement activities during the past year included:**

- Regular quarterly and ad hoc meetings with the Council for Medical Schemes on various regulatory matters impacting on the Scheme and the industry
- Discussions with the National Department of Health and the Council for Medical Schemes on the issue of high-cost drugs, including private sector pricing, international price benchmarking, pharmaco-economics, bargaining council funding strategies, access to state pricing, risk sharing models and implications for Prescribed Minimum Benefits
- Discussions with the Minister of Health and senior officials of the National Department of Health on various matters of importance to the industry
- Interacting with the Competition Commission on various proposed scheme amalgamations in the industry
- Providing expert input to the National Department of Health on matters pertaining to private sector regulations, for example Single Exit Price (SEP) legislation. Discovery Health (Pty) Ltd hosted training of 45 delegates of various healthcare industries in the World Health Organization's pharmaceutical coding system. This medicine classification system forms the basis of medicine benefit design and risk management in the private sector and will be used to define medicine baskets of care for National Health Insurance. The training was the first initiative of its kind in Africa, and has set the stage for future training urgently needed in South Africa.

# The Administrator of the Scheme (Discovery Health (Pty) Ltd)

Discovery Health (Pty) Ltd provides administration and managed healthcare 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. The Administrator is also expected to investigate and report to the Trustees on many issues of policy to facilitate decision-making by the Trustees.

The relationship between the Scheme and Discovery Health (Pty) Ltd is a contractual one. The contractual service levels are reviewed annually by the Scheme's Board of Trustees, which ensures that the services provided to the Scheme by the Administrator are consistent with the agreement in place and continuously monitors compliance with this agreement at all levels. The Trustees negotiate the administration and managed care fees with the Administrator on an annual basis.

**There are frequent engagements between the Scheme and the Administrator, which revolve around:**

- Scheme performance
- Scheme strategy
- Design and implementation of Scheme benefits
- Marketing of Scheme plans and benefits
- Member communication
- Regulatory and industry matters
- Service level agreement assessment and monitoring
- Enterprise risk management.

# Healthcare intermediaries

Healthcare intermediaries play a very important role in providing necessary information and support services to the Scheme's members. Around 7 000 independent and 400 Discovery financial 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. To assist them, Discovery Health (Pty) Ltd hosts the Discovery Insights Series, a series of regular workshops on relevant industry topics. Discovery Health (Pty) Ltd also provides a range of additional knowledge courses, product launches, supporting marketing material and tools, training material and support, ongoing communication through electronic newsletters and website articles, and continuous professional development days that form part of quarterly training.

**Stakeholder engagement activities during the past year included:**

- A comparative analysis of the 2011 open medical scheme financials presented to all major corporate brokerages nationwide
- A comprehensive analysis of the South African medical schemes industry, including a report containing key industry insights, presented to all major corporate brokerages nationwide
- 2013 Discovery Health Medical Scheme updates presented to more than 3 000 financial advisers in September 2012
- Post-launch training presented to broker consultants and financial advisers at more than 30 sessions during October 2012
- Regular executive level engagements with key intermediaries to address any problems and to elicit valuable feedback.

# Doctors, professional societies and other healthcare providers

Doctors and other healthcare providers are critical to the sustainability of private healthcare delivery. The Discovery Health Medical Scheme has a wide range of innovative network and contracted payment arrangements in place with the majority of GPs and specialists, covering close to 90% of all contacts between these professionals and Scheme members. Similarly, the Scheme has led the industry in the implementation of innovative alternative reimbursement arrangements with the major hospital groups. These, together with effective risk management by Discovery Health (Pty) Ltd, have allowed the Scheme to achieve substantial cost advantage over all other open schemes in relation to hospital costs, a key element of the Scheme's claims expenditure. The Scheme also has contracts with all major pathology groups and radiology practices, as well as the majority of other healthcare professionals. Overall, they provide Scheme members with certainty of cover and a wide range of options to avoid co-payments, and they allow the Scheme to comply fully with all aspects of Prescribed Minimum Benefit legislation in terms of the Medical Schemes Act, No 131 of 1998, as amended.

The Administrator and the Scheme further engage actively and continuously with the representatives of health professionals through their various professional societies. Regular meetings, workshops and thought leadership summits are held where pertinent issues affecting healthcare in South Africa are examined. They also meet with representative bodies and societies on specific industry issues.

The Scheme and Discovery Health (Pty) Ltd also engage continuously 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. Because of Single Exit Price (SEP) legislation, negotiations with the pharmaceutical industry for lower market prices also benefit South Africans who are not members of the Scheme.

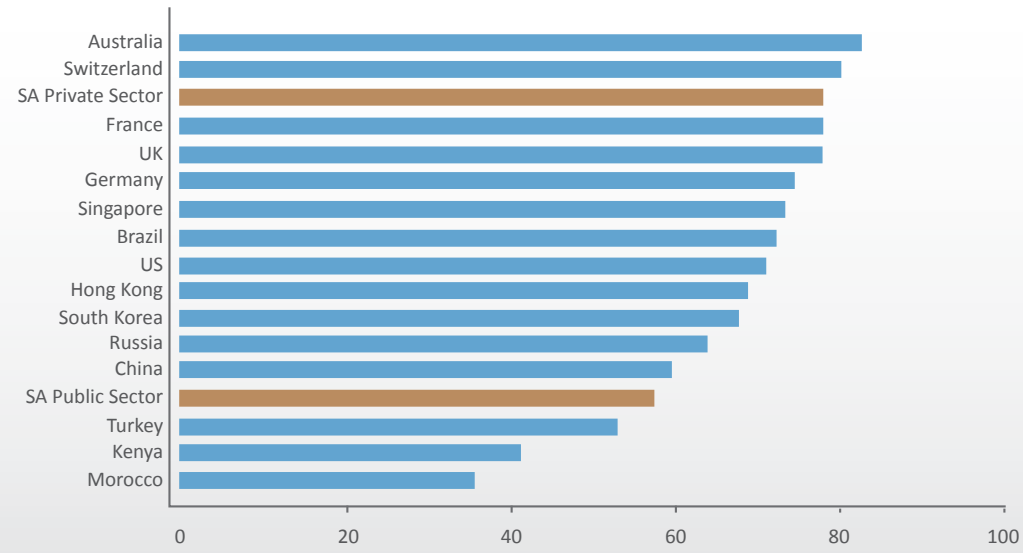
**Stakeholder engagement activities during the past year included:**

- **Healthcare professionals:**
  - Tariff negotiations, including alternative reimbursement models, with various disciplines, including pathology and radiology
  - End-to-end management of an open tender process for pathology in specific hospitals
  - Implementation of a new preferred provider network for allied professionals
  - Interaction with physician, paediatrician and GP societies on healthcare funding and policy matters
  - Working with various societies on the risk management of outlier providers, specialists and doctors, clinical protocols, and benefit design.
- **Hospitals:**
  - Tariff negotiations with all hospital groups
  - New alternative reimbursement contracts for 2013
  - Constructive engagement with outlier hospitals
  - Strengthening accountability processes on healthcare quality
  - Negotiating a new renal dialysis network contract for the low-income plans, resulting in substantial savings for 2013.
- **Pharmaceutical suppliers:**
  - Engagement with approximately 90 pharmaceutical companies on more than 1 200 products to reduce medicine prices
  - Working with retail pharmacies to improve the use of more cost-effective alternatives, including generics
  - Promotion and endorsement of pharmaceutical coding standards and new coding schemes to identify generic medicines
  - Commissioning research on high-cost medicine prices to determine prices in benchmark countries
  - Continued investigation of partnerships with pharmacy network chains for the procurement of high-cost drugs, patient channeling, discounted dispensing fees, formulary compliance and stock listing.
- **Surgical suppliers:**
  - New contracts with preferred supplier agreements for hip and knee surgery, resulting in substantial savings for the Scheme
  - Price negotiations for full supplier product ranges, and in certain cases, specific product lines
  - Ongoing review and classification of new products
  - Providing access to exclusive product and price arrangements for the low-income plans
  - End-to-end management of open tender processes.

# **Key strategic issues** facing the private healthcare industry

The South African private healthcare system is finding itself under more scrutiny than ever before, and medical schemes, as a critical backbone of the private healthcare system, are no exception. In the midst of public debate, it is easy to forget that our private healthcare system is a precious national asset and is ranked as one of the top healthcare systems in the world. It is highly developed and competes with the best in terms of speed and access to care, availability of outstanding specialist skills and the latest technology, as well as healthcare outcomes for patients.

**South Africa's private healthcare system is ranked as one of the top healthcare systems in the world:**




Source: Pool Stream database, Monitor Group (2008).

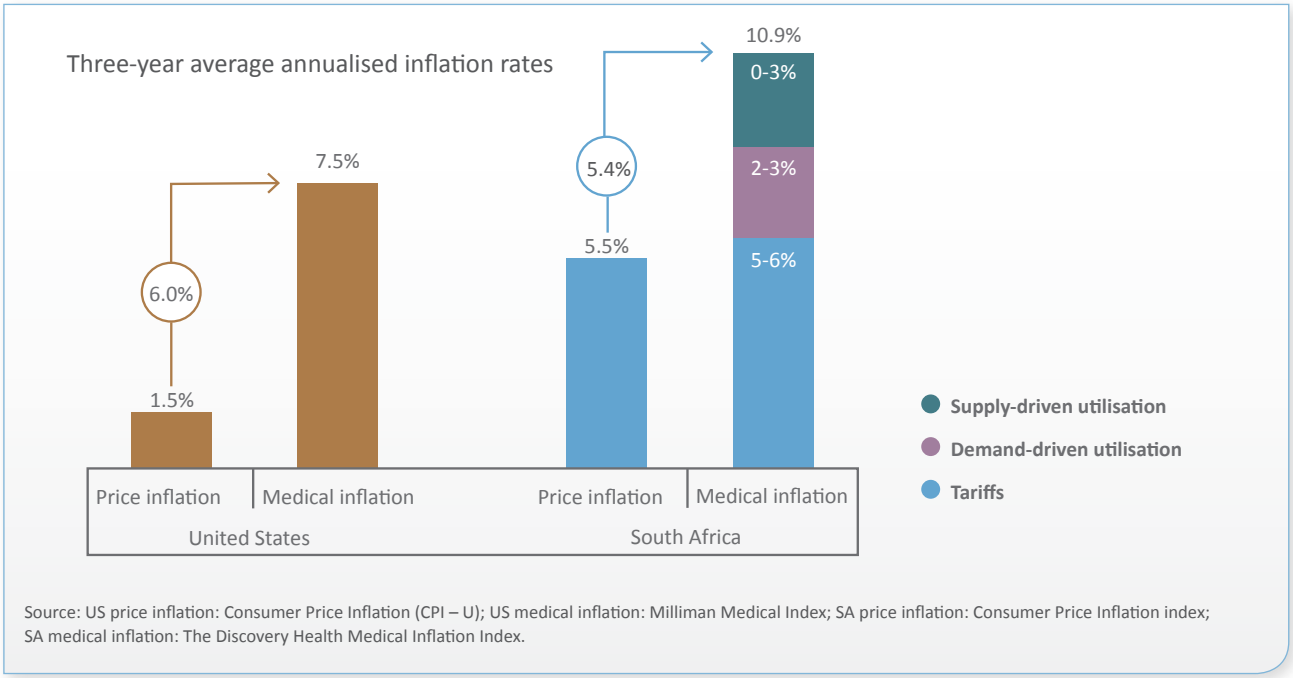
While South Africa's private healthcare system provides outstanding quality of care, it faces several challenges. These include the rising cost of healthcare and high medical inflation, the relatively slow growth in schemes' membership, the increasing prevalence of chronic lifestyle diseases, and some of the unintended consequences of South Africa's medical schemes legislation, such as adverse selection against open medical schemes by new joiners.

# The factors driving medical inflation

High medical inflation is not unique to South Africa, but rather a phenomenon that continues to impact the healthcare sector globally. It dwarfs consumer price inflation – over the past three years, medical inflation has grown by almost double the rate of consumer price inflation.

There is extensive evidence, both internationally and in our own system, that medical inflation is driven by a multitude of interacting factors acting in conjunction with Consumer Price Index increases. These include tariff increases, and a number of demand- and supply-side factors.

**High medical inflation is a result of several elements:**




Source: US price inflation: Consumer Price Inflation (CPI – U); US medical inflation: Milliman Medical Index; SA price inflation: Consumer Price Inflation index; SA medical inflation: The Discovery Health Medical Inflation Index.

Demand-side cost drivers include longer life expectancy, an ageing medical schemes population, and the rapidly growing disease burden and benefit utilisation. A cost driver characteristic of the medical scheme environment in South Africa is the problem of adverse selection. Our medical schemes legislation is based on open enrolment and community rating – schemes must accept all applicants regardless of age and health status, and schemes must charge the same contribution for all members in each option, regardless of health status or age. However, medical scheme membership in South Africa is also voluntary. This means young and healthy individuals can join a scheme only when they believe they will really need healthcare, and new joiners typically join lower benefit options and “buy up” to higher plans only if they become ill.

For example, the Discovery Health Medical Scheme's top-end plans are exposed to adverse selection as the highest-claiming members gravitate towards these benefit-rich options. The middle-range plans attract younger, healthier individuals that claim on average 38% less than the average existing members of the Scheme. The low-end plans offer affordable access to private healthcare cover through provider networks. Since membership is not compulsory, affordability constraints mean members only join when they believe they really need healthcare. These trends have a profound impact on open medical schemes, since schemes benefit less than in the past from the surpluses generated by the young and healthy, and thus face greater pressures in funding the claims of those with much greater healthcare needs.

Other key factors on the demand side include the increasing prevalence of chronic diseases and the associated costs of treating members with these conditions. During the past four years, the prevalence of Discovery Health Medical Scheme members with one or more chronic condition has increased by 60%. Claims data show that, on average, the costs of these members are about four times more than those of the average Scheme member without a chronic condition. Overall, the Scheme's "disease burden" has increased by about 12.2% in the past four years. About 8.1% of this can be explained by increasing age and increasing chronic disease conditions. The balance is due to a combination of the availability of new technologies, the rise in cancer incidence and other similar factors.

The ever-increasing cost of new medicines and technologies is an important supply-side cost driver. New medical technologies often provide huge improvements in survival and quality of life, but come onto the market at significantly higher prices than the older technologies they are replacing. For example, the Discovery Health Medical Scheme's cancer data shows that over the past three years, claims costs for cancer have increased by over 80%, to almost R1 billion each year. This is due to the rising incidence of cancer, but mainly to the fact that the medicines available today often cost 5 to 10 times more than they did just a few years ago. All medical schemes need to find ways of funding these new medicines and medical technologies while ensuring the scheme remains sustainable for its members over the long term.

Two fundamental features of South Africa's private healthcare delivery system which have a substantial impact on supply-side costs are the fee-for-service payment system, and the fragmented structure of our private healthcare system, in which doctors, hospitals and all other providers work in silos, with almost no coordination between them. Both these features contribute to rising healthcare costs – for obvious reasons, fee-for-service payments encourage those who deliver healthcare services to provide more services; and fragmented, uncoordinated healthcare systems lead to more waste, quality problems and higher costs than more inclusive, team-based healthcare systems in which there is greater information sharing and coordination.

> "Two fundamental features of South Africa's private healthcare delivery system which have a substantial impact on supply-side costs are the fee-for-service payment system, and the fragmented structure of our private healthcare system."

# The factors affecting the sustainability of medical schemes

In the face of high medical inflation, six key factors affect the sustainability of medical schemes. All medical schemes must effectively address these issues in order to ensure their long-term sustainability and the wellbeing of their members into the future.

**The six key factors are:**

- **Growth.** The average age of members in a medical scheme is significant, as older members generally have higher medical costs related to chronic diseases and aging. Growing a scheme organically with young and healthy members is critical to offset the increasing disease burden of existing members and the effects of adverse selection. Schemes that demonstrate consistent growth in new membership are much more likely to be sustainable and strong in the medium to long term.
- **Pricing.** Pricing of medical contributions is always a topical issue for members and other stakeholders. Contribution increases must balance the need to meet the cost of healthcare claims, while ensuring that healthcare remains affordable for members and that benefits are maintained or enhanced. In addition, schemes have to keep solvency requirements in mind.
- **Benefit design.** The funding ability of a medical scheme is finite. As a result, benefits must be designed to ensure that the scheme provides funding for appropriate, high-quality care for its members when they need it most, while ensuring that inappropriate or unnecessary care is avoided wherever possible. Finding this balance requires difficult choices, but it is critical for the long-term sustainability of medical schemes. The general trend, both in South Africa and internationally, is to shift funds towards the higher-cost, critical healthcare services over time.
- **Benefit management.** Medical schemes must have access to effective and accessible health service network assets, and claims risk management and forensic capabilities to ensure that claims are paid out in accordance with the rules of the scheme, and to help "bend the cost curve". While all schemes are experiencing claims inflation in excess of consumer price inflation, active risk and benefit management can have a material impact on the claims inflation experienced by schemes. Where such management is effective and dynamic, it is possible to slow the rate of claims inflation. Conversely, where schemes under-invest in benefit and risk management, claims inflation is likely to be higher and to continue to rise at a faster rate.
- **Innovation.** In five years' time, technological innovation will change healthcare as we know it today. Innovation has the potential to change the industry quickly, and investment in technology by medical schemes will result in better quality care, as well as better balance between the cost of medical scheme membership and the extent and quality of benefits provided to scheme members.
- **Wellness interventions.** Effective wellness programmes are having a measurable impact on the health of members of medical schemes. Many of the health issues people are facing today can be minimised by embracing a comprehensive health and wellness programme. These programmes engage participants and encourage them to take a more active role in leading a healthy life.

# **Key differentiators** of the Discovery Health Medical Scheme

## An industry benchmark in South Africa

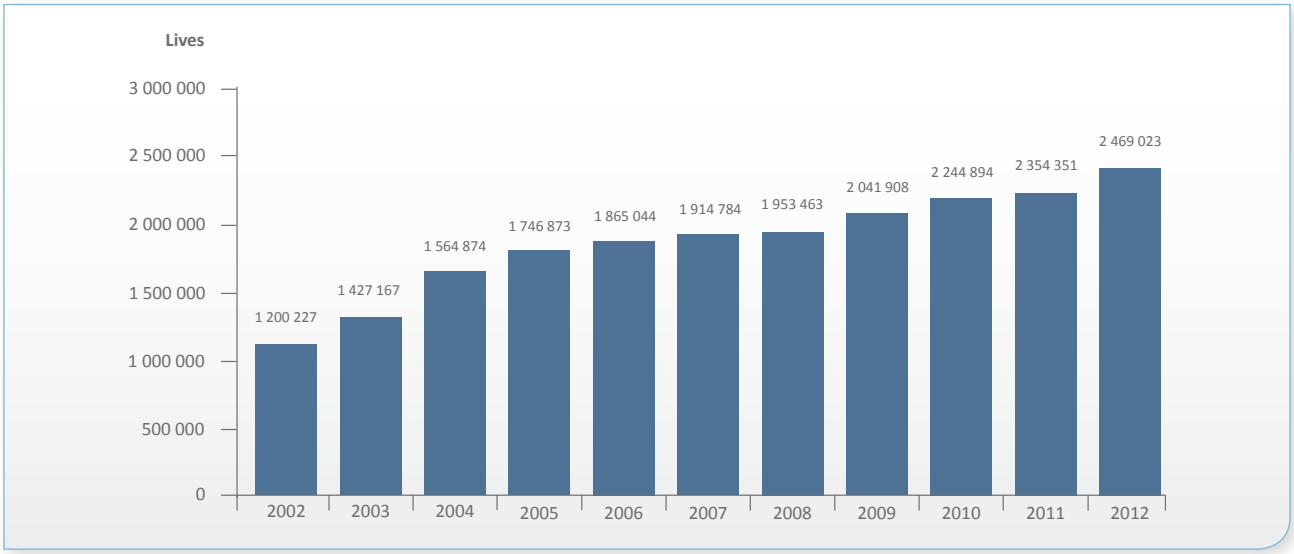
The Discovery Health Medical Scheme is now the benchmark open medical scheme in South Africa – it is by far the largest, strongest and most stable scheme in the country. Its financial performance for 2012 has been excellent. The Scheme has generated a net surplus of R789 million, which goes towards building the Scheme's reserves, which now stand at R8.2 billion.

The financial strength of a medical scheme is dependent largely on two factors – growth of scheme membership, and the average age of its lives covered.

The South African medical scheme industry divides into open schemes, such as the Discovery Health Medical Scheme, and schemes with restricted membership access, such as the Government Employees Medical Scheme (GEMS). Over the past decade, the overall industry has grown from just below 7 million lives to about 8.5 million lives. This growth has primarily taken place in the restricted schemes area, with the formation of GEMS in 2005 contributing to the majority of this growth. The open schemes segment of the market has struggled to grow membership over the same period, largely due to the significant loss of membership from open schemes to GEMS, and increasing financial pressure on consumers, making private healthcare increasingly difficult to afford for low-income families.

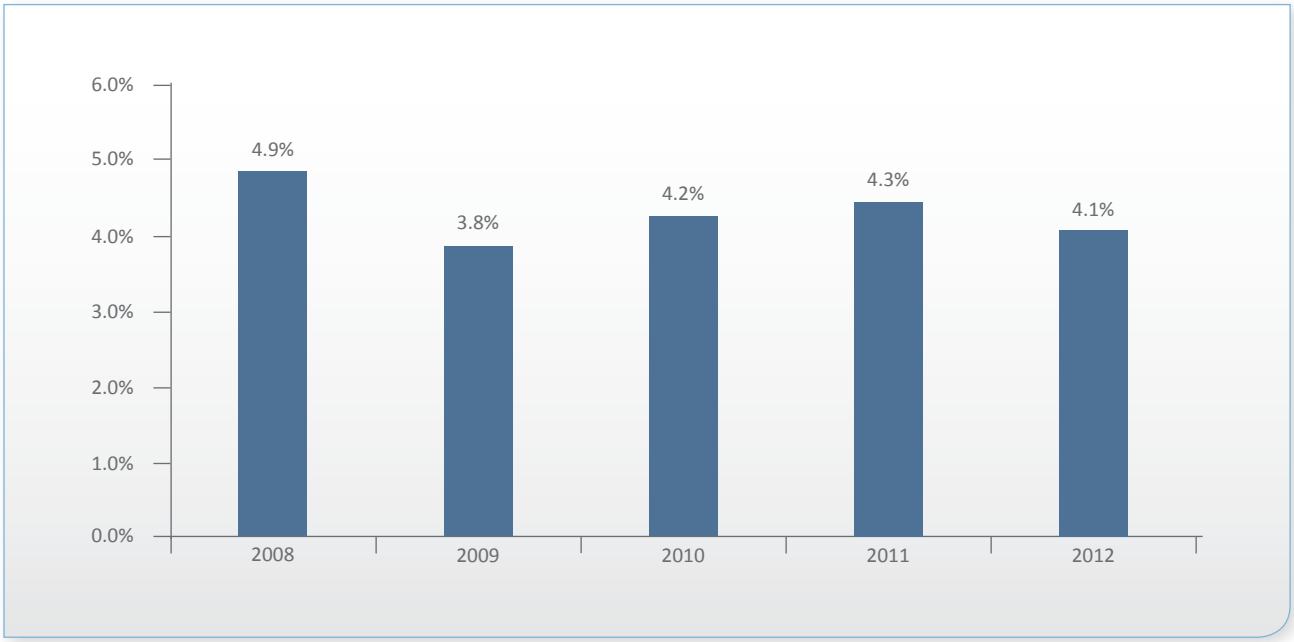
However, the Discovery Health Medical Scheme has bucked this trend, showing substantial member growth since the Scheme's inception. This trend has continued strongly over the past few years. The Scheme has grown by more than 100 000 lives each year since 2008, to 2 469 023 lives at the end of 2012. Over the same time period, all other open schemes which compete with the Discovery Health Medical Scheme have lost over 800 000 lives. The Scheme now covers 51% of the lives in the open medical scheme industry and 30% of the total medical scheme industry. These figures confirm the Discovery Health Medical Scheme as the scheme to which most employers and new members wish to belong, with the highest growth rate, offering continuity, financial stability and predictability for members.

**The Discovery Health Medical Scheme has grown to over 2.4 million lives in 2012:**



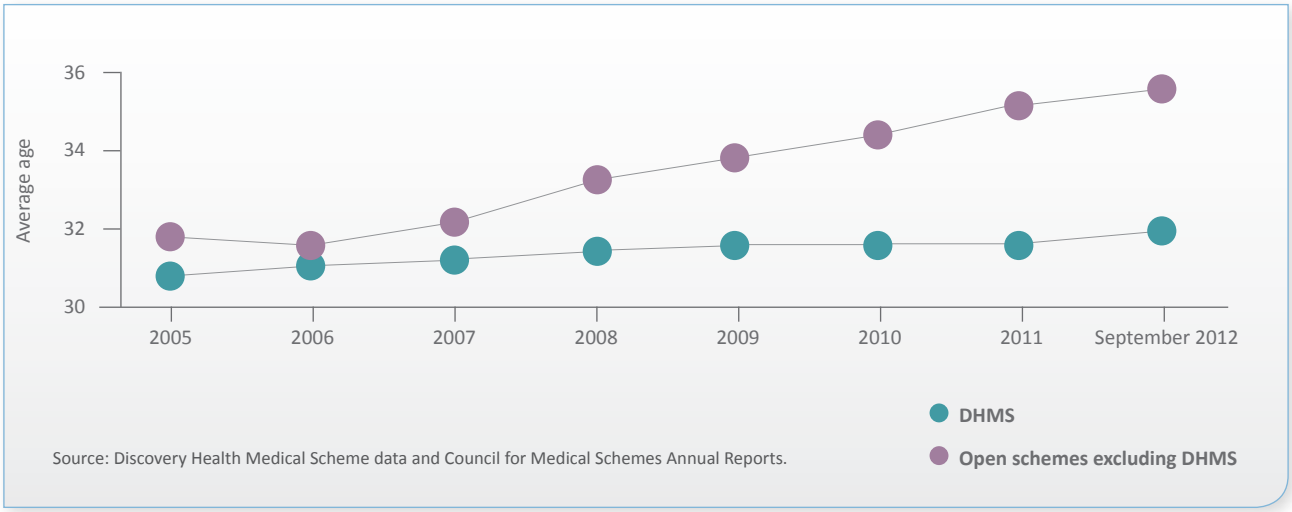
This confidence in the Discovery Health Medical Scheme is confirmed by the low average lapse rate, which has over the past year further reduced to 4.1% and remains the lowest in the open schemes market by a significant margin.

**Annualised lapse rates of the Discovery Health Medical Scheme:**




While the membership of the Discovery Health Medical Scheme keeps growing, the average age of its lives covered is lower than the industry average. From 2006 to 2011, other open schemes have seen their average age increase from 31.7 to 34.8 years, while the Discovery Health Medical Scheme's average age has risen from 31.1 to only 31.8 years. This illustrates the positive impact that the Scheme's strong growth performance is having on its average age profile and hence on its risk and claims experience.

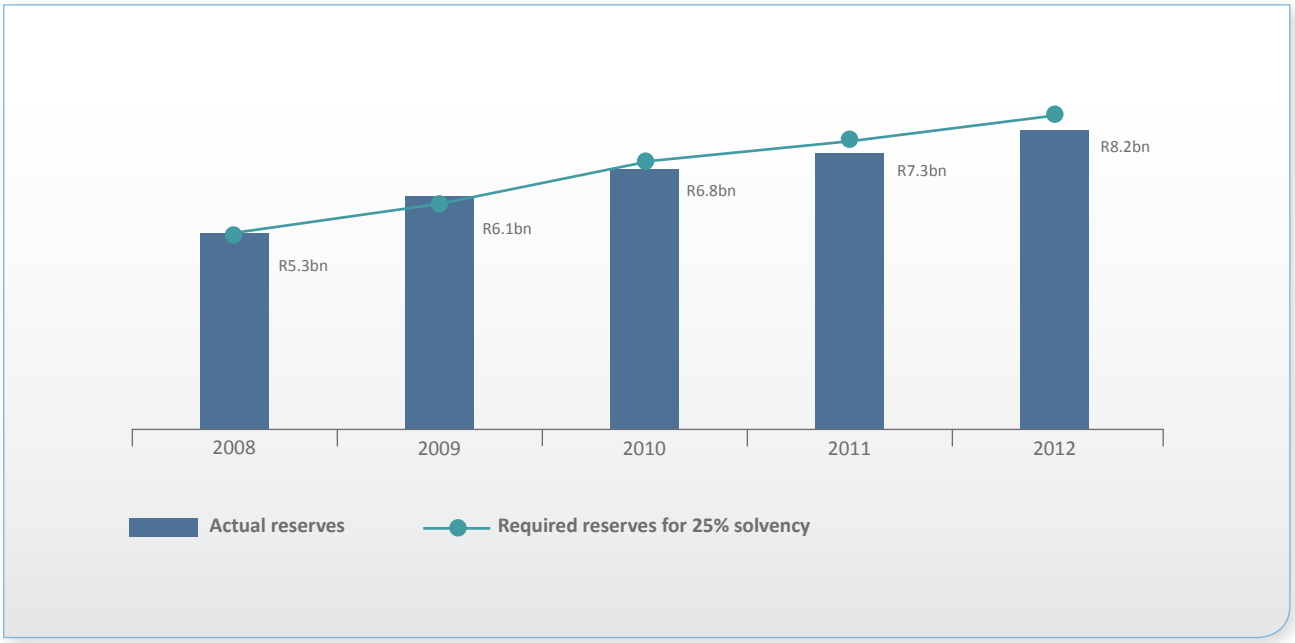
**Growth has significantly improved the demographic profile of the Discovery Health Medical Scheme:**




Source: Discovery Health Medical Scheme data and Council for Medical Schemes Annual Reports.

Membership growth, particularly organic growth, is vital for sustaining the demographic profile of a medical scheme and ensures that the balance of healthy lives subsidising those that need medical care, is preserved. However, membership growth also creates solvency pressures on medical schemes, since each new member sets a scheme back in terms of its solvency, as defined by the Medical Schemes Act, No 131 of 1998, as amended. 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 the 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 levels.

**The Discovery Health Medical Scheme currently has R8.2 billion in reserves:**




The solvency ratio of the Discovery Health Medical Scheme is at 23.41%, which is slightly below the statutory level of 25%. The way in which the Regulator works out the statutory solvency ratio means a growing scheme will experience solvency strain. The Discovery Health Medical Scheme has grown consistently over time, and its exceptional rate of growth over the past few years is the cause of the current solvency level being below the 25% level. The Council for Medical Schemes allows schemes to address their solvency requirements over specified timelines. The Council has approved the business plan submitted by the Discovery Health Medical Scheme, which envisages the Scheme increasing solvency to 25% by 31 December 2015.

The position of the Discovery Health Medical Scheme as the benchmark medical scheme in South Africa has been validated by independent credit rating agency Global Credit Rating, with an AA+ credit rating, the highest rating an open medical scheme can receive. The Scheme has kept this rating – which in South Africa has only been awarded to the Discovery Health Medical Scheme – for 12 consecutive years. The rating rationale focuses on financial strength and ability to pay claims, member growth and demographic profile, investment return on member funds, and ability to adapt to industry changes.

# Balancing cost, quality and sustainability

Medical schemes in South Africa and the world over operate in a very complex and challenging environment – they are continuously struggling to maintain the fragile balance between quality, access and the increasing cost of healthcare. By applying sophisticated benefit design and health risk management techniques, medical schemes have to provide access to top quality healthcare for their members, including the latest medical technologies, while at the same time effectively managing and containing the cost of care to ensure the long-term sustainability of the scheme.

Given the complexity of healthcare funding in South Africa, most medical schemes require sophisticated expertise to manage and administer them effectively to meet the needs of all stakeholders in a sustainable way. The Discovery Health Medical Scheme is administered by Discovery Health (Pty) Ltd – a dynamic, innovative and financially strong medical scheme administrator and health risk management organisation, which provides the highest quality administration and managed healthcare 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.

> “Discovery Health (Pty) Ltd focuses on all three pillars of care for the Discovery Health Medical Scheme: cost, quality and access.”

Discovery Health (Pty) Ltd focuses on all three pillars of care for the Discovery Health Medical Scheme: cost, quality and access. The Administrator improves the quality of care provided to members of the Scheme, adding significant value for members, as well as all other users of private healthcare services in South Africa. This includes structural and process interventions focusing on systematic improvement in the coordination of care between providers in the private healthcare system, as well as the improvement of healthcare quality and efficiency.

Over the past 20 years, Discovery Health (Pty) Ltd has developed a unique and successful health risk management operating model to manage healthcare funding efficiently and cost-effectively to ensure the sustainability of the Discovery Health Medical Scheme. The model is built on innovation, collaboration, good corporate governance, transparency and member engagement, and brings together consumer-orientated products, world-class risk management expertise and systems, healthcare provider networks and assets, digital health tools and value-added services not provided by other administrators. The Vitality wellness programme is also available to members of the Scheme on a voluntary basis.

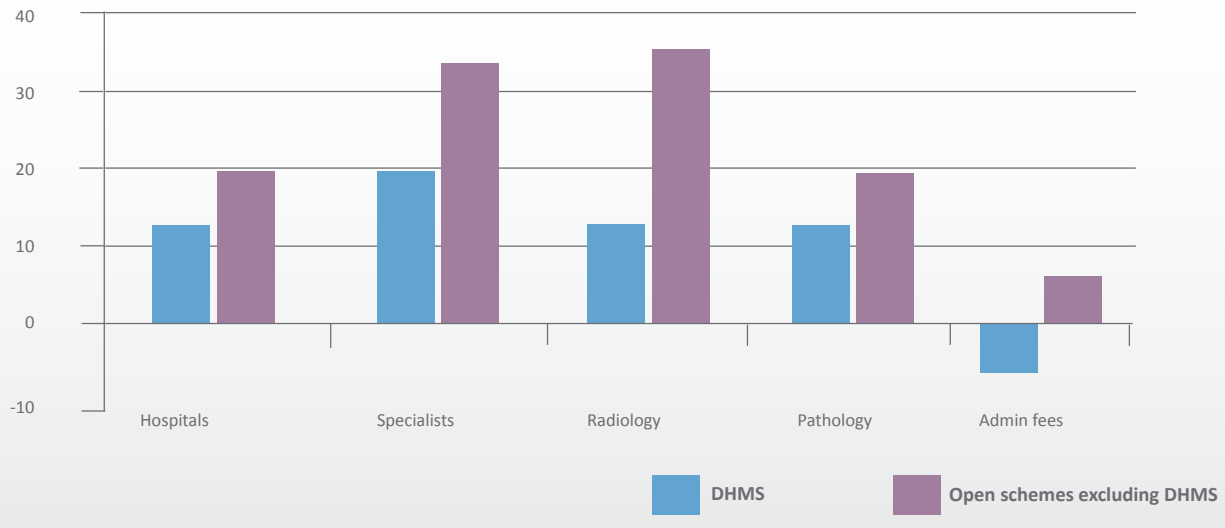
Other medical schemes often obtain various elements of their administration and managed healthcare services from multiple service providers. The fully integrated model developed by Discovery Health (Pty) Ltd – in which all aspects of administration and managed care are provided in an integrated way – is far more efficient, and results in much greater alignment between the Trustees of the Discovery Health Medical Scheme and the Administrator, as well as between all aspects of administration and risk management. The Scheme has benefited significantly, and continues to benefit, from this aligned operating model.

The efficiency of this integrated model is demonstrated by the success of the Discovery Health Medical Scheme relative to all its competitors, on every performance metric. The model has resulted in the Scheme performing exceptionally well in an environment where other schemes are battling to grow their membership and contain costs. Apart from areas of performance such as ongoing membership growth, high levels of reserves, industry-best service levels and continued innovation, it has resulted in lower average claims costs and contribution increases experienced by the Scheme relative to the rest of the industry. The Discovery Health Medical Scheme's contributions, across a broad range of plans, are on average 13% cheaper for a family of four, and on average 15% cheaper for a principal member. The Scheme's track record of contribution increases is one of the best in the industry: the five-year annualised contribution increase was 9.8%, compared to the industry average of 11.3%.

In particular, the competitive contributions paid by Discovery Health Medical Scheme members are a direct result of the ability of Discovery Health (Pty) Ltd to negotiate highly competitive tariffs and contracts with hospital groups and other service providers, as well as its best-of-breed risk management systems and skills. This means that the Scheme is able to purchase each unit of healthcare at a substantially lower cost than all other schemes in South Africa. The net result is that the Discovery Health Medical Scheme is able to offer its members richer benefits than other schemes at very competitive contributions.

**The claims costs of the Discovery Health Medical Scheme compared to those of other open schemes per claims bucket:**

Percentage growth in Per Life Per Month (PLPM) costs (2008 – 2011, CPI adjusted)

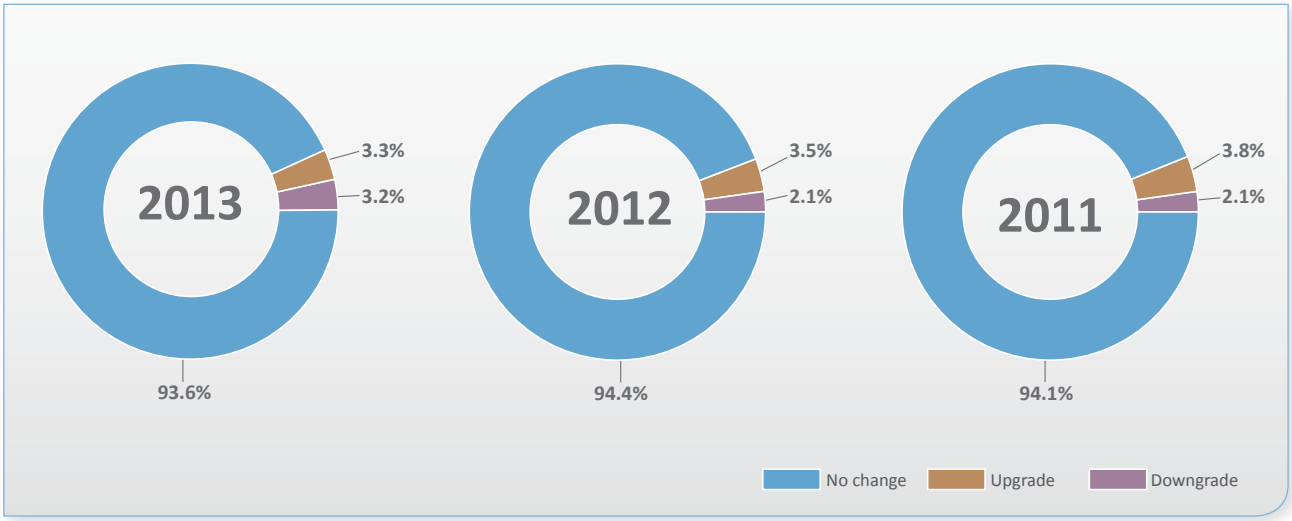



Source: Discovery Health Medical Scheme data and Council for Medical Schemes Annual Reports.

While a small number of selective benefit adjustments have been implemented in the past, principally to curb significant abuse in specific benefit areas, the main trend within the Discovery Health Medical Scheme has been to consistently increase benefits particularly in areas of most critical need, such as hospitalisation, chronic medication and cancer. In all of these areas, the Scheme's benefits provide the richest cover available in the South African market.

This combination of rich benefits at highly competitive contributions is the reason Discovery Health Medical Scheme members have over the past four years, for the most part, either remained with their current benefit plans (94%) or bought up to higher benefit plans (4%). Buy-down rates have been very low, at 2% over the period.

**Plan movements of Discovery Health Medical Scheme members:**




# Risk management assets to bend the cost curve

Much of the lower claims inflation experienced by the Discovery Health Medical Scheme can be attributed to significant investment by Discovery Health (Pty) Ltd in a wide range of benefit and risk management assets and tools. These capabilities and assets have brought down the cost of healthcare for both Scheme members and the industry, contributing to the continued sustainability of the Scheme.

**These assets include:**

- **Hospital and health professional networks providing significant cost and efficiency advantages.** Discovery Health (Pty) Ltd deploys a wide range of network assets to assist in benefit and risk management of the Discovery Health Medical Scheme. These network arrangements save costs for Scheme members without compromising the quality of care.

  Discovery Health (Pty) Ltd's designated service provider network coverage is unique in the South African industry, in that it provides access to all relevant categories of service providers within the private sector, all at fully contracted rates, and with no co-payment exposure for members. Close to 90% of all Discovery Health Medical Scheme member interactions with GPs and specialists now happen in a network or within a payment arrangement.

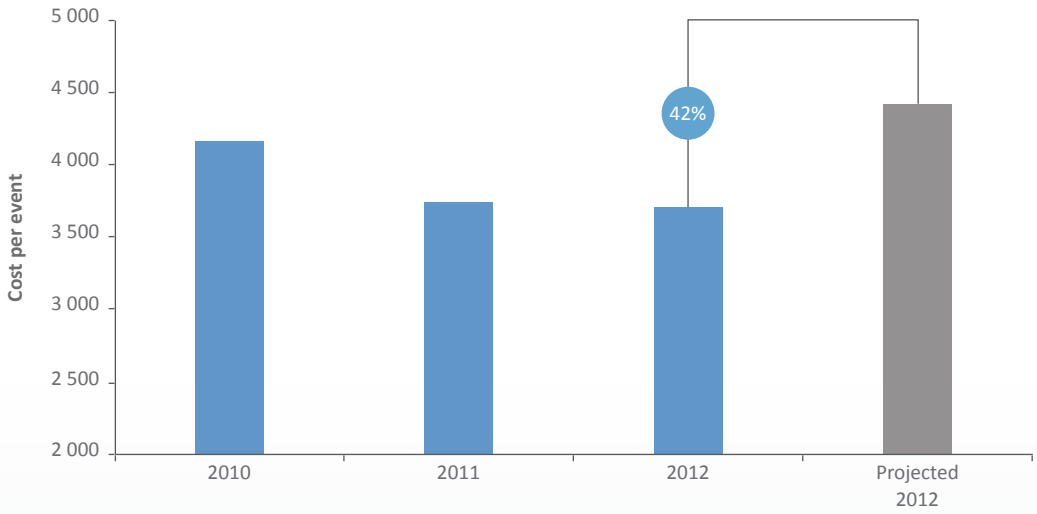
  The Discovery Health (Pty) Ltd hospital networks, such as the KeyCare and Delta networks, are on average at least 10% more cost efficient than the average, and contracts with the public sector in certain provinces have ensured full cover for a broader range of Scheme members through a wider network of hospital facilities.

## The KeyCare Day Surgery Network: Saving on cost

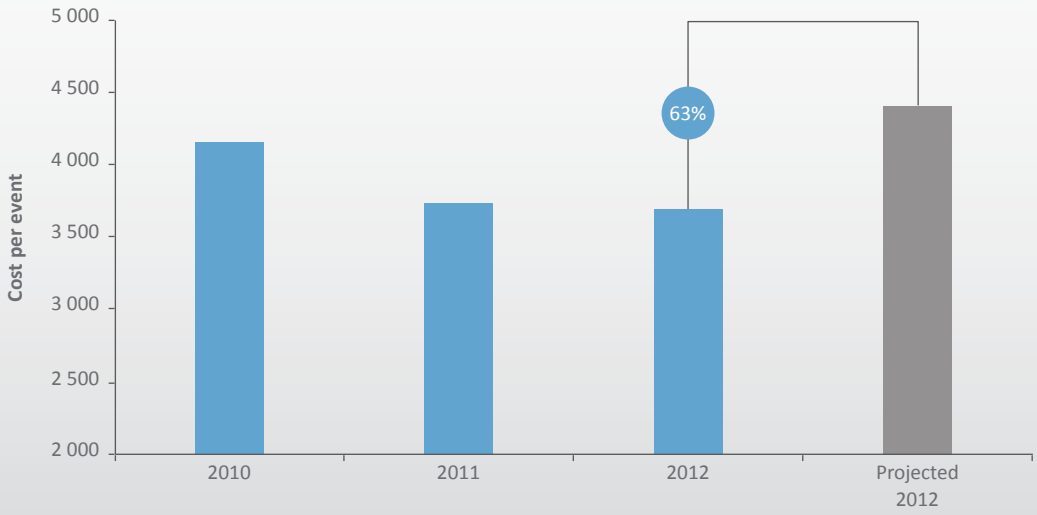
An example of a hospital network which is having a marked impact on cost for the Discovery Health Medical Scheme is the KeyCare Day Surgery Network, which was introduced in 2011. This followed the introduction of the KeyCare day procedures benefit to provide affordable healthcare cover to a broader segment of the community at a more appropriate setting. Day surgery procedures were selected based on high frequency events with average to low costs, and significant discounts were negotiated for these procedures. KeyCare members are required to use the Day Surgery Network for this list of defined procedures, such as tonsillectomies and circumcisions. At least 10% of all admissions now occur in the daycare setting, with a resultant net savings to the KeyCare plan range.

**The impact of the KeyCare Day Surgery Network on cost:**

**Case study: Tonsillectomies**




**Case study: Circumcisions**



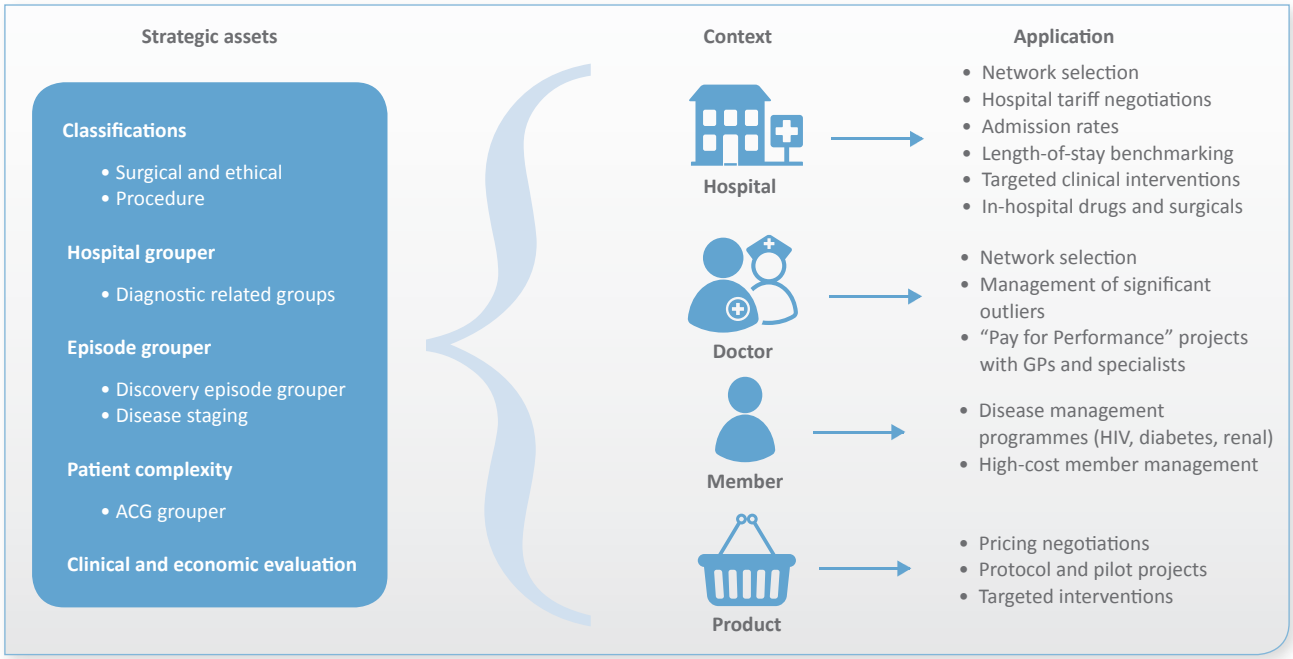
- **Sophisticated risk-sharing reimbursement arrangements with hospitals.** Discovery Health (Pty) Ltd has consistently been able to negotiate the lowest tariffs in the market from all the major hospital groups. The Administrator has also worked closely with hospital groups over the past few years to pioneer the development and implementation of alternative reimbursement models. Around 90% of hospital admissions for Discovery Health Medical Scheme members are today covered by alternative payment arrangements. These arrangements represent a move away from the fee-for-service payment system to greater alignment of the goals of the hospitals with those the Scheme. As a result, hospitals contracted with the Scheme on this basis have begun to focus on maximising cost efficiency rather than revenues, with benefits for all parties. Over time, this has created a significant cost advantage for the Scheme, as the Scheme's total costs for hospitalisation are increasingly below those of the rest of the industry.

  The healthcare professional and hospital network assets, and payment models of Discovery Health (Pty) Ltd provide the Discovery Health Medical Scheme with unique protection against the rising costs of funding the Prescribed Minimum Benefit conditions at the full cost charged by health professionals. Across all plans, the Scheme paid 97.1% of all in-hospital claims and 99.8% of oncology claims during the year under review.

- **Forensics and fraud management.** Discovery Health (Pty) Ltd applies a wide range of sophisticated software and other analytic tools to detect fraud and abuse through a dedicated forensic investigative unit comprising 30 full-time experienced investigators. This unit works with actuarial, statistical and clinical teams to investigate every suspected case thoroughly and take swift action where necessary. For 2012, the work done by the forensics unit on fraud and non-disclosure resulted in savings of more than R250 million for the Discovery Health Medical Scheme.

- **A sophisticated health analytic system.** Discovery Health (Pty) Ltd has built a sophisticated health analytic system, comprising a range of risk adjustment tools and software assets, as well as a large team of skilled actuaries, analysts, statisticians and clinical professionals. These tools and expertise are deployed to improve the quality of care for Scheme members and eliminate inefficiencies. Health analytics is a critical skill and asset for healthcare funders as it enables them to better manage risk over the long term. It is estimated that good risk management saves the Discovery Health Medical Scheme around R3 billion per year – or 10% of total claims. Health analytics also enables data analysis and interpretation of a range of issues that impact the quality and cost of healthcare.

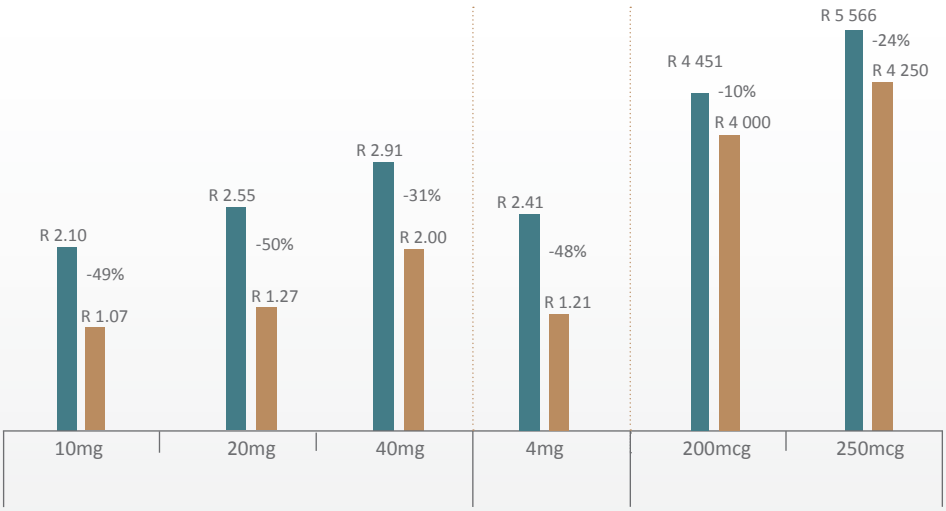
**The risk assets developed by Discovery Health (Pty) Ltd can be summarised as follows:**



## Health analytics: Driving down the cost of medicine

Health analytics, and more specifically the application of health economics and technology evaluation techniques, has enabled Discovery Health (Pty) Ltd to negotiate lower and more cost-efficient prices with medicine manufacturers. For example, Discovery Health (Pty) Ltd has focused on driving down the cost of medicine during the past year, through regular engagement with the pharmaceutical industry to get the best possible prices for Scheme members, thereby protecting the pool of funds from which members' claims are paid. Negotiations prior to the December 2012 launch of Adco-Atorvastatin, used to treat hyperlipidaemia, led to it being introduced at the lowest price seen in South Africa for its class. As a direct result, negotiations have led to a reduction in the price of Aspavor to match that of Adco-Atorvastatin – a major benefit to members with chronic conditions using Aspavor. Similarly, lower prices were negotiated for the hypertension drug Ran-perindopril and the renal failure drug Mircera. Because of Single Exit Price (SEP) legislation, these drug price reductions benefit all users in the private healthcare system. Conservative estimates suggest total annual savings of about R319 million per year are achieved for the Scheme in medicine expenditure.

**Ongoing success in reducing medicine prices for the entire industry:**

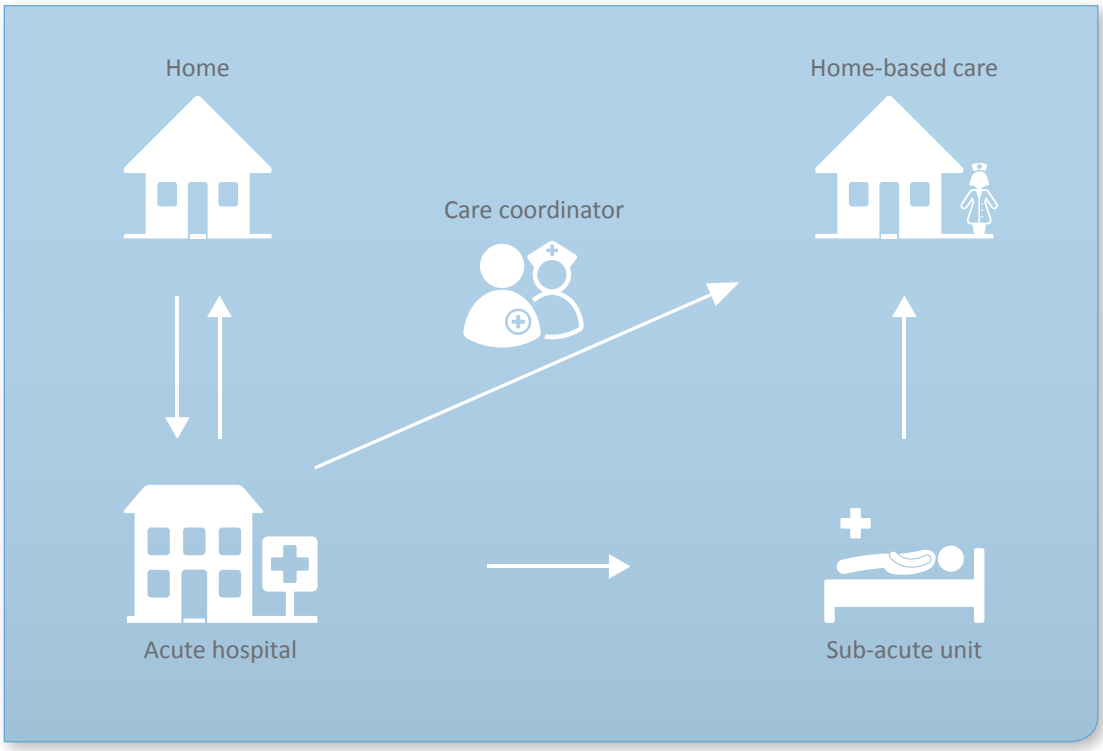



(Adco-Atorvastatin was launched in December 2012, and the comparison above shows the launch price relative to average 2011 prices for comparable statins.)

Prices per unit tablet (including VAT).

- **Driving quality of care through the Care Coordination Programme.** This voluntary programme, for those Scheme members with the highest clinical needs, has resulted in lower costs and improved quality of life. The Discovery Care Coordination Programme enables Scheme members to be discharged from hospital and moved to a participating care facility where they can regain their health. Discovery Health (Pty) Ltd provides all the necessary support without any additional cost to members, and appoints a care coordinator – a registered nurse to assist members throughout the entire process. After members are discharged from the facility, they continue to receive treatment at home and in their communities for as long as is necessary. The range of services includes rehabilitation, disease education, psychosocial support and nursing services. There are currently 11 facilities and 400 providers involved in the programme in the five regions it covers. The programme was initially launched in the Western Cape and Gauteng, and was recently expanded to KwaZulu-Natal and the Free State. A total of 1 749 Discovery Health Medical Scheme members were enrolled on the programme by the end of 2012.

**Care Coordination Programme for members with the highest clinical needs:**

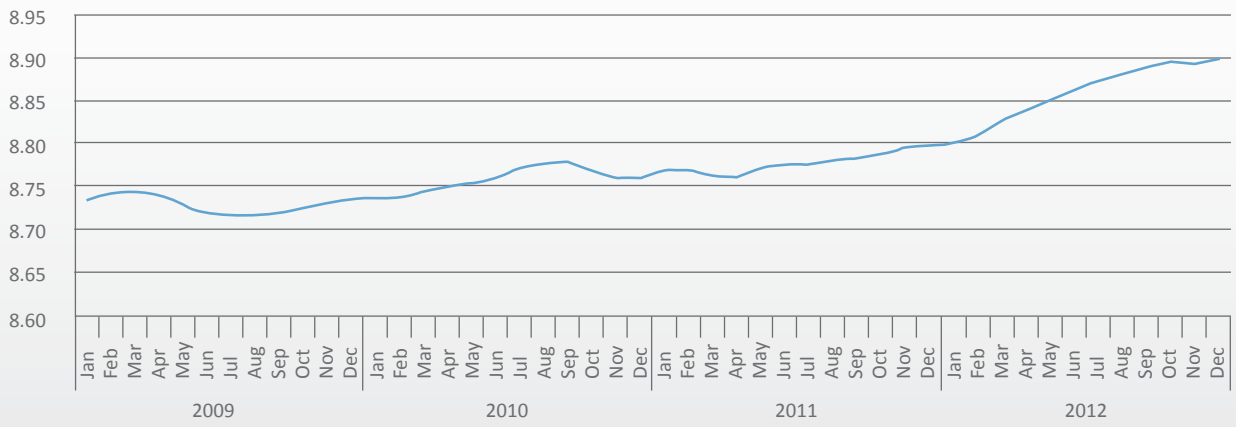



- **A highly-rated service infrastructure.** The scale of the operations of Discovery Health (Pty) Ltd is unparalleled in the industry, with over 35 300 calls answered per day and 82% of queries resolved during the first call. More than 50 000 hospital admissions are authorised each month. Independent industry surveys have verified that the services provided by Discovery Health (Pty) Ltd are among the most highly rated in the industry. In 2012, Discovery Health (Pty) Ltd achieved an all-time high client satisfaction score of 8.96 (out of 10).

## Members of the Discovery Health Medical Scheme receive world-class service:

| Operational metrics: | | |
|---|---|---|
| | 2012 | 2011 |
| Calls per day | 35 374 | 34 015 |
| Calls answered within 20 seconds | 77% | 83% |
| Emails per day | 76 000 | 67 000 |
| Claims volumes per month | 3.9 million | 3.7 million |
| Claims submitted electronically | 89% | 88% |
| Claims paid per working hour | R13.8 million | R12.4 million |
| Average days from receipt to paid (members) | 1.85 days | 1.81 days |
| Member satisfaction score | 8.9 | 8.87 |
| Billing per month | R3.3 billion | R2.9 billion |

## Member service perceptions:




Source: Discovery Health (Pty) Ltd Service Lab data.

# Ongoing innovation in unique value-added products and services

Discovery Health (Pty) Ltd offers members of the Discovery Health Medical Scheme exclusive, value-added products and services not offered by other administrators. Through ongoing innovation, these products and services are continuously enhanced to ensure quality of care for Scheme members, greater control of costs, and the improvement of members' experience in the healthcare system.

In a continuous effort to simplify access for members, Discovery Health (Pty) Ltd is using the power of technology and digitising the healthcare environment through some revolutionary innovations. These include smartphone and iPad applications for both healthcare professionals and members (providing real-time access to information when and where doctors or members need it), telemetry and other devices (providing improved accuracy of data to doctors and to increase awareness among members), and iPad applications for financial advisers.

**Key value-added products and services offered by Discovery Health (Pty) Ltd include:**

- **Maximising cover for Scheme members.** To ensure that Scheme members have access to the latest developments in medicine and technology, Discovery Health (Pty) Ltd is continuously working to enhance members' cover. Enhancements over the past few years include the introduction of the Specialised Medicine and Technology Benefit, the Trauma Recovery Extender Benefit, the Insured Network Benefit and the Oncology Benefit.

- **A "health concierge" team.** This dedicated team provides compassionate support and service to members and their families when they need it most. It includes liaison managers who offer a support service to Scheme members in 54 of South Africa's busiest hospitals and 14 oncology practices. Liaison managers assist members in navigating their way through the hospital system to enjoy a better service experience. A special "high-touch" team offers personalised support and counselling to Scheme members in traumatic circumstances such as severe accidents or unexpected conditions (for example, encephalitis).

- **The Life Fourways Member Lounge.** This facility provides members and their families with a wide range of support services during hospital stays and doctor visits at the Life Fourways Hospital in Gauteng.

> "Discovery Health (Pty) Ltd offers members of the Discovery Health Medical Scheme exclusive, value-added products and services not offered by other administrators."

- **Discovery MedXpress.** This is a dedicated national medicine delivery service that provides Scheme members in major metropolitan areas home delivery of acute and chronic medicines at no charge. This occurs through a contracted network of retail pharmacy partners and a courier pharmacy. MedXpress service agents advise members on cost-effective alternatives for their medicines, ensuring they are always charged at the Discovery Health Medicine Rate or less to avoid co-payments.


- **Discovery Health MedSaver.** Through the MedSaver benefit offered by Discovery Health (Pty) Ltd, Scheme members can potentially save more than R130 million a year. Members can earn up to 25% cash back every time they purchase over-the-counter medicine (schedule 1 and 2) at Clicks pharmacies countrywide. The cash back is paid monthly into members' nominated bank accounts.

- **Discovery Health Wallet.** This is a flexible funding alternative offered by DiscoveryCard, which can be activated to operate seamlessly alongside a Scheme member's health plan. The Health Wallet automatically offers severe illness cover for the main member, spouse and children, based on their Vitality status.

- **Helping members save on optometry.** Discovery Health Medical Scheme members spend over R600 million a year on optometry from their day-to-day benefits. For 2013, Discovery Health (Pty) Ltd has created an extensive network of optometrists, where all Scheme members will receive a 20% discount on frames and lenses when they use an optometrist in the network. The lower costs will help preserve members' Medical Savings Accounts and optometry limits.

- **Support for members with chronic conditions.** Discovery Health (Pty) Ltd is committed to providing the best of care to Scheme members with chronic conditions. The following value-added services have been developed:

    - From 2013, Scheme members registered on the Chronic Illness Benefit for any chronic condition qualify for up to 25% cash back at Dis-Chem pharmacies on a wide range of specialised products that will help them live healthier lives. Scheme members can potentially save more than R380 million on chronic care products, by activating the benefit online and completing a Vitality Health Check.

    - Vitality's online health and wellness programme (**www.livingvitality.discovery.co.za**) empowers Scheme members to understand their chronic conditions using experts, tools and social media. Tracker tools help members increase their awareness, better manage their condition and keep accurate electronic records of their health. They can also connect with and gain support from relevant communities, participate in challenges, interact online with health and wellness experts, and view relevant articles of interest.

    - Using telemetry, a diabetes device pilot programme was carried out towards the end of 2012 with 50 Scheme members with diabetes to monitor their condition using their smartphone and an application. The programme aimed to determine the impact of telemetry on diabetes management. The members were issued with a glucose monitoring device measuring their blood sugar four times a day, and the results were relayed to their doctor through their mobile phones. The device triggered alerts when readings were out of range. The initial member feedback has been very positive – 82% of patients rated the pilot experience an 8 or higher out of 10. The telemetry devices will be rolled out to the majority of the 55 000 Discovery Health Medical Scheme members with diabetes during 2013.

- **Developing clearly defined member "journeys".** With over 200 000 member interactions a 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. The Administrator monitors each of these interactions closely and has used the experiences of more than 2.4 million Scheme lives to identify and develop clearly defined and differentiated member "experiences" or "journeys" through the healthcare system. These journeys include visiting a hospital (from pre-authorisation to leaving the hospital), having a baby, registering and managing a chronic condition, healthcare cover when travelling internationally, and adding or removing a dependant from a healthcare plan.

- **Tools to navigate the often complex healthcare system.** To assist Scheme members on their individual journeys through the healthcare system, Discovery Health (Pty) Ltd has developed a range of useful tools that ensure seamless online navigation of the more frequent and typical member experiences. These include:
  - **HospitalXpress** – a range of services that make admissions to hospital convenient and seamless by offering members the ability to plan and authorise hospital admissions, and confirm cover
  - **MedAdviser** – this tool helps members see exactly how much they will pay for medicine, whether there will be a co-payment, and whether they can choose generic medicine
  - **MaPS Adviser** – gives members the online convenience of locating a healthcare professional who participates in a payment arrangement with Discovery Health (Pty) Ltd
  - **Hospital Adviser** – calculates whether members can expect full cover for the hospital and medical specialists they have chosen
  - **Benefit Adviser** – allows members to better manage their day-to-day healthcare costs by showing, in real time, how close they are to reaching their day-to-day limits.

- **Innovation to digitise the healthcare environment.** Discovery Health (Pty) Ltd has developed a range of groundbreaking digital innovations to assist both Discovery Health Medical Scheme members and healthcare professionals. These include:
  - **Helping members manage their health plan online.** Discovery's recently relaunched interactive website, **www.discovery.co.za**, has made it more convenient than ever for Discovery Health Medical Scheme members to manage their health plans online (see page 46).
  - **Discovery Member Smartphone App.** Discovery Health (Pty) Ltd has designed a smartphone application to put Scheme members fully in touch with their health plan, no matter where they are (see page 47).
  - **Discovery HealthID.** A critical innovation launched in May 2012 was HealthID, a healthcare information application for doctors developed by Discovery Health (Pty) Ltd and a first in South Africa (see page 48).

- **Keeping Scheme members informed.** Discovery Health (Pty) Ltd is committed to finding engaging and interactive ways to keep Scheme members informed about their healthcare cover and benefits. These include:
  - **Procedure information guides.** To inform Scheme members on what to expect when they go to hospital for a surgical procedure, Discovery Health (Pty) Ltd has introduced a library of 265 procedure information guides. The guides have been drawn up in association with EIDO Healthcare, a UK-based company specialising in communicating clinical information to patients. The guides are available on the Discovery website, as well as on the Discovery Member Smartphone App.
  - **Member education videos.** To create awareness and understanding of potentially complex healthcare issues in an easy-to-understand way, Discovery Health (Pty) Ltd has developed a series of videos for Scheme members. They are available on YouTube or via the Discovery website or the Discovery Member Smartphone App. The videos also assist Scheme members to choose Full Cover Choice options to maximise their healthcare cover. Video titles currently available are:

– ***You've just joined:*** What members need to know if they've just joined the Scheme.

– ***Going to hospital:*** Gives members all the information they need for a planned hospital admission.

– ***Co-payment on medicine:*** How members can make the Full Cover Choice and reduce or avoid co-payments.

– ***Self-payment gap:*** Understanding the self-payment gap and tips on how it can be reduced.

– ***You're pregnant:*** What members should do before going to hospital, how the Scheme covers childbirth, specialists and antenatal care, and how members can make the Full Cover Choice.

## www.discovery.co.za: Health plans at Scheme members' fingertips

Towards the end of 2012, the Discovery fully interactive website, **www.discovery.co.za**, was relaunched. Featuring new, responsive design elements, it is now more convenient than ever for Discovery Health Medical Scheme members to manage their health plans online. It has been designed to work on a variety of different digital devices, and provides members with a seamless end-to-end experience on their journey through the healthcare system.

**Scheme members can now perform the following functions online:**

- Keep track of their available benefits
- Authorise hospital admissions – members receive an authorisation number immediately
- Order medicine, and check current medicine prices and the availability of alternatives
- Find a healthcare professional the Scheme will cover in full
- Manage their health condition, such as diabetes or cancer
- Check which treatments or procedures they are covered for

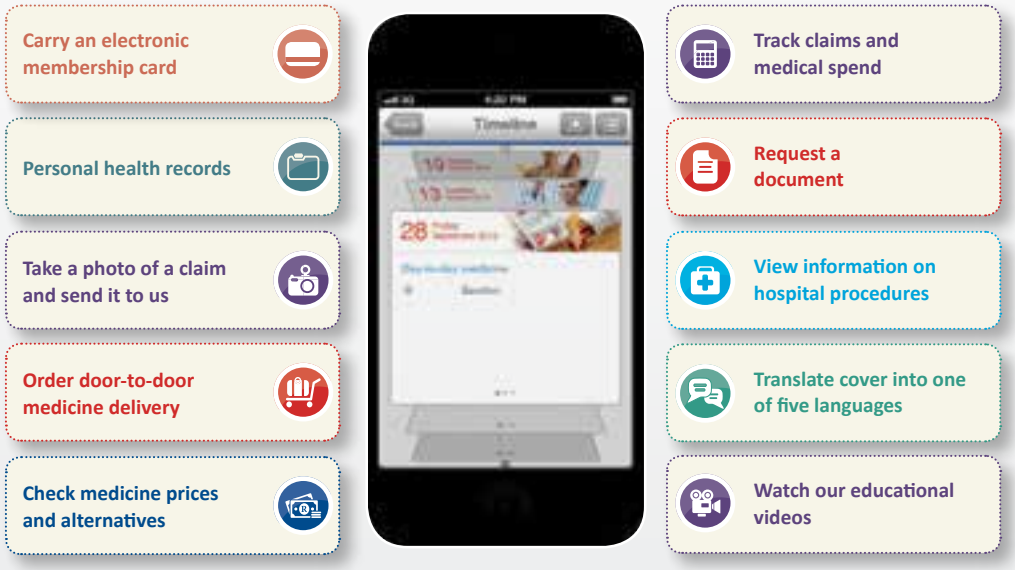
- Keep track of claims
- Find out everything they need to know in the case of pregnancy
- Access important documents such as tax certificates and application forms
- Make use of Vitality's suite of tools to help manage their health and wellness goals
- Engage with LivingVitality – an interactive platform assisting members to track and improve their health and fitness

To help Scheme members maximise their healthcare cover, Full Cover Choice options have been made available online to guide members to make decisions that will ensure they do not experience any shortfalls in cover when they need to claim. Members can look out for the Full Cover Choice stamp in their health plans online to find out which healthcare services – hospitalisation, specialists in hospital, chronic medicine and GP consultations – will be fully covered.

## Discovery Member Smartphone App: A 'health plan on the go'

Launched in September 2012, the concept underlying the Discovery Member Smartphone App is to provide members with "a health plan on the go" – if members have their smartphones with them, they will also have access to their health plans. The application is available on Apple and Android devices.

**The application allows members to perform the following functions:**




By December 2012, the application was downloaded nearly 90 000 times. There is an average of 43 409 logins per month on the iPhone app, and 6 170 logins per month on the Android version.

The smartphone application is continuously being enhanced, and new functionalities are rolled out on an ongoing basis to the application store. Over the course of 2013, members will also be able to check their medicine prices and alternatives, and translate their International Travel Benefit cover into one of five languages.


## Discovery HealthID: A revolution in electronic health records in SA

HealthID is a groundbreaking iPad application which aims to provide a platform for sharing clinical information to facilitate better coordination of care, improve efficiency and patient outcomes and streamline doctors' administration.

The development of HealthID started over a decade ago, and aims to transform billions of lines of claims data into accessible health records that make it more efficient for healthcare professionals and patients to interact with the healthcare system. It was developed in response to a growing need in the healthcare system for an integrated view of information as well as the global trend towards and mainstream adoption of mobile digital technologies. It provides an opportunity to transform the way healthcare professionals and patients navigate the healthcare system, and offers long-term benefits for the quality of care across the healthcare system.

**HealthID enables doctors to:**

- Access Discovery Health Medical Scheme members' full electronic health records, including details of previous doctor and hospital visits, previously prescribed medicines, blood test results, as well as health measures
- Prescribe medicine for chronic and acute conditions, and send electronic prescriptions directly to members' pharmacies
- Complete an electronic Chronic Illness Benefit application form with the required information and validation built into the electronic process
- View Scheme members' personal and benefit information
- Refer Scheme members to another healthcare professional by using the electronic referral tool.

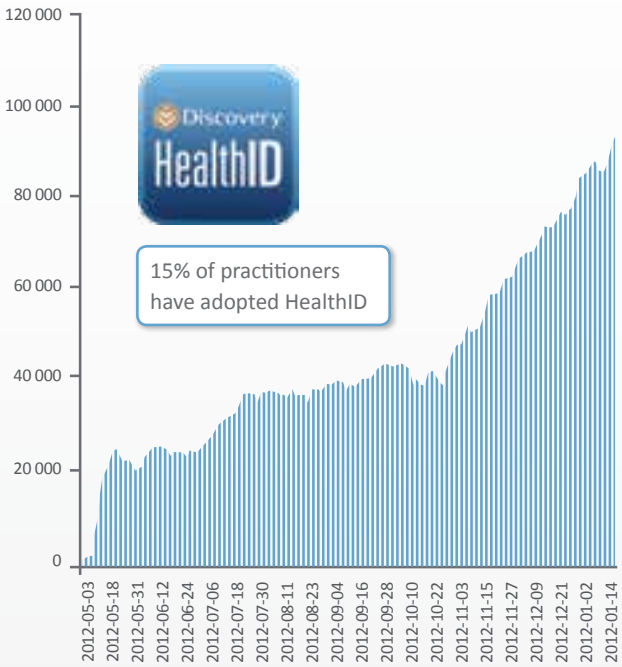
Emergency HealthID is a unique QR code-based identifier for each Discovery Health Medical Scheme member which gives emergency personnel secure access to essential information in an emergency. By scanning the QR code, placed on the car windscreen, authorised paramedics can gain access to potentially lifesaving data on a member's identity, next of kin, allergies and other critical health information.

There has been an overwhelmingly positive reaction from both doctors and Scheme members since HealthID was launched, and it is already having a significant impact on the quality of care provided to Scheme members by doctors. By December 2012, there were over 1 000 doctors regularly using HealthID in their practices, and over 95 000 members had given consent for their doctors to use HealthID to access their medical records.

## HealthID: Delivering an exceptional member journey:

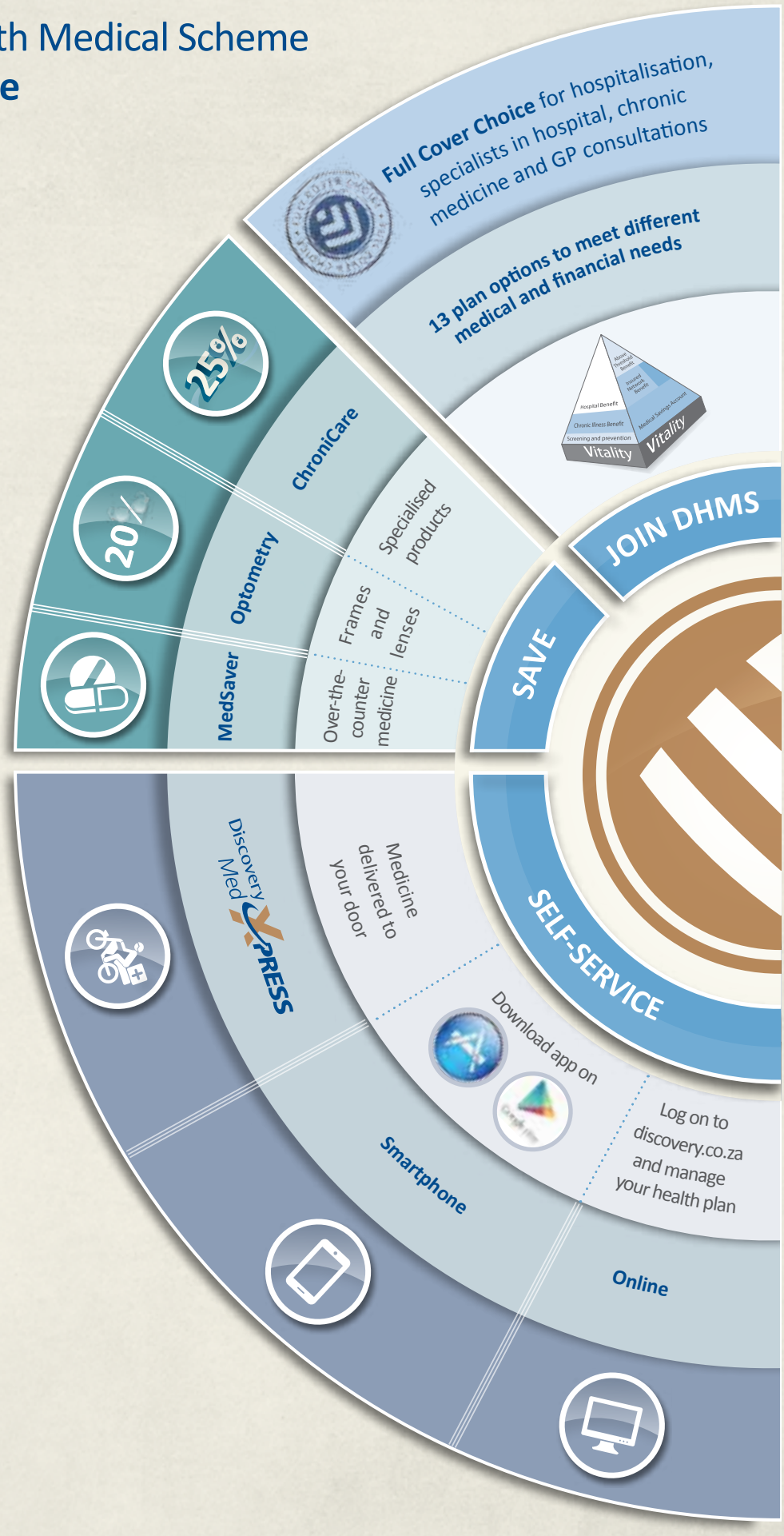
### Member consents

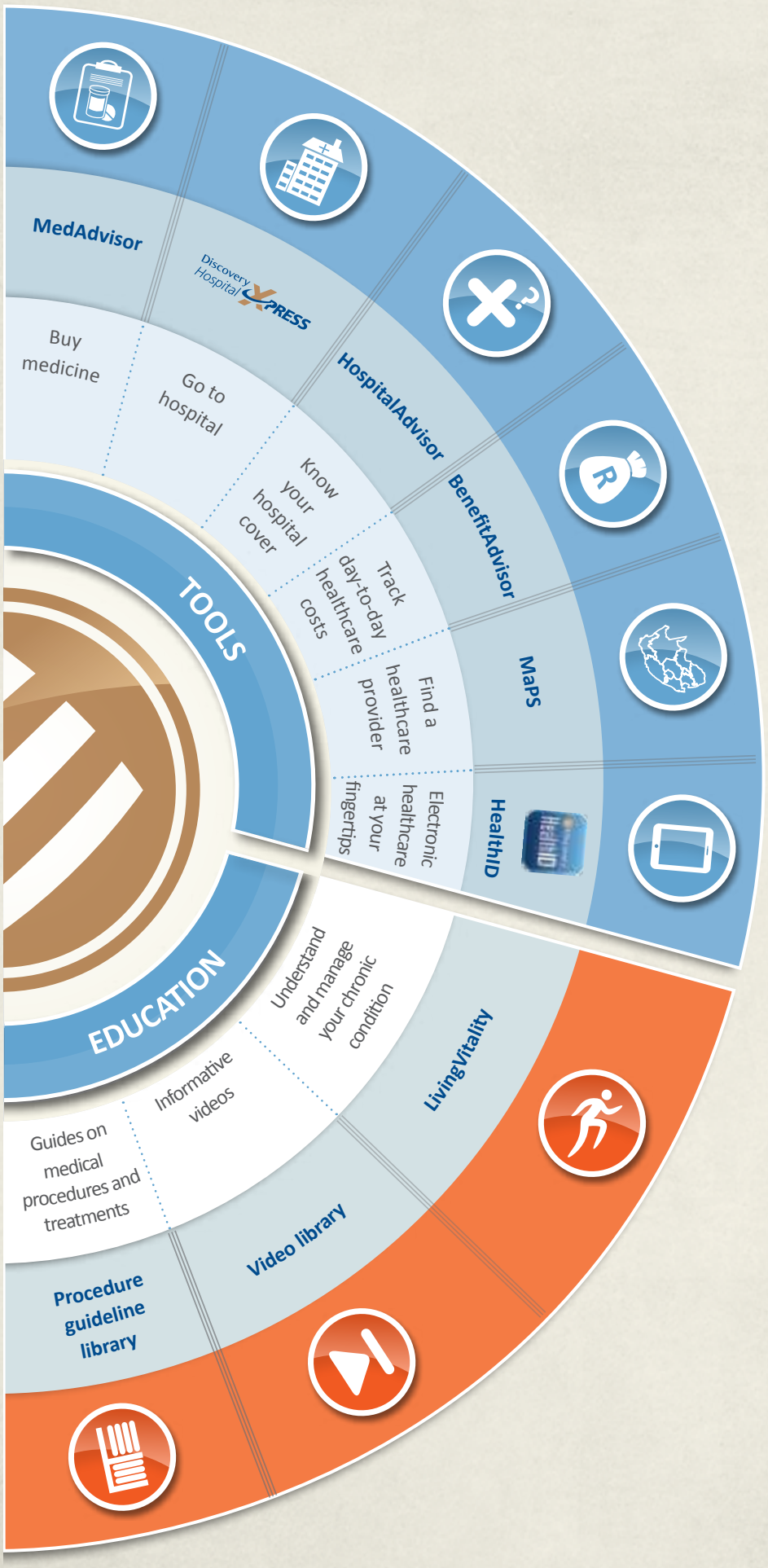

### Unique practitioners logged in over a period of 7 days




HealthID will continue to be enhanced, with new functionalities added regularly, including providing doctors with the ability to include their own clinical notes in the application, the addition of fields read by telemetric devices, a series of intelligent alerts to treating doctors, such as drug interactions, and the ability of doctors to submit claims directly via the HealthID application.

# The Discovery Health Medical Scheme **member experience**




TOOLS
EDUCATION
MedAdvisor
Buy medicine
HospitalAdvisor
Discovery Hospital EXPRESS
Go to hospital
BenefitAdvisor
Know your hospital cover
MaPS
Track day-to-day healthcare costs
HealthID
Find a healthcare provider
Electronic healthcare at your fingertips
LivingVitality
Understand and manage your chronic condition
Video library
Informative videos
Procedure guideline library
Guides on medical procedures and treatments

# Improving members' health through Vitality

Members of the Discovery Health Medical Scheme have access to Vitality, Discovery Ltd's internationally recognised, science-based wellness programme. Launched in 1997, the programme is the largest of its kind in the world, with more than five million members on four continents. By using a combination of financial incentives and behavioural economic principles, Vitality encourages healthy behaviour that reduces long-term healthcare costs. The programme works on the premise that it is essential to change ingrained behaviour, such as unhealthy diet and lack of exercise, to achieve better health outcomes over the long term. It achieves this through meaningful environmental and structural changes. The HealthyFood and gym benefits, for example, have lowered the financial barriers to a healthier lifestyle by rewarding Vitality members for purchasing healthy foods and for exercising regularly.

> "The Vitality wellness programme is a significant factor contributing to the sustained growth, stability and healthy profile of the Discovery Health Medical Scheme."

Vitality Healthstyle (Pty) Ltd is wholly owned by Discovery Ltd and is a separate legal entity to the Discovery Health Medical Scheme. Membership of Vitality is offered to all Scheme members on a purely voluntary basis. Members pay a separate monthly premium to Vitality Healthstyle (Pty) Ltd.

The Vitality wellness programme is a significant factor contributing to the sustained growth, stability and healthy profile of the Discovery Health Medical Scheme. It has been independently validated as a scientifically proven intervention that helps alleviate the risk related to chronic diseases of lifestyle. It complements the Scheme, as the programme encourages members to be healthy and to lead an active lifestyle. The Scheme benefits materially from Vitality – it has allowed the Scheme to attract and retain healthy members, and the Scheme's lapse rates are by far the lowest in the industry.

The Vitality programme has been the subject of a number of scientific studies – today there is substantial, peer-reviewed evidence, published in leading international and local journals, that shows the significant impact on health status, health claims and health outcomes, of engagement in the Vitality programme. In short, members' health, hospital admissions, and mortality rates improve in a linear manner as they engage more with Vitality. Without Vitality, the Discovery Health Medical Scheme's claims would be significantly higher, and this would impact materially on its financial stability, and the level of monthly contributions.

Vitality has attracted international recognition and has been the subject of much press coverage. Most recently, in a report released by the Workplace Wellness Alliance at the World Economic Forum held in January 2013 in Davos, Switzerland, Vitality was acknowledged as a global case study on wellness, and a gold standard for incentivising healthy behaviour and outcomes.

# Research findings on the impact of Vitality

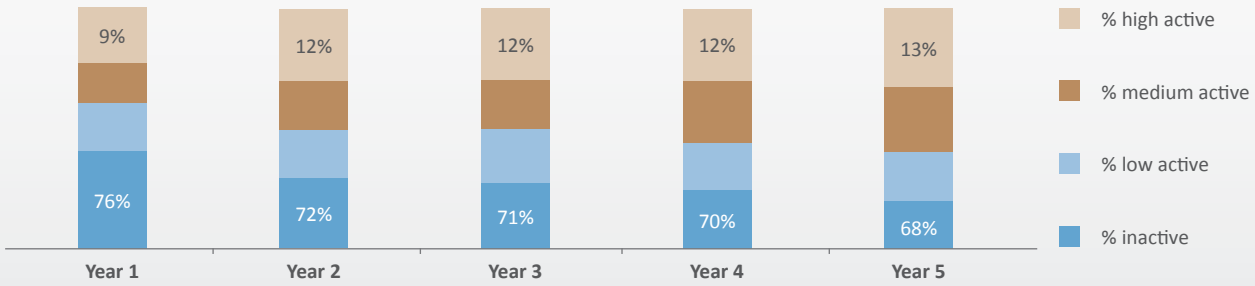
Vitality's research agenda to determine the programme's impact on members' health and healthcare costs is evolving significantly, supported by both national and international collaborations.

Three academic studies (the Vitality Insured Persons studies) published in September 2008 found that Vitality members actively leading a healthy lifestyle spent less on healthcare. The studies found they had lower hospital admission rates, incurred lower costs in hospital and spent less on chronic medicine for certain diseases than non-Vitality members or Vitality members not managing their health. Researchers from the universities of Cape Town, the Witwatersrand and Harvard conducted the research using data from almost one million Discovery Health Medical Scheme members.

A retrospective study conducted by Discovery in 2011 in collaboration with the same researchers validated Vitality's ability to get people engaged in complex fitness activities, and sustain this engagement over time. The study, the results of which were published in the American Journal of Health Promotion, tracked over 300 000 Discovery Health Medical Scheme members over a five-year period. It focused on the impact of changes in their engagement with fitness related activities on their risk and cost of hospital admissions.

The results of the study showed that participation in fitness-related activities is associated with significantly lower healthcare costs. More specifically:

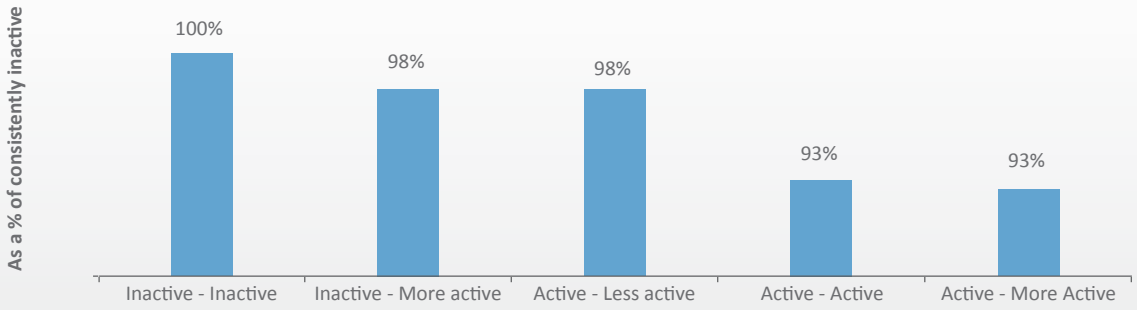
- **Vitality motivates people to become more active.**




Source: Participation in Fitness-Related Activities of an Incentive-Based Health Promotion Program and Hospital Costs: A Retrospective Longitudinal Study, The American Journal of Health Promotion, May 2011.

- **Physically active members have a 7% lower chance of being admitted to hospital.** The research found that an increase in weekly activity levels decreased the incidence of hospital admission for the member by between 3% and 4%.

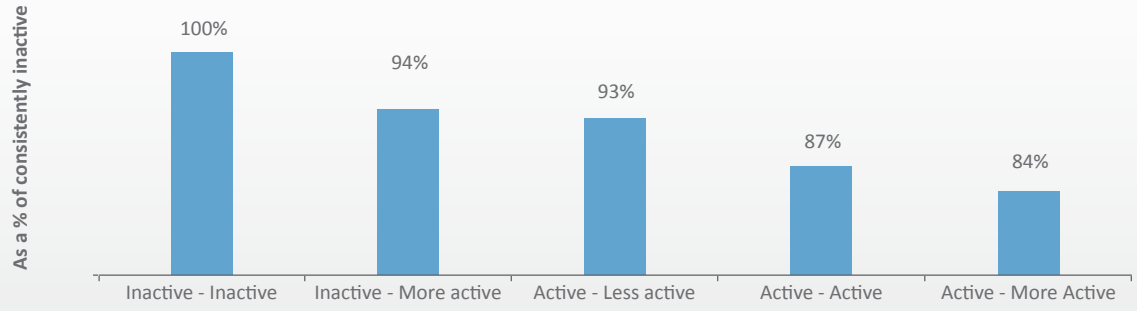
**Probability of admission in years 4 and 5 by change in activity levels in years 1 to 3:**




Source: Participation in Fitness-Related Activities of an Incentive-Based Health Promotion Program and Hospital Costs: A Retrospective Longitudinal Study, The American Journal of Health Promotion, May 2011.

- **Physically active members who are admitted to hospital incur lower costs.** As member engagement with fitness offerings increased, the subsequent cost of hospital admissions decreased.

**Cost per admission in years 4 and 5 by change in activity levels in years 1 to 3:**




Source: Participation in Fitness-Related Activities of an Incentive-Based Health Promotion Program and Hospital Costs: A Retrospective Longitudinal Study, The American Journal of Health Promotion, May 2011.

Another longitudinal study looked at the take-up of the Vitality programme's HealthyFood benefit and the impact on Vitality members' food-spending patterns during the first year after the benefit was launched in 2009. It showed significant increases in HealthyFood purchases with corresponding decreases in unhealthy food purchases over the period. The proportion of HealthyFood in the average basket has increased steadily since then. Higher levels of HealthyFood purchases have been strongly correlated with decreased probability of being diagnosed with chronic, lifestyle-related diseases. At the start of 2012, the HealthyFood model was expanded to encourage positive behaviour by Vitality members in an additional two areas – learning about their health and understanding their risk for chronic diseases of lifestyle, and learning about their fitness levels and how to improve them.

During 2012, the results of the second Discovery Healthy Company Index were announced. The results again provided Vitality with additional evidence to validate Vitality Age* as a predictor of morbidity risk. More than 19 000 employees from 110 companies participated in the survey.

Research currently in the pipeline includes international collaborations with the University of Pennsylvania, Carnegie Mellon, the RAND Corporation, Duke and Tulane University and Emory University. The research includes studies on incentives, healthy eating, preventive screening and decision-making in improving healthy behaviour.

Overall, the research is showing that through its rich range of benefits and incentives, Vitality is promoting healthier behaviour among members of the Discovery Health Medical Scheme. With the increasing burden of disease and healthcare costs increasing at well above inflation, an effective wellness intervention is essential. Vitality is having a positive impact on individuals by assisting them in leading a healthier lifestyle. As a result of incentivising healthier choices, Vitality is having a significant positive financial impact on the Discovery Health Medical Scheme – recent estimates suggest that the participation of Scheme members in Vitality leads to significant savings for the Scheme.

> "Vitality is promoting healthier behaviour among members of the Discovery Health Medical Scheme."

** Vitality Age is a medically and actuarially derived tool that calculates an individual's health risk-related age based on lifestyle behaviours and clinical measures, and is used to present an individual's health risk as years "lost" or "gained", relative to chronological age, because of unhealthy or healthy practices.*

# **Strategic objectives** for the Discovery Health Medical Scheme

**The Discovery Health Medical Scheme will focus on the following key strategic objectives during the 2013 benefit year:**

- Ensuring continuous best practice governance
- An enhanced focus on bending the cost curve through innovation in risk management and the implementation of alternative reimbursement strategies
- Enhanced stakeholder engagement and relationship strategies
- An increased focus on product design to maintain and enhance the Scheme's competitive and product leadership positions.

During 2012, the Scheme developed new plans for implementation on 1 January 2013 to provide members with more choice. An outline of the two new plans as well as the 2013 contribution increase approach are discussed below:

## New plans to give members more choice

In 2013, the Discovery Health Medical Scheme's strategic focus is to continue to provide the best of care to all Scheme members, while enhancing benefits, expanding access of affordable healthcare to the lower end of the market through KeyCare and balancing value and cost for the sustainability of healthcare cover. In pursuit of these objectives, two new plans were introduced for the 2013 Scheme year:

- **Extending the Comprehensive Series to include Classic Comprehensive Zero MSA:** This new health plan offers the same security of extensive private healthcare cover in hospital and for chronic medicine as Classic Comprehensive, but with the flexibility to fund day-to-day healthcare needs without a Medical Savings Account. If the member reaches the annual threshold, claims will be paid from the Above Threshold Benefit. All benefits and limits are the same as on Classic Comprehensive, but the plan does not have the Insured Network Benefit and the Trauma Recovery Extender Benefit. MRI and CT scans are covered only when the member reaches the Above Threshold Benefit.
- **A new access point, KeyCare Access:** A pattern has emerged over the past few years of new members joining the Discovery Health Medical Scheme at lower plan levels than in the past, which suggests that households are under more financial pressure and are looking for lower-cost options. In line with the Scheme's commitment to maintain an affordable and sustainable access point for lower-income earners, a new plan option in the KeyCare Series has been made available from 2013. KeyCare Access offers a low-cost entry point for lower-income earners and provides cover in the healthcare areas members value most: private GP visits, emergencies and accidental trauma in a private hospital, childbirth and care for newborns in private hospitals and elective procedures in the Discovery Health (Pty) Ltd contracted network of state facilities. At the core of this plan is the belief that if the correct primary care is received initially, further complications may be avoided. This serves to drive down hospital admissions, improve the health of insured lives, as well as offer access to private healthcare to a greater proportion of currently uninsured South Africans.

# The Discovery Health Medical Scheme's 2013 contribution increases

Medical scheme contribution increases must always balance affordability and sustainability of healthcare cover. In 2013, contribution increases vary by plan to maintain this balance, while keeping the Discovery Health Medical Scheme the most affordable choice in the market across the entire spectrum of healthcare needs.

The 2013 contribution increases for the Discovery Health Medical Scheme range between 9.8% and 11.8% (with a weighted average of 10.9%). Four main factors have driven the increases: tariffs, which are closely correlated with the Consumer Price Index; demand-side factors that reflect changing demographics such as ageing membership, increasing disease burden and adverse selection; supply-side factors that are due to advances in medical technology and practice; and benefit enhancements. Demand-side factors tend to create pressure on the highest- and the lowest-cost plans in a medical scheme, with the result that claim levels vary across plan categories. To maintain an equitable contribution level, the Scheme's contribution increases for 2013 reflect these differences.

Contributions have also been impacted by the need to grow the Scheme's solvency to meet the regulatory requirement of 25%.

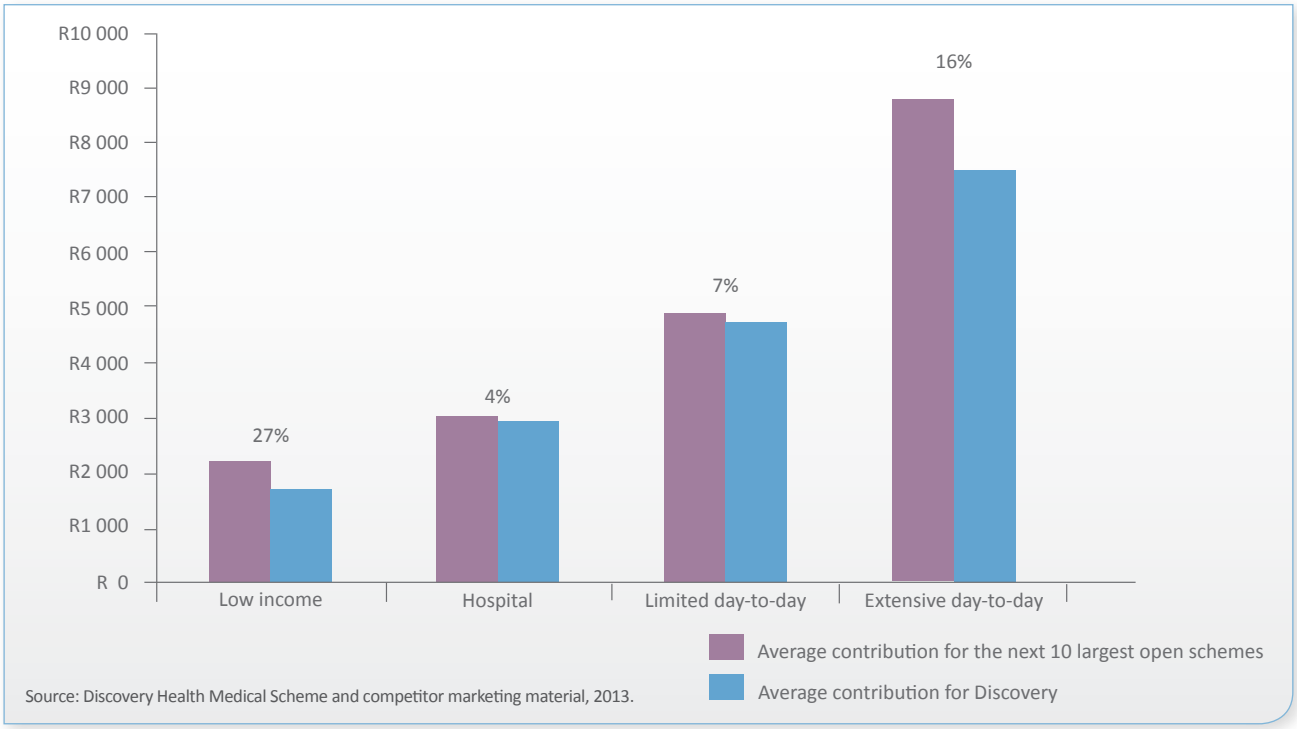
It is important to note that the administration and managed healthcare costs paid by the Discovery Health Medical Scheme to Discovery Health (Pty) Ltd have been deflationary, to the extent of a 4.6% real reduction over the past five years. These reductions are expected to continue and reflect ongoing economies of scale as the Scheme continues to grow, and have assisted in reducing the overall contribution increase.

**The 2013 contribution increases have been set to achieve the following aims:**

- Keep the value proposition of the Discovery Health Medical Scheme for all members
- Recognise the difference in demand-side effects between different plans
- Ensure the sustainability of cover for low-income members
- Continue to build solvency while growing membership.

The Discovery Health Medical Scheme remains the most affordable medical scheme choice across the entire spectrum of healthcare needs. An analysis of 2013 contributions for a family of four points towards the Scheme staying between 4% and 27% more affordable than comparable plans for the next 10 largest open schemes.

**Comparison of 2013 contributions for a family of four:**




Source: Discovery Health Medical Scheme and competitor marketing material, 2013.

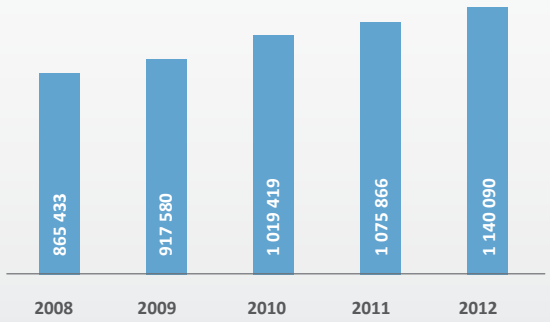
**Performance Review for 2012:**
Report by the Board of Trustees

# Performance Review

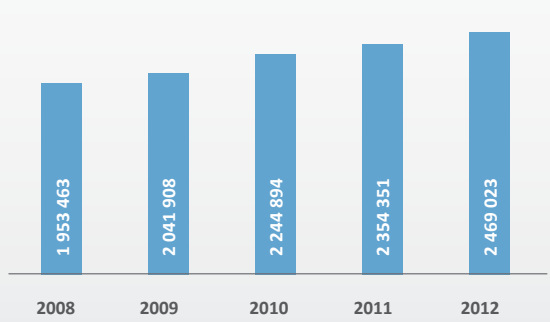
## For the year ended 31 December 2012

## Financial and performance highlights

### Increase in Scheme principal members

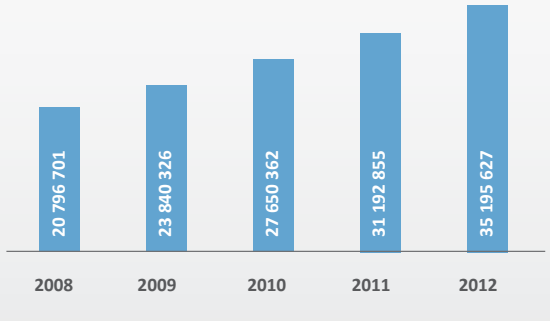



### Increase in Scheme lives



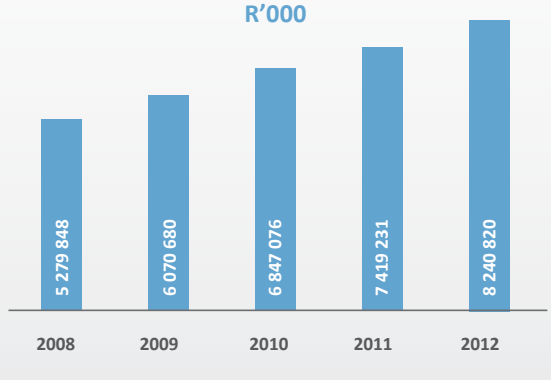

### Increase in gross contributions

R'000




### Growth in members' funds

R'000




| | |
|---|---|
| 23.41% | Statutory solvency level |
| 6.00% | Average growth in principal members |
| 4.1% | Annualised lapse rate |
| 2.2 | Average family size |
| 12.83% | Increase in gross contributions |
| 8.76% | Admin fees as % of gross contributions |
| 6.98% | Average investment return on investment portfolios |
| AA+ | Independent credit rating for claims-paying ability |

## Overview of financial performance

The Discovery Health Medical Scheme continued to deliver on its core purpose of funding evidence-based, cost-effective, quality healthcare cover and supporting the enhancement of the healthcare system for Scheme members and stakeholders. This objective is underpinned by sound financial management, governance, stewardship and effective risk management efforts, ensuring long-term sustainability, and is evidenced by the strong financial performance for the year under review.

The net healthcare result increased from a negative result of R77 million to a positive R187 million. The investment income of R617 million contributed to the net surplus for the year ended 31 December 2012 of R789 million, which includes a provision of R80 million for additional interest due to members with positive Medical Savings Accounts balances, as required by Circular 38 of 2011. The Scheme's strong financial performance increased members' funds to over R8.2 billion, with the Scheme's investments and cash exceeding R8.3 billion 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 an independent credit rating agency, Global Credit Rating Co.

In an environment where the majority of medical schemes are shrinking, the Scheme continues to attract and retain members. Over the past five years the Scheme has grown by 515 560 lives. At 31 December 2012, the Scheme provided cover to 1 140 090 principal members and 2 469 023 lives. The average increase in principal members was 6% compared to 6.73% the previous year. The ability of the Scheme to retain members is demonstrated by extremely low lapse rates with an annualised lapse rate for 2012 of 4.1%. This large and diverse membership base provides significant financial, risk and actuarial stability within the Scheme.

The detailed results of the Scheme are set out in the Annual Financial Statements on pages 79 to 156.

The Scheme continues to offer substantial member flexibility, well-priced plans and comprehensive and effective benefit design compared to its peers. 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 lapse rates.

## Benefit plans

**The Scheme offered 13 benefit plans to members for 2012. 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 |
| KeyCare | KeyCare Plus |
| | KeyCare Core |

# Solvency

The Scheme is required to maintain accumulated funds of 25% of gross annual contributions 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%.

## Calculation of regulatory capital requirement

| | 2012 R'000 | 2011 R'000 |
|---|---|---|
| Total members' funds per Statement of Financial Position | 8 240 820 | 7 419 231 |
| Less: cumulative unrealised net gain on remeasurement of investments to fair value | - | (90 436) |
| Accumulated funds per Regulation 29 | 8 240 820 | 7 328 795 |
| Gross contribution income | 35 195 627 | 31 192 855 |
| Solvency margin = Accumulated funds / gross contribution income x 100 | **23.41%** | **23.50%** |

At 31 December 2012 the Scheme's regulatory capital was R558 million less than the statutory capital requirement of 25%.

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 for the Scheme increasing 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.

## The approved phase-in solvency levels are as follows:

| Year ended | Solvency level |
|---|---|
| 31 December 2012 | 22.3% |
| 31 December 2013 | 23.0% |
| 31 December 2014 | 24.3% |
| 31 December 2015 | 25.4% |

At 31 December 2012, the Scheme's solvency margin stood at 23.41%, exceeding the approved phase-in solvency level of 22.3% by R392 million.

## Annual growth in membership

The Scheme now provides cover to over 2.4 million lives.

**Total membership per benefit plan was as follows:**

| Benefit plan | 31 December 2012 principal members | 31 December 2012 total lives | 31 December 2012 % of total lives | 31 December 2011 total lives |
|---|---|---|---|---|
| Executive Plan | 11 964 | 27 644 | 1.12 | 27 659 |
| Classic Comprehensive | 184 153 | 438 966 | 17.78 | 447 796 |
| Classic Core | 50 892 | 110 043 | 4.46 | 107 763 |
| Classic Saver | 202 537 | 441 050 | 17.86 | 404 702 |
| Classic Priority | 100 772 | 232 561 | 9.42 | 223 614 |
| Essential Comprehensive | 27 873 | 59 076 | 2.39 | 65 388 |
| Essential Core | 25 770 | 54 981 | 2.23 | 48 181 |
| Essential Saver | 70 606 | 154 137 | 6.24 | 140 870 |
| Essential Priority | 9 704 | 20 442 | 0.83 | 20 369 |
| Coastal Saver | 156 447 | 361 272 | 14.63 | 340 623 |
| Coastal Core | 75 018 | 166 807 | 6.76 | 157 061 |
| Foundation Core | - | - | - | 1 657 |
| KeyCare Plus | 209 230 | 378 054 | 15.31 | 343 811 |
| KeyCare Core | 15 124 | 23 990 | 0.97 | 24 857 |
| **Total** | **1 140 090** | **2 469 023** | **100.00** | **2 354 351** |

## Market share

The Scheme's share of the open medical scheme market at the end of the 2012 financial year, in terms of membership base, was over 51% (2011: 50%), reflecting its position as the largest and most stable open medical scheme in South Africa.

## Competitive contribution increase

The Scheme's weighted contribution increase for 2013 is 10.9% across all plans and family sizes and supports 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, while ensuring the competitiveness of its product offering and offering comprehensive cover for members' needs at different product price levels.

# Key financial and service metrics

| | 2012 | 2011 |
|---|---|---|
| Members' funds | R8.2 billion | R7.4 billion |
| Solvency ratio | 23.41% | 23.50% |
| Membership (lives) | 2.47 million | 2.35 million |
| Gross contribution income | R35.19 billion | R31.19 billion |
| Risk contribution income | R28.23 billion | R24.97 billion |
| Average net contributions Per Member Per Month (PMPM) | R2 116 | R1 985 |
| Average net claims Per Member Per Month (PMPM) | R1 739 | R1 640 |
| Average accumulated funds per member at year-end | R7 228 | R6 896 |
| Average return on investments as a percentage of investments | 5.83% | 6.31% |
| Number of hospital admissions | 588 936 | 547 705 |
| Average age at year-end | 32.95 | 32.78 |
| Pensioner ratio at year-end | 7.36% | 7.05% |

| 2012 | New member applications | Customer service call centre | Claims processing | Hospital and walk-in centre visits |
|---|---|---|---|---|
| Volume | 1 631 lives of new business applications are activated per working day | The Administrator received 35 384 calls per day | Average of 164 815 claims processed per working day | 50 250 hospital patients were visited by member liaison managers<br>67 620 members visited the 5 walk-in centres |
| Average service delivery | On average, applications are processed within 3 days | On average, 77.31% of calls received are answered within 20 seconds | 1.84 days from receipt to payment for members and 4.82 days for healthcare professionals | Average member-based research score out of 10 for member liaison managers increased to 9.40 |
| | | | 0.79% error rate | |

# Prudent financial management

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

| Year ended | December 2012 R'000 | December 2011 R'000 | December 2010 R'000 |
|---|---|---|---|
| Gross contributions | 35 195 627 | 31 192 855 | 27 650 362 |
| Total outstanding – excluding December contributions | 5 986 | 8 304 | 15 315 |
| % outstanding | 0.02% | 0.03% | 0.06% |

# 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 Committees, as well as the internal auditors and Compliance Officer, have an ongoing role in monitoring compliance to ensure the Scheme meets all the statutory and 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.

## Matters of non-compliance for the year ended 31 December 2012

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

At 31 December 2012, the Scheme's accumulated funds expressed as a percentage of gross annual contributions was 23.41% (2011: 23.50%), which is less than the statutory requirement of 25%. The Scheme advised the Council for Medical Schemes during 2012 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 with phase-in solvency levels as set out below.

| Year ended | Solvency level |
|---|---|
| 31 December 2012 | 22.3% |
| 31 December 2013 | 23.0% |
| 31 December 2014 | 24.3% |
| 31 December 2015 | 25.4% |

## 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 must be financially sound.

### At 31 December 2012 the following benefit plans did not comply with Section 33(2):

| Plan | Net underwriting deficit [excluding other income] R'000 | Net (deficit)/surplus [including other income] R'000 |
|---|---|---|
| Executive | (264 887) | (257 041) |
| Classic Comprehensive | (678 279) | (557 543) |
| Coastal Saver | (27 719) | 71 500 |
| Coastal Core | (2 267) | 44 500 |
| KeyCare Plus | (369 556) | (242 252) |

## 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. 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.

## 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 the Scheme follows regarding these contributions are set out in Note 32 to the Annual Financial Statements.

## 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 contributions. In some instances brokers were compensated prior to receipt of the relevant monthly contributions. The Scheme has implemented additional controls to address this matter and continues to monitor the resulting instances where this requirement was contravened.

# Operational statistics

| 2012 | 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 | 11 964 | 184 153 | 50 892 | 203 537 | 100 772 | 27 873 | 25 770 | 70 606 |
| Number of beneficiaries at the end of the accounting period | 27 644 | 438 966 | 110 043 | 441 050 | 232 561 | 59 076 | 54 981 | 154 137 |
| Average number of members for the accounting period | 12 092 | 186 101 | 49 578 | 197 034 | 100 132 | 28 184 | 24 055 | 67 869 |
| Average number of beneficiaries for the accounting period | 28 003 | 444 176 | 107 538 | 428 802 | 230 195 | 59 704 | 51 573 | 148 564 |
| Average risk contributions per member per month (R') | 4 541 | 3 655 | 2 129 | 2 015 | 2 462 | 3 224 | 1 710 | 1 759 |
| Average risk contributions per beneficiary per month (R') | 1 961 | 1 531 | 982 | 926 | 1 071 | 1 522 | 797 | 804 |
| Average net claims incurred per member per month (R') | 5 949 | 3 538 | 1 391 | 1 398 | 1 875 | 2 446 | 1 116 | 1 058 |
| Average net claims incurred per beneficiary per month (R') | 2 569 | 1 482 | 641 | 643 | 815 | 1 154 | 521 | 483 |
| Average administration costs per member per month (R') | 255 | 255 | 255 | 255 | 255 | 255 | 255 | 255 |
| Average administration costs per beneficiary per month (R') | 110 | 107 | 118 | 117 | 111 | 121 | 119 | 117 |
| Average Managed care: management services per beneficiary per month (R') | 32 | 31 | 34 | 34 | 32 | 35 | 35 | 34 |
| Beneficiaries per member at 31 December | 2.32 | 2.39 | 2.17 | 2.18 | 2.30 | 2.12 | 2.14 | 2.19 |
| Dependants per member at 31 December | 1.32 | 1.39 | 1.17 | 1.18 | 1.30 | 1.12 | 1.14 | 1.19 |
| Relevant healthcare expenditure as a percentage of risk contributions (%) | 131 | 97 | 65 | 69 | 76 | 76 | 65 | 60 |
| Non-healthcare expenditure as a percentage of risk contributions (%) | 9 | 11 | 18 | 20 | 17 | 13 | 23 | 22 |

| 2012 | Essential Priority | Coastal Saver | Coastal Core | KeyCare Plus | KeyCare Core | Total |
|---|---|---|---|---|---|---|
| Number of members at the end of the accounting period | 9 704 | 156 447 | 75 018 | 209 230 | 15 124 | **1 140 090** |
| Number of beneficiaries at the end of the accounting period | 20 442 | 361 272 | 166 807 | 378 054 | 23 990 | **2 469 023** |
| Average number of members for the accounting period | 9 403 | 153 237 | 72 313 | 197 123 | 14 316 | **1 111 438** |
| Average number of beneficiaries for the accounting period | 19 756 | 354 608 | 161 112 | 357 700 | 22 735 | **2 414 467** |
| Average risk contributions per member per month (R') | 2 212 | 1 674 | 1 605 | 1 065 | 926 | **2 116** |
| Average risk contributions per beneficiary per month (R') | 1 053 | 723 | 720 | 587 | 583 | **974** |
| Average net claims incurred per member per month (R') | 1 358 | 1 282 | 1 213 | 1 008 | 494 | **1 739** |
| Average net claims incurred per beneficiary per month (R') | 647 | 554 | 545 | 556 | 311 | **801** |
| Average administration costs per member per month (R') | 255 | 255 | 255 | 133 | 70 | **231** |
| Average administration costs per beneficiary per month (R') | 122 | 110 | 115 | 73 | 44 | **106** |
| Average Managed care: management services per beneficiary per month (R') | 35 | 32 | 33 | 41 | 47 | **34** |
| Beneficiaries per member at 31 December | 2.10 | 2.31 | 2.23 | 1.81 | 1.59 | **2.17** |
| Dependants per member at 31 December | 1.10 | 1.31 | 1.23 | 0.81 | 0.59 | **1.17** |
| Relevant healthcare expenditure as a percentage of risk contributions (%) | 61 | 77 | 76 | 91 | 53 | **82** |
| Non-healthcare expenditure as a percentage of risk contributions (%) | 18 | 24 | 24 | 23 | 19 | **18** |

## Operational statistics (continued)

| 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** |

## 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 7 to the Annual Financial Statements.

## Personal Medical Savings Account

The Personal Medical Savings Account (PMSA) 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 Personal 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 Personal Medical Saving 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 9) and is repayable in terms of Regulation 10 of the Medical Schemes Act, No 131 of 1998, as amended.

In accordance with Circular 38 of 2011 issued by the Council for Medical Schemes, the PMSA assets have been invested separately to the Scheme's assets. Momentum Asset Management and Taquanta Asset Managers were appointed to manage the PMSA assets and the funds were transferred to these portfolios prior to 31 December 2012. The Scheme has submitted an exemption application to the Council for Medical Schemes in respect of certain aspects of the circulars, but as at 31 December 2012, no response had been received. Pending the response, the Scheme has calculated additional interest due to members at a per-member level, and a provision for the additional interest of R80 million has been made.

## 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 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 Committee.

**Annual** Financial Statements

# **Statement of Responsibility** by the Board of Trustees

## For the year ended 31 December 2012

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 79 to 156 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 Integrated Annual Report and are responsible for its accuracy as well as 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 77 to 78.

**The Annual Financial Statements were approved by the Board of Trustees on 8 April 2013 and are signed on its behalf by:**

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

# Report of the Audit Committee

## For the year ended 31 December 2012

We are pleased to present our report for the financial year ended 31 December 2012. The Audit Committee (the Committee) is an independent statutory committee. Duties are delegated to the Committee by the Board of Trustees.

### Audit 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 Committee members, meeting attendance and assessment

The Committee consists of three independent members and two Trustee members and meets at least four times per 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 |
|---|---|---|---|
| Mr D Eriksson (Chairperson) | CA (SA) | 5 | 5 |
| Mr N Novick | CA (SA) | 5 | 5 |
| Mr S Green | BSc (Hons) | 5 | 5 |
| Mr B Stott (Trustee) | CA (SA) | 5 | 5 |
| Mr G Waugh (Trustee) | FIA, FASSA | 5 | 5 |

Members of the Committee collectively keep up to date with key developments affecting their required skill set. The effectiveness of the Committee and its individual members is assessed annually.

## Role and responsibilities

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 2012.

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 of appointing the auditor 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, among other things, evaluated the adequacy and effectiveness of the Scheme's systems of internal control and made appropriate recommendations to the Board of Trustees. This 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.

### 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.

**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 are achieved. No significant improvements are required.*

### Ethics and compliance

The Committee is responsible for reviewing any major breach of the relevant Scheme charters, 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, No 131 of 1998, as amended:

- Note 34 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 2012. The ratio of accumulated funds expressed as a percentage of gross annual contributions was 23.41%. 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 2012 is 22.30%.
- Note 34 also details the disclosure in respect of five of the Scheme's 13 benefit plans which were not self-sustaining as at 31 December 2012 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 members' funds exceed R8.2 billion, with cash and money market investments exceeding R6.6 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 2013, the Audit 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 based on the assessment conducted, the Board of Trustees could be advised 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 2012 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 with 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 Committee

**8 April 2013**

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

## For the year ended 31 December 2012

We have audited the Annual Financial Statements of the Discovery Health Medical Scheme set out on pages 79 to 156, which comprise the Statement of Financial Position as at 31 December 2012, and the Statements of Comprehensive Income, Changes in Funds and Reserves, and Cash Flows for the year then ended, and the notes, comprising a summary of significant accounting policies and other explanatory information.

### Trustees' responsibility for the Annual Financial Statements

The Discovery Health Medical Scheme's Trustees are responsible for the preparation and fair presentation of these Annual 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 is necessary to enable the preparation of Annual 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 Annual 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 Annual Financial Statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the Annual Financial Statements. The procedures selected depend on the auditor's judgement, including the assessment of the risks of material misstatement of the Annual Financial Statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the Annual 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 Annual 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 Annual Financial Statements present fairly, in all material respects, the financial position of the Discovery Health Medical Scheme as at 31 December 2012, and its financial performance and its 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 34 of the Annual Financial Statements indicates that the Scheme did not comply with Regulation 29(2) of the Medical Schemes Act, No 131 of 1998, as amended. The required 25% accumulated funds ratio had not been met as at 31 December 2012. The ratio of accumulated funds, expressed as a percentage of gross annual contributions, was 23.41% as at 31 December 2012.

Furthermore, we draw attention to the detailed disclosure in Note 34 of the Annual Financial Statements where some of the benefit plans were not self-supporting during 2012 as required by Section 33(2) of the Medical Schemes Act, No 131 of 1998, as amended.

**PricewaterhouseCoopers Inc**
Director: Corlia Volschenk
Registered Auditor
Sunninghill

**12 April 2013**

# Statement of **Financial Position**

## At 31 December 2012

| | Notes | 2012 R'000 | 2011 R'000 |
|---|---|---|---|
| **ASSETS** | | | |
| *Current assets* | | 12 108 480 | 10 580 460 |
| Financial assets at fair value through profit or loss | 2 | 6 968 790 | 8 012 078 |
| Derivative financial instruments | 8 | - | 23 424 |
| Trade and other receivables | 3 | 1 459 601 | 1 318 307 |
| Cash and cash equivalents | | | |
| Personal Medical Savings Account trust assets | 4 | 2 260 141 | - |
| Medical Scheme assets | 5 | 1 419 948 | 1 226 651 |
| **Total assets** | | **12 108 480** | **10 580 460** |
| **FUNDS AND LIABILITIES** | | | |
| *Members' funds* | | 8 240 820 | 7 419 231 |
| Accumulated funds | | 8 240 820 | 7 419 231 |
| *Current liabilities* | | 3 867 660 | 3 161 229 |
| Outstanding claims provision | 7 | 768 675 | 567 845 |
| Derivative financial instruments | 8 | 32 673 | 2 218 |
| Personal Medical Savings Account trust liabilities | 9 | 2 291 580 | 1 930 591 |
| Trade and other payables | 10 | 774 732 | 660 564 |
| Members' trust funds | 6 | - | 11 |
| **Total funds and liabilities** | | **12 108 480** | **10 580 460** |

# Statement of **Comprehensive Income**

## For the year ended 31 December 2012

| | Notes | 2012 R'000 | 2011 R'000 |
|---|---|---|---|
| **Risk contribution income** | 11 | **28 225 777** | **24 972 943** |
| **Relevant healthcare expenditure** | | **(23 093 400)** | **(20 509 303)** |
| Net claims incurred | 12 | (23 194 642) | (20 651 339) |
| Claims incurred | 12 | (23 332 148) | (20 777 150) |
| Third party claim recoveries | 12 | 137 506 | 125 811 |
| Net income on risk transfer arrangements | 13 | 101 242 | 142 036 |
| Risk transfer arrangement fees | 13 | (263 898) | (229 132) |
| Recoveries from risk transfer arrangements | 13 | 365 140 | 371 168 |
| **Gross healthcare result** | | **5 132 377** | **4 463 640** |
| Managed care: management services | 14 | (991 216) | (882 883) |
| Broker service fees | 15 | (755 803) | (688 812) |
| Expenses for administration | | (3 084 814) | (2 863 572) |
| Other operating expenses | 16 | (113 365) | (105 973) |
| **Net healthcare result** | | **187 179** | **(77 600)** |
| **Other income** | | **719 388** | **679 474** |
| Investment income | 21 | 617 289 | 565 296 |
| Net fair value gains on financial assets at fair value through profit or loss | 22 | 96 067 | 109 248 |
| Sundry income | 23 | 6 032 | 4 930 |
| **Other expenditure** | | **(117 777)** | **(31 464)** |
| Expenses for asset management services rendered | | (13 701) | (11 956) |
| Interest on Personal Medical Savings Accounts | 24 | (104 076) | (19 508) |
| **Net surplus for the year** | | **788 790** | **570 410** |
| **Other comprehensive income** | | - | - |
| **Total comprehensive income for the year** | | **788 790** | **570 410** |

# Statement of **Changes in Funds and Reserves**

## For the year ended 31 December 2012

| | Note | 2012 R'000 Accumulated funds | 2011 R'000 Accumulated funds |
|---|---|---|---|
| Balance at the beginning of the year | | 7 419 231 | 6 847 076 |
| Total comprehensive income for the year | | 788 790 | 570 410 |
| Reserves transferred from other medical schemes | 25 | 32 799 | 1 745 |
| Balance at the end of the year | | **8 240 820** | **7 419 231** |

# Statement of **Cash Flows**

## For the year ended 31 December 2012

| | Notes | 2012 R'000 | 2011 R'000 |
|---|---|---|---|
| **CASH FLOWS FROM OPERATING ACTIVITIES** | | | |
| Cash flows from operations before working capital changes | 29 | 224 977 | (47 125) |
| Working capital changes: | | | |
| Increase in trade and other receivables | | (186 861) | (220 563) |
| Increase in outstanding claims provision | | 200 830 | 7 248 |
| Increase in Personal Medical Savings Accounts | | 360 989 | 212 149 |
| Increase/(decrease) in trade and other payables | | 114 169 | (4 878) |
| Cash generated/(utilised) by operations | | 714 104 | (53 169) |
| Purchases of financial instruments | | (1 938 983) | (2 032 830) |
| Proceeds from sale of financial instruments | | 3 132 216 | 1 492 527 |
| Interest received | 29 | 600 265 | 554 426 |
| Dividend income | 21 | 17 124 | 10 896 |
| Interest on Personal Medical Savings Accounts | 24 | (104 076) | (19 508) |
| **Net cash flows from operating activities** | | **2 420 650** | **(47 658)** |
| **CASH FLOWS FROM FINANCING ACTIVITIES** | | | |
| Payments out of members' trust funds | | (11) | (339) |
| Reserves transferred from other medical schemes | 25 | 32 799 | 1 745 |
| **Net cash flows from financing activities** | | **32 788** | **1 406** |
| **NET INCREASE/(DECREASE) IN CASH AND CASH EQUIVALENTS** | | 2 453 438 | (46 252) |
| Cash and cash equivalents at the beginning of the year | | 1 226 651 | 1 272 903 |
| **CASH AND CASH EQUIVALENTS AT THE END OF THE YEAR** | | **3 680 089** | **1 226 651** |
| **Cash and cash equivalents comprise of:** | | | |
| Personal Medical Savings Accounts trust assets | 4 | 2 260 141 | - |
| Medical Scheme assets | 5 | 1 419 948 | 1 226 651 |
| | | **3 680 089** | **1 226 651** |

# Accounting Policies

## For the year ended 31 December 2012

### 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 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 twelfth consecutive year.

These Annual Financial Statements were authorised for issue by the Board of Trustees on 8 April 2013.

### 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 33.

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 2012 but not relevant to the Scheme:**

- IFRS 1 (amendment) – Severe hyperinflation and removal of fixed dates for first-time adopters – Effective 1 January 2012.
- IAS 1 (amendment) – The amendment requires that an entity must group together items within other comprehensive income that may be reclassified to the profit or loss section of the income statement in order to facilitate the assessment of their impact on the overall performance of an entity – Effective 1 July 2012.
- IAS 12 (amendment) – Income taxes on investment property – Effective 1 January 2012.

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

- IFRS 7 (amendment) – Financial instruments (This amendment requires entities to disclose gross amounts subject to right of set-off, amounts set off in accordance with accounting standards followed, and the related net credit exposure) – Effective 1 January 2013.
- IFRS 9 (new standard) – This standard introduces new requirements for the classification and measurement of financial assets. All recognised financial assets that are currently within the scope of IAS 39 will be measured at either amortised cost or fair value. The standard has also been updated to include guidance on financial liabilities and the de-recognition of financial instruments – Effective 1 January 2015.
- IFRS 13 (new standard) – This standard aims to improve consistency and reduce complexity by providing a precise definition of fair value and a single source of fair value measurements and disclosure requirements for use across IFRSs – Effective 1 January 2013.
- IAS 1 (amendment) – The amendment clarifies the disclosure requirements for comparative information – Effective 1 January 2013.

The above new standards and amendments are not expected to have a material impact on the Scheme's results, but may result in additional disclosures in the Annual Financial Statements.

# Accounting Policies

## For the year ended 31 December 2012

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

- IFRS 1 (amendment) – Exception to the retrospective application of IFRS for first-time adopters – Effective 1 January 2013.
  (amendment) – Clarify options for users where repeated application of IFRS 1 is required – Effective 1 January 2013.
  (amendment) – Borrowing cost amendments – Effective 1 January 2013.
- IFRS 10 (new standard) – Consolidated financial statements – control – Effective 1 January 2013.
  (amendment) – Amendments to the transition guidance of IFRS 10 – Effective 1 January 2013.
  (amendment) – Exception to the principle that all subsidiaries must be consolidated – Effective 1 January 2014.
- IFRS 11 (new standard) – Joint arrangements – joint ventures and joint operations – Effective 1 January 2013.
  (amendment) – Amendments to the transition guidance of IFRS 11 – Effective 1 January 2013.

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

- IFRS 12 (new standard) – Disclosure of interest in other entities – Effective 1 January 2013.
  (amendment) – Amendments to the transition guidance of IFRS 12 – Effective 1 January 2013.
  (amendment) – New disclosures required for investment entities – Effective 1 January 2013.
- IAS 1 (amendment) – Employee benefits actuarial gains and losses – Effective 1 July 2013.
- IAS 16 (amendment) – Amendment to recognition and classification of servicing equipment – Effective 1 January 2013.
- IAS 19 (amendment) – Employee benefits (defined benefit pension) – Effective 1 January 2013.
- IAS 27 (amendment) – Consolidated and separate financial statements – Effective 1 January 2013.
  (amendment) – Requirement to account for interests in investment entities – Effective 1 January 2014.
- IAS 28 (amendment) – Investments in associates – Effective 1 January 2013.
- IAS 32 (amendment) – Clarify the tax effect of distribution to holders of equity instruments – Effective 1 January 2013
- IAS 34 (amendment) – Interim financial reporting - Effective 1 January 2013.
- IFRIC 20 (interpretation) – Stripping costs in the production phase of surface mining – Effective 1 January 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
- Personal Medical Savings Accounts trust liabilities.

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**

This applies 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 a 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 surplus or deficit section of the Statement of Comprehensive Income.

## 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 is 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 surplus or deficit section of the Statement of Comprehensive Income.

Gains or losses arising from subsequent changes in fair value are recognised under Other income in 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.

# Accounting Policies

## For the year ended 31 December 2012

### 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, as amended, prescribes that assets and liabilities of the parties to amalgamations shall vest and become binding upon the party to 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 measureable 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.

## 7. IMPAIRMENT OF FINANCIAL ASSETS (CONTINUED)

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.

## 8. MEMBERS' FUNDS

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

## 9. FINANCIAL LIABILITIES

Financial liabilities 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.

### Personal Medical Savings Accounts trust liabilities

Members' Personal Medical 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' Personal Medical 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 on which the amount could be required to be paid. Subsequent to initial measurement, the liability is measured at amortised cost using the effective interest method.

Unspent savings at year-end are carried forward to meet future expenses for which 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' Personal Medical Savings Accounts is expensed when incurred.

# Accounting Policies

## For the year ended 31 December 2012

### 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' Personal Medical 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 not recognised because:
  - It is not probable that an outflow of resources will be required to settle an obligation
  - 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 31.

### 13. CONTRIBUTION INCOME

Gross contributions comprise medical contributions and Personal 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 Personal 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' Personal Medical 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 that the Scheme may incur as a result of carrying on the business of a medical scheme. Risk transfer arrangements do not reduce the Scheme's primary obligations to its members and their dependants, but the arrangements 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.

# Accounting Policies

## For the year ended 31 December 2012

### 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.

Owing 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 fully recognises 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.

## 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 service 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 2012

### 1. ACCOUNTING POLICIES

The accounting policies of the Scheme are set out on pages 83 to 91.

### 2. FINANCIAL ASSETS AT FAIR VALUE THROUGH PROFIT OR LOSS

| The Scheme's financial assets are summarised by measurement category as follows: | 2012 R'000 | 2011 R'000 |
|---|---|---|
| Financial assets at fair value through profit or loss | 6 968 790 | 8 012 078 |
| Loans and receivables (Note 3) | 163 765 | 146 682 |
| **Total financial assets** | **7 132 555** | **8 158 760** |

The details of assets in each of the categories are detailed below.

**Financial assets held at fair value through profit or loss**

| | | |
|---|---|---|
| Held for trading: | | |
| Current assets | 6 968 790 | 8 012 078 |
| – Offshore bond portfolio | 422 942 | 528 352 |
| – Listed equities | 472 567 | 377 102 |
| – Yield-enhanced bond portfolios | 850 412 | 741 992 |
| – Money market portfolios | 5 222 869 | 6 364 632 |
| | **6 968 790** | **8 012 078** |

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 | 8 012 078 | 7 383 719 |
| Acquisitions | 1 939 565 | 2 032 830 |
| Disposals | (3 124 263) | (1 490 825) |
| Gain on revaluation of investments to fair value | 141 410 | 86 354 |
| **At the end of the year** | **6 968 790** | **8 012 078** |

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.

| | 2012 R'000 | 2011 R'000 |
|---|---|---|

## 3. TRADE AND OTHER RECEIVABLES

| | | |
|---|---|---|
| **Insurance receivables** | | |
| Contribution receivables | 1 189 794 | 1 039 209 |
| Contributions outstanding | 1 193 672 | 1 045 331 |
| Less: Provision for impairment | (3 878) | (6 122) |
| Member and service provider claims receivables | 53 795 | 59 823 |
| Amount due | 205 303 | 200 132 |
| Less: Provision for impairment | (151 508) | (140 309) |
| Other risk transfer arrangements | 3 208 | 3 501 |
| Recoveries due from other risk transfer arrangements | 81 | 64 |
| Share of outstanding claims provision (Note 7) | 3 127 | 3 437 |
| Broker fee receivables | 190 | 96 |
| Amounts due from brokers | 532 | 389 |
| Less: Provision for impairment | (342) | (293) |
| Other insurance receivables | 48 849 | 68 996 |
| **Total receivables arising from insurance contracts** | **1 295 836** | **1 171 625** |
| **Loans and receivables** | | |
| Balance due by related party | 19 800 | 15 000 |
| Discovery Third Party Recovery Services (Pty) Ltd | 19 800 | 15 000 |
| Sundry accounts receivable | 142 491 | 129 596 |
| Interest receivable | 1 474 | 2 086 |
| **Total receivables arising from loans and receivables** | **163 765** | **146 682** |
| | **1 459 601** | **1 318 307** |

At 31 December 2012 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 practice. The procedures that the Scheme follows regarding these contributions are set out in Note 32.

# Notes to the **Annual Financial Statements**

## For the year ended 31 December 2012

| | 2012 R'000 | 2011 R'000 |
|---|---|---|
| **4. PERSONAL MEDICAL SAVINGS ACCOUNTS** | | |
| (Monies managed by the Scheme on behalf of members) | | |
| **CASH AND CASH EQUIVALENTS** | | |
| **PERSONAL MEDICAL SAVINGS ACCOUNT TRUST PORTFOLIO** | | |
| (Managed by Momentum Asset Management) | | |
| **Balance at the beginning of the year** | - | - |
| Additional investments | 1 128 127 | - |
| Interest income | 1 880 | - |
| Fair value adjustments | (25) | - |
| **Balance at the end of the year** | **1 129 982** | - |
| **PERSONAL MEDICAL SAVINGS ACCOUNT TRUST PORTFOLIO** | | |
| (Managed by Taquanta Asset Managers (Pty) Ltd) | | |
| **Balance at the beginning of the year** | - | - |
| Additional investments | 1 128 577 | - |
| Interest income | 1 582 | - |
| Fair value adjustments | - | - |
| **Balance at the end of the year** | **1 130 159** | - |
| **Total Personal Medical Savings Account trust assets** | **2 260 141** | - |

These funds represent members' Personal Medical Savings Account assets managed by the Scheme on behalf of its members. As required by Circular 38 of 2011 and Circular 5 of 2012 issued by the Council for Medical Schemes, these assets have been invested separately with effect from the 2012 financial year. The difference between total Personal Medical Savings Account trust assets and Personal Medical Savings Account trust liabilities arises from the timing of cash flows to or from the portfolios.

Details relating to these portfolios are provided under Note 32.

| | 2012 R'000 | 2011 R'000 |
|---|---|---|

## 5. CASH AND CASH EQUIVALENTS

| | | |
|---|---|---|
| Call accounts | 510 000 | 580 000 |
| Current accounts | 300 861 | 389 128 |
| Money market instruments | 609 087 | 257 523 |
| | **1 419 948** | **1 226 651** |

At 31 December 2012 the carrying amounts of cash and cash equivalents approximate their fair values due to the short-term maturities of these assets.

## 6. MEMBERS' TRUST FUNDS

| | | |
|---|---|---|
| Mega reserves | - | 11 |
| Less: | | |
| Current portion included in current liabilities | - | (11) |
| | - | - |

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.

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 5) and interest accrues directly to these reserves.

During the 2012 financial year, these funds were fully utilised to fund the pensioner contributions.

# Notes to the **Annual Financial Statements**

## For the year ended 31 December 2012

| | 2012 R'000 | 2011 R'000 |
|---|---|---|
| **7. OUTSTANDING CLAIMS PROVISION** | | |
| Outstanding claims provision - not covered by risk transfer arrangements | 765 548 | 564 408 |
| Outstanding claims provision - covered by risk transfer arrangements | 3 127 | 3 437 |
| | **768 675** | **567 845** |
| ***Analysis of movement in outstanding claims*** | | |
| Balance at the beginning of the year | 567 845 | 560 597 |
| Payments in respect of prior year | (619 353) | (545 737) |
| (Under)/over provision in prior year | (51 508) | 14 860 |
| Adjustment for current year | 820 183 | 552 985 |
| Covered by risk transfer arrangements | 3 127 | 3 437 |
| Not covered by risk transfer arrangements | 817 056 | 549 548 |
| **Balance at the end of the year** | **768 675** | **567 845** |
| ***Analysis of outstanding claims provision*** | | |
| Estimated gross claims | 812 328 | 589 743 |
| Less: | | |
| Estimated recoveries from savings plan accounts (Note 9) | (43 653) | (21 898) |
| **Balance at the end of the year** | **768 675** | **567 845** |

| | | |
|---|---|---|
| **8. DERIVATIVE FINANCIAL INSTRUMENTS** | | |
| **Financial assets held at fair value through profit or loss** | | |
| Current assets | | |
| – Derivative financial instruments held for trading | - | 23 424 |
| | - | **23 424** |
| **Financial liabilities held at fair value through profit or loss** | | |
| Current liabilities | | |
| – Derivative financial instruments held for trading | (32 673) | (2 218) |
| **Derivative financial (liability)/asset at the end of the year** | **(32 673)** | **21 206** |

| | 2012 R'000 | 2011 R'000 |
|---|---|---|

## 8. DERIVATIVE FINANCIAL INSTRUMENTS (CONTINUED)

**Reconciliation of the balance at the beginning of the year to the balance at the end of the year:**

| | | |
|---|---|---|
| **Derivative financial asset at the beginning of the year** | 21 206 | 15 |
| **Realised gain on derivative financial instruments transferred to:** | **(7 953)** | **(1 702)** |
| Realised gain on revaluation of derivative financial instruments to fair value | (4 302) | (3 349) |
| – Equity portfolio derivatives | (3 033) | (1 620) |
| – Bond portfolio derivative | (1 269) | (1 729) |
| Realised loss on revaluation of derivative financial instruments to fair value | 3 205 | 1 647 |
| – Equity portfolio derivatives | 256 | 1 399 |
| – Bond portfolio derivatives | 2 949 | 248 |
| Realised gain on foreign exchange currency | (6 856) | - |
| – Forward exchange contract | (6 856) | - |
| **Net (loss)/gain on revaluation of derivative financial instruments to fair value:** | **(45 926)** | **22 893** |
| Gain on revaluation of derivative financial instruments to fair value | 4 066 | 24 905 |
| – Equity portfolio derivatives | 4 066 | - |
| – Equity derivatives (zero-cost short-fence) | - | 3 931 |
| – Forward exchange contract | - | 16 659 |
| – Bond portfolio derivatives | - | 4 315 |
| Loss on revaluation of derivative financial instruments to fair value | (49 991) | (2 012) |
| – Equity portfolio derivatives | - | (2 012) |
| – Equity derivatives (zero-cost short-fence) | (34 745) | - |
| – Forward exchange contract | (9 802) | - |
| – Bond portfolio derivatives | (5 444) | - |
| **Derivative financial (liability)/asset at the end of the year** | **(32 673)** | **21 206** |

**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 Scheme's equity managers entered into All Shareholder 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 32).

# Notes to the **Annual Financial Statements**

## For the year ended 31 December 2012

| | 2012 R'000 | 2011 R'000 |
|---|---|---|
| **9. PERSONAL MEDICAL SAVINGS ACCOUNT TRUST LIABILITIES** | | |
| (Personal Medical Savings Account trust monies managed by the Scheme on behalf of its members) | | |
| Balance on Personal Medical Savings Accounts at the beginning of the year | 1 930 591 | 1 718 442 |
| Add: | | |
| Personal Medical Savings Account contributions received or receivable | 6 969 850 | 6 219 912 |
| For the current year (Note 11) | 6 969 850 | 6 219 912 |
| Interest on Personal Medical Savings Accounts (Note 24) | 104 076 | 19 507 |
| Transfers received from other medical schemes | 17 211 | 11 659 |
| Less: | | |
| Claims paid to or on behalf of members (Note 12) | (6 581 347) | (5 911 391) |
| Refunds on death or resignation | (148 801) | (127 538) |
| **Balance due to members on personal medical savings held in trust at the end of the year** | **2 291 580** | **1 930 591** |

It is estimated that claims to be paid out of members' Personal Medical Savings Accounts in respect of claims incurred in 2012 but not recorded will amount to approximately R43 652 635 (2011: R21 898 422) (Note 7).

As at 31 December 2012 the carrying amount of members' Personal Medical Savings Accounts was 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 allocated on these Personal Medical Savings Account balances in accordance with Circular 38 of 2011 and Circular 5 of 2012 issued by the Council for Medical Schemes. The Scheme does not charge interest on negative Personal Medical Savings Account balances.

Members' Personal Medical Savings Account funds are separately invested as required by Circular 38 of 2011 and Circular 5 of 2012 issued by the Council for Medical Schemes as set out in Note 4.

## 10. TRADE AND OTHER PAYABLES

| | 2012 R'000 | 2011 R'000 |
|---|---|---|
| **Insurance liabilities** | | |
| Contributions received in advance | 52 584 | 46 409 |
| Contribution refunds due to employers | 131 | 212 |
| Reported claims not yet paid | | |
| Balance at the beginning of the year | 319 265 | 271 403 |
| Movement for the year | 32 417 | 47 862 |
| Balance at the end of the year | 351 682 | 319 265 |
| Broker fee creditors | 67 496 | 61 654 |
| Accredited brokers | 67 496 | 61 654 |
| Other insurance liabilities | 7 | 21 |
| **Total liabilities arising from insurance contracts** | **471 900** | **427 561** |
| **Financial liabilities** | | |
| Balance due to related parties | 284 030 | 220 673 |
| Discovery Health (Pty) Ltd | 284 030 | 220 673 |
| Unallocated funds | 5 169 | 3 567 |
| Total accruals | 13 633 | 8 763 |
| General accruals | 13 429 | 8 657 |
| Leave pay provision | 204 | 106 |
| **Total arising from financial liabilities** | **302 832** | **233 003** |
| | **774 732** | **660 564** |

At 31 December 2012 the carrying amounts of insurance and other payables approximate their fair values due to the short-term maturities of these liabilities.

# Notes to the **Annual Financial Statements**

## For the year ended 31 December 2012

| | 2012 R'000 | 2011 R'000 |
|---|---|---|
| **11. RISK CONTRIBUTION INCOME** | | |
| Gross contributions per scheme registered rules | 35 195 627 | 31 192 855 |
| Less: | | |
| Personal Medical Savings Account contributions (Note 9) | (6 969 850) | (6 219 912) |
| **Risk contribution income per Statement of Comprehensive Income** | **28 225 777** | **24 972 943** |
| **12. NET CLAIMS INCURRED** | | |
| Current year claims per registered scheme rules | 29 712 665 | 26 681 293 |
| Claims not covered by risk transfer arrangements | 29 347 526 | 26 310 125 |
| Claims covered by risk transfer arrangements | 365 139 | 371 168 |
| Movement in outstanding claims provision | 200 830 | 7 248 |
| Under/(over) provision in prior year (Note 7) | 51 508 | (14 860) |
| Adjustment for current year | 149 322 | 22 108 |
| | 29 913 495 | 26 688 541 |
| Less: | | |
| Claims charged to members' Personal Medical Savings Accounts (Note 9) | (6 581 347) | (5 911 391) |
| Claims incurred | **23 332 148** | **20 777 150** |
| Third party claim recoveries | (137 506) | (125 811) |
| | **23 194 642** | **20 651 339** |

## 12. NET CLAIMS INCURRED (CONTINUED)

### Risk transfer arrangements

During 2012 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 option for the 2012 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 2012 PLPM rate is multiplied by the lives exposure for this arrangement's membership and reduced by the actual claims 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.

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

   The cost of the dental group of procedures 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.

# Notes to the **Annual Financial Statements**

## For the year ended 31 December 2012

| | 2012 R'000 | 2011 R'000 |
|---|---|---|
| **13. NET INCOME ON RISK TRANSFER ARRANGEMENTS** | | |
| Other risk transfer arrangements: | | |
| Capitation fees paid | (263 898) | (229 132) |
| Recoveries under risk transfer arrangements | 365 140 | 371 168 |
| Claims incurred in respect of related risk transfer arrangements | 288 461 | 305 925 |
| Recoveries received | 76 679 | 65 243 |
| | **101 242** | **142 036** |
| **14. MANAGED CARE: MANAGEMENT SERVICES** | | |
| The Managed care: management services have been grouped into the following categories of services: | | |
| Discovery Health (Pty) Ltd | | |
| Clinical protocols | 24 780 | 22 072 |
| Disease management | 148 682 | 132 432 |
| Hospital management | 515 434 | 459 099 |
| Pharmaceutical benefit management | 148 682 | 132 433 |
| Provider networks | 153 638 | 136 847 |
| | **991 216** | **882 883** |
| **15. BROKER SERVICE FEES** | | |
| Brokers' fees | 755 803 | 688 812 |
| | **755 803** | **688 812** |

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.

## 16. OTHER OPERATING EXPENSES

| | 2012 R'000 | 2011 R'000 |
|---|---|---|
| Association fees | 32 | 5 342 |
| Audit fees | 4 004 | 3 289 |
| Audit services for the year ended 2010 | - | 1 658 |
| Audit services for the year ended 2011 | 1 932 | 1 581 |
| Audit services for the year ended 2012 | 1 658 | - |
| Other services | 414 | 50 |
| Audit and Risk Committees fees (Note 17) | 729 | 650 |
| Audit and Risk Committees training | 9 | 5 |
| Bank charges | 6 957 | 8 625 |
| Council for Medical Schemes | 26 209 | 21 641 |
| Custodian fees | 295 | 438 |
| Debt-collecting fees | 1 936 | 1 470 |
| Dispute Committee fees | 362 | 128 |
| General meeting costs | 278 | 297 |
| Investment Committee fees | - | 25 |
| Investment reporting fees | 884 | - |
| Legal fees | 1 852 | 461 |
| Net impairment losses (Note 18) | 45 465 | 37 452 |
| Other expenses | 10 246 | 9 536 |
| Principal Officer fees | 4 029 | 3 782 |
| Principal Officer office costs | 1 784 | 618 |
| Printing, postage and stationery | 170 | 21 |
| Professional fees | 2 654 | 1 158 |
| Specialist referral fees | - | 7 311 |
| Staff costs (Note 19) | 2 607 | 1 386 |
| Sundry amounts written off | 46 | 28 |
| Trustees' remuneration and consideration expenses (Note 20) | 2 817 | 2 310 |
| | **113 365** | **105 973** |

# Notes to the **Annual Financial Statements**

## For the year ended 31 December 2012

| | 2012 R'000 | 2011 R'000 |
|---|---|---|
| **17. AUDIT AND RISK COMMITTEES FEES** | | |
| D Eriksson – Chairperson | 384 | 358 |
| N Novick – member | 185 | 142 |
| S Green – member | 160 | 150 |
| | **729** | **650** |

These are payments to independent members of the Audit and Risk Committees. These members are not Trustees of the Scheme and the amounts paid to Trustee members of these Committees are disclosed in Note 20.

| | | |
|---|---|---|
| **18. NET IMPAIRMENT LOSSES** | | |
| **Insurance and other receivables** | | |
| Contributions that are not collectable | (2 244) | (2 037) |
| Movement in provision | (2 244) | (2 037) |
| Members' and service providers' portions that are not recoverable | 47 763 | 39 630 |
| Movement in provision | 47 763 | 39 630 |
| Amounts due by brokers that are not recoverable | 48 | (66) |
| Movement in provision | 48 | (66) |
| Receivables written off | 213 | 103 |
| Less: | | |
| Previously written off receivables recovered | (315) | (178) |
| | **45 465** | **37 452** |
| **19. STAFF COSTS** | | |
| Salaries and bonuses | 2 326 | 1 276 |
| Pension costs – defined contribution plans | 101 | 55 |
| Medical and other benefits | 35 | 23 |
| Increase in leave pay accrual | 145 | 32 |
| | **2 607** | **1 386** |

## 20. TRUSTEES REMUNERATION AND CONSIDERATION EXPENSES

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

| 31 December 2012 | Sub-committee fees | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Services as Trustee | Audit and Risk Committees | Investment Committee | Clinical Governance Committee | Non-healthcare Expenditure Committee | Product Committee | Governance Review Committee | Training | Trustee travel | Total |
| | R'000 | R'000 | R'000 | R'000 | R'000 | R'000 | R'000 | R'000 | R'000 | R'000 |
| M van der Nest (Chairperson) | 406 | - | - | - | - | - | 11 | - | - | 417 |
| P Maserumule | 206 | - | 144 | - | - | - | - | - | - | 350 |
| N Sangweni | 225 | - | - | 160 | - | 25 | - | - | - | 410 |
| B Stott | 238 | 117 | 96 | - | 14 | - | 18 | - | - | 483 |
| N Graves | 226 | - | - | - | 14 | - | 26 | - | - | 266 |
| Z van der Spuy | 227 | - | - | 106 | - | - | - | - | 52 | 385 |
| G Waugh | 228 | 117 | 96 | - | 14 | 25 | 26 | - | - | 506 |
| **Total** | **1 756** | **234** | **336** | **266** | **42** | **50** | **81** | **-** | **52** | **2 817** |

| 31 December 2011 | Sub-committee fees | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Services as Trustee | Audit and Risk Committees | Investment Committee | Clinical Governance Committee | Non-healthcare Expenditure Committee | Product Committee | Governance Review Committee | Training | Trustee travel | Total |
| | R'000 | R'000 | R'000 | 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** |

Δ = Resigned
* = New appointment

# Notes to the **Annual Financial Statements**

## For the year ended 31 December 2012

| | 2012 R'000 | 2011 R'000 |
|---|---|---|
| **21. INVESTMENT INCOME** | | |
| Financial assets at fair value through profit or loss: | 561 729 | 499 483 |
| Dividend income | 17 124 | 10 896 |
| Interest income | 544 606 | 488 587 |
| Cash and cash equivalents interest income | 55 560 | 65 813 |
| **Investment income per Statement of Comprehensive Income** | **617 289** | **565 296** |
| The Scheme's total interest income is summarised below. | | |
| **Financial assets not at fair value through profit or loss:** | | |
| Loans and receivables | 55 660 | 65 839 |
| Interest received from Administrator (Note 23) | 100 | 26 |
| Cash and cash equivalents interest income | 55 560 | 65 813 |
| **Financial assets at fair value through profit or loss:** | | |
| Interest income | 544 606 | 488 587 |
| **Total interest income** | **600 265** | **554 427** |
| **22. 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: | (11 543) | (5 214) |
| – Offshore bonds | (11 543) | (5 214) |
| Net fair value gains on financial assets at fair value through profit or loss including derivatives: | 157 601 | 125 363 |
| – Equity securities | 39 624 | - |
| – Derivatives held for trading | 4 066 | 24 905 |
| – Money market | 1 050 | 10 597 |
| – Offshore bonds | 96 833 | 84 188 |
| – Local bonds | 16 028 | 5 673 |
| Net fair value losses on financial assets at fair value through profit or loss including derivatives: | (49 991) | (10 901) |
| – Equity securities | - | (8 796) |
| – Derivatives held for trading | (49 991) | (2 012) |
| – Local bonds | - | (93) |
| | **96 067** | **109 248** |

| | 2012 R'000 | 2011 R'000 |
|---|---|---|

## 23. SUNDRY INCOME

| | | |
|---|---|---|
| Interest received from Administrator | 100 | 26 |
| Prescribed amounts written back | 1 419 | 1 851 |
| Stale cheques written back | 4 513 | 3 053 |
| | **6 032** | **4 930** |

## 24. INTEREST PAID

| | | |
|---|---|---|
| Financial assets not at fair value through profit or loss: | | |
| Interest on Personal Medical Savings Accounts (Note 9) | 104 076 | 19 507 |
| Interest paid to Administrator | - | 1 |
| | **104 076** | **19 508** |

## 25. RESERVES TRANSFERRED FROM OTHER MEDICAL SCHEMES

| | | |
|---|---|---|
| Reserves transferred from other schemes | | |
| Umed Medical Scheme | (46) | 1 792 |
| Afrisam Medical Scheme | (8) | (47) |
| Edcon Medical Scheme | 32 853 | - |
| | **32 799** | **1 745** |

## 26. AMALGAMATIONS

An amalgamation between the Scheme and the Edcon Medical Scheme ("Edcon MS") was approved, effective from 1 January 2012.

### Edcon Medical Scheme

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

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

The Scheme obtained control of Edcon MS 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.

# Notes to the **Annual Financial Statements**

## For the year ended 31 December 2012

### 26. AMALGAMATIONS (CONTINUED)

**Edcon 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:

| | 2012 R'000 | 2011 R'000 |
|---|---|---|
| Consideration effectively transferred: | | |
| (Acquisition date fair value of Edcon MS's members' interest) | | 34 145 |
| Net recognised values of Edcon MS'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) | |
| Personal Medical Savings Accounts | (6 128) | |
| **Goodwill** | | - |

## 26. 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 |
| Contribution debtors | 832 |
| 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) |
| Contribution debtors | - |
| Member and service provider claim debtors | (94) |
| Hospital network discount debtors | (113) |

# Notes to the **Annual Financial Statements**

## For the year ended 31 December 2012

### 26. AMALGAMATIONS (CONTINUED)

**Edcon Medical Scheme (continued)**

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

| | R'000 |
|---|---|
| | **44 991** |
| **Current assets** | 43 886 |
| Cash and cash equivalents | 832 |
| Contribution debtors | 35 |
| Member claim debtors | 69 |
| Service provider claim debtors | 146 |
| Interest receivable | 23 |
| Other accounts receivable | |
| **Current liabilities** | **(10 846)** |
| Outstanding claims provision | (1 240) |
| Contributions received in advance | - |
| Reported claims not yet paid | (1 317) |
| Unallocated funds | (25) |
| General accruals | (2 136) |
| Personal Medical Savings Accounts | (6 128) |
| | **34 145** |

**Nampak SA Medical Scheme**

An amalgamation between the Scheme and Nampak SA Medical Scheme ("Nampak") was approved during the year under review and will be effective from 1 March 2013.

The effective date of the amalgamation is after 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. These disclosures are provided below.

Nampak is a not-for-profit restricted medical scheme registered in terms of the Medical Schemes Act, No 131 of 1998, as amended. Membership of Nampak is open to all current and retired employees of Nampak (Pty) Ltd, its subsidiaries and associates. Retired employees of subsidiaries and associates that have been disposed of can choose to continue their membership.

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 Nampak voted that the amalgamation of Nampak with the Scheme would be in the best interest of Nampak members.

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

The recognised value of the identifiable assets and liabilities that will be transferred is equal to the consideration transferred, and therefore no goodwill will be recognised as a result of this transaction.

## 26. AMALGAMATIONS (CONTINUED)

### Nampak SA 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:

| | 2012 R'000 | 2011 R'000 |
|---|---|---|
| Consideration effectively transferred: | | |
| (Acquisition date fair value of Nampak's members' interest) | | 159 096 |
| Net recognised values of Nampak's identifiable assets and liabilities: | | 159 096 |
| **Non-current assets** | 182 868 | |
| Available-for-sale financial assets | 182 868 | |
| **Current assets** | 15 693 | |
| Cash and cash equivalents | 14 924 | |
| Contribution receivables | 225 | |
| Member and service provider claims receivables | 459 | |
| Interest receivable | 45 | |
| Other accounts receivable | 40 | |
| **Current liabilities** | (39 466) | |
| Outstanding claims provision | (10 029) | |
| Reported claims not yet paid | (720) | |
| Unallocated funds | (80) | |
| General accruals | (1115) | |
| Personal Medical Savings Accounts | (27 522) | |
| **Goodwill** | | - |

# Notes to the **Annual Financial Statements**

## For the year ended 31 December 2012

### 26. AMALGAMATIONS (CONTINUED)

**Nampak SA Medical Scheme (continued)**

As a result of the amalgamation, the Scheme acquired the following receivables:

| | R'000 |
|---|---|
| **Fair value of receivables acquired:** | |
| Insurance receivables | 724 |
| Contribution debtors | 225 |
| Members claim debtors | 540 |
| Service provider claim debtors | 91 |
| Other accounts receivable | 40 |
| Provision for impairment | (172) |
| Loans and receivables | 45 |
| Interest receivable | 45 |
| **Gross contractual amounts receivable:** | |
| Insurance receivables | 896 |
| Contribution debtors | 225 |
| Member claim debtors | 540 |
| Service provider claim debtors | 91 |
| Other accounts receivable | 40 |
| Loans and receivables | 45 |
| Interest receivable | 45 |
| **Best estimate at the acquisition date of the contractual cash flows not expected to be collected are:** | |
| Insurance receivables | (172) |
| Contribution debtors | (6) |
| Member and service provider claim debtors | (166) |
| Hospital network discount debtors | - |

## 26. AMALGAMATIONS (CONTINUED)

### Nampak SA 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** | 182 868 |
| Available-for-sale financial assets | 182 868 |
| **Current assets** | 15 693 |
| Cash and cash equivalents | 14 923 |
| Contribution debtors | 219 |
| Member claim debtors | 375 |
| Service provider claim debtors | 91 |
| Interest receivable | 45 |
| Other accounts receivable | 40 |
| **Current liabilities** | (39 466) |
| Outstanding claims provision | (10 029) |
| Contributions received in advance | - |
| Reported claims not yet paid | (720) |
| Unallocated funds | (80) |
| General accruals | (1115) |
| Personal Medical Savings Accounts | (27 522) |
| | **159 096** |

# Notes to the **Annual Financial Statements**

## For the year ended 31 December 2012

### 27. 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:

| | 2012 R'000 | 2011 R'000 |
|---|---|---|
| **Statement of Comprehensive Income transactions** | | |
| *Compensation* | | |
| Short-term employee benefits | (8 064) | (6 820) |
| *Contributions and claims* | | |
| Gross contributions received | 384 | 418 |
| Claims paid from the Scheme | (138) | (108) |
| Claims paid from the Personal Medical Savings Account | (96) | (88) |
| **Statement of Financial Position transactions** | | |
| Contribution debtors | 8 | 6 |
| Amounts due to executive officers | (203) | - |
| Personal Medical Savings Account balances | 4 | 35 |
| Trustee remuneration payable | (69) | - |

## 27. RELATED PARTY TRANSACTIONS (CONTINUED)

### Transactions with key management personnel (Board of Trustees and Principal Officer) 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. |
| Personal Medical Savings Account balances | The amounts owing to the related parties relate to Personal 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. |

# Notes to the **Annual Financial Statements**

## For the year ended 31 December 2012

### 27. RELATED PARTY TRANSACTIONS (CONTINUED)

**Transactions with entities that have significant influence over the Scheme**

| | 2012 R'000 | 2011 R'000 |
|---|---|---|
| **Discovery Health (Pty) Ltd – Administrator** | | |
| **Statement of Comprehensive Income transactions** | | |
| Administration fees paid | (3 084 814) | (2 863 572) |
| Interest received on monthly balances (Note 23) | 100 | 26 |
| Interest paid on monthly balances (Note 24) | - | (1) |
| **Statement of Financial Position transactions** | | |
| Balance due to Discovery Health (Pty) Ltd at year-end (Note 10) | (191 876) | (145 456) |
| **Discovery Health (Pty) Ltd – Managed care organisation** | | |
| **Statement of Comprehensive Income transactions** | | |
| Managed care fees paid | (991 216) | (882 882) |
| Managed care: management services | (991 216) | (882 882) |
| **Statement of Financial Position transactions** | | |
| Balance due to Discovery Health (Pty) Ltd at year-end (Note 10) | (92 154) | (75 216) |
| **Discovery Third Party Recovery Services (Pty) Ltd** | | |
| **Statement of Comprehensive Income transactions** | | |
| Third party collection fees | (9 922) | (9 418) |
| **Statement of Financial Position transactions** | | |
| Balance due to the Scheme at year-end (Note 3) | 19 800 | 15 000 |

## 27. 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 are 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 are 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**

## For the year ended 31 December 2012

### 27. RELATED PARTY TRANSACTIONS (CONTINUED)

**Transactions with entities that have significant influence over the Scheme (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
- 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 2012 and 31 December 2012 for the amount of R19.8 million.

**Guarantees**

At 31 December 2011, Discovery Health (Pty) Ltd guaranteed the recoverability of certain member claims receivables to the value of R10.9 million as well as certain forensic claims recoveries to the value of R100 million. The guarantees were payable on 31 December 2012. By 31 December 2012, the majority of the guaranteed receivables had been recovered. Due to the forensic recoveries process, the Trustees have agreed to extend the settlement of the guarantees to 30 June 2013, and the outstanding balance will accrue interest.

## 28. SURPLUS/(DEFICIT) FROM OPERATIONS PER BENEFIT PLAN

| 2012 | Executive | Classic Comp | Classic Core | Classic Saver | Classic Priority | Essential Comp | Essential Saver | Essential Core |
|---|---|---|---|---|---|---|---|---|
| | R'000 | R'000 | R'000 | R'000 | R'000 | R'000 | R'000 | R'000 |
| **Risk contribution income** | **658 921** | **8 161 363** | **1 266 663** | **4 764 944** | **2 958 447** | **1 090 378** | **1 432 565** | **493 523** |
| Net claims incurred | (863 146) | (7 900 665) | (827 445) | (3 306 324) | (2 252 527) | (827 094) | (861 277) | (322 205) |
| Claims incurred | (868 702) | (7 951 688) | (832 137) | (3 324 314) | (2 266 031) | (831 873) | (865 999) | (324 151) |
| Third party claim recoveries | 5 556 | 51 023 | 4 692 | 17 990 | 13 504 | 4 779 | 4 722 | 1 946 |
| Net income/(expense) on risk transfer arrangements | 68 | (1 873) | - | - | - | (459) | - | - |
| Risk transfer arrangement fees | (7 687) | (97 281) | - | - | - | (10 678) | - | - |
| Recoveries from risk transfer arrangements | 7 755 | 95 408 | - | - | - | 10 219 | - | - |
| **Relevant healthcare expenditure** | **(863 078)** | **(7 902 538)** | **(827 445)** | **(3 306 324)** | **(2 252 527)** | **(827 553)** | **(861 277)** | **(322 205)** |
| **Gross healthcare result** | **(204 157)** | **258 824** | **439 218** | **1 458 620** | **705 920** | **262 825** | **571 288** | **171 318** |
| Managed care: management services | (10 784) | (165 971) | (44 215) | (175 722) | (89 301) | (25 135) | (60 528) | (21 453) |
| Broker service fees | (10 400) | (162 492) | (32 176) | (149 214) | (81 778) | (24 306) | (44 985) | (13 632) |
| Expenses for administration | (37 053) | (570 279) | (151 918) | (603 750) | (306 832) | (86 366) | (207 960) | (73 706) |
| Other operating expenses | (1 231) | (18 942) | (5 057) | (20 101) | (10 203) | (2 869) | (6 930) | (2 460) |
| **Net healthcare result** | **(263 625)** | **(658 860)** | **205 852** | **509 833** | **217 806** | **124 149** | **250 885** | **60 067** |
| Investment income | 6 718 | 103 396 | 27 537 | 109 429 | 55 624 | 15 659 | 37 689 | 13 355 |
| Net fair value gains on financial assets at fair value through profit or loss | 1 062 | 16 328 | 4 275 | 17 023 | 8 725 | 2 471 | 5 831 | 2 036 |
| Sundry income | 66 | 1 012 | 269 | 1 069 | 544 | 152 | 368 | 130 |
| **Other income** | **7 846** | **120 736** | **32 081** | **127 521** | **64 893** | **18 282** | **43 888** | **15 521** |
| Expenses for asset management services rendered | (148) | (2 283) | (611) | (2 430) | (1 231) | (345) | (838) | (298) |
| Interest paid | (1 114) | (17 136) | (4 633) | (18 477) | (9 295) | (2 592) | (6 402) | (2 291) |
| **Other expenditure** | **(1 262)** | **(19 419)** | **(5 244)** | **(20 907)** | **(10 526)** | **(2 937)** | **(7 240)** | **(2 589)** |
| ***Net surplus/(deficit) for the year*** | **(257 041)** | **(557 543)** | **232 689** | **616 447** | **272 173** | **139 494** | **287 533** | **72 999** |

# Notes to the **Annual Financial Statements**

## For the year ended 31 December 2012

### 28. SURPLUS/(DEFICIT) FROM OPERATIONS PER BENEFIT PLAN (CONTINUED)

| 2012 | Essential Priority | Coastal Saver | Coastal Core | KeyCare Plus | KeyCare Core | Discontinued plan | TOTAL |
|---|---|---|---|---|---|---|---|
| | R'000 | R'000 | R'000 | R'000 | R'000 | | R'000 |
| **Risk contribution income** | **249 616** | **3 078 094** | **1 392 639** | **2 518 958** | **159 045** | **622** | **28 225 777** |
| Net claims incurred | (153 276) | (2 358 159) | (1 052 906) | (2 385 097) | (84 848) | 327 | (23 194 642) |
| Claims incurred | (154 165) | (2 370 967) | (1 059 057) | (2 398 091) | (85 300) | 327 | (23 332 148) |
| Third party claim recoveries | 889 | 12 808 | 6 151 | 12 994 | 452 | - | 137 506 |
| Net income/(expense) on risk transfer arrangements | - | - | - | 103 506 | - | - | 101 242 |
| Risk transfer arrangement fees | - | - | - | (148 252) | - | - | (263 898) |
| Recoveries from risk transfer arrangements | - | - | - | 251 758 | - | - | 365 140 |
| **Relevant healthcare expenditure** | **(153 276)** | **(2 358 159)** | **(1 052 906)** | **(2 281 591)** | **(84 848)** | **327** | **(23 093 400)** |
| **Gross healthcare result** | **96 340** | **719 935** | **339 733** | **237 367** | **74 197** | **949** | **5 132 377** |
| Managed care: management services | (8 386) | (136 662) | (64 491) | (175 801) | (12 767) | - | (991 216) |
| Broker service fees | (6 891) | (109 593) | (40 859) | (74 764) | (4 711) | (2) | (755 803) |
| Expenses for administration | (28 812) | (469 552) | (221 579) | (315 006) | (12 001) | - | (3 084 814) |
| Other operating expenses | (960) | (15 627) | (7 382) | (20 141) | (1 462) | - | (113 365) |
| **Net healthcare result** | **51 291** | **(11 499)** | **5 422** | **(348 345)** | **43 256** | **947** | **187 179** |
| Investment income | 5 222 | 85 110 | 40 159 | 109 442 | 7 949 | - | 617 289 |
| Net fair value gains on financial assets at fair value through profit or loss | 810 | 13 277 | 6 216 | 16 793 | 1 220 | - | 96 067 |
| Sundry income | 51 | 832 | 392 | 1 069 | 78 | - | 6 032 |
| **Other income** | **6 083** | **99 219** | **46 767** | **127 304** | **9 247** | **-** | **719 388** |
| Expenses for asset management services rendered | (116) | (1 888) | (893) | (2 443) | (177) | - | (13 701) |
| Interest paid | (883) | (14 332) | (6 796) | (18 768) | (1 357) | - | (104 076) |
| **Other expenditure** | **(999)** | **(16 220)** | **(7 689)** | **(21 211)** | **(1 534)** | **-** | **(117 777)** |
| ***Net surplus/(deficit) for the year*** | **56 375** | **71 500** | **44 500** | **(242 252)** | **50 969** | **947** | **788 790** |

## 28. SURPLUS/(DEFICIT) FROM OPERATIONS PER BENEFIT PLAN

| 2011 | Executive | Classic Comp | Classic Core | Classic Saver | Classic Priority | Essential Comp | Essential Saver | Essential Core |
|---|---|---|---|---|---|---|---|---|
| | R'000 | R'000 | R'000 | R'000 | R'000 | R'000 | R'000 | R'000 |
| **Risk contribution income** | **597 963** | **7 591 106** | **1 141 213** | **4 017 376** | **2 603 388** | **1 102 238** | **1 205 377** | **397 262** |
| Net claims incurred | (817 528) | (7 415 085) | (734 397) | (2 777 521) | (1 948 750) | (828 618) | (730 073) | (253 414) |
| Claims incurred | (822 366) | (7 461 294) | (738 841) | (2 794 381) | (1 960 509) | (833 670) | (734 412) | (254 875) |
| Third party claim recoveries | 4 838 | 46 209 | 4 444 | 16 860 | 11 759 | 5 052 | 4 339 | 1 461 |
| Net income/(expense) 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)** | **(730 073)** | **(253 414)** |
| **Gross healthcare result** | **(217435)** | **200 264** | **406 816** | **1 239 855** | **654 638** | **276 023** | **475 304** | **143 848** |
| Managed care: management services | (10 011) | (158 037) | (40 907) | (151 275) | (80 881) | (25 912) | (51 457) | (17 407) |
| Broker service fees | (10 017) | (159 826) | (30 263) | (130 278) | (75 443) | (25 518) | (38 781) | (11 276) |
| Expenses for administration | (35 624) | (573 335) | (147 128) | (527 684) | (286 635) | (97 013) | (184 972) | (61 303) |
| Other operating expenses | (1 126) | (17 778) | (4 573) | (16 891) | (9 066) | (2 917) | (5 130) | (2 522) |
| **Net healthcare result** | **(274 213)** | **(708 712)** | **183 945** | **413 727** | **202 613** | **124 663** | **194 964** | **51 340** |
| Investment income | 6 409 | 101 164 | 26 192 | 96 862 | 51 781 | 16 586 | 29 501 | 14 600 |
| Net fair value losses on financial assets at fair value through profit or loss | 1 230 | 19 418 | 5 058 | 18 740 | 9 978 | 3 181 | 5 723 | 2 851 |
| Sundry income | 56 | 884 | 228 | 844 | 453 | 145 | 257 | 127 |
| **Other income** | **7 695** | **121 466** | **31 478** | **116 446** | **62 212** | **19 912** | **35 481** | **17 578** |
| Expenses for asset management services rendered | (135) | (2 126) | (554) | (2 051) | (1 091) | (348) | (626) | (312) |
| Interest paid | (221) | (3 490) | (904) | (3 343) | (1 787) | (572) | (1 018) | (504) |
| **Other expenditure** | **(356)** | **(5 616)** | **(1 458)** | **(5 394)** | **(2 878)** | **(920)** | **(1 644)** | **(816)** |
| ***Net surplus/(deficit) for the year*** | **(266 874)** | **(592 862)** | **213 965** | **524 779** | **261 947** | **143 655** | **228 801** | **68 102** |

# Notes to the **Annual Financial Statements**

## For the year ended 31 December 2012

### 28. SURPLUS/(DEFICIT) FROM OPERATIONS PER BENEFIT PLAN (CONTINUED)

| 2011 | Essential Priority | Coastal Saver | Coastal Core | Foundation Core | KeyCare Plus | KeyCare Core | TOTAL |
|---|---|---|---|---|---|---|---|
| | R'000 | R'000 | R'000 | R'000 | R'000 | R'000 | R'000 |
| **Risk 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/(expense) 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 losses 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** |

| | 2012 R'000 | 2011 R'000 |
|---|---|---|
| **29. CASH FLOWS FROM OPERATIONS BEFORE WORKING CAPITAL CHANGES** | | |
| Net surplus for the year | 788 790 | 570 410 |
| Adjustments for: | | |
| Impairment losses | 45 567 | 37 527 |
| Interest received | (600 265) | (554 426) |
| Dividend income | (17 124) | (10 896) |
| Interest on Personal Medical Savings Account | 104 076 | 19 508 |
| Net losses on financial assets at fair value through profit or loss | (96 067) | (109 248) |
| | **224 977** | **(47 125)** |

## 30. EVENTS AFTER THE REPORTING PERIOD

Subsequent to the reporting date, members of the Scheme voted in favour of a proposed amalgamation with the IBM (South Africa) Medical Scheme at a Special General Meeting held on 19 February 2013. The proposed amalgamation date is set as July 2013, pending final approval by the Regulator. No other 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 2012

### 31. 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 to 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 if members are 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 including 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 Personal Medical Savings Account 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.

## 31. 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 before an elective admission
- The amendment to the preauthorisation 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) – 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 options.

The actions 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 2012

### 31. INSURANCE RISK MANAGEMENT REPORT (CONTINUED)

**Insurance risk (continued)**

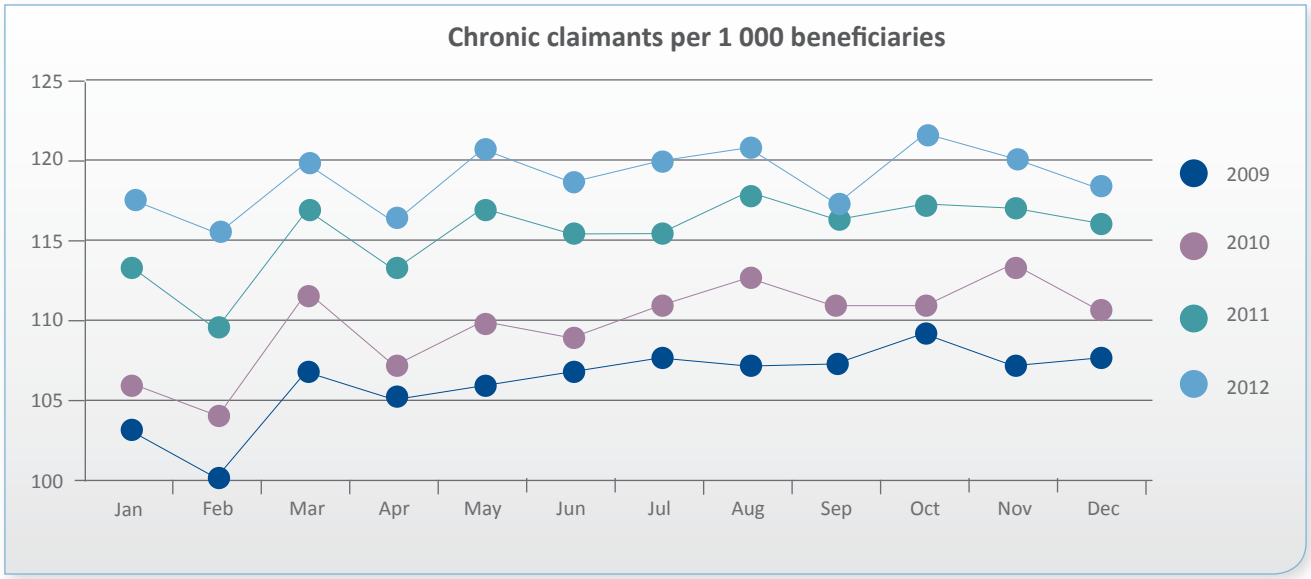
**Chronic Illness Benefit (CIB) risk**

***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 medicine 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.

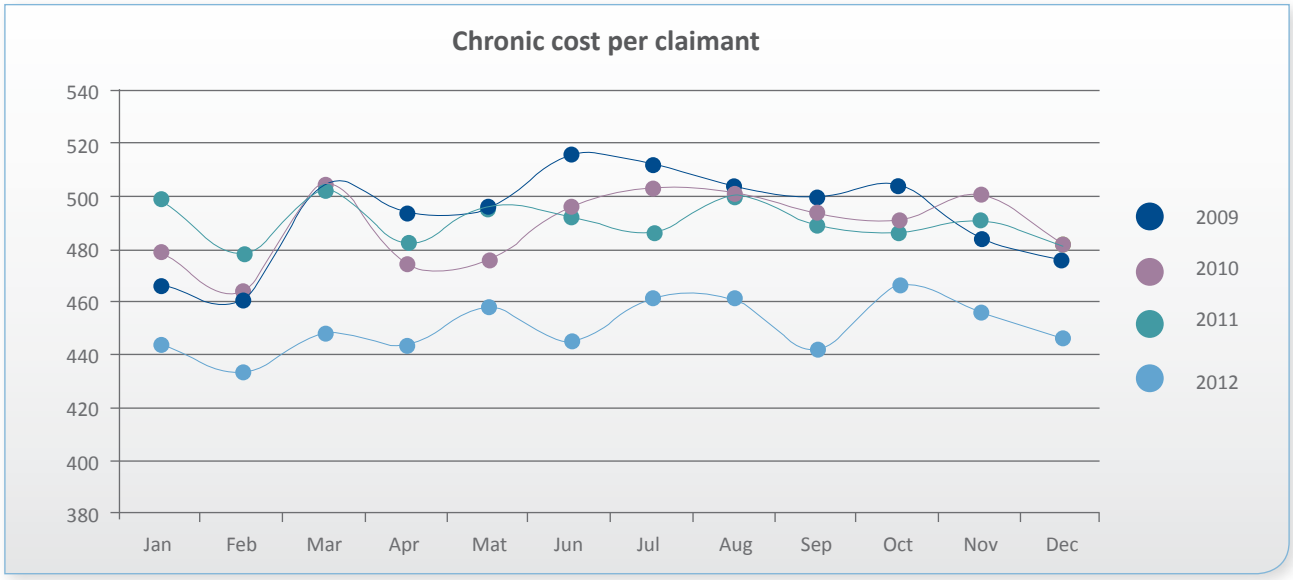
The following graphs indicate the change in the number of claimants over the past four years as well as the impact on the cost per claimant. These graphs are indexed to a value of 100 as at January 2009.



## 31. INSURANCE RISK MANAGEMENT REPORT

**Insurance risk (continued)**

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




The Scheme manages and mitigates the risks associated with CIB 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 2012

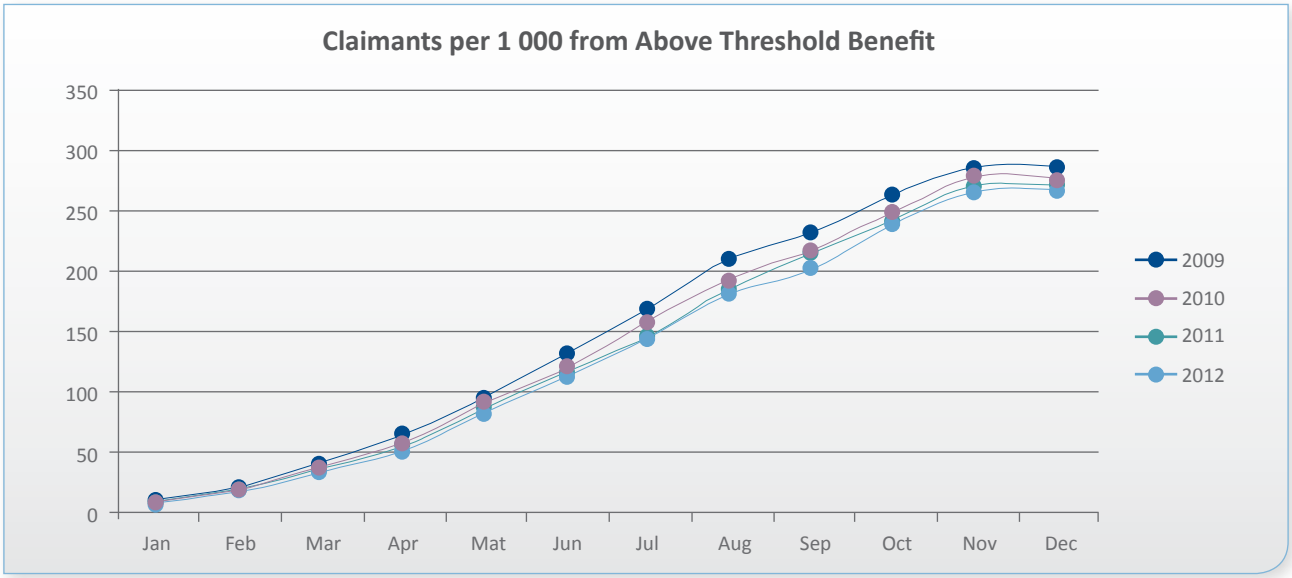
### 31. INSURANCE RISK MANAGEMENT REPORT (CONTINUED)

**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 option.




**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 options that meet a variety of members' needs. This makes the Scheme 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 option.

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 by members of the Scheme during the year, subject to three months' written notice.

## 31. 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 option. There are two arrangements providing optometry and dentistry services to members on the KeyCare Plus option. 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, 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 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 exposure both for individual types of risks insured and overall risks. These methods include internal risk measurement models, sensitivity analyses, scenario analyses and stress testing, 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 over-servicing of members. The Scheme uses alternative reimbursement arrangements to mitigate this risk and to peer-review 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 that 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 2012

### 31. 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 2012 outstanding claims provision was made in accordance with Advisory Practice Note 304 of the Actuarial Society. In accordance with this guidance note, the following factors are checked to determine whether they 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 re-opened 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 2013 in respect of treatment dates during 2012, the recommended provision for outstanding claims as at December 2012 is R769 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.

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.

## 31. INSURANCE RISK MANAGEMENT REPORT (CONTINUED)

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

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, among others, 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 preauthorisation 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 is 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 on certain variables and assumptions that could differ when claims arise.

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

| | 2012 R'000 | 2011 R'000 |
|---|---|---|
| **Total estimate of incurred claims** | | |
| In-hospital claims incurred | 16 259 043 | 14 246 218 |
| Chronic claims incurred | 1 551 849 | 1 567 473 |
| Out-of-hospital risk claims incurred | 5 191 964 | 4 792 298 |

# Notes to the **Annual Financial Statements**

## For the year ended 31 December 2012

### 31. INSURANCE RISK MANAGEMENT REPORT (CONTINUED)

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

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

| | Change in variable % | Impact on outstanding claims provision 2012 R'000 | Impact on outstanding claims provision 2011 R'000 |
|---|---|---|---|
| In-hospital claims incurred | 1% increase in claims costs | 162 590 | 142 462 |
| Chronic claims incurred | 1% increase in claims costs | 15 518 | 15 675 |
| Out-of-hospital risk claims incurred | 1% increase in claims costs | 51 920 | 47 923 |

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 and the last six months. Other reasonability checks are also performed, namely checks against the expected loss ratio taking into account the seasonality of claims, checks of preauthorisation statistics relating to hospital admissions, as well as known hospital admission rates and consideration of the number of working days in recent months.

## 32. 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 are not sufficient to fund the obligations arising from its insurance contracts.

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

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

The Scheme manages these risks through various risk management processes. These processes have been developed to ensure that the long-term investment return on assets supporting the insurance liabilities is sufficient to 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.
- Asset management agreements are concluded in the best interest of the Scheme's members and an external legal adviser is used to review these agreements.

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.

### Personal Medical Savings Account trust assets

These portfolios have been established to manage members' Personal Medical Savings Account balances in portfolios which are distinct and separate from the Scheme.

During the year under review the Scheme appointed two asset managers, Momentum Asset Management and Taquanta Asset Managers, to administer the members' Personal Medical Savings Account balances. These portfolios are managed in accordance with Circular 38 of 2011 and Circular 5 of 2012 issued by the Council for Medical Schemes.

Changes in interest rates have no bearing on the Scheme's surplus or deficit as the investment income earned, net of fees, is allocated to the members' Personal Medical Savings Accounts. Consequently, no further analysis is presented.

# Notes to the **Annual Financial Statements**

## For the year ended 31 December 2012

### 32. FINANCIAL RISK MANAGEMENT REPORT (CONTINUED)

#### 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 investment diversification, the Scheme has invested 5% of its investments and cash offshore. At 31 December 2012 this equates to R423 million (2011: R528 million).

#### Currency risk sensitivity analysis

The sensitivity analysis is based on the Rand / US Dollar spot rate as at 31 December 2012, with all other remaining variables constant.

A 5% increase or decrease in the value of the Rand against the US Dollar will result in a R21.15 million profit and a R21.15 million loss respectively.

#### 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 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.

#### Equity derivative financial instrument (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 pre-determined level. The Scheme has 6% of its investments and cash in local equity.

The fair value of the collar as at 31 December 2012 is a negative R31 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 R47.3 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 R26.3 million in the Statement of Comprehensive Income.

In the event that stock markets perform particularly well during 2013, 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.

## 32. 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 portfolio 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 reprising or maturity dates.

| As at 31 December 2012 | 0 - 3 months R'000 | 3 - 12 months R'000 | > 12 months R'000 | Total R'000 |
|---|---|---|---|---|
| Cash and cash equivalents | 1 419 948 | - | - | 1 419 948 |
| Money market instruments carried at fair value through profit or loss | - | 5 222 869 | - | 5 222 869 |
| Yield-enhanced bond instruments carried at fair value through profit or loss | - | 850 412 | - | 850 412 |
| Offshore bond instruments carried at fair value through profit or loss | - | - | 422 942 | 422 942 |

| 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 |

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

| | 2012 % | 2011 % |
|---|---|---|
| Money market instruments carried at fair value through profit or loss | 7.03% | 7.11% |
| Cash and cash equivalents | 4.75% | 5.27% |

The weighted average effective interest rate on short-term bank deposits (namely call account deposits) was 5.05% (2011: 5.24%). These deposits have an average maturity of 17 days (2011: 15 days).

# Notes to the **Annual Financial Statements**

## For the year ended 31 December 2012

### 32. FINANCIAL RISK MANAGEMENT REPORT (CONTINUED)

#### 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 ended 31 December 2013 is 14.40%, resulting in a return of R68.1 million (addition) to the equity portfolio. This expected portfolio return has risk, and there is a 16% probability that the expected return could reduce by 20.04%, or R94.7 million (resulting in a total return of -6.04% or loss of R28.5 million on the equity portfolio). On the upside there is a 16% probability that the Scheme's net surplus and accumulated funds could increase by R94.7 million above the expected return based on December 2012 market values.

#### 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 Top40 Index. These instruments are traded on SAFEX and settled daily.

As at 31 December 2012 the following instrument with the respective market value was in use:

- FTSE/JSE Top 40 Index futures with a market value loss of R929 544.

#### Offshore portfolios

The expected return for the 12 months ended 31 December 2013 is 4.93%, resulting in a return of $2.5 million (addition) to the offshore bond portfolio in US Dollars. This expected portfolio return has risk, and there is a 16% probability that the expected Dollar return could reduce by 6.36%, or $3.1 million (resulting in a total return of -$0.6 million on the foreign bond portfolio). On the upside there is a 16% probability that the Scheme's net surplus and accumulated funds could increase by $3.1 million above the expected return based on December 2012 market values.

## 32. FINANCIAL RISK MANAGEMENT REPORT (CONTINUED)

### Cash flow sensitivity analysis

### Money market portfolios

The expected return for the 12 months ended 31 December 2013 is 6.0%, resulting in a return of R313.2 million (addition) to the money market portfolio. This expected portfolio return has risk, and there is a 16% probability that the expected return could reduce by 0.64%, or R33.4 million. On the upside there is a 16% probability that the Scheme's net surplus and accumulated funds could increase by R33.4 million above the expected return based on December 2012 market values.

### Yield-enhanced bond portfolios

The expected return for the 12 months ended 31 December 2013 is 8.9%, resulting in a return of R75.7 million (addition) to the bond portfolio. This expected portfolio return has risk, and there is a 16% probability that the expected return could reduce by 6.81%, or R57.9 million. On the upside there is a 16% probability that the Scheme's net surplus and accumulated funds could increase by R57.9 million above the expected return based on December 2012 market values.

The Scheme's portfolio managers purchased bond futures to reduce the sensitivity of these portfolios to changes in the level of medium- and long-term interest rate levels. The market value of the future as at the 31 December 2012 is a loss of R929 109.

### 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 2012 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 2012

### 32. FINANCIAL RISK MANAGEMENT REPORT (CONTINUED)

**Capital management**

The Scheme is subject to the capital requirement imposed by Regulation 29(2) of 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.

| | 2012 R'000 | 2011 R'000 |
|---|---|---|
| Total members' funds per Statement of Financial Position | 8 240 820 | 7 419 231 |
| Less: cumulative unrealised net gain on remeasurement of investments to fair value | - | (90 436) |
| Accumulated funds per Regulation 29 | 8 240 820 | 7 328 795 |
| Gross contribution income | 35 195 627 | 31 192 855 |
| Solvency margin | | |
| = Accumulated funds / gross contribution income x 100 | **23.41%** | **23.50%** |

At 31 December 2012, the Scheme's regulatory capital was R558 million less than the statutory capital requirement of 25% but R392 million higher than the solvency phase-in level approved by the Council for Medical Schemes in terms of the business plan.

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.

## 32. FINANCIAL RISK MANAGEMENT REPORT (CONTINUED)

### 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 Personal Medical Savings Account must be taken as a cash benefit when the member terminates his or her membership of the Scheme or benefit option, and enrols in another benefit option or medical scheme without a savings account or does not enrol in another medical scheme. Therefore the carrying values of the members' Personal Medical 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.

### Breakdown of investments

### Money market portfolios:

The Scheme has two local money market portfolios and one offshore money market portfolio.

**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 75% 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 2012

### 32. FINANCIAL RISK MANAGEMENT REPORT (CONTINUED)

**Investment risk (continued)**

**Breakdown of investments (continued)**

**Bond portfolios:**

**Local portfolios:**
During the prior year the Board of Trustees further diversified the Scheme's investments by appointing an independent asset manager to manage 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 Scheme 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 12% 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 6% of the Scheme's financial assets at fair value through profit or loss.

**Equity portfolios:**
The Scheme has two 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 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 7% of the Scheme's financial assets at fair value through profit or loss.

## 32. FINANCIAL RISK MANAGEMENT REPORT (CONTINUED)

### Investment risk (continued)

### Breakdown of investments (continued)

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.

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 2012 R'000 | As at 31 December 2011 R'000 |
|---|---|---|
| Offshore bond portfolio | 422 942 | 528 352 |
| Local equity portfolios | 472 567 | 377 102 |
| Local yield-enhanced bond portfolio | 850 412 | 741 992 |
| Local money market portfolios | 5 222 869 | 6 364 632 |
| Derivatives | (32 673) | 21 206 |
| **Total** | **6 936 117** | **8 033 284** |

### Cash and cash equivalents

Cash and cash equivalents are made up of the following:

| | As at 31 December 2012 R'000 | As at 31 December 2011 R'000 |
|---|---|---|
| Deposits on call | 510 000 | 580 000 |
| Overnight deposits with financial institutions | 300 861 | 389 128 |
| Money market portfolios | 75 764 | 257 523 |
| Treasury portfolio | 533 323 | - |
| **Total** | **1 419 948** | **1 226 651** |

**Treasury portfolio:**
To enhance the returns generated on the Scheme's operating cash, the Board of Trustees appointed Taquanta Asset Managers (Pty) Ltd to administer a portion of the Scheme's operating cash flows.

# Notes to the **Annual Financial Statements**

## For the year ended 31 December 2012

### 32. 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 2012** | | | | | | | |
| Investments | | | | | | | |
| – Offshore bond portfolio | - | 422 942 | - | - | - | **422 942** | **422 942** |
| – Listed equities | - | 472 567 | - | - | - | **472 567** | **472 567** |
| – Yield-enhanced bond portfolio | - | 850 412 | - | - | - | **850 412** | **850 412** |
| – Money market portfolios | - | 5 222 869 | - | - | - | **5 222 869** | **5 222 869** |
| Cash and cash equivalents: | | | | | | | |
| Medical Scheme assets | - | - | 1 419 948 | - | - | **1 419 948** | **1 419 948** |
| Personal Medical Savings Account trust assets | | | 2 260 141 | | | **2 260 141** | **2 260 141** |
| Trade and other receivables | - | - | 163 765 | 1 295 836 | - | **1 459 601** | **1 459 601** |
| | | | | | | | |
| Personal Medical Savings Accounts | - | - | - | (2 291 580) | - | **(2 291 580)** | **(2 291 580)** |
| Trade and other payables | - | - | - | (471 900) | (302 832) | **(774 732)** | **(774 732)** |
| Members' trust funds | | | | | | | |
| – Non-current portion | - | - | - | - | - | - | - |
| – Current portion | - | - | - | - | - | - | - |
| Derivatives held for trading | | | | | | | |
| – Forward exchange contract | - | - | - | - | - | - | - |
| – Collar | - | (30 814) | - | - | - | **(30 814)** | **(30 814)** |
| – Other | - | (1 859) | - | - | - | **(1 859)** | **(1 859)** |
| | **-** | **6 936 117** | **3 843 854** | **(1 467 644)** | **(302 832)** | **9 009 495** | **9 009 495** |

## 32. 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 | - | 528 352 | - | - | - | **528 352** | **528 352** |
| – Offshore bond portfolio | - | 377 102 | - | - | - | **377 102** | **377 102** |
| – Listed equities | - | 741 992 | - | - | - | **741 992** | **741 992** |
| – Yield-enhanced bond portfolio | - | 6 364 632 | - | - | - | **6 364 632** | **6 364 632** |
| – Money market portfolios | | | | | | | |
| 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** |
| Personal Medical 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 2012

### 32. FINANCIAL RISK MANAGEMENT REPORT (CONTINUED)

**Fair value hierachy for financial assets measured at fair value**

Assets measured at fair value:

| 2012 | 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 | **472 567** | 472 567 | - |
| Government bonds | **271 249** | 271 249 | - |
| Corporate bonds | **2 057 294** | - | 2 057 294 |
| Other investments | **4 135 007** | - | 4 135 007 |
| | **6 936 117** | **743 816** | **6 912 301** |

| 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** |

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. FINANCIAL RISK MANAGEMENT REPORT (CONTINUED)

### Credit risk

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

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 has exposure from its loans and receivables. The management of this risk is discussed in detail on page 146.
- Financial assets are valued at fair value through profit or loss. These assets comprise money market and bond instruments entered into to fund the obligations arising from its insurance contracts and to invest 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 have been appointed to manage these instruments. Information regarding the aggregated credit risk exposure is provided on page 153.
- 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 153.

# Notes to the **Annual Financial Statements**

## For the year ended 31 December 2012

### 32. FINANCIAL RISK MANAGEMENT REPORT (CONTINUED)

**Credit risk (continued)**

**Trade and other receivables**

The Scheme's trade and other receivables (Note 3) at 31 December comprise:

| | 2012 R'000 | 2011 R'000 |
|---|---|---|
| **Insurance receivables** | 1 295 836 | 1 171 625 |
| Contribution receivables [1.] | 1 193 672 | 1 045 331 |
| Less provision for impairment | (3 878) | (6 122) |
| Member and service provider claims receivables [2.] | 205 303 | 200 132 |
| Less provision for impairment | (151 508) | (140 309) |
| Recoveries due from other risk transfer arrangements | 81 | 64 |
| Share of outstanding claims provision (Note 6) | 3 127 | 3 437 |
| Broker fee receivables | 532 | 389 |
| Less provision for impairment | (342) | (293) |
| Other insurance receivables | 48 849 | 68 996 |
| **Loans and receivables** | 163 765 | 146 682 |
| Balance due by related parties | 19 800 | 15 000 |
| Sundry accounts receivables[3.] | 142 491 | 129 596 |
| Interest receivable | 1 474 | 2 086 |
| **Total** | **1 459 601** | **1 318 307** |

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 then handed to specialist debt collection agencies.*
3. *As set out in Note 27, the Scheme obtained guarantees for the recoverability of certain member claims receivables and forensic claims recoveries from Discovery Health (Pty) Ltd.*

## 32. 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 2012 | Impairment 2012 | Gross 2011 | Impairment 2011 |
|---|---|---|---|---|
| | R'000 | R'000 | R'000 | R'000 |
| Not past due | 1 187 686 | | 824 303 | - |
| Past due 4 - 30 days not impaired | 6 020 | | 214 913 | - |
| Past due 31 - 60 days not impaired | 4 850 | | 3 888 | - |
| Past due 61 - 90 days not impaired | (1 357) | | 2 445 | - |
| 91 days to more than one year | (3 527) | (3 878) | (218) | (6 122) |
| **Total** | **1 193 672** | **(3 878)** | **1 045 331** | **(6 122)** |

| Total member and service provider claims debtors | Gross 2012 | Impairment 2012 | Gross 2011 | Impairment 2011 |
|---|---|---|---|---|
| | R'000 | R'000 | R'000 | R'000 |
| Not past due | - | | - | - |
| Past due 0 - 30 days not impaired | 12 942 | | 21 090 | - |
| Past due 31 - 60 days not impaired | 8 094 | | 529 | - |
| Past due 61 - 90 days not impaired | 4 546 | | 6 084 | - |
| Past due 91 - 120 days not impaired | 5 769 | | 11 185 | - |
| Past due 121 - 150 days not impaired | 11 852 | | 7 686 | - |
| 151 days to more than one year | 162 100 | (151 508) | 153 558 | (140 309) |
| **Total** | **205 303** | **(151 508)** | **200 132** | **(140 309)** |

# Notes to the **Annual Financial Statements**

## For the year ended 31 December 2012

### 32. FINANCIAL RISK MANAGEMENT REPORT (CONTINUED)

**Credit risk (continued)**

**Trade and other receivables (continued)**

**Exposure to credit risk (continued)**

| Active member claims debtors | Gross 2012 | Impairment 2012 | Gross 2011 | Impairment 2011 |
|---|---|---|---|---|
| | R'000 | R'000 | R'000 | R'000 |
| Not past due | - | - | - | - |
| Past due 0 - 30 days not impaired | 2 605 | - | 2 734 | - |
| Past due 31 - 60 days not impaired | 1 023 | - | 1 526 | - |
| Past due 61 - 90 days not impaired | 1 013 | - | 1 370 | - |
| Past due 91 - 120 days not impaired | 1 337 | - | 1 443 | - |
| Past due 121 - 150 days not impaired | 1 823 | - | 1 146 | - |
| 151 days to more than one year | 27 948 | (17 394) | 27 974 | (15 397) |
| **Total** | **35 749** | **(17 394)** | **36 193** | **(15 397)** |

| Withdrawn member claims debtors | Gross 2012 | Impairment 2012 | Gross 2011 | Impairment 2011 |
|---|---|---|---|---|
| | R'000 | R'000 | R'000 | R'000 |
| Not past due | - | - | - | - |
| Past due 0 - 30 days not impaired | 6 354 | - | 7 390 | - |
| Past due 31 - 60 days not impaired | 3 964 | - | 4 347 | - |
| Past due 61 - 90 days not impaired | 4 793 | - | 5 641 | - |
| Past due 91 - 120 days not impaired | 5 974 | - | 6 563 | - |
| Past due 121 - 150 days not impaired | 6 906 | - | 8 886 | - |
| 151 days to more than one year | 129 282 | (124 518) | 120 971 | (116 689) |
| **Total** | **157 273** | **(124 518)** | **153 798** | **(116 689)** |

## 32. FINANCIAL RISK MANAGEMENT REPORT (CONTINUED)

**Credit risk (continued)**

**Trade and other receivables (continued)**

**Exposure to credit risk (continued)**

| Service provider claims debtors | Gross 2012 | Impairment 2012 | Gross 2011 | Impairment 2011 |
|---|---|---|---|---|
| | R'000 | R'000 | R'000 | R'000 |
| Not past due | - | - | - | - |
| Past due 0 - 30 days not impaired | 3 983 | - | 10 966 | - |
| Past due 31 - 60 days not impaired | 3 107 | - | (5 344) | - |
| Past due 61 - 90 days not impaired | (1 260) | - | (927) | - |
| Past due 91 - 120 days not impaired | (1 542) | - | 3 179 | - |
| Past due 121 - 150 days not impaired | 3 123 | - | (2 346) | - |
| 151 days to more than one year | 4 870 | (9 596) | 4 613 | (8 223) |
| **Total** | **12 281** | **(9 596)** | **10 141** | **(8 223)** |

| Other risk transfer arrangements | Gross 2012 | Impairment 2012 | Gross 2011 | Impairment 2011 |
|---|---|---|---|---|
| | R'000 | R'000 | R'000 | R'000 |
| Not past due | 3 208 | - | 3 501 | - |
| 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** | **3 208** | **-** | **3 501** | **-** |

| Broker fee debtors | Gross 2012 | Impairment 2012 | Gross 2011 | Impairment 2011 |
|---|---|---|---|---|
| | R'000 | R'000 | R'000 | R'000 |
| Not past due | - | | - | - |
| Past due 0 - 30 days not impaired | 248 | | 363 | - |
| Past due 31 - 60 days not impaired | 107 | | 21 | - |
| Past due 61 - 90 days not impaired | 123 | | (181) | - |
| Past due 91 - 120 days not impaired | (100) | | (7) | - |
| Past due 121 - 150 days not impaired | 60 | | 15 | - |
| 151 days to more than one year | 94 | 342 | 178 | (293) |
| **Total** | **532** | **342** | **389** | **(293)** |

# Notes to the **Annual Financial Statements**

## For the year ended 31 December 2012

### 32. 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 counter party.

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 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** |
| **Balance as at 1 January 2012** | **6 122** | **140 309** | **-** | **293** | **146 724** |
| Increase/(decrease) in provision for impairment | (2 244) | 47 763 | - | 48 | 45 567 |
| Amounts utilised during the year | - | (36 564) | - | - | (36 564) |
| **Balance as at 31 December 2012** | **3 878** | **151 508** | **-** | **342** | **155 727** |

## 32. 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:

| | 2012 R'000 | 2011 R'000 |
|---|---|---|
| **Insurance receivables** | | |
| Counterparties without external credit rating net of provision for impairment: | | |
| Contribution debtors | 1 189 794 | 1 039 209 |
| Member and service provider claim debtors | 53 795 | 59 823 |
| Active member claim debtors | 18 355 | 20 796 |
| Withdrawn member claim debtors | 32 755 | 37 109 |
| Service provider claim debtors | 2 685 | 1 918 |
| Broker fee debtors | 190 | 96 |
| Other insurance receivables | 48 849 | 68 996 |
| | **1 292 628** | **1 168 124** |

## 32. FINANCIAL RISK MANAGEMENT REPORT (CONTINUED)

### Contribution debtors

The Scheme collected over 98% (2011: 97%) of outstanding debt in January 2013. 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 49% (2011: 43%) of the debtors has been raised, The percentage covered by the impairment increases to 70% 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 79% (2011: 76%) of the total amount due has been raised and the Trustees are satisfied that this is adequate.

### 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.

# Notes to the **Annual Financial Statements**

## For the year ended 31 December 2012

### 32. FINANCIAL RISK MANAGEMENT REPORT (CONTINUED)

**Credit risk (continued)**

**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:

| | 2012 R'000 | 2011 R'000 |
|---|---|---|
| Financial assets held at fair value through profit or loss | | |
| **Current assets** | | |
| – Offshore bond portfolio | 422 942 | 528 352 |
| – Listed equities | 472 567 | 377 102 |
| – Yield-enhanced bond portfolios | 850 412 | 741 992 |
| – Derivative financial instruments held for trading | - | 23 424 |
| – Money market portfolios | 5 222 869 | 6 364 632 |
| | **6 968 790** | **8 035 502** |

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 of 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.

## 32. FINANCIAL RISK MANAGEMENT REPORT (CONTINUED)

### Credit risk (continued)

### Financial assets held at fair value through profit or loss (continued)

### Credit quality

| R'000 | Total | Govt | F1+ | F1 | AAA | AA+ to AA- | A+ to A- | B to BBB | CCC to CCC+ | Not rated |
|---|---|---|---|---|---|---|---|---|---|---|
| **2012** | | | | | | | | | | |
| **At fair value through profit or loss:** | 6 496 223 | 271 249 | - | - | 750 364 | 3 692 272 | 1 508 721 | 188 281 | 4 963 | 80 373 |
| – Offshore bond portfolio | 422 942 | 205 215 | - | - | 1 014 | 5 304 | 21 280 | 105 715 | 4 963 | 79 451 |
| – Yield-enhanced bond portfolio | 850 412 | 66 034 | - | - | 114 961 | 252 866 | 333 984 | 82 566 | - | - |
| – Money market portfolios | 5 222 869 | - | - | - | 634 388 | 3 434 102 | 1 153 456 | - | - | 922 |
| **Cash and cash equivalents** | 3 680 089 | - | 516 268 | 300 861 | 5 749 | 2 614 086 | - | - | - | 243 125 |
| **Total** | **10 176 313** | **271 249** | **516 268** | **300 861** | **756 113** | **6 306 358** | **1 508 721** | **188 281** | **4 963** | **323 498** |
| **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 | 149 999 |
| – Offshore bond portfolio | 528 352 | 144 758 | - | - | 44 905 | 3 372 | 30 927 | 172 496 | 9 165 | 122 729 |
| – Yield-enhanced bond portfolio | 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 |
| **Total** | **8 861 627** | **321 351** | **1 747 431** | **224 809** | **1 712 484** | **3 424 595** | **976 377** | **199 633** | **9 165** | **245 783** |

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.

# Notes to the **Annual Financial Statements**

## For the year ended 31 December 2012

### 32. 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 2012 1.9% (2011: 1.0%) 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 2012 0.4% (2011: 0.7%) 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 2012 0.4% (2011:0.5%) 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.

## 32. 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.

Approximately 85% of the Scheme's insurance claim liabilities are settled within four 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 2012 | Less than 1 year R'000 | Between 1 and 2 years R'000 | Between 2 and 5 years R'000 |
|---|---|---|---|
| Members' trust funds | - | | - |
| Personal Medical Savings Accounts | 2 291 580 | - | - |
| Insurance and other payables (Note 10) | 302 832 | - | - |

| 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 | - | - |
| Personal Medical Savings Accounts | 1 930 591 | - | - |
| Insurance and other payables (Note 10) | 233 003 | - | - |

# Notes to the **Annual Financial Statements**

## For the year ended 31 December 2012

### 33. 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 31.

**Other risk transfer arrangements**

The critical estimates and judgements relating to other risk transfer arrangements are set out under Note 12.

**Impairment of assets**

The critical estimates made by the Scheme are set out under Note 32 and judgements relating to the impairment of assets are set out under Note 7 of the accounting policies.

### 34. 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 2012, the Scheme's accumulated funds expressed as a percentage of gross annual contributions was 23.41% (2011: 23.5%) which is less than the statutory requirement of 25%. The Scheme advised the Council for Medical Schemes during 2012 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 2012 the following plans did not comply with Section 33(2):

| Plan | Net underwriting deficit R'000 | Net (deficit)/surplus R'000 |
|---|---|---|
| Executive | (264 887) | (257 041) |
| Classic Comprehensive | (678 279) | (557 543) |
| Coastal Saver | (27 719) | 71 500 |
| Coastal Core | (2 267) | 44 500 |
| KeyCare Plus | (369 556) | (242 252) |

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. 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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