Discovery
Health Medical Scheme

Discovery Health Medical Scheme
Annual Report 2010

Discovery Health Medical Scheme Annual Report

About this report

The aim of the Discovery Health Medical Scheme Annual Report for 2010 is to provide readers with information about the Discovery Health Medical Scheme's financial and operational performance for the period 1 January 2010 to 31 December 2010. 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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Discovery
Health Medical Scheme

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Discovery
Health Medical Scheme

Executive reports

Chairperson's report

Dr Dhesan Moodley

The 2010 financial year for the Discovery Health Medical Scheme has been a successful one. The private healthcare funding industry faces many challenges. These include medical inflation, the continuous increase in costs and utilisation of medical technology, fraud and abuse, the solvency requirements of schemes, the disease burden – especially chronic diseases, cancer and HIV – and an ageing medical scheme population. These challenges are complex and need specific strategies to mitigate risks for medical schemes. The medical scheme industry has been consolidating and non-viable medical schemes have been actively pursuing merger partners, or have taken a route of dissolution. This industry trend is predicted to continue.

The Discovery Health Medical Scheme has been able to manage these complexities favourably for its membership. The Scheme's 2010 contribution increase of 9.8% is evidence of the Scheme's ability to navigate a complex environment successfully. This contribution increase again falls within the Council for Medical Schemes guidelines of Consumer Price Inflation (CPI) plus 3%. The Discovery Health Medical Scheme has consistently achieved this over the last number of years, creating a measure of contribution certainty for its membership. The healthy reserve position of the Discovery Health Medical Scheme of over R6.8 billion provides significant protection and security for members.

The Discovery Health Medical Scheme's Board of Trustees is committed to best practice governance and the principles of the King III Code of Corporate Governance. During the 2009 Annual General Meeting held on 24 June 2010, the membership of the Discovery Health Medical Scheme elected a new Board of Trustees for three years, as the Scheme rules stipulate. The members of this new Board of Trustees have exceptional skills and experience to oversee the management and governance of the Discovery Health Medical Scheme on behalf of its members.

The various sub-committees introduced by the Board of Trustees – the Audit and Risk Committee, the Investment Committee, the Clinical Governance Committee, the Remuneration Committee and the Disputes Committee – add further impetus to the Scheme's best practice governance principles. The Discovery Health Medical Scheme also employs the services of independent experts for independent advice and review.

To further enhance the Scheme's governance focus during the year under review, we appointed an independent asset consultant to advise the Board of Trustees as well as the Investment Committee on the Scheme's future investment strategy based on the Scheme's substantial investment portfolio. This resulted in the appointment of best-of-breed asset managers through a tender process to manage the Scheme's investment portfolio. This process has yielded positive results so far.

The Board of Trustees is actively involved in setting the Scheme's strategic objectives to maintain its competitive advantage. In light of this I would like to thank Discovery Health (Pty) Ltd, the administrator of the Discovery Health Medical Scheme, for its innovative product solutions and relentless pursuit of service excellence to ensure our members receive the highest quality care and service on a continuous basis.

A future focus for the Board of Trustees is to clearly identify stakeholder relations strategies to optimally serve all stakeholders of the Scheme. I am confident that the Board of Trustees will continue to act in the best interest of all members and stakeholders to ensure the continued financial strength and stability of the Discovery Health Medical Scheme.

Dr Dhesan Moodley

Principal Officer's report

Milton Streak

The Discovery Health Medical Scheme achieved solid financial performance during the 2010 financial year. The Scheme had an exceptionally strong membership growth rate, growing total membership by 15.97%. The rate of members leaving the Scheme was also exceptionally low at 4.2%. These are remarkable performances, considering that this was off an already high base, and that this occurred during a period of significant economic challenge for employers and individuals. We attribute this excellent growth rate to the clear perception in the market that the Discovery Health Medical Scheme is efficient, well governed, and financially strong and stable, and that it will provide a solid and secure health insurance home for members, in contrast to many other schemes which have shown significant financial and governance weaknesses in recent years, leaving hundreds of thousands of members vulnerable. Overall, the Scheme added 101 839 new members, and ended the year with 2 245 million lives, resulting in a 48% share of the open medical schemes market, and a 38% share of the total medical schemes market.

The scale and financial strength of the Discovery Health Medical Scheme allowed for major benefit improvements for members during the 2010 financial year, focusing on removing gaps in cover that members may have experienced in the past. The Discovery Health Medical Scheme's contribution increase of 9.8% for 2010 was one of the lowest in the industry, and was within the guideline of the Council for Medical Schemes.

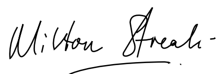
The higher than expected membership growth experienced during the 2010 financial year had a slight negative impact on the solvency ratio of the Discovery Health Medical Scheme. The required statutory solvency ratio, in terms of the Medical Schemes Act, is 25% of annual contribution income and the Discovery Health Medical Scheme ended the 2010 financial year with a solvency ratio of 24.7%, slightly lower than the required level. This is due to the fact that when members join the Scheme, the Scheme is immediately required to hold 25% of their gross annual contribution income in reserves, although members do not bring these reserves with them when they join. Growing schemes therefore always experience temporary downward pressure on their solvency margins. However, the Board of Trustees of the Discovery Health Medical Scheme is convinced that this ongoing pattern of strong growth in membership is unequivocally positive for Scheme members. Not only does this increase the size and hence stability of the Scheme, but also each year the average age of new joiners is lower than that of the existing Scheme members, thus improving the overall risk profile of the Scheme. The Global Credit Rating has reaffirmed the Discovery Health Medical Scheme's credit rating (AA+), the highest possible for a medical scheme in South Africa. This rating supports the financial strength and scale of the Discovery Health Medical Scheme in the private healthcare industry.

The Discovery Health Medical Scheme's annual budget is based on a break-even scenario and it has achieved this result for the financial year under review. With net investment income of R615 million, the net surplus of the scheme for the 2010 period is R594 million. Non-healthcare expenses have been managed prudently and are decreasing year-on-year, measured as a percentage of total annual contribution income. The Scheme values the efficiencies that its administrator, Discovery Health (Pty) Ltd, is effecting on an annual basis, resulting in lower delivery costs, while continuing to improve service levels and additional services for Discovery Health members.

The Discovery Health operating model plays an important role in the financial performance, competitive advantage and sustainability of the Scheme. Product and service innovation are core focus areas of this model which ensures continuous service improvement and sustainable, cost-effective and quality healthcare delivery for our members. Discovery Health (Pty) Ltd has invested extensively in building healthcare systems, skills, expertise and relationships to enhance the healthcare system for our membership. This strategy is dynamic and recognises healthcare professionals as key partners in developing sustainable healthcare delivery strategies for the Discovery Health Medical Scheme.

The Discovery Health Medical Scheme continues its commitment to provide exceptional value to its members through strong stakeholder alliances and constructive supplier partnerships. The partnership with Vitality, for example, is yielding very encouraging results for members and the Scheme through access to wellness and lifestyle benefits, which further contain healthcare costs. In this context, there is growing scientific evidence to demonstrate that active participation in the Vitality programme reduces the rate of hospital admissions, reduces long-term healthcare costs, and reduces mortality rates, relative to non-Vitality members.

The Discovery Health Medical Scheme will focus on contribution and benefit stability as well as enhancing the quality of care for our members as key future strategic objectives. The Discovery Health Medical Scheme Board of Trustees, through its best practice governance commitment, and Discovery Health (Pty) Ltd, supporting the Scheme through its innovation, skills and expertise, will navigate the complex private healthcare system optimally, to ensure continuous value for members.



Milton Streak

Overview

Overview

Discovery Health Medical Scheme

Key facts and figures

The Discovery Health Medical Scheme is a not-for-profit entity, registered under the Medical Schemes Act, No 131 of 1998. It is the largest open medical scheme in South Africa. Discovery Health (Pty) Ltd, an accredited administrator and managed care organisation, administers the Scheme.

2 244 894

The number of lives the Discovery Health Medical Scheme covers.

AA+

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

48%

Open medical scheme market share of the Discovery Health Medical Scheme.

4.2%

Discovery Health Medical Scheme lapse rate.

24.7%

Discovery Health Medical Scheme solvency level. This is slightly below the required level and is due to the marked increase in new membership numbers in 2010. The Scheme is working with the Council for Medical Schemes in targeting the small differential to reach the required ratio.

The operation of a medical scheme – where do members' contributions go?

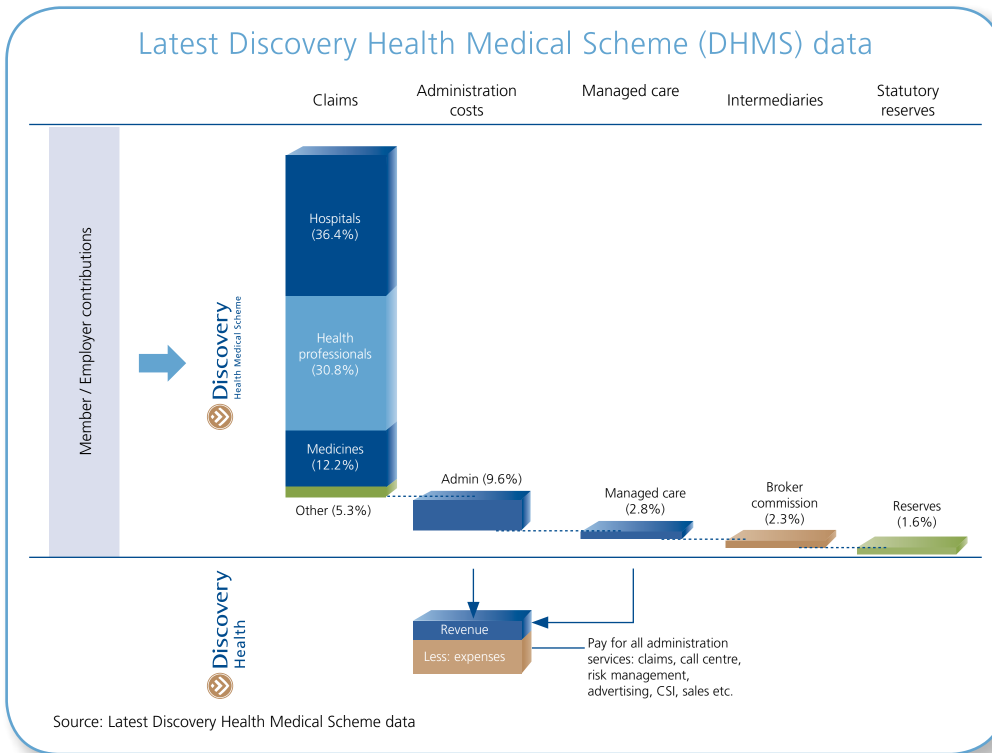
Medical scheme administration is complex and requires significant skills and technology investment to create the required service levels and efficiencies.

Contributions received by members and employers are used to pay claims, of which hospitals account for approximately 36%, medicines 12%, health professionals 31% and other claims 5%. Administration expenses account for 9.6%. The DHMS administration fee, expressed as a percentage of gross annual contribution income, is within the guideline set by the Council for Medical Schemes. Managed care activities, which are critical in the management of healthcare risks of the Discovery Health Medical Scheme population, account for 2.8%. Risk management requires intensive skill and expertise, and Discovery Health (Pty) Ltd has invested substantially in creating tools and healthcare assets to ensure appropriate risk management interventions. Broker fees account for 2.3%, and the remaining 1.6% goes towards funding the Scheme's reserve ratio. Where schemes experience membership growth, they must allow for funding the required reserve level for every new member joining the scheme, in order to comply with the legislated solvency level for medical schemes of 25% of gross annual contribution income.

Members have the option to join Vitality, regarded as the world's leading wellness programme, on a voluntary basis. Members pay their Vitality contribution directly to Vitality HealthStyle (Pty) Ltd. The contribution does not form part of the medical scheme contribution as the Discovery Health Medical Scheme and Vitality HealthStyle (Pty) Ltd are seperate legal entities. Vitality complements the Discovery Health Medical Scheme, as healthy and fit members experience lower healthcare costs and this improves the risk profile of the Scheme.

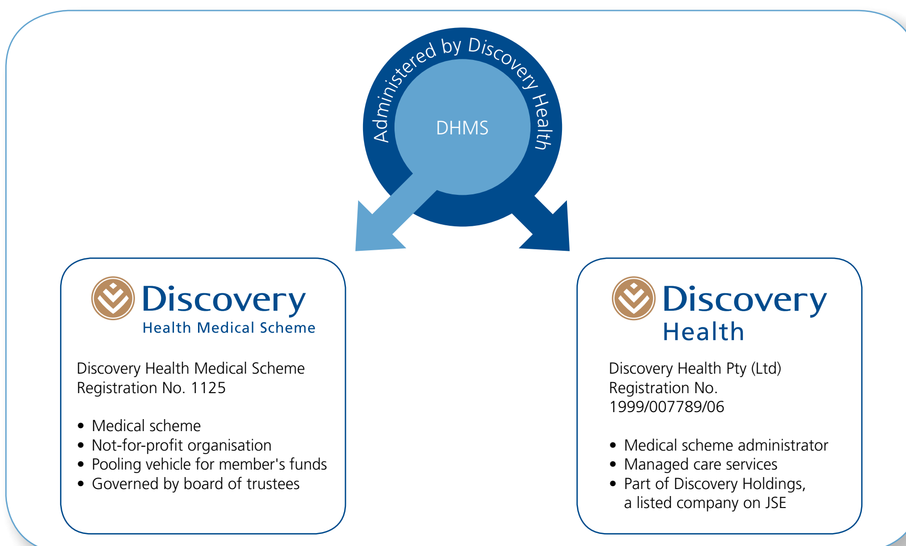
Overview

Discovery Health Medical Scheme (DHMS)

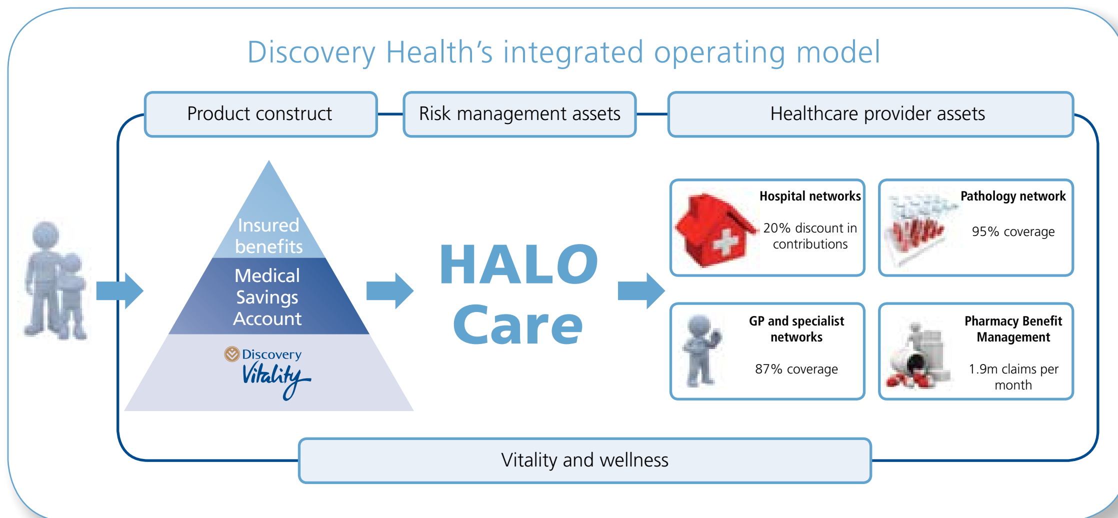


The above illustration explains how members' contributions are utilised.

The relationship between the Discovery Health Medical Scheme (DHMS) and Discovery Health (Pty) Ltd



The Discovery Health Medical Scheme is administered by Discovery Health (Pty) Ltd, an accredited medical scheme administrator and managed care organisation. Discovery Health (Pty) Ltd provides administration and risk management services to the Discovery Health Medical Scheme through a unique operating model. This ensures the competitive advantage of the Scheme in the private healthcare industry.



The Discovery Health model has three distinct parts:

1. **A consumer-engaged health plan benefit design.** The consumer-engaged Discovery Health Medical Scheme plan provides comprehensive cover for large and unforeseen events and chronic conditions, while empowering members to take control of their health spending for discretionary and day-to-day health events. It also gives them the ability to manage and improve their health, on a voluntary basis, through the Vitality wellness programme.

2. **Clinical risk management expertise and systems.** Discovery Health (Pty) Ltd currently employs over 150 actuaries, economists, analysts, doctors and other health professionals in its strategic risk management team. Discovery Health (Pty) Ltd's risk management capability and scale enable the Scheme to manage care and costs effectively, minimise abuse and fund the best quality healthcare, including the latest medical technologies. It does this by applying sophisticated health economics modelling and developing best practice funding protocols in collaboration with the health profession.

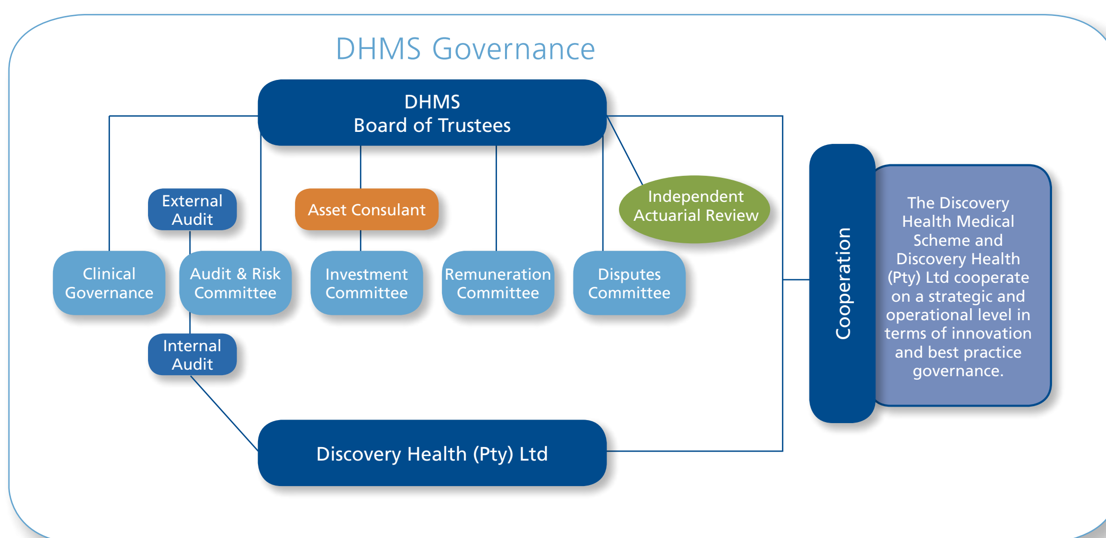
3. **Healthcare assets within the healthcare delivery system.** Using Discovery Health (Pty) Ltd's risk management capabilities and provider partnerships, Discovery Health has built a number of important healthcare provider assets within the healthcare system. These include the GP network and proprietary payment arrangements with specialists, which now cover 86% and 87% of GP and specialist visits respectively for Discovery Health Medical Scheme members. The Delta Network, a dynamically managed network of efficient hospitals, is another such asset, allowing for a 10% to 20% contribution discount on the Delta options within some of the Scheme's major plan types. The KeyCare hospital and GP networks, comprising 106 hospitals and over 2 000 GPs, enable the Discovery Health Medical Scheme to offer quality private healthcare access to lower-income earners, and specifically the previously uninsured market.

   This robust approach to risk management, and the assets deployed in the healthcare system, allow the Discovery Health Medical Scheme to contain supply costs without compromising the quality of cover for members. These advantages are enhanced by the Vitality wellness programme, which underpins the operating model. Research has proven Vitality members incur lower claims and are less likely to lapse their cover with the Scheme, which is a key element in the sustainability strategy of the Scheme.

Overview

Discovery Health Medical Scheme (DHMS)

Governance of the Discovery Health Medical Scheme (DHMS)



Discovery Health's operating model

The Board of Trustees of the Discovery Health Medical Scheme is responsible for ensuring adherence to the principles of best practice in corporate governance. The Scheme is committed to an open governance process that provides its members and stakeholders with the assurance that the Scheme is managed ethically within prudent risk parameters and in compliance with the Medical Schemes Act 131 of 1998 and the rules of the Scheme. The Scheme is working towards following the King III Code of Corporate Governance and has implemented structures to support best practice governance and the required independence principles. The governance framework allows for constructive cooperation between the Scheme and its administrator for the benefit of all members. The Scheme has introduced the following sub-committees of the Board to provide trustees with management oversight and control:

- Audit and Risk Committee
- Investment Committee
- Clinical Governance Committee
- Remuneration Committee
- Disputes Committee

Board of Trustees of the Discovery Health Medical Scheme

Dr DG Moodley
(elected 24 June 2010)

Chairperson

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

Occupation: Group President, Alexander Proudfoot

Prof ZM van der Spuy
(elected 24 June 2010)

Trustee

MBChB (Stellenbosch), MRCOG (Royal College of Obstetricians and Gynaecologists, PhD (University of London, UK), FRCOG 1991 (Royal College of Obstetricians and Gynaecologists), FCOG (SA) (South African College of Obstetricians and Gynaecologists)
Occupation: Professor of Obstetrics and Gynaecology, UCT

Adv NJ Graves
(elected 24 June 2010)

Trustee

BA LLB (UCT)

Occupation: Senior Counsel

S Handler
(appointed 24 June 2010)

BCom, FFA, FASSA Trustee

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

P Maserumule
(elected 24 June 2010)

Trustee

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

Occupation: Founder and Chairman, Maserumule Incorporated Lawyers

Dr N Sangweni
(re-elected 24 June 2010)

Trustee

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

Occupation: Programme Manager, NGOs and UGM Right to Care, Helen Joseph Hospital

B Stott
(elected 24 June 2010)

Trustee

CA (SA)

Occupation: Non-executive Company Director, retired partner, PricewaterhouseCoopers Inc, Responsible for financial services

Trustees whose term of office have expired

D Cohen
(term of office expired)

Trustee

B Compt (Hons)

Occupation: Director, RealJO Trading (Pty) Ltd and Lunga Consulting

Trustee, Ikageng Itireleng Property Trust

Adv M van der Nest
(term of office expired)

Chairman

BA (Law), LLB

Occupation: Senior Counsel

Prof B Jacobson
(term of office expired)

Trustee

MBChB (Pretoria), MMed (Haematology) (Wits), FRCS (Glasgow), PhD (Wits)
Occupation: President, Southern African Society of Thrombosis and Haemostasis. Head, Clinical Haematology, Department of Haematology and National Health Laboratory Service, The Charlotte Maxeke Johannesburg Academic Hospital, medical doctor

Overview

Discovery Health Medical Scheme

Stakeholders of the Discovery Health Medical Scheme

The Discovery Health Medical Scheme impacts a range of stakeholders in South Africa. Our relationship with these stakeholders, in turn, has an effect on the sustainability of the Scheme.

These stakeholders are:

- the members of the Discovery Health Medical Scheme
- the Regulator (the Council for Medical Schemes)
- National Department of Health
- the administrator of the Scheme
- the pharmaceutical industry
- suppliers of healthcare services and products
- all healthcare professionals in both the private and public sectors
- healthcare intermediaries.

Key strategic issues facing the private healthcare industry

Healthcare funding in South Africa is extremely complex and requires expertise to ensure that members' funds are managed appropriately. Medical schemes face many challenges to ensure they provide sustainable healthcare cover.

1. Balancing the needs of stakeholders in the healthcare system

As the funding mechanism for members' healthcare expenses, medical schemes play a pivotal role in the healthcare system. Schemes interact with a variety of stakeholders including healthcare professionals, hospitals, pharmaceutical providers, intermediaries and members. Each of these groups has different and, in some cases, opposing interests. Medical schemes need to balance these interests appropriately to ensure that:

- medical scheme members have access to appropriate benefits
- medical scheme contributions remain affordable
- the scheme is financially sound and can pay members' claims
- healthcare professionals receive appropriate remuneration.

The challenges of managing a complex healthcare environment have led to industry consolidation, both in the number of medical schemes and medical scheme administrators operating in private healthcare in South Africa. Over the past 10 years, 60 medical schemes have closed or merged. In addition, the cost pressures on schemes have led to continued financial underperformance.

2. Managing the complexities of a system based on cross-subsidisation

Medical schemes are required to operate within the constraints of the Medical Schemes Act. Legislation dictates that schemes:

- Have a limited ability to underwrite new members – schemes may not decline membership for any individual, and may only impose time-limited waiting periods for pre-existing conditions. This poses significant risk of 'anti-selection' for open schemes, whereby members with higher than average risks join schemes, whereas those with low risk tend to stay out of cover until they need it.
- Must calculate members' contributions on a community-rated basis, which means that members on the same plan must pay the same contribution, regardless of individual risk characteristics. This differs completely from conventional insurance, where contributions are closely related to risk.

These operating constraints are important and fundamental elements of healthcare funding in South Africa. However, they undermine the traditional element of cross-subsidisation between healthy and sick which occurs in many healthcare insurance systems, due to the anti-selection problem identified above. These challenges make the role of the health insurer in South Africa significantly more complex than in other environments, and place a much higher premium on sophisticated actuarial and risk management techniques. Healthier members traditionally perceive far less value in their medical scheme cover than higher-risk, higher-claiming members. However, for schemes to remain sustainable, schemes need to retain healthier members to ensure that contributions remain sustainable and affordable. The challenge for medical schemes is to design benefits in such a way that healthier, lower-claiming members still experience significant value from their cover, despite their relatively lower healthcare utilisation. At the same time, the scheme needs to ensure that high-risk members are receiving appropriate and clinically effective treatment that is funded in a sustainable way. The disparities between these groups are significant, and the challenge of finding this balance is equally significant. This challenging environment explains why so many schemes are currently failing, since they lack the scale and risk management expertise to navigate this highly complex environment.

3. Finding sustainable ways to fund new medical technologies

New medical technologies have a significant inflationary impact on the cost of care. There are limited funds available to medical schemes to fund healthcare expenses. Accessing and financing new medical technology means costs need to be funded through an increase in members' contributions. The challenge for schemes is to find sustainable ways to fund these new medical technologies that improve clinical outcomes.

For example, advances in medical technology for the treatment of cancer have led to a dramatic escalation in the cost of providing cover for such treatment. Medical advances have enabled healthcare professionals to detect cancer earlier and to treat it more effectively than 10 years ago. This has resulted in marked improvements in cancer survival rates. However, at the same time it has placed significant pressure on the cost of treatment. For medical schemes the funding decision can be complicated: many new types of treatments, medications and procedures come onto the market each year at significantly higher costs. While many show great promise for improving patient outcomes, not all are proven to be clinically and cost effective. Schemes have to weigh up the cost of providing access to these technologies against their clinical outcomes and against their cost impact on the membership base overall.

4. Managing medical scheme cost drivers

Increases in medical scheme contributions are driven by environmental factors and the effects of membership growth, as well as the financial performance of the scheme.

Medical scheme cost driver	Impact on medical scheme
Base medical inflation, rates of healthcare utilisation, and costs of new technologies	These are the primary cost drivers for schemes. Schemes can control their base medical inflation through tariff negotiations, risk management strategies and by managing their demographic profile.
Financial performance and solvency requirements	Schemes that have experienced operating losses require a margin in their contributions to curb these losses and return the scheme to a sustainable financial position. Schemes falling short of the regulatory solvency requirements need to price explicitly for additional future contributions to build solvency.
Expected membership growth	While positive membership growth has medium and long-term benefits to a scheme's risk profile and experience, it places strain on a scheme's solvency requirements in the short term. Growing schemes need to incorporate margins for growth in their contributions.

A medical scheme must manage these factors to ensure that the real value of members' benefits is protected, the long-term sustainability of the scheme is ensured and solvency requirements are met.

Overview

Discovery Health Medical Scheme

Strategic objectives for the Discovery Health Medical Scheme

1. **Ensuring benefits and contributions remain sustainable**

   An important strategic objective for the Discovery Health Medical Scheme is to ensure contributions and benefits remain sustainable for its members over the long term. This includes ensuring solvency levels are maintained in line with regulatory requirements. Key to achieving this is to ensure medical scheme cost drivers are managed appropriately. Although Consumer Price Inflation (CPI) has reduced over the past two years, medical inflation universally exceeds CPI, often by three or more percentage points. Cost drivers such as new medical technologies, an ageing population and the increasing prevalence of chronic diseases of lifestyle all impact medical inflation.

   The Discovery Health Medical Scheme's increase of 7.9% for 2011 addresses these issues and is well below the industry average. The scale of the Discovery Health Medical Scheme ensures competitive provider tariffs which are crucial in order to manage price increases annually. Robust clinical risk management interventions provide further support to manage the impact of cost drivers.

2. **Continuously improving the quality of care for members**

   The Discovery Health Medical Scheme's size and scale in South Africa's healthcare environment provides an ideal platform to improve the quality of care members receive through various care initiatives. This includes the Discovery Integrated Care Unit – the first initiative of its kind in South Africa. The programme provides members who have extensive and complex medical needs with holistic treatment from a team of medical experts, care coordinators and community-based care providers. By the end of 2012, 13 centres will be operating across South Africa. Other initiatives include the Discovery Trauma Support Service that provides 24/7 access to a fleet of trauma support vehicles, staffed by trained trauma counselors, as well as Discovery Med-Xpress, a dedicated new medicine delivery service that guarantees members in major metropolitan areas same-day delivery of their chronic and prescription medicines.

3. **Engaging with stakeholders in developing a sustainable healthcare model for South Africa**

   Details regarding the proposed National Health Insurance (NHI) system remain limited, although the industry is expecting the publication of a formal White Paper on NHI sometime in the near future, which will bring clarity to the discussions. Recent comments from the Minister of Health indicate that early focus is likely to be on such areas of need such as primary healthcare, with a particular focus on underserved rural areas. If this is the case, the NHI could make a significant contribution to improvement in the quality and accessibility of healthcare services for underserved communities over the next few years.

Performance for 2010: Report by the Board of Trustees

Performance for 2010:
Report by the Board of Trustees

Beyond the financial performance of the Scheme, the Trustees oversee appropriate management structures to ensure that the key objectives of the Scheme are achieved. These key objectives include:

- ensuring the Scheme has the ability to pay claims
- ensuring that members are getting value for money
- ensuring operational efficiency
- ensuring statutory and regulatory compliance.

Overview of performance

The Scheme experienced another year of excellent overall performance with several multi-year strategies continuing to yield positive results. Membership continued to increase during the year under review, resulting in strong growth for the Discovery Health Medical Scheme. Importantly, while new members joined the Scheme at a significant rate of 15.97%, the rate of members leaving the Scheme was only 4.2%. This resulted in a net membership growth of 11.0% for 2010.

The Scheme generated a net surplus of R594 million for the current year. The impact of the very high membership growth resulted in the statutory solvency level ending the year at 24.7%, below the 25% statutory solvency required by the Medical Schemes Act 131 of 1998. However, the Scheme continues to exhibit the highest possible level of financial strength and stability. This was confirmed by the credit rating of AA+, the highest possible rating in the industry, by the independent credit rating agency Global Credit Rating. We are confident that the Scheme will once again build its reserves to reach the 25% solvency requirement in the near future.

The results of the Scheme are set out in the financial statements on pages 36 to 111. This outstanding overall performance is attributable to continued and effective risk management efforts, while ensuring that members experience quality of care and receive value for money. The Scheme's hospital admission rate continued its decreasing trend in 2010, and the increase in cost per admission was also well-controlled and in line with budget expectations. The Scheme's General Practitioner Network and Specialist Direct Payment Arrangements currently cover more than 86% and 87% of members respectively, enabling lower out-of-pocket payments for members of the Scheme.

The Board of Trustees and external advisers perform regular comparisons of benefits and contribution rates against other medical schemes. The Scheme continues to offer substantial member flexibility, well-priced options and comprehensive and effective benefit design compared to similar schemes in the market. Stability of both contribution increases and benefit design remains high in an environment characterised by volatile contributions and benefits in many other medical schemes.

Administration fees have been decreasing as a percentage of gross contributions from 14% in 2001 to 9.6% by the end of 2010. The Scheme is committed to continuously reduce administration costs. When expressed as a percentage of gross contributions, administration fees decreased by 6.2% over this period.

Measured against its peers, the Scheme has had one of the lowest contribution increases in each of the last 10 years. The net result of all activities over the year is the annual contribution increase to members. At the end of 2010, the contribution increase was 7.9%. This was one of the lowest increases among South African open medical schemes.

Benefit options

The Scheme offered 14 benefit options to employers and members of the public for 2010. These were:

	Executive	Comprehensive	Priority	Core	Saver
Executive	✓	✗	✗	✗	✗
Classic	✗	✓	✓	✓	✓
Essential	✗	✓	✓	✓	✓
Coastal	✗	✗	✗	✓	✓

	Core	Plus
Foundation	✓	✗
KeyCare	✓	✓

Solvency and membership

The Scheme must maintain accumulated funds of 25% of gross annual contribution income for the accounting period under review (Regulation 29 (2) to the Medical Schemes Act 131 of 1998, as amended). As at 31 December 2010, the Scheme's solvency margin was 24.7%.

Calculation of regulatory capital requirement

	2010 R'000	2009 R'000
Total members' funds per Statement of Financial Position	6,847,076	6,070,680
Less: cumulative unrealised net gain on remeasurement of investments to fair value	(29,739)	(2,628)
Accumulated funds per Regulation 29	**6,817,337**	**6,068,052**
Gross contribution income	**27,650,362**	**23,840,326**
Solvency margin = Accumulated funds / gross contribution income x 100	**24.7%**	**25.4%**

Performance for 2010:
Report by the Board of Trustees

Annual growth in membership

The Scheme continued to enjoy strong membership growth in 2010 despite the decline in economic levels. The Scheme now covers over 2.2 million lives.

The total membership per benefit option was as follows:

Benefit option	31 December 2010 Principal members	31 December 2010 Total lives	31 December 2010 % of total lives	31 December 2009 Total lives
Executive	11,348	26,846	1.20	24,559
Classic Comprehensive	185,384	449,197	20.01	437,767
Classic Core	49,135	105,881	4.71	102,903
Classic Saver	166,644	364,319	16.22	307,353
Classic Priority	91,193	209,919	9.35	190,765
Essential Comprehensive	34,493	75,375	3.36	80,419
Essential Core	19,288	42,128	1.88	39,523
Essential Saver	59,919	134,636	6.00	131,032
Essential Priority	9,862	20,996	0.94	21,899
Coastal Saver	137,813	322,874	14.38	302,014
Coastal Core	67,910	150,625	6.71	145,034
Foundation Core	947	2,096	0.09	2,667
KeyCare Core	16,416	26,890	1.20	28,184
KeyCare Plus	169,067	313,112	13.95	227,789
Total	**1,019,419**	**2,244,894**	**100.00**	**2,041,908**

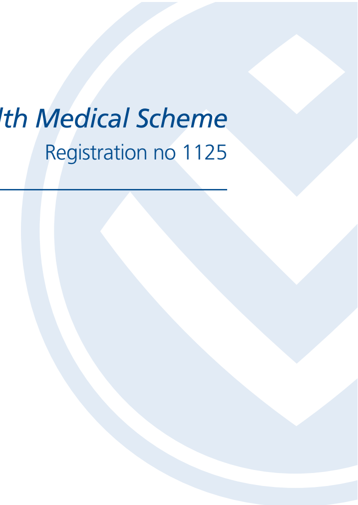
Market share

Despite the current complex economic environment, we have had a successful year with a membership base growth of 11% from the previous year (2009, 6%). Our share of the open medical scheme market at the end of the current financial year, in terms of membership base, is at 48% (2009, 45 %), enhancing our position as the largest open medical scheme in South Africa. Our target membership growth for 2011 is between 5% and 8%.

The Scheme's competitiveness

The Scheme's average contribution increase in 2011 is 7.9% across all plans and family sizes. This increase is in line with or below the industry increase, supporting the Scheme's promise of continued growth, long-term affordability and sustainability.

To maintain the contribution increases within the relevant guideline, the Scheme will in conjunction with its administrator, Discovery Health (Pty) Ltd, continue to develop, implement and measure various alternative reimbursement models with its service providers, and ensure competitiveness of its product offering and ability to meet clients' needs.



Key financial and service metrics

	2010	2009
Members' funds	R 6,8 billion	R 6,1 billion
Solvency ratio	24.66%	25.45%
Membership (lives)	2,24 million	2,04 million
Gross contribution income	R 27,65 billion	R 23,84 billion
Risk contribution income	R 22,12 billion	R 19,05 billion
Average net contributions per member per month	R 1,876	R 1,777
Average net claims per member per month	R 1,527	R 1,423
Average accumulated funds per member at year end	R 6,970	R 6,795
Average return on investments as a percentage of investments	7.49%	9.57%
Number of hospital events	506,434	479,337

<table>
<tr><th>2010</th><th>New member applications</th><th>Customer service call centre</th><th>Claims processing</th><th>Hospital and walk-in centre visits</th></tr>
<tr><td>Volume</td><td>1,150 lives per day</td><td>32,652 calls per day</td><td>Average of 163,857 claims processed per working day</td><td>102,417 hospital patients were visited by member liaison managers

59,569 members visited the four walk-in centres</td></tr>
<tr><td rowspan="2">Average service delivery</td><td rowspan="2">79% of new business applications are processed in less than 4 days</td><td rowspan="2">74.43 answered within 20 seconds</td><td>1.86 days from receipt to payment for members and 4.81 days for healthcare professionals</td><td>The average waiting time at the walk-in centres was one minute, 26 seconds (00:60:26)</td></tr>
<tr><td>0.99% error rate</td><td>Average member-based research score out of 10 for member liaison managers increased to 9.34</td></tr>
</table>

Performance for 2010:

Report by the Board of Trustees

Prudent financial management

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

Year ended	December 2010 R'000	December 2009 R'000	December 2008 R'000
Gross contributions	27,650,362	23,840,326	20,796,701
Total outstanding – excluding December contributions	15,315	9,482	6,625
% Outstanding	0.06%	0.04%	0.03%

Enhancing healthcare in a complex operating environment

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

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

Due application of Scheme rules

The Trustees keep a constant check on appropriate and consistent application of Scheme rules in relation to beneficiary entitlements 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 roles.

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

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

Matters of non-compliance for the year ended 31 December 2010

During the year the Scheme did not comply with the following:

Statutory Scheme Solvency

In terms of Regulation 29 (2) to the Medical Schemes Act 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 2010, the Scheme's accumulated funds expressed as a percentage of gross annual contributions was 24.66% which is less than the statutory requirement of 25% and the Scheme has advised the Council for Medical Schemes.

The Scheme is in the process of planning and implementing a comprehensive risk management strategy for all benefit options in order to improve the Scheme's solvency position during 2011.

Sustainability of benefit options

Section 33 (2) of the Medical Schemes Act 131 of 1998, as amended, stipulates that each option shall be self-supporting in terms of membership and financial performance and be financially sound. At 31 December 2010 the following options did not comply with Section 33 (2):

Option	Net underwriting deficit R'000	Net (deficit)/surplus R'000
Executive	(249,031)	(241,529)
Classic Comprehensive	(633,273)	(511,038)
Coastal Saver	(9,182)	80,172
KeyCare Plus	(286,034)	(186,340)

The Trustees continue to monitor these options with a view of improving their sustainability. At the same time, it should be pointed out that it is a structural reality of all open medical schemes that the higher options are loss making. This is the simple result of the medical scheme environment that allows sicker members of the scheme to upgrade to higher options at the beginning of the benefit year, with no underwriting applied. As it almost always makes sense for sicker members to upgrade (since claims from the scheme will more than make up for higher contributions), all open schemes face a situation in which their top-end plans have a majority of sicker members, resulting in overall negative loss ratios. 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 options.

Investments in employer groups

Section 35(8) (a) of the Medical Schemes Act 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 the Scheme or any administrator or any arrangement associated with a medical scheme. Due to the large number of the Scheme's employers being listed on the JSE, investments were made in certain of its employers listed on the JSE. The Council for Medical Schemes has granted the Scheme an exemption from this section of the Medical Schemes Act.

Contributions received after due date

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

Performance for 2010:
Report by the Board of Trustees

Matters of non-compliance for the year ended 31 December 2010 (continued)

Ring-fenced reserves

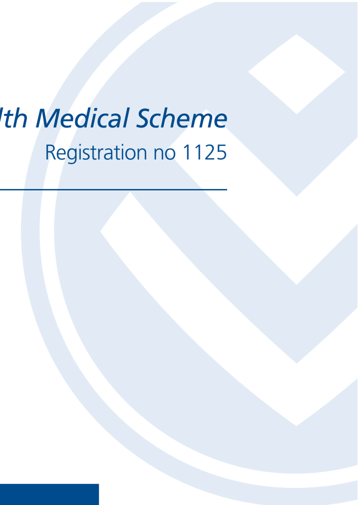
Regulation 4(4) to the Medical Schemes Act 131 of 1998, as amended, prohibits ring-fencing. The funds transferred from the CNA Gallo Medical Scheme (Note 5) meets the definition of ring-fencing. The Scheme has submitted a request for exemption from this regulation to the Council for Medical Schemes.

Broker fees paid before contributions are received

In terms of Regulation 28(5) to the Medical Schemes Act 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 before receipt of the relevant monthly contribution. The Scheme has implemented additional controls to address this matter, and continues to monitor instances where this requirement is contravened.

Operational statistics

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



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

Performance for 2010:

Report by the Board of Trustees

2009	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	10,262	179,405	47,743	141,216	82,754	35,906	17,974	57,639
Number of beneficiaries at the end of the accounting period	24,559	437,767	102,903	307,353	190,765	80,419	39,523	131,032
Average number of members for the accounting period	10,231	182,442	46,476	137,383	81,844	36,472	17,208	57,273
Average number of beneficiaries for the accounting period	24,578	445,028	100,394	298,568	187,969	81,904	38,185	130,443
Average risk contributions per member per month (R)	3,566	2,877	1,664	1,597	1,907	2,578	1,417	1,451
Average risk contributions per beneficiary per month (R)	1,484	1,179	770	735	831	1,148	638	637
Average net claims incurred per member per month (R)	4,773	2,750	1,013	1,061	1,444	1,885	894	878
Average net claims incurred per beneficiary per month (R)	1,987	1,127	469	488	629	839	403	385
Average administration costs per member per month (R)	246	247	245	245	245	247	244	246
Average administration cost per beneficiary per month (R)	102	101	114	113	107	110	110	108
Average managed care: Management services per beneficiary per month (R)	24	24	24	24	24	24	24	24
Beneficiaries per member at 31 December	2.39	2.44	2.16	2.18	2.31	2.24	2.20	2.27
Dependants per member at 31 December	1.39	1.44	1.16	1.18	1.31	1.24	1.20	1.27
Relevant healthcare expenditure as a percentage of risk contributions (%)	134	96	61	66	76	73	63	60
Non-healthcare expenditure as a percentage of risk contributions (%)	11	13	21	23	19	15	25	25

2009	Essential Priority	Coastal Saver	Coastal Core	Foundation Core	KeyCare Plus	KeyCare Core	TOTAL
Number of members at the end of the accounting period	10,135	128,574	65,499	1,200	122,191	17,082	917,580
Number of beneficiaries at the end of the accounting period	21,899	302,014	145,034	2,667	227,789	28,184	2,041,908
Average number of members for the accounting period	10,056	127,721	63,172	1,261	105,448	16,426	893,411
Average number of beneficiaries for the accounting period	21,715	299,885	140,379	2,782	198,120	26,917	1,996,866
Average risk contributions per member per month (R)	1,747	1,308	1,238	1,199	911	711	1,777
Average risk contributions per beneficiary per month (R)	809	557	557	543	485	434	795
Average net claims incurred per member per month (R)	1,029	947	851	838	780	449	1,423
Average net claims incurred per beneficiary per month (R)	476	403	383	380	415	274	637
Average administration costs per member per month (R)	245	246	245	248	127	81	229
Average administration cost per beneficiary per month (R)	114	105	110	112	68	49	102
Average managed care: Management services per beneficiary per month (R)	24	24	24	24	24	24	24
Beneficiaries per member at 31 December	2.16	2.35	2.21	2.22	1.86	1.65	2.23
Dependants per member at 31 December	1.16	1.35	1.21	1.22	0.86	0.65	1.23
Relevant healthcare expenditure as a percentage of risk contributions (%)	59	72	69	70	85	63	80
Non-healthcare expenditure as a percentage of risk contributions (%)	21	28	28	29	23	22	19

Performance for 2010:
Report by the Board of Trustees

Reserve accounts

Movements in the reserves are set out in the Statement of Changes in Funds and Reserves.

Outstanding claims

Movements in the outstanding claims provision are set out in Note 6 to the annual financial statements.

Medical Savings Account

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

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

The Scheme's liability to members in respect of the savings account is reflected as a current liability in the financial statements (Note 8) and is repayable in terms of Regulation 10 of the Medical Schemes Act 131 of 1998, as amended.

Going concern

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

Auditor independence

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

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

Corporate **Governance** Statement by the Board of Trustees

Corporate Governance

Statement by the Board of Trustees

The Discovery Health Medical Scheme is committed to the principles and practice of fairness, transparency, integrity and accountability in all its dealings with its stakeholders. The Trustees are proposed and elected by the members of the Scheme and employers, according to the provisions of the Medical Schemes Act 131 of 1998, as amended, and the rules of the Scheme.

Board of Trustees

The Trustees meet regularly and monitor the performance of the administrator, Discovery Health (Pty) Ltd. They address a range of key issues and ensure that discussion on policy, strategy and performance is critical, informed and constructive.

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

Internal control

The Scheme maintains internal controls and systems designed to provide reasonable assurance as to the integrity and reliability of the annual financial statements as well as to adequately safeguard, verify and maintain accountability for its assets. Such controls are based on established policies and procedures and are implemented by trained personnel with the appropriate segregation of duties.

No event or item has come to the attention of the Board of Trustees that indicates any material breakdown in the functioning of the key internal controls and systems during the year under review.

Transparency and ethics

The Scheme is bound by a Code of Conduct, mandates and principles of treating members fairly. The Code of Conduct outlines the principles that guide the Scheme in a way that contributes to the welfare of the key stakeholders and helps us balance the needs of all stakeholders in the system.

The Scheme's committees have mandates that set out its responsibilities and promote the principles of transparency and ethics. We are committed to open communication with our stakeholders about the Scheme's financial and business targets and to treat them fairly in all our business dealings.

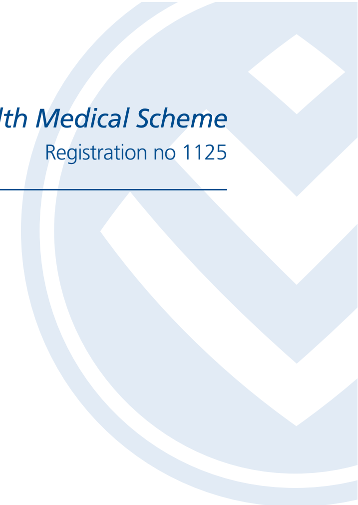
Board proceedings

The Board of Trustees met eight times during 2010. Additional meetings are convened as and when necessary. The Trustees have full and unrestricted access to relevant information.

During the past financial year the attendance was as follows:

Name	21 Jan 2010	25 Feb 2010	13 Apr 2010	21 Apr 2010	17 Jun 2010	30 Jun 2010	31 Aug 2010	16 Nov 2010
D Moodley*	N/A	✓	N/A	✓	N/A	✓	✓	✓
P Maserumule*	N/A	N/A	N/A	N/A	N/A	✓	✓	✓
S Handler*	✗	✓	✗	✓	✓	✗	✓	✓
N Sangweni*	✗	✓	✓	✓	✓	✓	✓	✓
N Graves*	N/A	N/A	N/A	N/A	N/A	✓	✓	✓
B Stott*	N/A	N/A	N/A	N/A	N/A	✓	✓	✓
Z Van Der Spuy*	N/A	N/A	N/A	N/A	N/A	✓	✓	✓
M Van Der Nest**	✓	✓	✓	✓	✓	N/A	N/A	N/A
B Jacobson**	✗	✓	✓	✗	✓	N/A	N/A	N/A
D Cohen**	✓	✓	✓	✓	✓	N/A	N/A	N/A

* Elected 24 June 2010
** Term of office expired on 24 June 2010



Investment Committee

The Investment Committee, established by the Board of Trustees, continues to invest excess funds in line with the Medical Schemes Act 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 Trustees.

For the year ended 2010, the Committee members were:

- P Maserumule BA Law, LLB - Chairperson
- S Handler B Com, FFA, FASSA (appointed 30 June 2010)
- D Moodley MBA, MSC (Medicine) Sports Science, MBChB
- D Cohen B Compt Hons (resigned – 24 June 2010)

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

Name	05 Feb 2010	10 Mar 2010	14 Apr 2010	10 Jun 2010	21 Jul 2010	21 Oct 2010
D Moodley	✓	✓	✓	✓	✓	✓
P Maserumule	✗	✓	✓	✓	✓	✓
S Handler	N/A	N/A	N/A	N/A	✓	✓
D Cohen	✓	✓	✓	✓	N/A	N/A

As part of the process to review and appoint asset managers, an independent asset consultant was appointed to assist with this. A tender process was conducted which was subject to an external audit review. Following the appointment of the asset managers, each investment manager agreement was subject to a review by an independent legal adviser.

Audit and Risk Committee

The responsibilities of the Audit and Risk Committee are:

- to assist in the execution of the Board's role of accountability
- to ensure integrity, reliability and accuracy of accounting and financial reporting systems
- to ensure that appropriate systems are in place for monitoring risk, control and compliance with laws and codes of conducts
- to evaluate the adequacy of and effectiveness of the risk management, internal audit and compliance process
- to maintain a transparent and appropriate relationship with the external auditors and set the principles of recommending the use of external auditors for non-audit services
- to review the scope, quality and cost of the statutory audit and the independence of the auditors.

The Audit and Risk Committee had five members at 31 December 2010, two of whom are members of the Board of Trustees. In compliance with Section 36 (11) of the Medical Schemes Act 131 of 1998, as amended, the majority of the members are not officers of the Scheme or of its administrator.

For the year ended 2010, the Committee members were:

- D Eriksson (Independent member) CA (SA) - Chairperson
- N Novick (Independent member) CA (SA)
- S Green (Independent member) BSc BCom (Hons)
- S Handler (Trustee member) BCom, FFA, FASSA
- B Stott (Trustee member) CA (SA)
- D Cohen (Trustee member) B Compt (Hons) (term of office expired 24 June 2010)

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

Corporate Governance

Statement by the Board of Trustees

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

Name	04 Mar 2010	25 Mar 2010	20 Jul 2010	20 Sep 2010	02 Nov 2010
D Eriksson	✓	✓	✓	✓	✓
S Handler	✗	✗	✓	✓	✓
N Novick	✓	✓	✓	✓	✓
B Stott	N/A	N/A	✓	✓	✓
S Green	✓	✓	✓	✓	✓
D Cohen	✓	✓	N/A	N/A	N/A

Clinical Governance Committee

During the year, we expanded the focus on risk to include the responsibility for overseeing clinical governance and the associated risks. To assist with this objective, we established a Clinical Governance Committee in terms of the Rules of the Scheme. The Board of Trustees mandates the Committee. The responsibilities of the Clinical Governance Committee are:

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

For the year ended 2010, the Committee members were:

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

The Committee met twice during the past financial year, on 30 August and 26 October 2010. All Committee members attended the Commitee meetings.

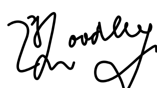
Trustee and sub-committee remuneration

The Trustees and members of the sub-committees have been remunerated for services to the Scheme. This remuneration was based on the skills, expertise, time and commitment needed to serve as a Trustee or sub-committee member of a large medical scheme, as well as market-related trends and surveys about medical schemes, pension funds and corporations of a similar size and nature to the Scheme.

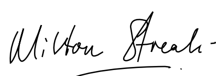
The remuneration payable to Audit and Risk Committee members and Trustees for the year ended 2010 is disclosed in Notes 16 and 19 respectively.

Events after the reporting period

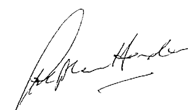
The Trustees are not aware of any events that have occurred after the end of the accounting period that materially affect the annual financial statements or that the Trustees consider need reporting on.



Dr D Moodley – Chairperson



M Streak – Principal Officer



S Handler – Trustee

Annual Financial **Statements**

Statement of Responsibility
by the Board of Trustees

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 36 to 111 have been prepared in accordance with International Financial Reporting Standards and include amounts based on judgements and estimates made by management.

The Trustees consider that in preparing the annual financial statements they have used the most appropriate accounting policies, consistently applied and that all applicable International Financial Reporting Standards have been followed. The Trustees are satisfied that the information contained in the annual financial statements fairly presents the results of operations for the year and the financial position of the Scheme at year end. The Trustees also reviewed the other information included in the annual report and are responsible for both its accuracy and its consistency with the annual financial statements.

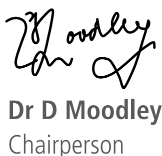
The Trustees are responsible for ensuring that accounting records are kept. The accounting records should disclose with reasonable accuracy the financial position of the Scheme to enable the Trustees to affirm that the financial statements comply with the relevant legislation.

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

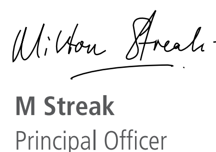
The going concern basis has been adopted in preparing the annual financial statements. The Trustees have no reason to believe that the Scheme will not be a going concern in the foreseeable future, based on forecasts and available cash resources. These financial statements support the viability of the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

The Code of Corporate Practices and Conduct has been adhered to. The Scheme's external auditors, PricewaterhouseCoopers Incorporated, audited the annual financial statements, and their report is presented on page 35.

The annual financial statements were approved by the Board of Trustees on 14 April 2011 and are signed on its behalf by:



Dr D Moodley
Chairperson



M Streak
Principal Officer

S Handler
Trustee

Independent auditor's report
to the members of Discovery Health Medical Scheme
for the year ended 31 December 2010

Report on the financial statements

We have audited the annual financial statements of the Discovery Health Medical Scheme which comprise the statement of financial position as at 31 December 2010 and the statements of comprehensive income, changes in funds and reserves and cash flows for the year then ended, and a summary of significant accounting policies and other explanatory notes as set out on pages 36 to 111.

Trustees' responsibility for the financial statements

The Scheme's Trustees are responsible for the preparation and fair presentation of these financial statements in accordance with International Financial Reporting Standards and in the manner required by the Medical Schemes Act, Act 131 of 1998 as amended, and for such internal control as the Trustees determine it necessary to enable the preparation of financial statements that are free from material misstatements, whether due to fraud or error.

Auditor's responsibility

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

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgement, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

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

Opinion

In our opinion, the financial statements present fairly, in all material respects, the financial position of the Discovery Health Medical Scheme as at 31 December 2010 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, Act 131 of 1998 as amended.

Report on other legal and regulatory requirements

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

Note 33 indicates that the Scheme did not comply with Regulation 29(2), of the Medical Schemes Act 131 of 1998, as amended. The accumulated funds required of 25% of annual contributions had not been met as at 31 December 2010. The ratio of accumulated funds, expressed as a percentage of gross annual contributions was 24.66% as at 31 December 2010, short of the required minimum of 25%.

Furthermore we draw attention to the detailed disclosure in Note 33 with respect to four of the fourteen benefit options which were not self-sustaining during 2010 as required by S33(2) of the Medical Schemes Act 131 of 1998 as amended.

PricewaterhouseCoopers Inc
Director: V Muguto
Registered Auditor
2 Eglin Road, Sunninghill, Johannesburg
20 April 2011

Statement of Financial Position

for the year ended 31 December 2010

	Notes	2010 R'000	2009 R'000
ASSETS			
Current assets		9,791,908	8,597,933
Financial assets at fair value through profit or loss	2	7,383,719	6,645,016
Derivative financial instruments	7	15	-
Trade and other receivables	3	1,135,271	828,861
Cash and cash equivalents	4	1,272,903	1,124,056
Total assets		**9,791,908**	**8,597,933**
FUNDS AND LIABILITIES			
Members' funds		6,847,076	6,070,680
Accumulated funds		6,847,076	6,070,680
Non-current liabilities		-	334
Members' trust funds	5	-	334
Current liabilities		2,944,832	2,526,919
Outstanding claims provision	6	560,597	473,512
Members' savings accounts	8	1,718,442	1,544,102
Trade and other payables	9	665,443	508,969
Members' trust funds	5	350	336
Total funds and liabilities		**9,791,908**	**8,597,933**

Statement of Comprehensive Income

for the year ended 31 December 2010

	Notes	2010 R'000	2009 R'000
NET CONTRIBUTION INCOME	10	**22,121,964**	**19,053,756**
Net claims incurred	11	(17,999,084)	(15,259,820)
Claims incurred	11	(18,089,129)	(15,298,448)
Third party claim recoveries	11	90,045	38,628
Net (expense)/income on risk transfer arrangements	12	48,924	(360)
Risk transfer arrangement fees	12	(169,965)	(95,022)
Recoveries from risk transfer arrangements	12	218,889	94,662
Relevant healthcare expenditure		**(17,950,160)**	**(15,260,180)**
Gross healthcare result		**4,171,804**	**3,793,576**
Managed care: management services	13	(787,872)	(565,273)
Broker service fees	14	(633,601)	(538,275)
Expenses for administration	25	(2,666,663)	(2,451,633)
Other operating expenses	15	(108,561)	(143,547)
Net healthcare result		**(24,893)**	**94,848**
Investment income	20	615,406	700,125
Net fair value gains on financial assets at fair value through profit or loss	21	22,837	17,830
Sundry income	22	9,020	11,345
Other income		647,263	729,300
Expenses for asset management services rendered		(8,469)	(8,421)
Interest paid	23	(19,829)	(24,895)
Other expenditure		**(28,298)**	**(33,316)**
Net surplus for the year		**594,072**	**790,832**
Other comprehensive income		**-**	**-**
Total comprehensive income for the year		**594,072**	**790,832**

Statement of Changes in Funds and Reserves

for the year ended 31 December 2010

	Note	2010 R'000 Accumulated funds	2009 R'000 Accumulated funds
Balance at beginning of the year		6,070,680	5,279,848
Total comprehensive income for the year		594,072	790,832
Reserves transferred from other medical schemes	24	182,324	-
Balance at end of the year		**6,847, 076**	**6,070,680**

Statement of Cash Flows

for the year ended 31 December 2010

	Notes	2010 R'000	2009 R'000
CASH FLOWS FROM OPERATING ACTIVITIES			
Cash flows from operations before working capital changes	28	13,151	139,278
Working capital changes			
Increase in trade and other receivables		(344,194)	(55,401)
Increase / (Decrease) in outstanding claims provision		87,085	(36,924)
Increase in members' savings accounts		174,340	113,358
Increase in trade and other payables		156,474	62,481
Cash generated by operations		86,856	222,792
Purchases of financial assets		(6,190,385)	(1,178,095)
Proceeds from sale of financial instruments		5,474,504	312,649
Interest received	28	609,240	697,039
Dividend income	20	6,457	3,413
Interest paid	23	(19,829)	(24,895)
Net cash flows from operating activities		**(33,157)**	**32,903**
CASH FLOWS FROM FINANCING ACTIVITIES			
Payments out of members' trust funds		(320)	(278)
Reserves transferred from other medical schemes	24	182,324	-
Net cash flows from financing activities		**182,004**	**(278)**
NET INCREASE IN CASH AND CASH EQUIVALENTS		148,847	32,626
Cash and cash equivalents at beginning of year		1,124,056	1,091,431
CASH AND CASH EQUIVALENTS AT END OF YEAR	4	**1,272,903**	**1,124,056**

Accounting Policies

for the year ended 31 December 2010

General Information

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

The Scheme is an open medical scheme registered in terms of the Medical Schemes Act 131 of 1998, as amended, and is domiciled in South Africa. The Scheme was awarded the highest rating in the industry for its claims paying ability by an independent rating agency, for the tenth consecutive year which was re-affirmed as AA+ by independent credit rating agency Global Credit Ratings.

These annual financial statements were authorised for issue by the Board of Trustees on 14 April 2011.

1. Basis of Preparation

The annual financial statements have been prepared in accordance with International Financial Reporting Standards as applicable in South Africa (IFRS). IFRS comprises International Financial Reporting Standards, International Accounting Standards and the Interpretations originated by the International Financial Reporting Interpretations Committee (IFRIC) or the former Standing Interpretations Committee (SIC). The standards referred to are set by the International Accounting Standards Board (IASB).

The principal 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 judgement in the process of applying the Scheme's accounting policies. The areas involving a higher degree of judgement, or areas where estimates are significant to the annual financial statements, are disclosed in note 32.

The annual financial statements are prepared on a going concern basis using the historical cost convention, except for certain financial assets and liabilities which include:

- financial instruments at fair value through profit or loss; and
- 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 thousands), unless otherwise indicated.

New standards, amendments and interpretations effective in 2010 but not relevant to the Scheme:

- **IFRS 1 (amendment)** - *First-time Adoption of International Financial Reporting Standards* - Effective 1 Jan 2010.
- **IFRS 2 (amendment)** - *Share Based Payments* - Effective 1 Jan 2010.
- **IFRS 5 (amendment)** - *Non-Current Assets Held for Sale and Discontinued Operations* - Effective 1 Jan 2010.
- **IFRS 8 (amendment)** - *Operating Segments* - Effective 1 Jan 2010.
- **IAS 1 (amendment)** - *Presentation of Financial Statements (Current or non-current classification of convertible instruments)* - Effective 1 Jan 2010.
- **IAS 7 (amendment)** - *Statement of Cash Flows (Classification of expenditures on unrecognised assets)* - Effective 1 Jan 2010.
- **IAS 17 (amendment)** - *Leases (Classification of leases of land and buildings)*- Effective 1 Jan 2010.
- **IAS 21 (amendment)** - *The Effects of Changes in Foreign Exchange Rates (Clarification on the transition rules in respect of the disposal or partial disposal of an interest in a foreign operation)* - 1 Effective 1 Jul 2010.
- **IAS 27 (amendment)** - *Consolidated and Separate Financial Statements* - Effective 1 Jul 2010.
- **IAS 28 (amendment)** - *Investments in Associates* - Effective 1 Jul 2010.
- **IAS 31 (amendment)** - *Interests in Joint Ventures* - Effective 1 Jul 2010.
- **IAS 32 (amendment)** - *Financial Instruments Presentation (Accounting for rights issues denominated in a currency other than the functional currency of the issuer* - Effective 1 Feb 2010.
- **IAS 36 (amendment)** - *Impairment of Assets (Unit of accounting for goodwill impairment test)* - Effective 1 Jan 2010.
- **IAS 38 (amendment)** - *Intangible Assets* - Effective 1 Jan 2010.
- **IAS 39 (amendment)** - *Financial Instruments: Recognition and Measurement (Treating loan prepayments as closely related embedded derivatives and cash flow hedge accounting)* - Effective 1 Jan 2010.
- **IFRIC 19 (interpretation)** - *Extinguishing Financial Liabilities with Equity Instruments* - Effective 1 Apr 2010.

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

- **IFRS 7 (amendment)** - *Financial Instruments: Disclosures* - Effective 1 Jan 2011. The amendment adds an explicit statement that qualitative disclosure should be made in the context of the quantitative disclosures to better enable users to evaluate an entity's exposure to risks arising from financial instruments.
- **IFRS 9 (new standard)** - *Financial Instruments* - Effective 1 Jan 2013. This is the first standard issued as part of a wider project to replace IAS 39. The standard simplifies the mixed measurement model and established two primary measurement categories for financial assets: amortised cost and fair value. The basis of classification depends on the entity's business model and the contractual cash flow characteristics of the financial asset.

Accounting Policies

for the year ended 31 December 2010

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

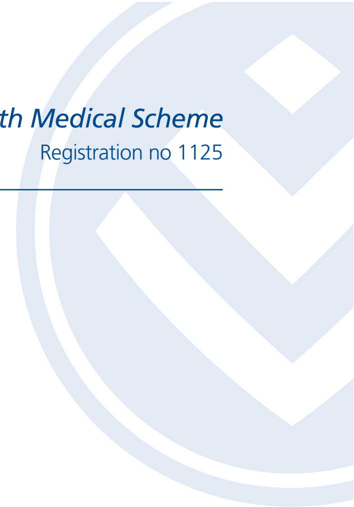
- **IFRS 3 (amendment)** - *Business Combinations (Amendments to transition requirements for contingent considerations from business combinations occurring prior to the effective date of the revised statement; clarification on measurement of non-controlling interests and additional guidance provided on un-replaced and voluntarily replaced share-based payment awards)* - Effective 1 Jan 2011.
- **IFRS 7 (amendment)** - *Financial Instruments: Disclosures (Disclosures on transfer transactions of financial assets, including possible effects of residual risks that the transferring entity retains)* - Effective 1 Jul 2011.
- **IAS 1 (amendment)** - *Presentation of Financial Statements (Clarification that disaggregation of changes in eachcomponent of equity arising from transactions recognised in other comprehensive income is also required to be presented in either the Statement of Changes in Equity or in the notes)* - Effective 1 Jan 2011.
- **IAS 12 (amendment)** - *Income Taxes* - Effective 1 Jan 2012.
- **IAS 24 (amendment)** - *Related Party Disclosures (Clarification of the definition of a related party which is not expected to materially impact the Scheme's related party disclosures. The amendment also modifies certain related party disclosures for government related entities* - Effective 1 Jan 2011.
- **IAS 34 (amendment)** - *Interim Financial Reporting (Clarification of disclosure requirements around significant events and transactions including financial instruments. The Scheme does note prepare interim financial reports therefore this amendment would not be relevant)* - Effective 1 Jan 2011.
- **IFRIC 13 (interpretation)** - *Customer Loyalty Programmes* - Effective 1 Jan 2011.
- **IFRIC 14 (amendment)** - *Prepayments of a minimum funding requirement* - Effective 1 Jan 2011.

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 at fair value through profit or loss, loans and receivables and financial liabilities measured at amortised cost. The Scheme has grouped its financial instruments into the following classes:

- Listed equities;
- Money market instruments;
- Derivatives held for trading;
- Trade and other receivables;
- Cash and cash equivalents;
- Members' trust funds;
- Trade and other payables;
- Members' savings accounts.

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



Offsetting financial instruments

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

Derecognition of financial assets and liabilities

The Scheme derecognises an asset when the contractual rights to the asset expire, where there is a transfer of the contractual rights that comprise the asset, or the Scheme retains the contractual rights of the asset but assumes a corresponding liability to transfer these contractual rights to another party and consequently transfers substantially all the risks and benefits associated with the asset.

Where the Scheme retains substantially all the risks and rewards of ownership of the financial asset, the Scheme continues to recognise the financial asset in its entirety and recognises a financial liability for the consideration received. In subsequent periods the financial liability is accounted for in terms of Accounting policy note 9.

Where the Scheme neither transfers nor retains substantially all the risks and rewards of ownership of the financial asset, the Scheme determines whether it has retained control of the financial asset. In this case:

(i) if the Scheme has not retained control, it derecognises the financial asset and recognises separately as assets or liabilities any rights and obligations created or retained in the transfer;

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

The Scheme derecognises a financial liability when the contractual obligations are discharged or expire, or if there is a substantial modification of the terms of a financial liability.

3. Financial Assets – Initial and Subsequent Measurement

Financial assets carried at fair value through profit or loss are initially recognised at fair value and the transaction costs are expensed in the Statement of Comprehensive Income. Loans and receivables are initially measured at fair value plus transaction costs and are subsequently measured at amortised cost using the effective interest method.

Gains or losses arising from changes in the fair value of the 'financial assets at fair value through profit or loss' category are presented in the Statement of Comprehensive Income within the period in which they arise. Dividend income from financial assets at fair value through profit or loss is recognised in the Statement of Comprehensive Income as part of investment income when the Scheme's right to receive payment is established.

Financial assets at fair value through profit or loss

This category has two subcategories: financial assets held for trading and those designated at fair value through profit or loss at inception.

A financial asset is classified into the 'financial assets at fair value through profit or loss' category at inception if acquired principally for the purpose of selling in the short-term, if it forms part of a portfolio of financial assets in which there is evidence of short-term profit taking. Derivatives are classified as held for trading unless they are designated as hedges.

Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments that are not quoted in an active market. They are included in current assets, except for maturities greater than 12 months after the reporting date. These are classified as non-current assets. The Scheme's loans and receivables comprise Trade and other receivables and Cash and cash equivalents in the Statement of Financial Position (Accounting policy notes 6 and 7 respectively).

4. Foreign Currency Translation

Functional and presentation currency

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

Transactions and balances

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

5. Business Combinations and Goodwill

Business combinations 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.

Where the cost of acquisition equates to the fair value of the share of the identifiable net assets acquired, no goodwill arises.

6. Trade and other Receivables

Trade and other receivables are recognised initially at fair value and subsequently measured at amortised cost, less impairment provision.

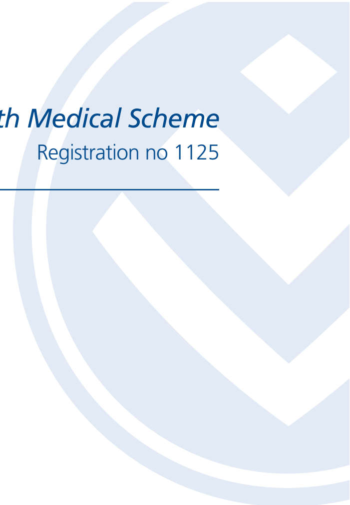
7. Cash and Cash Equivalents

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

- coins and bank notes;
- money on call and short notice; and
- 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.



8. Impairment of Financial Assets

General

A financial asset is impaired if its carrying amount is greater than its estimated recoverable amount.

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; or
- National or local economic conditions that correlate with non-payment of debtor contributions.

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

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

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

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

9 Financial Liabilities - Initial and Subsequent Measurement

Financial liabilities are initially recognised at fair value net of transaction costs incurred. After initial recognition, financial liabilities are measured at amortised cost using the effective interest method. Derivative financial instruments are initially measured at fair value on the date a contract is entered into and are subsequently measured at their fair value. In addition, the Scheme is not permitted to borrow, in terms of Section 35 (6)(c) of the Medical Schemes Act 131 of 1998, as amended. The Scheme therefore has no long-term financial liabilities. As a result, no fair value adjustments arise.

Trade payables

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

Members' savings accounts

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

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

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

Unspent savings at the year end are carried forward to meet future expenses for which the members are responsible for. In terms of the Medical Schemes Act 131 of 1998, as amended, balances standing to the credit of members are refundable only in terms of Regulation 10 of that Act.

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

10. Liabilities and Provisions

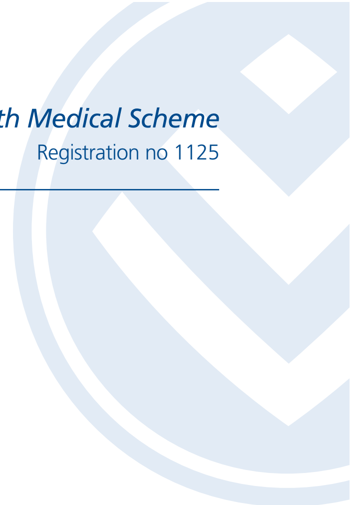
Liabilities and provisions

The Scheme recognises liabilities, including provisions when:

- 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; and
- 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, which include previous experience in claims patterns, claims settlement patterns, trends in claims frequency, changes in the claims processing cycle, and variations in the nature and average cost incurred per claim.

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

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

11. Member Insurance Contracts

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

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

12. Contribution Income

Gross contributions comprise medical contributions and Medical Savings Account contributions.

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

13. Relevant Healthcare Expenditure

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

13.1 Claims incurred

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

Net risk claims incurred comprise:

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

Net of:

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

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

Accounting Policies

for the year ended 31 December 2010

13.2 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 only decrease the loss the Scheme may incur as a result of carrying on the business of a medical scheme.

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

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

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

Amounts recoverable under risk transfer arrangements are assessed for impairment at each reporting date. These assets are deemed impaired if there is objective evidence, as a result of an event that occurred after its initial recognition, that the Scheme may not recover all amounts due and that the event has a reliably measurable impact on the amounts that the Scheme will receive under the risk transfer arrangement. The Scheme gathers the objective evidence that a risk transfer arrangement asset is impaired using the same process adopted for financial assets held at amortised cost. The impairment loss is also calculated following the same method used for these financial assets.These processes are described in Accounting policy note 8.

14. 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.

15. 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.

16. Broker Service Fees

Broker service fees are expensed as incurred.

17. Expenses for Administration and other Operating Expenses

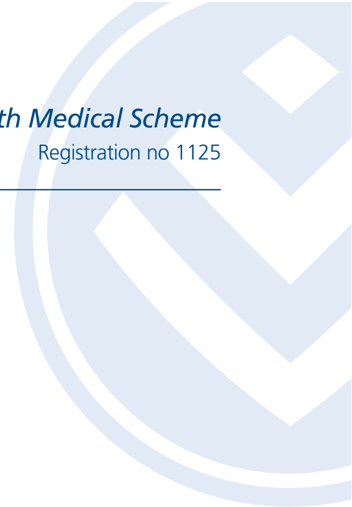
Expenses for administration and other operating expenses are expensed as incurred.

18. Investment Income

Investment income comprises dividends 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.



19. Reimbursements from the Road Accident Fund

The Scheme grants assistance to its members in defraying expenditure incurred in connection with 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 the member is reimbursed by the Road Accident Fund, they are obliged contractually to cede that payment to the Scheme to the extent that they have already been compensated.

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

20. Unallocated Funds

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

Unallocated funds that have legally prescribed, that is funds older than three years, are written back and 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.

21. Employee Benefits

Pension obligations

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

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

Other post-employment obligations

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

Leave pay accrual

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

Bonuses

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

22. Income Tax

In terms of Section 10 (1)(d) of the Income Tax Act 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.

Accounting Policies

for the year ended 31 December 2010

23. Allocation of Income and Expenditure to Benefit Options

The following items are directly allocated to benefit options:

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

The remaining items are allocated as detailed below:

- For contributions that are not directly allocated to benefit options these amounts are apportioned based on a percentage of net contribution income per plan;
- For claims that are not directly allocated to benefit options 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 option;
- Investment income is apportioned based on the number of members per benefit option;
- 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 option;
- Other income is apportioned based on the number of members per benefit option;
- Expenses for asset management services rendered are apportioned based on the number of members per benefit option;
- Interest paid is apportioned based on the number of members per benefit option.

24. 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 2010

	2010 R'000	2009 R'000

1. ACCOUNTING POLICIES

The accounting policies of the Scheme are set out on pages 40 to 50.

2. FINANCIAL ASSETS AT FAIR VALUE THROUGH PROFIT OR LOSS

The Scheme's financial assets are summarised by measurement category as follows:

	2010 R'000	2009 R'000
Financial assets at fair value through profit or loss	7,383,719	6,645,016
Loans and receivables (Note 3)	72,644	8,827
Total financial assets	**7,456,364**	**6,653,843**

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

Financial assets held at fair value through profit or loss

	2010 R'000	2009 R'000
Held for trading:		
Current assets	7,383,719	6,645,016
– Offshore bond portfolio	331,377	-
– Listed equities	422,757	125,641
– Yield enhanced bond portfolio	328,031	-
– Money market portfolios	6,301,554	6,519,375
	7,383,719	**6,645,016**

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

	2010 R'000	2009 R'000
At the beginning of the year	6,645,016	5,770,095
Acquisitions	6,190,385	1,178,095
Disposals	(5,473,892)	(338,276)
Gain on revaluation of investments to fair value	22,210	35,102
At the end of the year	**7,383,719**	**6,645,016**

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

Section 35 (8)(a) of the Medical Schemes Act 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 or any administrator or any arrangement associated with a medical scheme. Due to the large number of the Scheme's employers being listed on the JSE, investments were made in certain of its employers listed on the JSE. The Council for Medical Schemes has granted the Scheme an exemption from this section of the Medical Schemes Act.

	2010 R'000	2009 R'000
3. TRADE AND OTHER RECEIVABLES		
Insurance receivables		
Contribution receivables	963,717	754,375
Contributions outstanding	971,876	759,172
Less: Provision for impairment	(8,159)	(4,797)
Member and service provider claims receivables	52,373	38,386
Amount due	185,107	170,716
Less: Provision for impairment	(132,734)	(132,330)
Other risk transfer arrangements	348	286
Recoveries due from other risk transfer arrangements	27	18,265
Less: Provision for impairment	-	(18,265)
Share of outstanding claims provision (Note 6)	321	286
Broker fee receivables	444	139
Amounts due from brokers	803	645
Less: Provision for impairment	(359)	(506)
Other insurance receivables	45,745	26,848
Total receivables arising from insurance contracts	**1,062,627**	**820,034**
Loans and receivables		
Balance due by related party	50,000	-
Discovery Third Party Recovery Services (Pty) Ltd	50,000	-
Sundry accounts receivable	20,587	5,669
Interest receivable	2,057	3,158
Total receivables arising from loans and receivables	**72,644**	**8,827**
	1,135,271	**828,861**

At 31 December 2010 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 131 of 1998, as amended, states that all subscriptions or contributions shall be paid directly to a medical scheme not later than three days after payment thereof becoming due. There are instances where the Scheme received contributions after three days of becoming due, however there are no contracts in place agreeing to this arrangement. The procedures that the Scheme follows regarding these contributions are set out in Note 31.

	2010 R'000	2009 R'000

4. CASH AND CASH EQUIVALENTS

	2010 R'000	2009 R'000
Call accounts	653,506	604,623
Current accounts	355,268	331,157
Money market instruments	264,129	188,276
	1,272,903	**1,124,056**

At 31 December 2010 the carrying amounts of cash and cash equivalents approximate their fair values due to the short-term maturities of these assets.

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

	2010 R'000	2009 R'000
Call account	307	622
Current account	43	48
	350	**670**

5. MEMBERS' TRUST FUNDS

	2010 R'000	2009 R'000
Mega reserves	350	670
Less:		
Current portion included in current liabilities	(350)	(336)
	-	**334**

These funds were transferred to Discovery Health Medical Scheme in 1999 from 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) to the Medical Schemes Act 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 CNA Gallo Medical Scheme, the Mega reserves are held in separate bank accounts and are included under cash and cash equivalents (note 4) and interest accrues directly to these reserves.

	2010 R'000	2009 R'000
6. OUTSTANDING CLAIMS PROVISION		
Outstanding claims provision - not covered by risk transfer arrangements	560,276	473,226
Outstanding claims provision - covered by risk transfer arrangements	321	286
Provision arising from liability adequacy test	-	-
	560,597	**473,512**
Analysis of movement in outstanding claims		
Balance at beginning of the year	473,512	510,436
Payments in respect of prior year	(506,143)	(507,648)
Over / (under) provision in prior year	(32,631)	2,788
Adjustment for current year	593,228	470,724
Covered by risk transfer arrangements	321	286
Not covered by risk transfer arrangements	592,907	470,438
Balance at end of the year	**560,597**	**473,512**
Analysis of outstanding claims provision		
Estimated gross claims	580,873	520,498
Less:		
Estimated recoveries from savings plan accounts (Note 8)	(20,276)	(46,986)
Balance at end of the year	**560,597**	**473,512**

7. DERIVATIVE FINANCIAL INSTRUMENTS

	2010 R'000	2009 R'000
Financial assets held at fair value through profit or loss		
Current assets		
– Derivative financial instruments held for trading	15	-
	15	**-**
Reconciliation of the balance at beginning of the year to the balance at the end of the year:		
Derivative financial asset / (liability) at the beginning of the year	-	(8,355)
Net gain / (loss) on revaluation of derivative financial instruments to fair value	627	(17,272)
Gain on revaluation of derivative financial instruments to fair value	1,942	17,918
Loss on revaluation of derivative financial instruments to fair value	(1,315)	(35,190)
Less:		
Realised (gain) / loss on derivative financial instruments transferred to listed equity portfolio	(612)	25,627
Derivative financial asset at the end of the year	**15**	**-**

In order to generate an equity related return on the cash balances held in one of the Scheme's equity portfolios, the Scheme's asset manager entered into All Shareholder index (ALSI) futures contracts.

At the reporting date, 11 contracts were held at a level of 28,808. The multiplier for these contracts was 10. These contracts provide the Scheme with an exposure to the FTSE/JSE Top 40 Index of R3,168,880 and for every 1% increase or decrease in the index, the Scheme's surplus or deficit would increase or decrease by R31,680 respectively. These contracts expire on 17 March 2011. These instruments are traded on SAFEX and settled daily.

	2010 R'000	2009 R'000
8. MEMBERS' SAVINGS ACCOUNTS		
Balance on savings accounts at the beginning of the year	1,544,102	1,430,744
Add:		
Savings account contributions received or receivable	5,528,398	4,786,570
For the current year (Note 10)	5,528,398	4,786,570
Interest paid to members on savings accounts (Note 23)	19,829	24,878
Transfers received from other medical schemes	24,724	17,185
Less:		
Claims paid to or on behalf of members (Note 11)	(5,272,433)	(4,587,429)
Refunds on death or resignation	(126,178)	(127,846)
	1,718,442	**1,544,102**

It is estimated that claims to be paid out of members' savings accounts in respect of claims incurred in 2010 but not recorded will amount to approximately R20,276,024 (2009 - R46,986,249) (Note 6).

As at 31 December 2010 the carrying amount of the members' savings accounts were deemed to be equal to their fair values, which is the amount payable on demand. The amounts were not discounted, due to the demand feature.

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

9. TRADE AND OTHER PAYABLES

	2010 R'000	2009 R'000
Insurance liabilities		
Contributions received in advance	33,572	21,662
Premium refunds due to employers	331	304
Reported claims not yet paid		
Balance at the beginning of the year	219,660	164,178
Movement for the year	51,743	55,482
Balance at the end of the year	271,403	219,660
Broker fee creditors	53,284	9,418
Accredited brokers	53,284	9,418
Other insurance liabilities	47	60
Total liabilities arising from insurance contracts	**358,637**	**251,104**
Financial liabilities		
Balance due to related party	297,536	253,192
Discovery Health (Pty) Ltd	297,536	253,192
Unallocated funds	4,804	1,907
Total accruals	4,464	2,766
General accruals	4,367	2,573
Leave pay accrual	99	193
Total arising from financial liabilities	**306,806**	**257,865**
	665,443	**508,969**

At 31 December 2010 the carrying amounts of Trade 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 2010

	2010 R'000	2009 R'000
10. NET CONTRIBUTION INCOME		
Gross contributions	27,650,362	23,840,326
Risk contributions	22,121,964	19,053,756
Members' savings account contributions (Note 8)	5,528,398	4,786,570
LESS:		
Members' savings account contributions (Note 8)	(5,528,398)	(4,786,570)
	22,121,964	**19,053,756**
11. NET CLAIMS INCURRED		
Current year claims	23,274,477	19,922,800
Claims not covered by risk transfer arrangements	23,055,588	19,828,138
Claims covered by risk transfer arrangements	218,889	94,662
Movement in outstanding claims provision	87,085	(36,923)
Under / (Over) provision in prior year (Note 6)	32,631	(2,788)
Adjustment for current year	54,454	(34,135)
	23,361,562	19,885,877
Less:		
Claims charged to members' savings accounts (Note 8)	(5,272,433)	(4,587,429)
Claims incurred	**18,089,129**	**15,298,448**
Third party claim recoveries	(90,045)	(38,628)
	17,999,084	**15,259,820**

11. NET CLAIMS INCURRED (CONTINUED)

Risk transfer arrangements

During 2010 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 option.

   The claims experience for members on the KeyCare Plus option for the 2010 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 option.

   In order to determine the value of claims under this arrangement, the average 2010 PLPM rate is multiplied by the lives exposure for this arrangement's membership and reduced by the actual claims that the Scheme has paid under this arrangement.

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

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

3. Risk transfer arrangement providing dentistry services to members on the KeyCare Plus option and commenced on 1 August 2010.

   The Scheme had access to the actual claims relating to these members and has disclosed these claims paid under this arrangement.

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

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

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

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

12. NET INCOME ON RISK TRANSFER ARRANGEMENTS

	2010 R'000	2009 R'000
Other risk transfer arrangements:		
Capitation fees paid	(169,965)	(95,022)
Recoveries under risk transfer arrangements	218,889	94,662
Claims incurred in respect of related risk transfer arrangements	191,640	93,564
Recoveries received	27,249	1,098
	48,924	**(360)**

	2010 R'000	2009 R'000
13. MANAGED CARE: MANAGEMENT SERVICES		
Discovery Health (Pty) Ltd		
Clinical Protocols	19,697	14,132
Disease Management	118,181	84,791
Hospital Management	409,693	293,942
Pharmaceutical Benefit Management	118,181	84,791
Provider Networks	122,120	87,617
	787,872	**565,273**

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

	2010 R'000	2009 R'000
14. BROKER SERVICE FEES		
Brokers' fees	633,601	538,275
	633,601	**538,275**

In terms of Regulation 28 (5) to the Medical Schemes Act 131 of 1998, as amended, the Scheme broker fees shall be paid on a monthly basis and upon receipt by the Scheme of the relevant monthly contribution. In some instances brokers were compensated prior to receipt of the relevant monthly contribution. The Scheme has implemented additional controls to address this matter and continue to monitor the instances where this requirement is contravened.

15. OTHER OPERATING EXPENSES

	2010 R'000	2009 R'000
Association fees	6	231
Audit fees	3,892	2,928
Audit services for the year ended 2008	-	1,342
Audit services for the year ended 2009	1,900	1,266
Audit services for the year ended 2010	1,673	-
Other services	319	320
Audit and Risk committee fees (Note 16)	560	574
Bank charges	8,042	7,247
Clinical governance projects	3	10
Council for Medical Schemes	16,796	13,355
Custodian fees	190	-
Debt collecting fees	1,356	542
Dispute committee fees	30	97
Electronic checking fees	21,024	62,990
General meeting costs	448	270
Investment committee fees	266	288
Legal fees	865	533
Net impairment losses (Note 17)	37,828	42,613
Other expenses	5,287	3,748
Principal Officer fees	2,899	2,615
Principal Officer office costs	481	987
Printing, postage and stationery	20	9
Professional fees	1,771	121
Specialist referral fees	3,579	-
Staff costs (Note 18)	1,606	1,745
Sundry amounts written off	60	1,444
Trustees' remuneration and consideration expenses (Note 19)	1,552	1,200
	108,561	**143,547**

	2010 R'000	2009 R'000
16 AUDIT AND RISK COMMITTEE FEES		
D. Eriksson - chairman	285	251
N. Novick - member	149	146
S. Green - member	126	177
	560	**574**
17. NET IMPAIRMENT LOSSES		
Trade and other receivables		
Contributions that are not collectible	3,362	2,115
Movement in provision	3,362	2,115
Members' and service providers' portions that are not recoverable	34,569	40,114
Movement in provision	34,569	40,114
Amounts due by brokers that are not recoverable	(147)	(396)
Movement in provision	(147)	(396)
Receivables written off	96	810
Less:		
Previously written off receivables recovered	(52)	(30)
	37,828	**42,613**
18. STAFF COSTS		
Salaries and bonuses	1,599	1,350
Pension costs - defined contribution plans	68	56
Medical and other benefits	32	31
(Decrease)/Increase in leave pay accrual	(93)	308
	1,606	**1,745**

19. TRUSTEES REMUNERATION AND CONSIDERATION EXPENSES

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

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

31 December 2009	Services as Trustee R'000	Sub-committee fees Audit committee R'000	Investment committee R'000	Clinical Governance Committee R'000	Training R'000	Fees for consultancy services R'000	Total R'000
M. Van Der Nest (Chairman)	265	-	-	-	-	-	265
S. Handler	86	87	-	-	-	-	173
D. Cohen	153	92	89	-	1	-	335
N. Sangweni	154	21	-	-	-	-	175
B. Jacobson	90	-	-	-	-	-	90
D. Moodley**	78	-	21	-	-	-	99
P. Maserumule**	42	-	21	-	-	-	63
Total	**868**	**200**	**131**	**-**	**1**	**-**	**1,200**

** = Term of office expired

	2010 R'000	2009 R'000
20. INVESTMENT INCOME		
Financial assets at fair value through profit or loss:	529,732	619,767
Dividend income	6,457	3,413
Interest income	523,275	616,354
Cash and cash equivalents interest income	85,674	80,358
Investment income per Statement of Comprehensive Income	**615,406**	**700,125**
The Scheme's total interest income is summarised below.		
Financial assets not at fair value through profit or loss:		
Loans and receivables	85,965	80,685
Interest received from Administrator (Note 22)	291	325
Other interest received (Note 22)	-	2
Cash and cash equivalents interest income	85,674	80,358
Financial assets at fair value through profit or loss:		
Interest income	523,275	616,354
Total interest income	**609,240**	**697,039**

21. NET GAINS / (LOSSES) ON FINANCIAL ASSETS AT FAIR VALUE THROUGH PROFIT OR LOSS

	2010 R'000	2009 R'000
Net foreign exchange losses on financial assets at fair value through profit or loss:	(28,734)	-
- Offshore bonds	(28,734)	-
Net fair value gains on financial assets at fair value through profit or loss including derivatives:	61,102	35,399
- Equity securities	48,089	35,399
- Derivatives held for trading	627	-
- Money market	12,386	-
Net fair value losses on financial assets at fair value through profit or loss including derivatives:	(9,531)	(17,569)
- Equity securities	(9,531)	-
- Derivatives held for trading	-	(17,272)
- Money market	-	(297)
	22,837	**17,830**

	2010 R'000	2009 R'000
22. SUNDRY INCOME		
Interest received from Administrator	291	325
Other interest received	-	2
Prescribed amounts written back	6,043	7,748
Stale cheques written back	2,686	3,270
	9,020	**11,345**
23. INTEREST PAID		
Financial assets not at fair value through profit or loss:		
Interest paid on members' savings accounts (Note 8)	19,829	24,878
Interest paid other	-	1
Interest paid to Administrator	-	16
	19,829	**24,895**
24. RESERVES TRANSFERRED FROM OTHER MEDICAL SCHEMES		
Reserves transferred from other schemes		
UMED Medical Scheme	163,035	-
AfriSam South Africa Medical Scheme	19,289	-
	182,324	**-**

25. AMALGAMATIONS

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

AfriSam South Africa Medical Scheme

The AfriSam South Africa Medical Scheme (AfriSam) is a not-for-profit restricted medical scheme registered in terms of the Medical Schemes Act 131 of 1998, as amended. Membership of the Scheme is open to all current and retired employees of AfriSam South Africa (Pty) Ltd, its subsidiaries and associates. Retired employees of subsidiaries and associates, which have been disposed of, may continue their membership if they so elect.

The effective date of this amalgamation was 1 June 2010.

In terms of the Medical Schemes Act 131 of 1998, as amended, medical schemes do not have equity therefore the Scheme did not acquire any voting equity interest.

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

The Scheme obtained control of AfriSam by means of the exposition requirements as set out in Section 63 to the Medical Schemes Act 131 of 1998, as amended.

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

25. AMALGAMATIONS (CONTINUED)

AfriSam South Africa Medical Scheme

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

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

25. AMALGAMATIONS (CONTINUED)

AfriSam South Africa Medical Scheme

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

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

25. AMALGAMATIONS (CONTINUED)

AfriSam South Africa Medical Scheme

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

	R'000
Non-current assets	**252**
Available-for-sale financial assets	252
Current assets	**27,850**
Cash and cash equivalents	27,037
Contribution debtors	23
Member claim debtors	600
Service provider claim debtors	47
Interest receivable	136
Other accounts receivable	7
Available-for-sale reserves	**(200)**
Current liabilities	**(8,665)**
Outstanding claims provision	(1,245)
Contributions received in advance	(32)
Reported claims not yet paid	(840)
Unallocated funds	(177)
General accruals	(683)
Members' savings accounts	(5,688)
	19,237

25. AMALGAMATIONS (CONTINUED)

AfriSam South Africa Medical Scheme

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

No goodwill has arisen from this amalgamation.

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

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

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

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

UMED Medical Scheme

The UMED Medical Scheme (UMED) is a not-for-profit restricted medical scheme registered in terms of the Medical Schemes Act 131 of 1998, as amended. UMED was established in 1973 as a restricted membership medical scheme for Armscor and Denel employees and qualifying ex-employees.

The effective date of this amalgamation was 1 August 2010.

In terms of the Medical Schemes Act 131 of 1998, as amended, medical schemes do not have equity therefore the Scheme did not acquire any voting equity interest.

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

The Scheme obtained control of UMED by means of the exposition requirements as set out in Section 63 to the Medical Schemes Act 131 of 1998, as amended.

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

25. AMALGAMATIONS (CONTINUED)

UMED Medical Scheme

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

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

25. AMALGAMATIONS (CONTINUED)

UMED Medical Scheme

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

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

25. AMALGAMATIONS (CONTINUED)

UMED Medical Scheme

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

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

UMED Medical Scheme

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

No goodwill has arisen from this amalgamation.

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

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

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

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

26. RELATED PARTY TRANSACTIONS

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

Parties with significant influence over the Scheme

Administrator:

Discovery Health (Pty) Ltd has significant influence over the Scheme, as Discovery Health (Pty) Ltd participates in the Scheme's financial and operating policy decisions, but does not control the Scheme. Discovery Health (Pty) Ltd provides administration and 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).

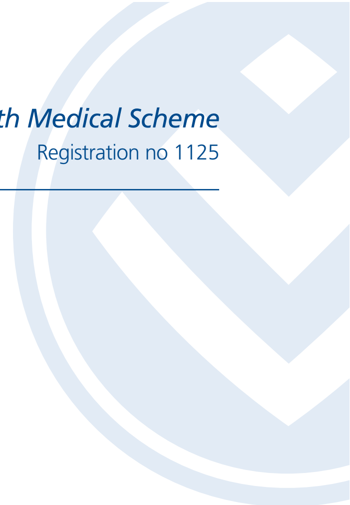
Close family members include close family members of the Board of Trustees and executive officers of the Scheme.

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.

	2010 R'000	2009 R'000
Statement of Comprehensive Income transactions		
Compensation		
Short-term employee benefits	(5,804)	(5,344)
Contributions and claims		
Gross contributions received	341	270
Claims paid from the Scheme	(89)	(15)
Claims paid from the Medical Savings Account	(51)	(78)
Healthcare provider fees paid	(36)	(69)
Statement of Financial Position transactions		
Contribution debtors	14	14
Amounts due to executive officers	(3)	(2)
Medical Savings Account balances	(18)	(11)
Trustee remuneration payable	-	(21)



26. 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.
Medical Savings Account balances	The amounts owing to the related parties relate to Medical Savings Account balances to which the parties have a right. In line with the terms applied to third parties, the balances earn interest monthly at predetermined interest rates, on an accrual basis. The amounts are all current, and would need to be payable on demand should an appropriate claim be issued, or should the member resign from the Scheme, as applicable to other members.
Healthcare provider fees paid/payable	These constitute fees paid to healthcare providers (medical practitioners). Fees are paid on the same basis as applicable to third parties.

26. RELATED PARTY TRANSACTIONS (CONTINUED)

Transactions with entities that have significant influence over the Scheme

	2010 R'000	2009 R'000
Discovery Health (Pty) Ltd - Administrator		
Statement of Comprehensive Income transactions		
Administration fees paid	(2,666,663)	(2,451,633)
Interest received on monthly balances (Note 22)	291	325
Interest paid on monthly balances (Note 23)	-	(16)
Statement of Financial Position transactions		
Balance due to Discovery Health (Pty) Ltd at year end (Note 9)	(229,788)	(205,174)
Discovery Health (Pty) Ltd - Managed care organisation		
Statement of Comprehensive Income transactions		
Managed care fees paid	(787,872)	(558,680)
Managed care: management services	(787,872)	(565,273)
Managed care: healthcare services	-	6,593
Statement of Financial Position transactions		
Balance due to Discovery Health (Pty) Ltd at year end (Note 9)	(67,748)	(48,018)
Discovery Third Party Recovery Services (Pty) Ltd		
Statement of Comprehensive Income transactions		
Third party collection fees	5,212	2,708
Statement of Financial Position transactions		
Balance due to the Scheme at year end (Note 3)	50,000	-

26. RELATED PARTY TRANSACTIONS (CONTINUED)

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

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

Administration agreement

The administration agreement is in terms of the Rules of the Scheme and in accordance with instructions given by the Board of Trustees. The agreement is automatically renewed each year unless notification of termination is received or following the cancellation of the Administrator's accreditation or the issue of a lawful directive to this effect by the Council for Medical Schemes in terms of the Medical Schemes Act 131 of 1998, as amended. The Scheme and the Administrator shall be entitled to terminate the agreement by giving notice in writing of not less than 90 days and not more than 180 days. The outstanding balance bears interest at Prime less 4.5% and is due within 30 days.

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

Managed care agreements

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

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 131 of 1998, as amended. The Scheme and Discovery Health (Pty) Ltd shall be entitled to terminate the agreement by giving notice in writing of not less than 90 days and not more than 180 days. The outstanding balance bears interest at Prime less 4.5% and is due within 30 days.

The services provided by the managed care organisation include:

- Managed healthcare services as defined in the Medical Schemes Act 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; and
- 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.

Notes to the Annual Financial Statements

for the year ended 31 December 2010

27. SURPLUS / (DEFICIT) FROM OPERATIONS PER BENEFIT OPTION

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

27. SURPLUS / (DEFICIT) FROM OPERATIONS PER BENEFIT OPTION (CONTINUED)

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

Notes to the Annual Financial Statements

for the year ended 31 December 2010

27. SURPLUS / (DEFICIT) FROM OPERATIONS PER BENEFIT OPTION (CONTINUED)

2009	Executive R'000	Classic Comp R'000	Classic Core R'000	Classic Saver R'000	Classic Priority R'000	Essential Comp R'000	Essential Core R'000	Essential Saver R'000
Net contribution income	**437,782**	**6,298,290**	**927,988**	**2,633,017**	**1,873,326**	**1,128,497**	**292,498**	**997,456**
Net claims incurred	(585,993)	(6,019,853)	(564,692)	(1,749,458)	(1,418,047)	(824,970)	(184,702)	(603,175)
Claims incurred	(587,506)	(6,035,132)	(566,104)	(1,753,900)	(1,421,674)	(827,025)	(185,169)	(604,697)
Third party claim recoveries	1,513	15,279	1,412	4,442	3,627	2,055	467	1,522
Net income/(expense) on risk transfer arrangements	(72)	(2,344)	-	-	-	(517)	-	-
Risk transfer arrangement fees	(4,481)	(61,400)	-	-	-	(7,979)	-	-
Recoveries from risk transfer arrangements	4,409	59,056	-	-	-	7,462	-	-
Relevant healthcare expenditure	**(586,065)**	**(6,022,197)**	**(564,692)**	**(1,749,458)**	**(1,418,047)**	**(825,487)**	**(184,702)**	**(603,175)**
Gross healthcare result	**(148,283)**	**276,093**	**363,296**	**883,559**	**455,279**	**303,010**	**107,796**	**394,281**
Managed care: management services	(6,957)	(125,980)	(28,419)	(84,519)	(53,210)	(23,185)	(10,809)	(36,926)
Broker service fees	(7,940)	(142,282)	(25,286)	(88,766)	(57,438)	(27,016)	(8,293)	(32,392)
Expenses for administration	(30,230)	(540,254)	(136,738)	(403,401)	(241,059)	(107,927)	(50,486)	(168,918)
Other operating expenses	(1,643)	(29,304)	(7,466)	(22,080)	(13,151)	(5,859)	(2,765)	(9,204)
Net healthcare result	**(195,053)**	**(561,727)**	**165,387**	**284,793**	**90,421**	**139,023**	**35,443**	**146,841**
Investment income	8,042	143,605	36,436	107,628	64,228	28,695	13,465	44,967
Net fair value losses on financial assets at fair value through profit or loss	207	3,691	928	2,727	1,635	734	342	1,148
Sundry income	130	2,326	590	1,744	1,041	465	218	728
Other income	**8,379**	**149,622**	**37,954**	**112,099**	**66,904**	**29,894**	**14,025**	**46,843**
Expenses for asset management services rendered	(96)	(1,719)	(438)	(1,295)	(771)	(344)	(162)	(540)
Interest paid	(287)	(5,131)	(1,296)	(3,826)	(2,287)	(1,025)	(478)	(1,602)
Other expenditure	**(383)**	**(6,850)**	**(1,734)**	**(5,121)**	**(3,058)**	**(1,367)**	**(640)**	**(2,142)**
Net surplus/(deficit) for the year	**(187,057)**	**(418,955)**	**201,607**	**391,771**	**154,267**	**167,548**	**48,828**	**191,542**

27. SURPLUS / (DEFICIT) FROM OPERATIONS PER BENEFIT OPTION (CONTINUED)

2009	Essential Priority R'000	Coastal Saver R'000	Coastal Core R'000	Foundation Core R'000	KeyCare Plus R'000	KeyCare Core R'000	TOTAL R'000
Net contribution income	**210,857**	**2,004,235**	**938,307**	**18,139**	**1,153,290**	**140,074**	**19,053,756**
Net claims incurred	(124,150)	(1,451,818)	(644,890)	(12,680)	(986,935)	(88,457)	(15,259,820)
Claims incurred	(124,469)	(1,455,458)	(646,509)	(12,714)	(989,404)	(88,687)	(15,298,448)
Third party claim recoveries	319	3,640	1,619	34	2,469	230	38,628
Net income/(expense) on risk transfer arrangements	-	-	-	-	2,573	-	(360)
Risk transfer arrangement fees	-	-	-	-	(21,162)	-	(95,022)
Recoveries from risk transfer arrangements	-	-	-	-	23,735	-	94,662
Relevant healthcare expenditure	**(124,150)**	**(1,451,818)**	**(644,890)**	**(12,680)**	**(984,362)**	**(88,457)**	**(15,260,180)**
Gross healthcare result	**86,707**	**552,417**	**293,417**	**5,459**	**168,928**	**51,617**	**3,793,576**
Managed care: management services	(6,147)	(84,891)	(39,739)	(787)	(56,084)	(7,620)	(565,273)
Broker service fees	(6,299)	(75,161)	(28,162)	(522)	(34,512)	(4,206)	(538,275)
Expenses for administration	(29,606)	(376,550)	(185,592)	(3,751)	(161,158)	(15,963)	(2,451,633)
Other operating expenses	(1,616)	(20,522)	(10,149)	(202)	(16,946)	(2,640)	(143,547)
Net healthcare result	**43,039**	**(4,707)**	**29,775**	**197**	**(99,772)**	**21,188**	**94,848**
Investment income	7,890	100,273	49,480	995	81,556	12,865	700,125
Net fair value losses on financial assets at fair value through profit or loss	200	2,558	1,261	25	2,046	328	17,830
Sundry income	128	1,624	801	16	1,326	208	11,345
Other income	**8,218**	**104,455**	**51,542**	**1,036**	**84,928**	**13,401**	**729,300**
Expenses for asset management services rendered	(95)	(1,204)	(595)	(12)	(995)	(155)	(8,421)
Interest paid	(281)	(3,573)	(1,759)	(36)	(2,857)	(457)	(24,895)
Other expenditure	**(376)**	**(4,777)**	**(2,354)**	**(48)**	**(3,852)**	**(612)**	**(33,316)**
Net surplus/(deficit) for the year	**50,881**	**94,971**	**78,963**	**1,185**	**(18,696)**	**33,977**	**790,832**

	2010 R'000	2009 R'000
28. CASH FLOWS FROM OPERATIONS BEFORE WORKING CAPITAL CHANGES		
Net surplus for the year	594,072	790,832
Adjustments for:		
Impairment losses	37,784	41,833
Interest received	(609,240)	(697,039)
Dividend income	(6,457)	(3,413)
Interest paid	19,829	24,895
Net (gains) / losses on financial assets at fair value through profit or loss	(22,837)	(17,830)
	13,151	**139,278**

29. EVENTS AFTER THE REPORTING PERIOD

There have been no facts or circumstances of a material nature that have occurred between the accounting date and the date of this report.

30. INSURANCE RISK MANAGEMENT REPORT

Nature and extent of risks arising from insurance contracts

The Scheme issues contracts that transfer insurance risk. The primary insurance activity carried out by the Scheme indemnifies covered members and their dependants against the risk of loss arising as a result of the occurrence of a health event (i.e. 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 or unexpected price increases and the cost of new technologies or drugs.

The Scheme offers members a range of benefit options 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 should members be admitted to hospital and the Scheme has authorised the treatment.

Chronic Illness Benefit

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

Day-to-day benefits

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

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

Hospital benefit risk

Frequency and severity of claims

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

A 1% increase or decrease in the admission rate is estimated to increase or decrease the Scheme's loss ratio by 0.52%. 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.

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

1. The development of protocols around various high cost conditions, such as lower back surgery;
2. The "See Your Doctor First" initiative which requires members to see their doctor prior to an elective admission;
3. The amendment to the pre-authorisation length of stay benchmarks;

30. INSURANCE RISK MANAGEMENT REPORT (CONTINUED)

Insurance risk (continued)

Hospital benefit risk (continued)

4. 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.
5. Increased statistical and actuarial investigations and techniques to detect, manage and prevent fraud and over servicing.
6. The establishment of a unit to focus on reducing surgical consumable spend.
7. The profiling of statistically significant outlier doctors on admission rate and generated costs as well as peer reviewing them.

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

Chronic Illness Benefit (CIB) risk

Frequency and severity of claims

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

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.

30. INSURANCE RISK MANAGEMENT REPORT (CONTINUED)

Insurance risk (continued)

Day-to-day benefit risk

Frequency and severity of claims

The Above Threshold Benefit component of the day-to-day benefit results in the most variable component of the risk to the Scheme. The frequency and severity of claims is 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 which meet a variety of members' needs. This results in the Scheme being representative of the medical scheme market and, as such, it is believed that this reduces the variability of the outcome.

The strategy is set out in the annual actuarial valuation, which specifies the benefits to be provided and the expected demographic profile for each benefit 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 during the year, subject to three month's written notice.

30. INSURANCE RISK MANAGEMENT REPORT (CONTINUED)

Risk transfer arrangements

The Scheme has four risk transfer agreements with service providers to cover specific risks. The first risk transfer arrangement covers in-hospital and out-of-hospital benefits for certain members on the KeyCare Plus 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, as and when required by the members. The Scheme does, however, remain liable to its members if any supplier fails to meet the obligations it assumes.

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

Claims development

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

Liquidity risk

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

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

Risk management objectives and policies for mitigating insurance risk

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

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

The following factors affect the frequency and severity of claims:

- Fee-for-service provider reimbursement combined with a third-party payer creates the incentive for overservicing of members. The Scheme uses alternative reimbursement arrangements to mitigate this risk and also peer review of service providers, network arrangements and statistical trend analyses.
- The demographic profile of the membership base i.e. older, sicker members require more frequent and more intense treatment than younger, healthier members. This risk is managed through the regular updating of internal risk management models which assess the impact of any changes to the Scheme's demographic profile.
- Technological advances in healthcare generally increases 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.

30. INSURANCE RISK MANAGEMENT REPORT (CONTINUED)

Outstanding claims provision

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

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

The estimation of the December 2010 outstanding claims provision was made in accordance with Professional Guidance Note 304 of the Actuarial Society. In accordance with this guidance note, we also checked whether the following factors would have any impact on the outstanding claims provision estimate:

1. The homogeneity of claims data;
2. The credibility of claims data;
3. Changes in emergence and settlement patterns;
4. The impact of seasonality;
5. The impact of re-opened or adjusted claims;
6. The impact of benefit limits and benefit changes;
7. External influences;
8. 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 2011 in respect of treatment dates during 2010, the recommended provision for outstanding claims as at December 2010 is R560m.

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 i.e. 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. Due 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 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 i.e. the claims development factors, can then be used to calculate claims payments for future development months.

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

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

30. INSURANCE RISK MANAGEMENT REPORT (CONTINUED)

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

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

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

Changes in assumptions and sensitivities to changes in key variables

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

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

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

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

	Change in variable %	Impact on Outstanding claims provision 2010 R'000	Impact on Outstanding claims provision 2009 R'000
In-hospital claims incurred	1% increase in claims costs	123,081	103,448
Chronic claims incurred	1% increase in claims costs	14,061	12,367
Out-of-hospital risk claims incurred	1% increase in claims costs	42,720	36,576

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 number of treatment-to-paid patterns scenarios. These include the treatment-to-paid patterns over the last 3, the last 6, and the last 9 months. Other reasonability checks are also performed, namely checks against the expected loss ratio taking into account the seasonality of claims, checks of pre-authorisation statistics relating to hospital admissions, as well as known hospital admission rates and consideration of the number of working days in recent months.

31. FINANCIAL RISK MANAGEMENT REPORT

Overview

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

The most important components of financial risk include credit risk, liquidity risk, interest rate risk and market risk. The Scheme's overall risk management programme focuses on the unpredictability of financial markets and seeks to minimise 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 (IC) is a sub-committee of the Board of Trustees and determines, recommends, implements and maintains investment policies and procedures. The IC 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 constantly monitored.
- An external asset consultant has been appointed to assist in formulating fund strategy and to provide ongoing reporting and monitoring of the asset managers.
- To ensure that asset management agreements are concluded in the best interest of the Scheme's members an external legal advisor is used to review these agreements.

Credit risk

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

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

Trade and other receivables comprising of Insurance receivables and Loans and receivables. The main components of Insurance receivables are in respect of contributions due from members and amounts recoverable from members in respect of claims debt. The Scheme does not have any significant exposure from its Loans and receivables. The management of this risk is discussed in detail on page 91.

Financial assets at fair value through profit or loss, comprising 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 by the IC 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 99.

31. FINANCIAL RISK MANAGEMENT REPORT (CONTINUED)

Credit risk (continued)

Trade and other receivables

The credit risk on Cash and cash equivalents is managed by monitoring exposure to external financial institutions against approved limits per institution. Information regarding the credit quality of cash and cash equivalents is provided on page 100.

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

	Note	2010 R'000	2009 R'000
Insurance receivables	3	1,062,627	820,034
Contribution receivables		971,876	759,172
Less provision for impairment		(8,159)	(4,797)
Member and service provider claims receivables		185,107	170,716
Less provision for impairment		(132,734)	(132,330)
Recoveries due from other risk transfer arrangements		27	18,265
Less provision for impairment		-	(18,265)
Share of outstanding claims provision (Note 6)		321	286
Broker fee receivables		803	645
Less provision for impairment		(359)	(506)
Other insurance receivables		45,745	26,848
Loans and receivables	3	72,644	8,827
Balance due by related party		50,000	-
Sundry accounts receivable		20,587	5,669
Interest receivable		2,057	3,158
Total		**1,135,271**	**828,861**

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 corporate 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 member remain uncollected for more than 120 days, the debtors are then handed to specialist debt collection agencies.

31. FINANCIAL RISK MANAGEMENT REPORT (CONTINUED)

Credit risk (continued)

Trade and other receivables (continued)

Exposure to credit risk

The carrying amount of Trade and other receivables represents the maximum credit exposure. The maximum exposure to credit risk at the reporting date was:

	Carrying amount	
	2010	**2009**
	R'000	**R'000**
Trade and other receivables		
Insurance receivables	1,062,627	820,034
Loans and receivables	72,644	8,827
Total	**1,135,271**	**828,861**

The maximum credit exposure to contribution receivables was:

	2010 R'000	2009 R'000
Contribution receivables	**963,717**	**754,375**
	963,717	**754,375**

The maximum credit exposure to member and service provider claims receivables was:

	2010 R'000	2009 R'000
Member claim receivables	50,112	37,009
Service provider claim receivables	2,261	1,377
	52,373	**38,386**

31. FINANCIAL RISK MANAGEMENT REPORT (CONTINUED)

Credit risk (continued)

Trade and other receivables (continued)

Exposure to credit risk (continued)

The Scheme ages and pursues unpaid accounts on a monthly basis. The ageing of the components of Insurance receivables at year end was:

Contribution debtors	Gross 2010 R'000	Impairment 2010 R'000	Gross 2009 R'000	Impairment 2009 R'000
Not past due	804,552	-	678,871	-
Past due 4 - 30 days not impaired	167,336	-	76,992	-
Past due 31 - 60 days not impaired	(13,628)	-	898	-
Past due 61 - 90 days not impaired	13,659	-	295	-
91 days to more than one year	(43)	(8,159)	2,116	(4,797)
Total	**971,876**	**(8,159)**	**759,172**	**(4,797)**

Total member and service provider claims debtors	Gross 2010 R'000	Impairment 2010 R'000	Gross 2009 R'000	Impairment 2009 R'000
Not past due	-	-	-	-
Past due 0 - 30 days not impaired	26,922	-	9,945	-
Past due 31 - 60 days not impaired	1,098	-	2,814	-
Past due 61 - 90 days not impaired	7,813	-	7,218	-
Past due 91 - 120 days not impaired	9,613	-	7,897	-
Past due 121 - 150 days not impaired	3,092	-	5,284	-
151 days to more than one year	136,569	(132,734)	137,558	(132,330)
Total	**185,107**	**(132,734)**	**170,716**	**(132,330)**

31. FINANCIAL RISK MANAGEMENT REPORT (CONTINUED)

Credit risk (continued)

Trade and other receivables (continued)

Exposure to credit risk (continued)

Active member claims debtors	Gross 2010 R'000	Impairment 2010 R'000	Gross 2009 R'000	Impairment 2009 R'000
Not past due	-	-	-	-
Past due 0 - 30 days not impaired	10,830	-	1,460	-
Past due 31 - 60 days not impaired	699	-	894	-
Past due 61 - 90 days not impaired	1,389	-	784	-
Past due 91 - 120 days not impaired	1,521	-	1,798	-
Past due 121 - 150 days not impaired	1,038	-	1,940	-
151 days to more than one year	24,575	(22,917)	24,414	(22,148)
Total	**40,052**	**(22,917)**	**31,290**	**(22,148)**

Withdrawn member claims debtors	Gross 2010 R'000	Impairment 2010 R'000	Gross 2009 R'000	Impairment 2009 R'000
Not past due	-	-	-	-
Past due 0 - 30 days not impaired	10,226	-	4,830	-
Past due 31 - 60 days not impaired	2,819	-	3,654	-
Past due 61 - 90 days not impaired	6,657	-	5,032	-
Past due 91 - 120 days not impaired	5,163	-	5,194	-
Past due 121 - 150 days not impaired	4,346	-	5,652	-
151 days to more than one year	110,713	(106,947)	108,699	(105,194)
Total	**139,924**	**(106,947)**	**133,061**	**(105,194)**

31. FINANCIAL RISK MANAGEMENT REPORT (CONTINUED)

Credit risk (continued)

Trade and other receivables (continued)

Exposure to credit risk (continued)

Service provider claims debtors	Gross 2010 R'000	Impairment 2010 R'000	Gross 2009 R'000	Impairment 2009 R'000
Not past due	-	-	-	-
Past due 0 - 30 days not impaired	5,866	-	3,655	-
Past due 31 - 60 days not impaired	(2,420)	-	(1,734)	-
Past due 61 - 90 days not impaired	(233)	-	1,402	-
Past due 91 - 120 days not impaired	2,929	-	905	-
Past due 121 - 150 days not impaired	(2,292)	-	(2,308)	-
151 days to more than one year	1,281	(2,870)	4,445	(4,988)
Total	**5,131**	**(2,870)**	**6,365**	**(4,988)**

Other risk transfer arrangements	Gross 2010 R'000	Impairment 2010 R'000	Gross 2009 R'000	Impairment 2009 R'000
Not past due	2,554	-	-	-
Past due 0 - 30 days not impaired	-	-	-	-
Past due 31 - 60 days not impaired	-	-	-	-
Past due 61 - 90 days not impaired	-	-	-	-
Past due 91 - 120 days not impaired	-	-	-	-
Past due 121 - 150 days not impaired	-	-	-	-
151 days to more than one year	-	-	18,265	(18,265)
Total	**2,554**	**-**	**18,265**	**(18,265)**

31. FINANCIAL RISK MANAGEMENT REPORT (CONTINUED)

Credit risk (continued)

Trade and other receivables (continued)

Exposure to credit risk (continued)

Broker fee debtors	Gross 2010 R'000	Impairment 2010 R'000	Gross 2009 R'000	Impairment 2009 R'000
Not past due	-	-	-	-
Past due 0 - 30 days not impaired	14,025	-	10,211	-
Past due 31 - 60 days not impaired	(1,373)	-	232	-
Past due 61 - 90 days not impaired	192	-	(33)	-
Past due 91 - 120 days not impaired	1,321	-	(183)	-
Past due 121 - 150 days not impaired	(1,457)	-	22	-
151 days to more than one year	(11,905)	(359)	(9,604)	(506)
Total	**803**	**(359)**	**645**	**(506)**

31. FINANCIAL RISK MANAGEMENT REPORT (CONTINUED)

Credit risk (continued)

Trade and other receivables (continued)

Exposure to credit risk (continued)

The Scheme establishes an allowance for impairment that represents its estimate of incurred losses in respect of trade and other receivables and investments. The main components of this allowance are a specific loss component that relates to individually significant exposures, and 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 class of financial asset, during the year was as follows:

	Trade and other receivables					
	Insurance receivables				*Loans and receivables*	Total
	Contribution debtors	Member and service provider claims debtors	Other risk transfer arrangements	Broker fee debtors		
	R'000	R'000	R'000	R'000	R'000	R'000
Balance as at 1 January 2009	**5,037**	**118,264**	**18,265**	**1,324**	**-**	**142,891**
Increase/(decrease) in provision for impairment	2,115	40,114	-	(396)	-	**41,832**
Amounts utilised during the year	(2,355)	(26,048)	-	(421)	-	**(28,824)**
Balance as at 31 December 2009	**4,797**	**132,330**	**18,265**	**506**	**-**	**155,898**
Balance as at 1 January 2010	**4,797**	**132,330**	**18,265**	**506**	**-**	**155,898**
Increase/(decrease) in provision for impairment	3,362	34,569	-	(147)	-	**37,784**
Amounts utilised during the year	-	(34,165)	(18,265)	-	-	**(52,430)**
Balance as at 31 December 2010	**8,159**	**132,734**	**-**	**359**	**-**	**141,252**

31. FINANCIAL RISK MANAGEMENT REPORT (CONTINUED)

Credit risk (continued)

Trade and other receivables (continued)

Exposure to credit risk (continued)

Based on past experience, the Scheme believes that no allowance 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 allowance 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 rates:

	2010 R'000	2009 R'000
Insurance receivables		
Counterparties without external credit rating net of provision for impairment:		
Contribution debtors	963,717	754,375
Member and service provider claim debtors	52,373	38,386
Active member claim debtors	17,135	9,142
Withdrawn member claim debtors	32,977	27,867
Service provider claim debtors	2,261	1,377
Broker fee debtors	444	139
Other insurance receivables	45,745	26,848
	1,062,279	**819,748**

Contribution debtors

On analysing the credit quality of contribution debtors the Scheme collected over 99% of these amounts in January 2011. This indicates a high credit quality relating to these debtors. Consequently no additional disclosure of the credit quality is provided.

Active member claim debtors

These debtors are current members of the Scheme and are expected to have similar credit quality to the Contribution debtors. 27% of the amount outstanding is less than 30 days and taking into consideration the additional debt collections procedures implemented during the year under review and that a provision for impairment covering 78% of the remaining debtors has been raised, no additional provision needs to be raised.

Withdrawn member claim debtors

These amounts are due from members that have withdrawn from the Scheme. A provision for impairment covering 78% (2009 - 79%) of the total amount due has been raised and the Trustees are satisfied that this is adequate.

31. FINANCIAL RISK MANAGEMENT REPORT (CONTINUED)

Credit risk (continued)

Financial assets held at fair value through profit or loss

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

	2010 R'000	2009 R'000
Financial assets held at fair value through profit or loss		
Current assets		
– Offshore bond portfolio	331,377	-
– Listed equities	422,757	125,641
– Yield enhanced bond portfolio	328,031	-
– Derivative financial instruments held for trading	15	-
– Money market portfolios	6,301,554	6,519,375
	7,383,734	**6,645,016**

None of the financial assets held at fair value through profit or loss are past due or impaired. The fair value of the listed equities has been determined by reference to quoted stock exchanges.

The maximum exposure to credit risk at the reporting date is the fair value of the instruments classified as fair value through profit or loss.

Exposure to credit risk

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

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

Annexure B of the Regulations to the Medical Schemes Act 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.

31. 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	Not rated
2010									
At fair value through profit or loss:	6,960,962	-	956,219	169,861	1,605,600	3,363,375	624,123	162,763	79,021
- Offshore bond portfolio	331,377	-	-	-	35,925	4,179	55,831	162,763	72,679
- Yield enhanced bond portfolio	328,031	-	119,724	-	45,509	55,402	101,054	-	6,342
- Money market portfolios	6,301,554	-	836,495	169,861	1,524,166	3,303,794	467,238	-	-
Cash and cash equivalents	1,272,903	-	1,183,381	-	85,220	4,123	-	-	179
	8,233,865	**-**	**2,139,600**	**169,861**	**1,690,820**	**3,367,498**	**624,123**	**162,763**	**79,200**
2009									
At fair value through profit or loss:									
- Money market portfolios	6,519,375	436,879	2,017,361	1,332,722	1,212,822	1,193,368	326,223	-	-
Cash and cash equivalents	1,124,056	-	1,124,056	-	-	-	-	-	-
	7,643,431	**436,879**	**3,141,417**	**1,332,722**	**1,212,822**	**1,193,368**	**326,223**	**-**	**-**

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.

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.

31. FINANCIAL RISK MANAGEMENT REPORT (CONTINUED)

Credit risk (continued)

Credit quality (continued)

Credit rating scales (continued)

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 2010 0.9% (2009: 0%) of the Scheme's Financial assets at fair value through profit or loss very invested in instruments with this credit rating.

BB: Speculative
BB ratings indicate an elevated vulerability 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 2010 0.3% (2009: 0%) of the Scheme's Financial assets at fair value through profit or loss very 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 2010 1.1% (2009: 0%) of the Scheme's Financial assets at fair value through profit or loss very invested in instruments with this credit rating.

Liquidity risk

Liquidity risk is the risk that the Scheme will not be able to meet its financial obligations as they fall due.

The Scheme's approach to managing liquidity is to ensure, as far as possible, that it will always have sufficient liquidity to meet its liabilities when due, under both normal and stressed conditions, without incurring unacceptable losses or risking damage to the Scheme's reputation. 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 four weeks.

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

As at 31 December 2009	Less than 1 year R'000	Between 1 and 2 years R'000	Between 2 and 5 years R'000
Members' trust funds	336	334	-
Members' savings accounts	1,544,102	-	-
Trade and other payables (Note 9)	257,865	-	-

31. 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

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

For the purpose of seeking international diversification, the Scheme has invested less than 5% of its assets offshore. At 31 December 2010 this equates to R329 million.

The scheme is exposed to currency risk in the form of an investment in a United States Dollar (USD) denominated offshore collective investment scheme and a USD denominated bank account.

Price risk

The Scheme is exposed to equity securities price risk because of investments held by the Scheme and classified as at fair value through profit or loss. The Scheme is not exposed to commodity risk. To manage its price risk arising from investments in equity securities, the Scheme diversifies its portfolio. Diversification of the portfolio is done by the asset managers in accordance with the mandate set by the Scheme.

The Scheme's equity investments are publicly traded on the Johannesburg Stock Exchange.

31. FINANCIAL RISK MANAGEMENT REPORT (CONTINUED)

Interest rate risk

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

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

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

As at 31 December 2009	0 - 3 Months R'000	3 - 12 Months R'000	> 12 Months R'000	Total R'000
Cash and cash equivalents	1,124,056	-	-	1,124,056
Money market instruments carried at fair value through profit or loss	-	6,519,375	-	6,519,375

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

	2010 %	2009 %
Money market instruments carried at fair value through profit or loss	7.97%	10.05%
Cash and cash equivalents	5.75%	7.11%

The weighted average effective interest rate on short-term bank deposits (namely call account deposits) was 6.17% (2009 - 8.12%). These deposits have an average maturity of 15 days (2009 - 14 days).

31. FINANCIAL RISK MANAGEMENT REPORT (CONTINUED)

Cash flow sensitivity analysis

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

Equity portfolios

The expected return for the 12 months to December 2011 is expected to be between 16.96% and negative 17.29% (at a 95% confidence level), and an annualised risk of 20.63%. On the upside the Scheme's surplus and accumulated funds could increase by R73,7million, based on December 2010 Market values. On the down side the Scheme's surplus and accumulated funds could decrease by R75,2 million.

The Scheme did not have significant equity exposure in 2009 and a sensitivity analysis was not performed.

Offshore bond portfolios

The expected return for the 12 months to December 2011 is expected to be between 7.06% and negative 3.68 % (at a 95% confidence level), and an annualised risk of 6.47%. On the upside the Scheme's surplus and accumulated funds could increase by US$3.54 million (R23,41 million) based on December 2010 Market values, and decrease by US$1,84 million (R12,20 million) on the downside.

After taking into account exposure to foreign currency the return in South African Rand is expected to be 13.42% which increases the Scheme's surplus and accumulated funds by R44,51 million, with an annualised risk of13.97%. The minimum expected negative return is estimated to be 9.77% which could decrease the Scheme's surplus and accumulated funds by R32,40 million.

Money market portfolios

The expected return for the 12 months to December 2011 is expected to be between 8.12% and 9.04% (at a 95% confidence level), and an annualised risk of 0.55%. The Scheme's surplus and accumulated funds could increase by a minimum of R528,33 million and a maximum of R588,19 million, based on market values at 31 December 2010.

In preparing the sensitivity analysis for 2009, a review of the movement of previous years prime rates as well as the fixed deposit rates for the following 12 months was performed. The profile of the Scheme's investments at the reporting date as well as the prevailing market conditions at the time of preparing the financial statements was also considered.

Due to the short-term duration of these instruments, a reasonably possible change in interest rates was 50 basis points. At 31 December 2009 the effect of this change increases or decreases the Scheme's surplus and accumulated funds by R31,96 million. This analysis assumed that all other variables remained constant. The main reason for changing the method used to determine the effect on the Scheme's results in 2010 is that this method provides a more objective measure and is expected to improve comparability for future reporting periods.

Yield enhanced bond portfolios

The expected return for the 12 months to December 2011 is estimated to be between 1.10% and 12.82% (at a 95% confidence level) and an annualised risk of 7.06%. Based on the market values of the portfolio at 31 December 2010 this would increase the Scheme's surplus and accumulated funds by a minimum of R4,12 million and a maximum of R48,04 million.

31. FINANCIAL RISK MANAGEMENT REPORT (CONTINUED)

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 2010 the Scheme did not consider there to be any significant concentration of legal risk that had not been provided for.

Capital management

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

	2010 **R'000**	**2009** **R'000**
Total members' funds per Statement of Financial Position	6,847,076	6,070,680
Less: cumulative unrealised net gain on remeasurement of investments to fair value	(29,739)	(2,628)
Accumulated funds per Regulation 29	**6,817,337**	**6,068,052**
Gross contribution income	**27,650,362**	**23,840,326**
Solvency margin = Accumulated funds / gross contribution income x 100	**24.66%**	**25.45%**

At 31 December 2010, the Scheme's regulatory capital was R95 million less than the capital requirement imposed by the Regulator.

31. 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 to the Medical Schemes Act 131 of 1998, as amended, any credit balance on a member's savings account must be taken as a cash benefit when the member terminates his or her membership of the Scheme or benefit 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' 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 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 131 of 1998, as amended, the Scheme submits monthly detailed investment schedules to the Council of 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 out performance of the targeted return.

The investment mandate is subject to the provisions of the Medical Schemes Act 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 2 years. The term of each individual instrument will not be 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 (Stef Cad) and the remainder of the portfolio against the STeFI Composite Index .

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

31. FINANCIAL RISK MANAGEMENT REPORT (CONTINUED)

Investment risk (continued)

Breakdown of investments (continued)

Bond portfolios:

Local portfolios:

During the 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 and interest rate swaps.

The investment mandate is subject to the provisions of the Medical Schemes Act 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 5% of the Scheme's Financial assets at fair value through profit or loss.

Offshore portfolio:

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

The investment mandate is subject to any applicable exchange control regulations and the provisions of the Medical Schemes Act 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 the Composite Global Strategic Income Bond.

This portfolio comprises approximately 3% 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 Holdings Limited or its subsidiaries and must comply with the Medical Schemes Act 131 of 1998, as amended.

The performance for the portfolios is the FTSE/JSE Shareholder weighted index (SWIX).

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

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; and
- Cash and cash equivalents.

31. FINANCIAL RISK MANAGEMENT REPORT (CONTINUED)

Investment risk (continued)

Breakdown of investments (continued)

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 2010 R'000	As at 31 December 2009 R'000
Offshore bond portfolio	331,377	-
Local equity portfolios	422,757	125,641
Local yield enhanced bond portfolio	328,031	-
Local money market portfolios	6,301,554	6,519,375
Derivatives	15	-
Total	**7,383,734**	**6,645,016**

Cash and cash equivalents

Cash and cash equivalents are made up of the following:

	As at 31 December 2010 R'000	As at 31 December 2009 R'000
Deposits on call	653,506	604,623
Overnight deposits with financial institutions	355,268	331,157
Money market portfolios	264,129	188,276
Total	**1,272,903**	**1,124,055**

31. FINANCIAL RISK MANAGEMENT REPORT (CONTINUED)

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

	Financial assets at fair value through profit and loss		Loans and receivables	Insurance receivables and (payables)	Financial liabilities at amortised cost	Total carrying amount	Fair value amount
	designated upon initial recognition	classified as held for trading					
	R'000	R'000	R'000	R'000	R'000	R'000	R'000
For the year ended 31 December 2010							
Investments							
– Offshore bond portfolio	-	331,377	-	-	-	**331,377**	**331,377**
– Listed equities	-	422,757	-	-	-	**422,757**	**422,757**
– Yield enhanced bond portfolio	-	328,031	-	-	-	**328,031**	**328,031**
– Money market portfolio	-	6,301,554	-	-	-	**6,301,554**	**6,301,554**
– Derivatives held for trading	-	15	-	-	-	**15**	**15**
Cash and cash equivalents	-	-	1,272,903	-	-	**1,272,903**	**1,272,903**
Trade and other receivables	-	-	72,644	1,062,627	-	**1,135,271**	**1,135,271**
Members' savings accounts	-	-	-	(1,718,442)	-	**(1,718,442)**	**(1,718,442)**
Trade and other payables	-	-	-	(358,637)	(306,806)	**(665,443)**	**(665,443)**
Members' trust funds							
– Non-current portion	-	-	-	-	-	**-**	**-**
– Current portion	-	-	-	(350)	-	**(350)**	**(350)**
	-	**7,383,734**	**1,345,547**	**(1,014,802)**	**(306,806)**	**7,407,673**	**7,407,673**

31. FINANCIAL RISK MANAGEMENT REPORT (CONTINUED)

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

	Financial assets 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 2009							
Investments							
– Listed equities	-	125,641	-	-	-	**125,641**	**125,641**
– Money market portfolio	-	6,519,375	-	-	-	**6,519,375**	**6,519,375**
– Derivatives held for trading	-	-	-	-	-	**-**	**-**
Cash and cash equivalents	-	-	1,124,056	-	-	**1,124,056**	**1,124,056**
Trade and other receivables	-	-	8,827	820,034	-	**828,861**	**828,861**
Members' savings accounts	-	-	-	(1,544,102)	-	**(1,544,102)**	**(1,544,102)**
Trade and other payables	-	-	-	(251,104)	(257,865)	**(508,969)**	**(508,969)**
Members' trust funds							
– Non-current portion	-	-	-	(334)	-	**(334)**	**(334)**
– Current portion	-	-	-	(336)	-	**(336)**	**(336)**
	-	**6,645,015**	**1,132,883**	**(975,842)**	**(257,865)**	**6,544,190**	**6,544,190**

31. FINANCIAL RISK MANAGEMENT REPORT (CONTINUED)

FAIR VALUE HIERARCHY FOR FINANCIAL ASSETS MEASURED AT FAIR VALUE

Assets measured at fair value

2010	Fair value measurement at end of the year using:		
	R'000	Level 1 R'000	Level 2 R'000
Financial assets at fair value through profit or loss:			
Equity instruments	**422,757**	422,757	-
Government bonds	**-**	-	-
Corporate bonds	**2,765,957**	-	2,765,957
Other investments	**4,195,005**	-	4,195,005
	7,383,719	**422,757**	**6,960,692**

2009	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	**125,641**	125,641	-
Government bonds	**26,025**	26,025	-
Corporate bonds	**852,175**	-	852,175
Other investments	**5,641,175**	-	5,641,175
	6,645,016	**151,666**	**6,493,351**

The fair value assets are classified using a fair value hierarchy that reflects the significance of the inputs used in determining the measurements.

The fair value hierarchy has the following levels:

Level 1 - These are assets measured using quoted prices in an active market.

Level 2 - These are assets measured using inputs other than quoted prices included within Level 1, that are either directly or indirectly observable.

Level 3 - These are assets measured using inputs that are not based on observable market data.

The Scheme does not have any assets falling under Level 3.

32. CRITICAL ACCOUNTING ESTIMATES AND JUDGEMENTS

Critical accounting estimates and assumptions

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

Outstanding claims provision

The critical estimates and judgements relating to the outstanding claims provision are set out under note 30.

Other risk transfer arrangements

The critical estimates and judgements relating to other risk transfer arrangements are set out under note 11.

Impairment of assets

The critical estimates made by the Scheme are set out under note 31 and judgements relating to the impairment of assets are set out under note 6 of the Accounting policies.

33. MATERIAL NON-COMPLIANCE MATTERS

Statutory Scheme Solvency

In terms of Regulation 29 (2) to the Medical Schemes Act 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 2010, the Scheme's accumulated funds expressed as a percentage of gross annual contributions was 24.66% which is less than the statutory requirement of 25% and have advised the Council for Medical Schemes.

The Scheme is in the process of planning and implementing a comprehensive risk management strategy for all benefit options in order to improve the Scheme's solvency position during 2011.

Sustainability of benefit options

In terms of Section 33 (2) of the Medical Schemes Act 131 of 1998, as amended, each option is required to be self-supporting in terms of membership and financial performance and be financially sound.

At 31 December 2010 the following options did not comply with Section 33 (2):

Option	Net underwriting deficit R'000	Net (deficit)/ surplus R'000
Executive	(249,031)	(241,529)
Classic Comprehensive	(633,273)	(511,038)
Coastal Saver	(9,182)	80,172
KeyCare Plus	(286,034)	(186,340)

The Trustees continue to monitor these options with a view to improving their sustainability.

At the same time, it should be pointed out that it is a structural reality of all open medical schemes that the higher options are loss making. This is the simple result of the medical scheme environment that allows sicker members of the scheme to upgrade to higher options at the beginning of the benefit year, with no underwriting applied. As it almost always makes sense for sicker members to upgrade (since claims from the scheme will more than make up for higher contributions), all open schemes face a situation in which their top-end plans have a majority of sicker members, resulting in overall negative loss ratios. 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 options.

Administration

Administration

Principal Officer

Milton Streak
Discovery Health Medical Scheme
16 Fredman Drive
Sandton
2146

Registered office address and postal address

Discovery Health Medical Scheme

16 Fredman Drive	P O Box 786722
Sandton	Sandton
2146	2146

Administrator of the Scheme

Discovery Health (Pty) Ltd

155 West Street	P O Box 786722
Sandton	Sandton
2146	2146

Auditors

PricewaterhouseCoopers Incorporated

2 Eglin Road	Private Bag X36
Sunninghill	Sunninghill
2157	2157

Principal bankers

First National Bank

4 First Place	P O Box 7791
Bank City	Johannesburg
Johannesburg	2000
2000	

Investment Managers

RMB Asset Management (Pty) Ltd

7 Merchant Place	P O Box 783414
Fredman Drive	Sandton
Sandton	2146
2196	

Investec Asset Management (Pty) Ltd

36 Hans Strijdom Avenue	P O Box 1826
Foreshore	Cape Town
Cape Town	8000
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Taquanta Asset Managers (Pty) Ltd

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Newlands Terraces	Claremont
Boundary Road	7735
Newlands	
Cape Town	
7700	

Element Investment Managers (Pty) Ltd

8th Floor	P O Box 13
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Cape Town	8000
8001	

Electus Equity Specialists (Pty) Ltd

Mutual Park	P O Box 878
Jan Smuts Drive	Cape Town
Pinelands	8000
7405	

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Discovery
Health Medical Scheme

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