2011

PROFMED ANNUAL INTEGRATED REPORT

Healthcare for Professionals

PROFMED

Profmed Notice
OF ANNUAL GENERAL MEETING 2012

Notice to members

Notice is hereby given that the 41st Annual General Meeting ("the meeting") of the members of Profmed will be held at 15 Eton Road, Parktown, Johannesburg on Wednesday 6 June 2012 at 15h30.

Agenda

1. To receive and adopt the annual financial statements for the year ended 31 December 2011 (including the reports of the trustees and the auditors of Profmed).
2. To re-appoint PricewaterhouseCoopers Inc. as the auditors of Profmed for 2012/13 in terms of rule 27 of the Rules of Profmed.
3. To confirm the 2011 remuneration of the trustees.
4. To announce the election of two trustees in accordance with the Rules of Profmed.
5. To transact such other business as may be transacted at the Annual General Meeting (subject to the Rules of Profmed, and in particular Rule 28.1.6, and the provisions of the Medical Schemes Act No. 131 of 1998, as amended).

The Annual Integrated Report, including the Form of Proxy, is available at www.profmed.co.za or by calling Client Services on 0860 679 200. Hard copies will be made available at the Annual General Meeting and at:

PMSA
269 Von Willigh Avenue
Block D, Corporate Park 66
Die Hoewes
Centurion

Profmed Client Walk-in Centre
6 Anerley Road
Parktown
Johannesburg.

By order of the Board of Trustees.

Graham R Anderson
Principal Officer and Chief Executive
9 May 2012

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Chairman's REPORT

There is a well-known adage, "necessity is the mother of invention". It is a fact that adversity, turbulence and uncertainty produce strength, creativity and tenacity and this has been true of Profmed over the past year. Profmed has faced adversity over the past year, but the steadfastness, knowledge and experience on the Profmed Board of Trustees and the management of the Scheme have resulted in the excellent results presented in this report.

Ms Esmé Prins-Van den Berg
Chairman of the Board of Trustees

In 2011, Profmed published one of the first integrated reports in the medical scheme industry and we are pleased that this year Profmed has been, and continues to be, one of the forerunners in this regard. This outstanding Annual Integrated Report is of the highest quality, both in terms of the quality of information and reporting, but also in that it is pioneering in its reporting on sustainability.

Committed to environmental sustainability

Profmed's trustees are committed to contributing to the future sustainability of our planet. To achieve this, the Scheme implemented the use of electronic agenda packs. This will not only reduce the Scheme's paper usage, but will also contribute to reducing South Africa's carbon footprint as the need to use courier services that utilise air and road transport will be eliminated. The Scheme's courier costs will also be reduced. The trustees and management of the Scheme will continue to find ways in which to conduct Profmed's business in a more environmentally friendly manner.

Profmed in the press

Profmed received negative publicity in the press at the end of 2011, which was factually incorrect. In the first instance, the Council for Medical Schemes (CMS) was reported to be threatening to deregister Profmed as the Scheme was not complying with the CMS's interpretation of Regulation 8 of the Medical Schemes Act, dealing with the payment of prescribed minimum benefits (PMBs). However, Profmed had received no such threat from the CMS. Although the Board of Trustees interprets Regulation 8 differently from the CMS based on legal opinion it obtained, the trustees nevertheless decided to fund the PMBs in line with the CMS's, instruction in the interest of its membership.

In the second instance, the press reported incorrectly on a judgment by the High Court. It was reported that the High Court had ruled that Profmed had to pay for hospitalisation from the risk benefit when, in fact, the ruling was that Profmed had to fund rehabilitation benefits from the risk benefit and not from the capped rehabilitation benefit. Profmed has always funded authorised hospitalisation from risk, in accordance with its approved rules. Profmed has subsequently been granted leave to appeal the judgment.

Financial

In 2009, the Board of Trustees agreed not to continue funding benefits from the Scheme's investment returns and adopted a strategy to achieve an operating surplus by the end of 2012. It was pleasing, therefore, that by December 2010 the Scheme had achieved this goal, which made it possible for the 2012 contribution increases to be kept to a minimum, and Profmed's increases for 2012 were one of the lowest in the industry. This bodes well for the Scheme for the future.

As there is no regulated tariff in terms of charging for PMBs, it is difficult to budget accurately for PMB claims but the Board continues to monitor PMBs closely and the impact thereof on the Scheme. The Scheme's financial results are excellent, and maintaining this healthy position will remain a focal point of the Board and the management of the Scheme.

Administration

Efficient administration is crucial to the success of any medical scheme. To ensure continued excellent service to all Profmed stakeholders, it became necessary for the Scheme to migrate to a new and upgraded IT platform. While the migration process encountered unavoidable challenges and caused unfortunate frustration to some members and providers, we are pleased to report that the system has settled down and service levels have returned to normal. The advanced technology will streamline the administration processes and ultimately enhance our stakeholders' experience of the Scheme's operations and service levels. Profmed prides itself on its excellent service levels and we will always place the needs of our members first.

Growth

The Board is of the view that Profmed is uniquely placed to harness the anticipated future changes in private healthcare in South Africa and is clear on what is required for the success of the Scheme. It has a definitive strategy to ensure Profmed's sustainability and the two most important elements of that strategy are to increase membership growth and to constantly strive to improve service levels, firstly to our valued members, and also to all our stakeholders.

Governance

During 2011, the CMS performed a routine inspection of Profmed's governance processes and policies. We are delighted to report that your Scheme received positive feedback from the CMS, which found the Scheme's governance levels impressive and of a very high standard. This should provide great comfort to members as it reinforces the stated commitment of your trustees to best governance practices and transparency at all times and in all aspects of Profmed's business.

Thanks

As the medical scheme run by professionals for professionals, it is no surprise that the Board is made up of highly qualified and capable trustees and I thank my colleagues on the Board for their dedication to Profmed and for sacrificing their personal time to serve on the Board of Trustees. On behalf of the Board, I also wish to thank the Principal Officer and staff of the Executive Office for their unwavering support of the Board and commitment to Profmed.

Ms Esmé Prins-Van den Berg
Chairman
12 April 2012

Report
SCOPE AND BOUNDARIES

Profmed's 2011 report is the Scheme's second annual integrated report and aims to provide a concise overview of the Scheme, integrating and connecting important information about strategy, risks and opportunities and relating them to the financial, economic, social and environmental performance for the reporting period 1 January to 31 December 2011. Material and relevant issues, that impact the Scheme, have been identified to create this report.

Use of guidelines

Profmed's non-financial accounting policies are aligned to the recommendations set out in the King Report on Governance for South Africa (King III) incorporating guidance from the Global Reporting Initiative (GRI) G3. The financial accounting policies are aligned to International Financial Reporting Standards (IFRS) with guidance from the Medical Schemes Accounting Guide, issued by the South African Institute of Chartered Accountants (SAICA).

Materiality

Material topics are defined as those reflecting significant economic, environmental and social impacts or those that would influence the decisions of the Scheme's stakeholders. The material topics disclosed in this report have been informed by regulatory obligations, internal financial and non-financial reports and voluntary disclosure standards.

Stakeholder inclusiveness

The principle of stakeholder inclusiveness has been employed to ensure that disclosures are material and relevant to the legitimate interests of Profmed's stakeholders. The primary vehicles informing stakeholders are the Scheme's annual integrated report, an interactive website, newsletters, benefit communication, Scheme rules, claims statements and individual communication where necessary. The Scheme's main stakeholders are identified as Profmed members, healthcare service providers, a third-party administrator, managed care service providers, employees and the Council for Medical Schemes.

Data measurement

Data measurement techniques are replicable and information is not reported if the margin for error is likely to substantially influence the ability of stakeholders to make informed decisions about the Scheme's performance. Measurement techniques, estimates and underlying assumptions are described where it is materially necessary to do so.

Assurance

The Scheme's external auditors, PricewaterhouseCoopers Inc., have audited the annual financial statements and their report is presented on page 24. The Scheme's independent actuaries have been consulted where estimates and projections are presented. The internal audit function of the Scheme's administrator performed a limited review on the non-financial information and qualitative data presented in this report. Global Credit Rating Co. has independently assessed the Scheme's claims paying ability.

Organisational OVERVIEW

1. Description of the Medical Scheme

1.1 Terms of registration

Profmed is a not-for-profit restricted medical scheme registered in terms of the Medical Schemes Act 131 of 1998 (the Act), as amended. Registration number 1194.

1.2 Healthcare options within Profmed

During the year the following Scheme options were available exclusively to graduate professionals:

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

2. Registered address and third-party service provider details

2.1 Registered office address and postal address

15 Eton Road
Parktown
Johannesburg

P.O. Box 1004
Houghton
2041.

2.2 Medical Scheme administrator during the year

Professional Medical Scheme Administrators (Proprietary) Limited
(Accreditation number: Admin 37)
269 Von Willigh Avenue
Block D, Corporate Park 66
Die Hoewes
Centurion

Private Bag X1031
Lyttelton
0140.

2.3 Auditors

PricewaterhouseCoopers Inc.
32 Ida Street
Menlo Park
Pretoria

P.O. Box 35296
Menlo Park
0102.

2.4 Investment managers

Investec Private Bank
(Financial Service Provider number: 8102)
100 Grayston Drive
Sandown
Sandton

P.O. Box 785700
Sandton
2146.

2.5 Actuaries

NMG Consultants and Actuaries (Proprietary) Limited
NMG House
411 Main Avenue
Randburg

P.O. Box 3075
Randburg
2125.

2.6 Attorneys

Knowles Husain Lindsay Incorporated
4th Floor, The Forum
2 Maude Street
Sandown
Sandton

P.O. Box 782687
Sandton
2146.

Report
OF THE BOARD OF TRUSTEES AND THE PRINCIPAL OFFICER

The Board of Trustees hereby presents its report for the year ended 31 December 2011.

1. Overview of the Scheme and its activities

The Report of the Board of Trustees is one of the documents that is presented together with, and accompanies, the annual financial statements. Accordingly, references have been made directly to the page numbers, figures, notes and other statistics contained in the accompanying financial statements. In addition, the same abbreviations for certain names have been used consistently in this report and in the financial statements.

The results of the Scheme's operations are set out on page 25 of the annual financial statements.

In the period under review, the ratio of relevant healthcare expenditure as a percentage of net contribution income was 82.35% (2010: 83.56%). Managed care service expenses were 2.24% of net contribution income (2010: 2.24%), while administration expenditure (inclusive of impairment losses) was 9.83% of net contribution income (2010: 10.14%).

1.1 Accumulated funds ratio

The accumulated funds ratio is calculated as follows:

	2011 R'000	2010 R'000
Total members' funds per Statement of Financial Position	**463 764**	395 925
Less: Reserve for unrealised investment gains	**(43 636)**	(36 662)
Accumulated funds per Regulation 29 of the Act	**420 128**	359 263
Annual contribution income per Statement of Comprehensive Income	**866 699**	761 802
Accumulated funds ratio calculated as the ratio of accumulated funds/gross annual contributions x 100	**48.47%**	47.16%
Minimum ratio required by Regulation 29 of the Act	**25.0%**	25.0 %

Average premium increases with effect 1 January were as follows:

	2012	**2011**	**2010**
ProPinnacle	7.63%	13.25%	16.00%
ProSecure Plus	7.64%	13.25%	16.00%
ProSecure	7.18%	13.00%	14.00%
ProActive Plus	6.76%	11.25%	12.00%
ProActive	6.23%	11.25%	12.00%

1.2 Strategy and risk

Profmed has a robust Operational and Business Risk (OBR) Report, which is evaluated and monitored quarterly by the Board of Trustees as well as the Audit Committee, Executive Committee, Governance Strategy and Risk (GSR) Committee, and Medical Committee. Each of these forums provides input to the OBR Report relating to their spheres of responsibility. The Board of Trustees holds a strategy session at least once a year, and an analysis is done of the risks facing the Scheme. Risks that could impact the Scheme within the strategy period under review are taken into account when setting the strategy.

2. Review of the accounting period's activities

2.1 Operational statistics per benefit option

2011	ProPinnacle	ProSecure Plus	ProSecure	ProActive Plus	ProActive	Total Scheme
Non-financial highlights						
Number of members at year-end	2 265	2 381	7 589	4 409	9 602	26 246
Average number of members for the year	2 298	2 385	7 557	4 185	9 607	26 032
Number of beneficiaries at year-end	4 659	5 145	18 250	9 882	25 811	63 747
Average number of beneficiaries for the year	4 749	5 132	18 239	9 385	25 929	63 434
Dependant ratio at year-end	1.06	1.16	1.40	1.24	1.69	1.43
Average age of beneficiaries per option	51.1	43.5	41.0	31.7	33.9	37.6
Pensioner ratio per benefit option (65 years and older)	29.19%	19.30%	15.32%	4.47%	6.01%	11.20%
Financial highlights						
Average net contributions per beneficiary per month	R2 952	R1 730	R1 363	R745	R672	R1 139
Average relevant healthcare expenditure per beneficiary per month	R2 933	R1 720	R1 195	R517	R387	R957
Average non-healthcare expenditure per beneficiary per month	R173	R163	R146	R149	R131	R144
Relevant healthcare expenditure as percentage of gross contributions (claims ratio)	99.37%	99.41%	87.76%	69.40%	57.86%	82.35%
Non-healthcare expenditure as a percentage of gross contributions	5.86%	9.42%	10.71%	20.00%	19.49%	12.71%

2010	ProPinnacle	ProSecure Plus	ProSecure	ProActive Plus	ProActive	Total Scheme
Non-financial highlights						
Number of members at year-end	2 412	2 343	7 390	3 630	9 713	25 488
Average number of members for the year	2 435	2 319	7 378	3 395	9 692	25 219
Number of beneficiaries at year-end	5 082	5 055	18 189	8 188	26 433	62 947
Average number of beneficiaries for the year	5 179	4 975	18 227	7 642	26 510	62 532
Dependant ratio at year-end	1.11	1.16	1.46	1.26	1.72	1.47
Average age of beneficiaries per option	49.9	42.4	40.3	31.4	33.4	37.2
Pensioner ratio per benefit option (65 years and older)	27.70%	17.67%	14.08%	4.33%	5.54%	10.62%
Financial highlights						
Average net contributions per beneficiary per month	R2 538	R1 525	R1 194	R702	R589	R1 015
Average relevant healthcare expenditure per beneficiary per month	R2 469	R1 544	R1 044	R480	R373	R846
Average non-healthcare expenditure per beneficiary per month	R154	R152	R132	R145	R119	R132
Relevant healthcare expenditure as percentage of gross contributions (claims ratio)	97.28%	101.24%	87.43%	67.30%	63.28%	83.56%
Non-healthcare expenditure as a percentage of gross contributions	6.05%	9.98%	11.07%	20.66%	20.27%	12.98%

2. Review of the accounting period's activities *(continued)*

2.2 Operational statistics for the Scheme

	2011	2010
Average accumulated funds and reserves per member	17 670	15 700
Investment return	5.1%	18.30%

3. Members' funds and reserve accounts

Movements in the members' funds and reserve accounts are set out in the Statement of Changes in Funds and Reserves on page 27. There were no unusual movements for the trustees to explain.

4. Outstanding claims

Movements in the outstanding claims provision are set out in Note 8 to the financial statements. The outstanding claims provision is made up of estimated claims incurred up to 31 December 2011 that had not been reported to the Scheme as at that date.

5. Actuarial services

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

6. Outsourcing of the Scheme's administration

Professional Medical Scheme Administrators (Proprietary) Limited continued to perform the administration function of the Scheme for the current year.

7. Subsequent events

There have been no adjusting or non-adjusting events that have occurred between the accounting date and the date of this report that affected the 2011 results.

Corporate GOVERNANCE

1. Management

1.1 Board of Trustees in office during the year under review

Ms EL Prins-Van den Berg	Chairman
Dr MM Bhikhoo	Vice-Chairman
Dr AD Behrman	
Dr JB Bekker	(term expired 8 June 2011)
Mr E Huggett	
Dr E Nkosi	
Dr RD Shuttleworth	
Mr A Tait	
Mr RN Theunissen	
Dr EJ Thorburn	
Ms MM van Garderen	(elected 8 June 2011).

1.2 Principal Officer

Mr GR Anderson

1.3 Corporate governance

The Profmed Charter and Rules of the Scheme address the qualifications, skills, performance and fit and proper criteria of trustees as well as key office bearers of the Scheme. The Profmed Charter incorporates the Code of Conduct and the Conflict of Interest Policy, and all three documents are reviewed annually by the Board of Trustees. The Code of Conduct sets out the ethics requirements for the trustees and conflicts of interest declared are dealt with in terms of the Conflict of Interest Policy. The Nominations Committee, which is an *ad hoc* committee of the Board, scrutinises nominations received by the Scheme for both appointed and elected trustees to ensure that nominees are fit and proper and have no conflict of interest, and possess the necessary skills, experience and qualifications to fulfil the fiduciary duties of a trustee.

The Profmed Charter, which is in line with King III, is reviewed annually by the Board of Trustees to ensure its relevance and that it is kept up to date in terms of new legislation and developments relating to corporate governance.

Internal control

Based on the results of the formal documented review of the Scheme and the administrator's system of internal control and risk management, including the design, implementation and effectiveness of internal financial controls conducted by the internal audit function of the administrator during the year, considering information and explanations given by management and discussions with the external auditor on the results of the audit, assessed by the Audit Committee, the Board of Trustees is of the opinion that the Scheme and the administrator's system of internal control and risk management is effective and that the internal financial controls form a sound basis for the preparation of reliable financial statements. The Board's opinion is supported by the Audit Committee.

1.4 Board proceedings

The Board met seven times during 2011 (2010: seven times). The trustees have full and unrestricted access to relevant information. The trustees are elected or appointed from the Profmed membership.

2. Attendance at trustee and committee meetings

The following schedule sets out Board of Trustee and committee meeting attendance. Trustee remuneration is disclosed in Note 17 to the annual financial statements.

Name	Board Meetings		Executive Committee		Audit Committee		Governance, Strategy and Risk Committee		Medical Committee		Remuneration Committee		*Ad Hoc* Meetings
	A	B	A	B	A	B	A	B	A	B	A	B	B
Ms EL Prins-Van den Berg	7	7	5	5	3	3†	3	3‡	4	2‡	2	2	34
Dr MM Bhikhoo	7	7	5	5					4	4			9
Dr AD Behrman	7	6							2	1			4
Dr JB Bekker	3	3							2	2			1
Mr M Brown*					3	3					2	2	2
Ms MM van Garderen	4	4					2	2					5
Mr E Huggett	7	6			3	3							5
Mr KG Mockler*					3	3					2	2	6
Dr E Nkosi	7	7					3	3					5
Dr Y Omar Carrim*					3	3							
Dr RD Shuttleworth	7	7	5	3					4	4			5
Mr A Tait	7	5					3	2					5
Mr RN Theunissen	7	7	5	5	3	2	3	3					13
Dr EJ Thorburn	7	7							4	3			4

A – Total possible number of meetings that could have been attended
B – Actual number of meetings attended
* – Independent committee member
† – By invitation
‡ – *Ex officio*

3. Audit Committee

The Scheme has an established Audit Committee, which was set up in accordance with Section 36 of the Medical Schemes Act 1998, as amended. The Audit Committee is mandated by the Board of Trustees by means of written terms of reference, which determine its membership, authority and duties. The main functions and responsibilities of the Audit Committee are to assist the Board of Trustees in carrying out its duties relating to the Scheme's accounting policies, internal control systems and financial reporting practices. The external auditors formally report to the Committee on critical findings arising from auditing activities. The Audit Committee is satisfied that the Scheme has optimised the assurance coverage obtained from management, internal and external assurance providers in accordance with an appropriate combined assurance model.

The Audit Committee is independent and the majority of the members, including the chairman, are not trustees of the Scheme or directors of its administrators. The composition of the Audit Committee is in terms of the regulatory requirements of Section 36 of the Medical Schemes Act 1998, as amended, and not in terms of King III requirements. The Committee met on three occasions during the course of the year.

The Audit Committee comprised:

Mr KG Mockler (Chairman)	Independent member
Mr M Brown	Independent member
Mr E Huggett	Trustee
Dr Y Omar Carrim	Independent member
Mr RN Theunissen	Trustee.

The Chairman of the Board, the Principal Officer, Chief Financial Officer of the administrator, internal and external auditors attend the Committee meetings by invitation and have unrestricted access to the chairman of the Committee.

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

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

Statutory duties

The Committee's role and responsibilities include statutory duties as set out in Section 36 of the Medical Schemes Act 1998, as amended. The Committee executed its duties in terms of King III and, in the instance where a King III requirement was not applied, the reason for it was explained.

External auditor

The Committee, in consultation with executive management, agreed to the engagement letter, audit plan and budgeted audit fees for the financial year. The auditor is not required to provide any non-audit services. The Committee reviewed the auditor's report to management and management's response.

Financial statements, accounting policies and practices

The Committee reviewed and discussed with the Chief Financial Officer of the administrator and the external auditor the accounting policies and practices, including any changes thereto, and the financial statements of the Scheme and was satisfied that they were appropriate and complied with the effective International Financial Reporting Standards (IFRS) including any interpretations, guidelines and directives issued. The Committee also reviewed significant adjustments resulting from the audit, of which there were none in the year under review. No concerns or complaints in relation to the reporting practices of the Scheme were received.

Internal financial controls

The Committee oversaw the process in terms of which internal audit provided a written assessment of the effectiveness of the Scheme and the administrator's system of internal control and risk management, including internal financial controls. This written assessment formed the basis for the Committee's recommendation in this regard to the Board of Trustees, in order for the Board to report thereon. The Board report on the effectiveness of the system of internal control is on page 8. The Committee supports the opinion of the Board in this regard.

Whistle blowing

No concerns or complaints, whether from within the Scheme or its administrator or outside the Scheme, relating to the accounting practices and internal audit, the content or auditing of the financial statements or any related matters were received during the year under review.

3. Audit Committee *(continued)*

Duties assigned by the Board of Trustees

In addition to the statutory duties of the Committee, as reported above, the Board has determined further functions for the Committee to perform as set out in the Committee's terms of reference. These include the following:

Integrated reporting and combined assurance

The Committee fulfils an oversight role regarding the annual integrated report and the reporting process. The Committee reviewed the annual integrated report, including the Scheme's sustainability information, and assessed its consistency with the operational and other information known to Committee members, and for consistency with the annual financial statements. The Committee discussed the report with management and considered the conclusion of the external auditor. The Committee was satisfied that the information is reliable and consistent with the financial results.

The Committee recommended to the Board that an external assurance provider should not be appointed to perform an assurance engagement on key performance indicators included in the Scheme's sustainability report. The administrator's internal audit function performed a limited review on the key performance indicators of the sustainability report. It made this recommendation because it believes that the relative straightforward nature and extent of the information did not warrant an external assurance provider's appointment.

The Committee evaluated the annual integrated report, including the annual financial statements and recommended to the Board that it be adopted.

Going concern

The Committee reviewed the documented assessment, including key assumptions, prepared by management of the going concern status of the Scheme and made a recommendation to the Board accordingly. The Board's statement on the going concern status of the Scheme is set out on page 23.

Governance of risk

The Board has assigned oversight of the risk management function to the Governance, Strategy and Risk Committee. The Audit Committee reviewed the risk management process, the effectiveness of the risk management activities, the key risks facing the Scheme and the responses to address them. The Committee fulfilled its oversight role regarding financial reporting risks, internal financial controls, fraud and information technology risks as they relate to financial reporting.

Internal audit

The Scheme has outsourced the internal audit function to its administrator. The Committee ensured that the internal audit function of the administrator was independent and had the necessary resources, standing and authority to enable it to discharge its duties. Furthermore, the Committee oversaw co-operation between the internal and external auditors and served as a link between the Board and these functions.

The Committee reviewed and recommended the internal audit charter for approval by the Board. The annual audit plan was approved by the Committee.

The internal auditor of the administrator reported to the Committee. It reviewed and provided assurance on the adequacy of the internal control environment across all of the Scheme's operations. The head of the internal audit team had direct access to the Committee through its chairman. The Committee assessed the effectiveness of the internal audit function.

Evaluation of the expertise and experience of the Chief Financial Officer of the administrator
The Scheme has outsourced the finance function to its administrator. The Committee satisfied itself that the Chief Financial Officer of the administrator had the appropriate expertise and experience.

The Committee satisfied itself of the effectiveness, including the appropriateness of the expertise and adequacy of resources, of the finance function and the experience of senior members responsible for the finance function. The Chairman of the Board of Trustees was informed of the outcome of the review.

Assurance

External audit

The Scheme's financial reporting process is audited and assessed by an external auditor appointed at the annual general meeting. The auditor acts in the interest of the members of the Scheme and reports any significant findings regarding accounting matters and any significant internal control deficiencies via the Audit Committee to the Board and in the auditor's report on page 24.

Internal audit

The Scheme's administrator's internal audit function reports to the Audit Committee. The internal audit function provides independent and objective assurance primarily within internal control over financial processes. To ensure that the function works independently of management, its charter, audit plan and budget are approved by the Audit Committee.

Internal control

Profmed's risk management and internal controls in relation to financial processes are designed with the purpose of effectively controlling the risk of material misstatements. A detailed description of the implemented internal controls and risk management system in relation to financial reporting processes is available from the Scheme. Profmed must ensure that there are no material weaknesses in the internal controls that could lead to a material misstatement in the financial reporting.

4. Governance, Strategy and Risk Committee

The Scheme has an established Governance, Strategy and Risk Committee. The Committee is mandated by the Board of Trustees by means of written terms of reference, which determine its membership, authority and duties. The main functions and responsibilities of the Committee are to assist the Board of Trustees in their implementation of governance processes, the setting of strategic intent and assessment and management of risks and the impact thereof on the Scheme.

The Council for Medical Schemes performed a routine inspection of the Scheme in terms of Section 44(4) of the Medical Schemes Act and Section 3 of the Inspections of Financial Institutions Act. The purpose of the inspection was to inspect, monitor and report compliance with the Medical Schemes Act. The inspection covered the affairs of the Scheme for the period 1 January 2010 to 31 October 2011 and focused on any person or entity associated with it, including service providers, the Board of Trustees, the Principal Officer and any other officers of the Scheme. The inspection concluded that the level of governance within the Scheme is impressive and that the Scheme has done a lot to achieve and maintain good corporate governance. The Scheme and its officials have proper controls and procedures in place that are transparent and covered by various Board committees and policies. The Board of Trustees plays an active and definitive role in managing the affairs of the Scheme, supported by a strong principal officer and senior management.

4. Governance, Strategy and Risk Committee *(continued)*

The Governance, Strategy and Risk Committee comprised:

Mr RN Theunissen (Chairman)	Trustee
Dr AD Behrman	Trustee (outgoing 9 June 2011)
Dr E Nkosi	Trustee
Ms EL Prins-Van den Berg	Chairman of the Board of Trustees (*ex officio* 9 June 2011)
Mr A Tait	Trustee
Ms MM van Garderen	Trustee (incoming 9 June 2011)
Mr GR Anderson (non-voting)	Principal Officer.

The Governance, Strategy and Risk Committee discharged its responsibilities for the year under review as follows:

- Governance
  Ensured that appropriate governance processes were in place and monitored compliance with all relevant legislative and regulatory requirements.
- Strategy
  Monitored the implementation of the strategy compiled by the Board and scheduled strategic planning sessions as and when appropriate at the instruction of the Board.
- Risk
  Identified and categorised industry and other business risks and monitored the management of the risks.

5. Executive Committee

The Scheme has an established Executive Committee. The Committee is mandated by the Board of Trustees by means of written terms of reference, which determine its membership, authority and duties. The main functions and responsibilities of the Committee are assisting the Board of Trustees in ensuring the quality, integrity and reliability of the management of the Scheme and performing functions of the Board of Trustees in between Board meetings. It also supports the Principal Officer in the day-to-day management of the Scheme.

The Executive Committee comprises the Chairman and Vice-Chairman of the Board and the chairmen of the Medical Committee and the Governance, Strategy and Risk Committee. The Executive Committee comprised:

Ms EL Prins-Van den Berg (Chairman)	Chairman of the Board of Trustees (re-elected 9 June 2011)
Dr MM Bhikhoo	Vice-Chairman of the Board of Trustees (re-elected 9 June 2011)
Dr RD Shuttleworth	Chairman of the Medical Committee (re-elected 9 June 2011)
Mr RN Theunissen	Chairman of the Governance, Strategy and Risk Committee (re-elected 9 June 2011)
Mr GR Anderson (non-voting)	Principal Officer.

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

- Reviewed the performance of the administrator and other outsourced parties to assess their efficiency, appropriateness and cost-effectiveness;
- Reviewed nominations received from members nominating trustees to the Board and ascertained whether such nominees were eligible and "fit and proper" to hold the position of trustee;
- Considered general operational issues in order to provide support to the Principal Officer and the Executive Office;
- Monitored marketing and communication to, *inter alia*, members, potential members, brokers, regulators, service providers and outsourced partners;
- Monitored reserves to ensure the solvency ratio remained within the targets set by the Board and the statutory requirements;

- Maintained oversight of the functions of the Executive Office and monitored compliance with the requirements of the Medical Schemes Act 131 of 1998, as amended, and Regulations, Rules of the Scheme, instructions of the Board and any other statutory/regulatory requirements;
- Reviewed urgent matters pending referral to the Board of Trustees for ratification and assisted the Principal Officer to offer such decisions to the Board;
- Made recommendations to the Remuneration Committee in respect of remuneration of the Board, Board committees and the Principal Officer;
- Proposed and monitored the investment strategy adopted by the Board and reviewed the performance of the asset managers and compliance with Schedule B to the Regulations in terms of the Medical Schemes Act 131 of 1998, as amended;
- Reviewed the performance of the Principal Officer;
- Apprised the Board of Trustees of the Principal Officer's performance and the remuneration approved by the Remuneration Committee.

6. Medical Committee

The Scheme has an established Medical Committee. The Committee is mandated by the Board of Trustees by means of written terms of reference, which determine its membership, authority and duties. The main functions and responsibilities of the Committee include assisting the Board of Trustees in setting clinical protocols and procedures for appropriate and cost-effective funding of members' benefits.

The Medical Committee comprised:

Dr RD Shuttleworth (Chairman)	Trustee
Dr AD Behrman	Trustee (incoming 9 June 2011)
Dr JB Bekker	Trustee (outgoing 9 June 2011)
Dr MM Bhikoo	Trustee
Dr EJ Thorburn	Trustee
Ms EL Prins-Van den Berg	Chairman of the Board of Trustees (*ex officio* 9 June 2011)
Mr GR Anderson (non-voting)	Principal Officer.

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

- Reviewed the performance and quarterly reports of the managed healthcare providers and ensured compliance with the service level agreements;
- Reviewed and approved clinical protocols as proposed by the medical advisor as well as by the managed care providers;
- Considered *ex gratia* requests;
- Participated in the benefit design to ensure clinical appropriateness, quality of care and cost-effectiveness;
- Considered appeals from members;
- Provided support to the medical/clinical advisor;
- Dealt with any other relevant matters referred for its consideration.

7. Remuneration Committee and Remuneration Policy

The Scheme has an established independent Remuneration Committee. The Committee is mandated by the Board of Trustees by means of written terms of reference, which determine its membership, authority and duties. The main functions and responsibilities of the Committee are to assist the Board of Trustees in setting the policy for, and determining the remuneration of the trustees, committee members and the Principal Officer.

7. Remuneration Committee and Remuneration Policy *(continued)*

The Committee comprised two independent members with relevant expertise and experience, and the Chairman of the Board of Trustees, as follows:

Mr KG Mockler (Chairman)	Independent member
Mr M Brown	Independent member
Ms EL Prins-Van den Berg (non-voting)	Chairman of the Board of Trustees (re-elected 9 June 2011).

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

- Engaged the services of an independent consultant, who is an expert in the field of executive remuneration, to provide the Committee with information on industry and market-related benchmarks;
- Recommended to the Board the general policy on the remuneration of the Board and committees, and the Principal Officer;
- Recommended to the Board the remuneration package of the Principal Officer; and
- Recommended to the Board the fees and other allowances and the policy with regard to the reimbursement of expenses relating to Board and Board committee members.

The remuneration policy of the Board and committees recognises that most persons occupying such positions sacrifice income from their professional practices to do so. Accordingly, trustees are remunerated in such a manner so as to compensate them for the loss of income from their practices.

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

Guaranteed component

All permanent employees, irrespective of level, receive a guaranteed element of remuneration. This comprises a fixed cash portion as well as compulsory benefits (medical scheme and retirement fund membership). The target level for the guaranteed portion of the remuneration package is set at the 50th percentile of the industry. Increases in the guaranteed component are determined in line with market increases in the 50th percentile, whilst annual performance-related assessments may cause remuneration increases at a higher rate such that superior performance by an individual will result in the employee earning above the 50th percentile for his or her position. Employees in a sales function also receive a variable monthly remuneration linked directly to their productivity. The level of this remuneration is also benchmarked to the general market.

Short-term incentive component

The Scheme uses short-term incentives to achieve stipulated annual objectives, thereby ensuring that a portion of pay is variable and linked to performance. The performance-related remuneration of employees relates directly to their function and may be allocated annually at the discretion of the Scheme. No long-term incentive schemes are available to employees.

8. Investment policy of the Scheme

The Scheme's investments are subject to Regulation 30 of the Medical Schemes Act, read with Annexure B, and the Scheme's investment strategy complies with these regulations. The investment strategy is regularly reviewed by the Board of Trustees and was reviewed, revised and approved during the financial year after recommendations from an *ad hoc* investment committee comprising three trustees and the Principal Officer.

The targeted investment growth is CPI + 3% measured on a rolling three-year period and the investment managers must perform in the top quartile when compared with their peers (medical scheme investment

managers) and it was agreed that the Scheme's annual operating budget should not be funded by more than 1% of total investment income.

The Scheme's investment manager's mandate has been to invest in a fully discretionary portfolio.

Money market portfolio
The Scheme's investment manager's mandate is to invest 60% to 80% in a money market portfolio. The portfolio invests in bonds and cash instruments. The investments are subject to a credit rating of at least a F1+ Short Term credit rating and a Long Term credit rating of A or higher.

For diversification purposes, corporate bonds, Government bonds, Parastatals and Securitisation bonds are allowed by the Act, but the maximum is limited. The limit approved by the trustees is a maximum of 10% per institution.

The performance of the portfolio has been measured against the Alexander Forbes Short Term Fixed Interest Money Market Index (known as the Stefi Index). This is a composite index consisting of four different sector indices which represent a maturity spectrum over three, six, nine and 12 months.

Equity portfolio
The portfolio may only be invested in South African equities. The portfolio is prohibited from investing in PPS Insurance Company Ltd or its subsidiaries.

Regulation 30 of the Medical Schemes Act, read with Annexure B, stipulates that medical schemes may invest only 40% of reserves in equities. Due the fact that the Scheme enjoys reserves in excess of the statutory requirements, application was made to the Council for Medical Schemes for exemption to invest up to 50% of its reserves in equities, which was granted.

9. Management of insurance risk

The primary insurance activity carried out by the Scheme assumes the risk of loss from members and their dependants that are directly subject to the risk. This risk relates to the health of the Scheme members. As such the Scheme is exposed to the uncertainty surrounding the timing and severity of claims under the contract.

The Scheme manages its insurance risk through benefit limits and sub-limits, approval procedures for transactions that involve pricing guidelines, pre-authorisation and case management, protocols and the monitoring of emerging issues.

The Scheme uses several methods to assess and monitor insurance risk exposures both for individual types of risks insured and overall risks. These methods include internal risk measurement models, sensitivity analyses, scenario analyses and stress testing. The theory of probability is applied to the pricing and provisioning for a portfolio of insurance contracts. The principal risk is that the frequency and severity of claims are greater than expected.

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

9. Management of insurance risk *(continued)*

Medical schemes are required to fund prescribed minimum benefits (PMBs) in full at invoice price in terms of the interpretation by the Council for Medical Schemes of Regulation 8 of the Medical Schemes Act No. 131 of 1998, as amended. The Scheme was previously funding PMB claims in terms of its rules, however, the Board of Trustees subsequently agreed to comply with the Council for Medical Scheme's interpretation. This poses a potential financial risk to the Scheme as there is no regulated tariff for providers and the Scheme is therefore unable to accurately budget for PMB claims.

The Board of Healthcare Funders (BHF) applied to the North Gauteng High Court requesting a declaratory order on the interpretation of Regulation 8. Unfortunately, the Court did not rule on the merits of this case but rather that BHF did not have *locus standi* in this matter. BHF has appealed this judgment.

10. Broad-Based Black Economic Empowerment (BB BEE)

The Board of Trustees undertook a gap analysis to establish Profmed's status in terms of the requirements of the Broad-Based Black Economic Empowerment Act, No. 53 of 2003. It was established that Profmed does not meet the requirements to achieve Level Eight Contributor status, the lowest level of compliance, and would likely not be in a position to become compliant in the foreseeable future, largely due to the restrictions of the Medical Schemes Act. Nevertheless, the Board of Trustees fully endorses and supports the principles of transformation and the ethos of the BB BEE Act and is committed to implementing the principles relevant to pillars of the BB BEE Act in which Profmed could work towards being compliant, i.e. Board composition, staff complement and procurement.

11. Non-compliance with Medical Schemes Act 131 of 1998 and Regulations

11.1 Contribution income not received after three days of becoming due

In terms of Section 26(7) of the Medical Schemes Act 131 of 1998, contribution income shall be received within three days of becoming due. There were instances where the Scheme did not receive all contributions within three days of becoming due. This is mainly as a result of members paying contributions after the third day of them becoming due, members having insufficient funds in their bank accounts at the time of collection and members resigning without informing the Scheme. Contributions not received within three days are actively pursued.

11.2 Financial soundness of benefit options

In terms of Section 33(2) of the Medical Schemes Act 131 of 1998, each benefit option shall be self-supporting in terms of membership and financial performance and be financially sound. For the year, two of the options had deficits. The Scheme has taken this factor into account with the review of the 2012 contribution rates and business plan. The limitations placed on the contribution increases by the Council for Medical Schemes, together with the consideration of the potential impact on members and the Scheme in terms of buy-down risk and loss of members, contributed to the Scheme not being able to achieve option self-sufficiency.

11.3 Compliance with Section 26(1)(b) and Regulation 8(1) – Prescribed minimum benefits (PMBs)

Section 26(1)(b) of the Act states that: "Any medical scheme registered under this Act shall – (b) assume liability for and guarantee the benefits offered to its members and their dependants in terms of its rules". Regulation 8(1) of the Act states that: "Subject to the provisions of this regulation, any benefit option that is offered by a medical scheme must pay in full, without co-payment or the use of deductibles, the diagnosis, treatment and care costs of the prescribed minimum benefit conditions." Profmed paid PMBs in excess of the Scheme rules for the latter part of the 2011 financial period in order to comply with the Council for Medical Scheme's interpretation of Regulation 8(1). Medical schemes are required to fund PMBs in full at invoice price in terms of the Council's interpretation of this regulation. Please refer to Management of insurance risk on page 16 for further information in this regard.

Sustainability

Profmed's corporate sustainability is seen as the creation and protection of value for all stakeholders through effectively managing financial and non-financial factors impacting the Scheme's economic performance. Profmed's vision is to address the healthcare needs of professionals through appropriate benefits.

1. Key sustainability indicators

	2011	2010
Number of principal members at year-end	**26 246**	25 488
Number of beneficiaries at year-end	**63 747**	62 947
Reserves per principal member	**R17 670**	R15 700
Solvency ratio	**48.47%**	47.16%
Positive cash flow	**R44 441 000**	R27 669 000
Number of claims lines assessed	**3 314 592**	3 226 769
Number of Council for Medical Schemes complaints received	**57**	28
Monetary value of significant fines and total number of non-monetary sanctions for non-compliance with environmental laws and regulations	**–**	–
Paper used in member communication material	**126 tons**	56 tons
Direct energy consumption at the Executive Office	**236 MW**	273 MW
Total water consumption at the Executive Office	**2 968 KL**	3 002 KL
Number of permanent employees	**23**	21

2. Value-added statement

	2011 R'000	2010 R'000
Value added		
Contribution income	**866 699**	761 802
Net realised investment income	**17 874**	32 762
Investment income – unrealised	**6 974**	18 440
Administration and acquisition expenses	**(16 198)**	(14 477)
	875 348	798 527
Value allocated to stakeholders		
Profmed members: Healthcare benefits to service providers	**713 726**	639 400
Third-party administration service providers and managed care organisations	**77 657**	69 628
Broker service fees	**5 531**	4 588
Employee remuneration	**10 634**	10 213
Retention of reserves	**67 800**	74 698
	875 348	798 527

3. Growth, reserves and the solvency ratio

One of Profmed's long-term strategies is to grow the membership base of the Scheme. By growing the membership base the risk pool will be increased, reducing the effects of high-impact claims. This enables the Scheme to provide healthcare benefits to its members in the long-term.

During the current period under review 2 503 (2010: 2 564) new members' joined and 1 745 (2010: 1 622) members resigned from the Scheme. Management has implemented a member retention process to ensure member attrition is minimised.

The solvency ratio is the ratio of Scheme reserves as a percentage of its annual contribution income. At year-end the Scheme's solvency ratio increased to 48.47%, which equates to R17 670 of reserves per member.

3. Growth, reserves and the solvency ratio *(continued)*

The solvency ratio is placed under pressure by the eroding effects of medical inflation, resulting in annual contribution increases. Growth of the membership base also adversely affects the solvency ratio as it results in increased contribution income and effectively reduces the reserves per member due to the fact that the reserves are spread over a larger number of members. Refer to section 1.1 of the Report of the Board of Trustees and the Principal Officer for the calculation of the Scheme's solvency ratio.

The Scheme has consulted with independent actuaries to project the solvency ratio for the next five years and has used two membership growth and two membership loss scenarios as presented in the tables below. A 1% poorer claims experience in 2012 than currently budgeted has been allowed for in the scenarios below. The age profile of the membership has been relatively stable over the past few years, with Profmed attracting younger members to the Scheme, which has counteracted the expected ageing of the current membership. Should this continue in future, contribution increases can be expected to equal claims inflation on each option.

Scenario 1

Year ending 31 December	Annual net membership growth of 2% across all options		Annual net membership loss of 2% across all options	
	Expected average number of principal members	Expected solvency	Expected average number of principal members	Expected solvency
2013	27 237	43.35%	26 211	44.78%
2015	28 249	40.13%	25 173	43.65%
2017	29 301	39.40%	24 176	44.28%

Scenario 2

Year ending 31 December	Annual net membership growth of 10% across all options		Annual net membership loss of 10% across all options	
	Expected average number of principal members	Expected solvency	Expected average number of principal members	Expected solvency
2013	29 421	40.31%	24 071	48.43%
2015	35 601	33.17%	19 499	53.92%
2017	43 078	30.26%	15 796	60.40%

The projections provided above indicate that even high membership growth will sustain a sufficient solvency level, and that Profmed has sufficient reserves to sustain an annual membership growth of 10% over a period of five years.

4. Administration

The Board of Trustees and management of the Scheme are responsible for ensuring that administration of the Scheme is effective and that the administrators perform in line with strict service level agreements. Below is an extract of the operational statistics of service levels of the administrator:

	2011	2010
Client service centre		
Calls received	**160 996**	160 973
Percentage calls answered	**97.41%**	96.10%
Managed care service centre		
Calls received	**53 274**	50 092
Percentage calls answered	**95.64%**	96.50%

The table below illustrates what the impact would have been had the administrator and the managed care providers not properly applied the Rules of the Scheme. This intervention report is used as a tool to measure the value added by third party service providers.

2011	PMSA	MediKredit	Dental Risk Company	Opticlear	Total
Total amount claimed	R700 557 075	R171 294 132	R60 579 915	R19 123 236	R951 554 358
Total intervention amount by party	R145 537 431	R44 080 812	R33 197 737	R12 793 034	R235 609 015
Intervention % (of total)	20.8%	25.7%	54.8%	66.9%	24.8%

5. Future sustainability of the Scheme

There are a number of challenges facing the Scheme that could pose a threat to its future sustainability. Profmed is an ageing scheme and it is imperative that younger members are attracted to the Scheme to reduce the average age of its membership. To achieve this, Profmed embarked on changing the eligibility criteria of the Scheme to include professional corporate organisations, whereby the Scheme would be in a position to accept onto membership the entire staff complement of an organisation, including the professionals and the support staff. To date, however, attempts by the Scheme to register amended rules in this regard have been unsuccessful.

A further threat to the Scheme is the interpretation by the Council for Medical Schemes of Regulation 8(1) of the Medical Schemes Act that schemes are required to fund prescribed minimum benefit (PMB) conditions at full invoice price. To mitigate the risk to the Scheme, managed healthcare principles and protocols are applied to the funding of PMBs, in terms of the Medical Schemes Act.

The implementation of National Health Insurance (NHI) poses a challenge to the Scheme in that those members who are unable to fund membership of both a medical scheme and NHI might exit the Scheme. However, NHI will be phased in over the next 10 to 15 years and as such the Board of Trustees is of the opinion that this is a low risk in the short to medium term. Also, the nature of the profile of the membership of Profmed is such that it is unlikely that the Scheme will experience high volumes of member resignations due to NHI.

6. Wellness programme

Profmed broadened its risk management approach by offering the Multiply Wellness Programme to its members. This programme is used as a tool to contain costs on the supply side without compromising the quality of benefits to the members. Members who subscribe to the Multiply programme are expected to incur lower claims and are also less likely to resign as members of the Scheme, which serves to support the sustainability of the Scheme.

World Economic Forum statistics compiled over 3.5 years found that correct engagement with incentivised wellness programmes resulted in a 27% reduction in sick leave absenteeism and a 26% reduction in healthcare costs.

The Scheme's objectives are to:

- improve benefits, lower costs and protect solvency over the long term;
- enhance risk management tools – to anticipate, control and reduce risk factors, improving the financial model construct and reducing embedded risk;
- incentivise members to reduce sedentary lifestyle and increase activity, improve nutrition and actively engage in early detection tests;
- provide members with an established, structurally sound and tested wellness programme business model.

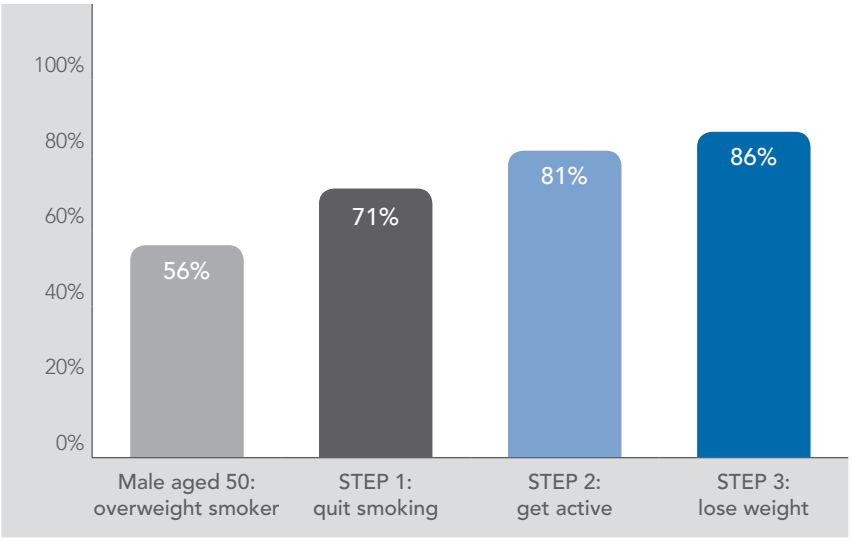
6. Wellness programme *(continued)*

In making the Multiply programme available to members, the Scheme aims to reduce health risk and encourage health, fitness and wellness amongst Scheme members. Multiply is an established, structured programme with significant intellectual and financial capital investment.

Using Multiply's largest scheme as a yardstick, health claims experience indicates lower hospitalisation and chronic costs, at an average of 27% lower (or R306 less per month) for Multiply members compared to non-Multiply scheme members over a five-year period.

By offering Multiply, Profmed provides a more holistic healthcare solution for its members. The Scheme uses Multiply to obtain a definitive advantage in both risk management, benefit design and incentives for members to actively engage in wellness improvement.

Incentivised wellness is aimed at improving lifestyle – people live longer with a lower claim propensity, and enjoy tangible rewards, as illustrated in the graph below:



Source: Lifestyle and 15-year survival free of heart attack, stroke and diabetes in middle-aged British men. Archives of Internal Medicine (1998), SG Wannamethee *et al.*

Statement

OF CORPORATE GOVERNANCE BY THE BOARD OF TRUSTEES

The Corporate Governance report on page 8 provides additional details on the corporate governance of the Board of Trustees.

Profmed is committed to the principles and practices of fairness, openness, integrity and accountability in all dealings with its stakeholders. The Profmed Board Charter, which includes the Code of Conduct, including ethics, has been adhered to. The Scheme is also fully committed to the principles of the Code of Corporate Practices and Conduct set out in the King Report on Governance (King III). Trustees are elected or appointed for a three-year period of office and may be re-elected or re-appointed. Five of the trustees are elected by the members of the Scheme. The other five are appointed by the Board of Trustees.

Board of Trustees

The trustees meet regularly and monitor the performance of the Scheme. They address a range of key issues and ensure that discussion of items of 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, subject to the procedures adopted by the Board of Trustees. The trustees are encouraged to undergo appropriate training in terms of the training policy. The Code of Conduct is maintained by the Board of Trustees.

Internal control

The administrators of the Scheme maintain internal controls and systems designed to provide reasonable but not absolute assurance as to the integrity and reliability of the annual financial statements and to 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.

Information technology security controls and procedures were reviewed by the Board, and the Scheme and its administrator are in the process of ensuring that they align with the requirements of King III. The information security team provides annual feedback to the Board on matters related to IT governance and information security.

No event or matter has come to the attention of the Board of Trustees that would indicate a material breakdown in the functioning of the key internal controls and systems which were in operation during the year under review.

Chairman

Trustee

Principal Officer

12 April 2012

Statement

OF RESPONSIBILITY BY THE BOARD OF TRUSTEES

The trustees are responsible for the preparation, integrity, and fair presentation of the Annual Integrated Report of Profmed. The annual financial statements, presented on pages 25 to 56, have been prepared in accordance with International Financial Reporting Standards and the Medical Schemes Act of South Africa and include amounts based on judgements and estimates made by management.

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

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

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

Profmed operated in a well-established control environment, which is well documented and regularly reviewed. This incorporates risk management and internal control procedures.

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 annual financial statements support the viability of the Scheme.

The Scheme's external auditors, PricewaterhouseCoopers Inc., have audited the annual financial statements and their report is presented on page 24.

The annual financial statements were approved by the Board of Trustees on 12 April 2012 and are signed on its behalf by:

Chairman

Trustee

Principal Officer

12 April 2012

Independent Auditor's REPORT TO THE MEMBERS OF PROFMED

We have audited the annual financial statements of Profmed, which comprise the Statement of Financial Position as at 31 December 2011, 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 information as set out on pages 25 to 56.

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 is 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 as to 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 Profmed as at 31 December 2011, 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 instance of non-compliance with the Medical Schemes Act, which we consider to be material:

We draw attention to Note 19 in the financial statements, which indicates that Profmed did not comply with Section 33(2), of the Medical Schemes Act, Act 131 of 1998, as amended, as some of the benefit options were not self-supporting in terms of membership and financial performance.

PricewaterhouseCoopers Inc.
Director: G Kapp
Registered Auditor
Sunninghill
26 April 2012

Statement
OF FINANCIAL POSITION AS AT 31 DECEMBER 2011

	Notes	2011 R'000	2010 R'000
Assets			
Non-current assets		358 999	210 481
Office furniture and equipment	2	552	711
Available-for-sale financial assets	4	358 447	209 770
Current assets		166 007	243 563
Available-for-sale financial assets	4	139 317	218 500
Accounts receivable	5	1 370	2 039
Cash and cash equivalents	6	25 320	23 024
Total assets		525 006	454 044
Liabilities			
Current liabilities		61 281	58 119
Accounts payable	7	36 155	35 591
Outstanding claims provision	8	25 126	22 528
Total liabilities		61 281	58 119
Total net assets		463 725	395 925
Net assets			
Members' funds and reserves		463 725	395 925
Accumulated funds		420 089	359 263
Revaluation reserve		43 636	36 662
Members' funds and reserves		463 725	395 925

Statement

OF COMPREHENSIVE INCOME FOR THE YEAR ENDED 31 DECEMBER 2011

	Notes	2011 R'000	2010 R'000
Net contribution income	9	**866 699**	761 802
Relevant healthcare expenditure	10	**(713 726)**	(636 555)
Net claims incurred		**(713 726)**	(636 555)
Claims incurred	10	**(714 818)**	(637 139)
Third-party claim recoveries	10	**1 092**	584
Gross healthcare result		**152 973**	125 247
Managed care: Management services	11	**(19 381)**	(17 042)
Administration expenditure	12	**(85 185)**	(77 222)
Broker service fees	13	**(5 531)**	(4 588)
Net impairment losses on healthcare receivables	24.3	**(4)**	(54)
Net healthcare result		**42 872**	26 341
Other income		**20 551**	34 970
Investment income	14	**20 471**	34 755
Sundry income	15	**80**	215
Other expenditure		**(2 597)**	(2 208)
Asset management fees	16	**(2 597)**	(2 208)
Net surplus/(deficit) for the year		**60 826**	59 103
Other comprehensive income			
Revaluation reserve for available-for-sale financial assets		**6 974**	18 440
Fair value adjustment on available-for-sale investments	4	**6 974**	18 440
Total comprehensive income for the year		**67 800**	77 543

Statement

OF CHANGES IN FUNDS AND RESERVES FOR THE YEAR ENDED 31 DECEMBER 2011

	Accumulated funds	Revaluation reserve for available-for-sale financial assets	Total members' funds and reserves
	R'000	R'000	R'000
Balance at 1 January 2010	300 160	18 222	318 382
Total comprehensive income for the year	59 103	18 440	77 543
Surplus for the year	59 103	–	59 103
Other comprehensive income	–	18 440	18 440
Balance at 31 December 2010	359 263	36 662	395 925
Total comprehensive income for the year	60 826	6 974	67 800
Surplus for the year	60 826	–	60 826
Other comprehensive income	–	6 974	6 974
Balance at 31 December 2011	420 089	43 636	463 725

Statement

OF CASH FLOWS FOR THE YEAR ENDED 31 DECEMBER 2011

	Notes	2011 R'000	2010 R'000
Cash flow from operating activities			
Cash generated/(utilised) from operations	18	44 441	27 669
Net cash generated/(utilised) from operating activities		44 441	27 669
Cash flow from investing activities			
Acquisition of office furniture and equipment	2	(174)	(161)
Proceeds on disposal of office furniture and equipment		7	10
Capital contribution	4	(46 100)	(16 500)
Withdrawals	4	–	1 747
Reclassification of investments to cash and cash equivalents		(16 349)	(19 206)
Interest	14	20 471	21 183
Dividends	14	–	226
Net cash generated from investing activities		(42 145)	(12 701)
Net increase/(decrease) in cash and cash equivalents		2 296	14 968
Cash and cash equivalents at beginning of year		23 024	8 056
Cash and cash equivalents at end of year	6	25 320	23 024

1. Summary of significant accounting policies

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

1.1 Basis of preparation

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

The preparation of financial statements in conformity with IFRS requires the use of certain critical accounting estimates. It also requires the Scheme's management to exercise judgement in the process of applying the Scheme's accounting policies. The areas involving a higher degree of judgement or complexity, or areas where assumptions and estimates are significant to the financial statements, are disclosed in Note 8 and Note 25.

1.2 Changes to accounting policy and disclosures

New and amended standards adopted by the Scheme

There are no IFRSs or IFRIC interpretations that are effective for the first time for the financial year beginning on or after 1 January 2011 that would be expected to have a material impact on the Scheme.

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

- IFRS 7 'Financial instruments: Disclosures' on transfers of financial assets (amendments)
- IFRS 9 'Financial instruments', addresses the classification, measurement and recognition of financial assets and financial liabilities
- IFRS 10 'Consolidated financial statements'
- IFRS 11 'Joint arrangements'
- IFRS 12 'Disclosures of interests in other entities'
- IFRS 13 'Fair value measurement'
- IAS 12 'Income taxes' (amendment)
- IAS 19 'Employee benefits'.

1.3 Office furniture, equipment and leasehold improvements

Office furniture, equipment and leasehold improvements are stated at historical cost less accumulated depreciation and accumulated impairment losses. Historical cost includes expenditure that is directly attributable to the acquisition of the items. Subsequent costs are included in the carrying amount when it is probable that future economic benefits associated with the asset will flow to the Scheme and the cost of the item can be measured reliably. Repairs and maintenance are charged to the Statement of Comprehensive Income during the financial period in which they are incurred.

Depreciation on furniture and equipment is calculated using the straight-line method to allocate their cost over their estimated useful lives. Depreciation on leasehold improvements is calculated using the straight-line method to allocate their cost over the period of the lease agreement.

The estimated maximum useful lives of the assets are:

Office furniture	10 years
Office equipment	3 years
Leasehold improvements	3 years.

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

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

1.4 Financial instruments

Financial assets and liabilities are recognised when the Scheme becomes party to the contractual provisions of the instrument (the trade date). The Scheme classifies its financial assets into two categories, namely, Accounts receivable and Available-for-sale financial assets. The classification depends on the purpose for which the financial assets were acquired. The Scheme determines the classification of its financial assets at initial recognition.

Initial recognition of financial instruments

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

Accounts receivable

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

Accounts receivable from the Road Accident Fund

The timing and monetary value of Road Accident Fund recoveries are considered to be uncertain and therefore debtors are not raised for amounts receivable at year-end. Amounts received during the year are deducted from Relevant healthcare expenditure (Note 10) as part of Third-party claim recoveries.

Available-for-sale financial assets

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

1. Summary of significant accounting policies *(continued)*

as Investment income in the Statement of Comprehensive Income. Dividends on available-for-sale equity instruments are recognised as Investment income in the Statement of Comprehensive Income when the Scheme's right to receive payments is established.

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

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

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

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

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

1.5 Impairment of financial assets

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

An asset is impaired if its carrying amount is greater than its recoverable amount. The recoverable amount of all assets, excluding available-for-sale investments, is the greater of the selling price and value in use. In assessing value in use, the estimated future cash flows are discounted to their present value using a pre-tax discount rate that reflects current market assessments of the time value of money and the risks specific to the asset.

Impairment of available-for-sale financial assets

In the case of equity securities classified as available-for-sale, a significant or prolonged decline in the fair value of a security below its cost is considered as objective evidence that the financial assets are impaired. If any such evidence exists for available-for-sale financial assets, the cumulative loss, measured as the difference between the acquisition cost and the current fair value, less any impairment loss on that financial asset previously recognised in profit or loss, is removed from reserves and recognised in the Statement of Comprehensive Income.

Impairment of receivables and other financial assets carried at amortised cost

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

- Significant difficulty of service provider or member debtors;
- Breach of contract, such as non-payment of member contributions when due and if these remain unpaid for extended periods;

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

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

Reversal of impairment

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

1.6 Derecognition of financial instruments

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

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

If a transfer does not result in derecognition because the Scheme has retained substantially all the risks and rewards of ownership of the transferred asset, the Scheme continues to recognise the transferred asset in its entirety and recognises a financial liability for the consideration received. In subsequent periods, the Scheme recognises any income on the transferred asset and any expense incurred on the financial liability.

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

(i) if the Scheme has not retained control, it derecognises the financial asset and recognises separately as assets or liabilities any rights and obligations created or retained in the transfer;
(ii) if the Scheme has retained control, it continues to recognise the financial asset to the extent of its continuing involvement in the financial asset.

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

1. Summary of significant accounting policies *(continued)*

1.7 Offsetting of financial instruments

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

1.8 Cash and cash equivalents

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

1.9 Provisions

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

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

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

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

Outstanding claims provision

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

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

1.10 Member insurance contracts

Contracts under which the Scheme accepts significant insurance risk from members by agreeing to compensate the member or other beneficiary if a specified uncertain future event (the insured event) adversely affects the member or other beneficiary are classified as insurance contracts. The contracts issued compensate the Scheme's members for healthcare expenses incurred.

1.11 Contribution income

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

1.12 Relevant healthcare expenditure

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

Net risk claims incurred comprise:

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

Net of:

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

1.13 Expenses for the acquisition of member insurance contracts

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

1.14 Investment income

Investment income comprises dividends and interest on cash and cash equivalents and other available-for-sale financial assets.

Interest income is recognised using the effective interest rate method, taking into account the principal amount outstanding and the effective rate over the period to maturity, when it is determined that such income will accrue to the Scheme.

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

1.15 Retirement benefits

Defined contribution plan

The Scheme's employee pension fund is funded through payments to insurance companies. The Scheme has a defined contribution plan, which is a pension plan, governed by the Pensions Fund Act, where the Scheme pays fixed contributions into a separate entity. Once the contributions have been paid, the Scheme has no legal or constructive obligations to pay further contributions if the pension fund does not

1. Summary of significant accounting policies *(continued)*

hold sufficient assets to pay all employees their entitlement. The pension contributions are recognised as staff remuneration when they are due and payable.

1.16 Unallocated funds

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

1.17 Segment reporting

No segmental business information is presented as the entire Scheme's business is considered to be one business segment.

1.18 Liabilities and related assets under the liability adequacy test

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

1.19 Allocation of income and expenditure to benefit options

The following items are directly allocated to benefit options:

- Contribution income;
- Claims incurred;
- Broker fees.

The remaining items are apportioned based on the number of principal members on each option:

- Managed care: Management services;
- Administration fees;
- Other income;
- Other expenditure.

2. Office furniture, equipment and leasehold improvements

	Office equipment & software R'000	Office furniture R'000	Leasehold improvements R'000	Total R'000
Year ended 31 December 2011				
Opening carrying amount	267	360	84	711
Acquisitions during the year	145	5	24	174
Disposals during the year	(33)	–	–	(33)
Depreciation charge	(160)	(50)	(90)	(300)
Closing carrying amount	219	315	18	552
Cost or valuation	1 017	544	345	1 906
Accumulated depreciation	798	229	327	(1 354)
Carrying amount	219	315	18	552
Year ended 31 December 2010				
Opening carrying amount	305	408	191	904
Acquisitions during the year	161	–	–	161
Disposals during the year	(4)	–	–	(4)
Depreciation charge	(195)	(48)	(107)	(350)
Closing carrying amount	267	360	84	711
Cost or valuation	928	538	320	1 786
Accumulated depreciation	(661)	(178)	(236)	(1 075)
Carrying amount	267	360	84	711

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

	2011 R'000	2010 R'000
Available-for-sale financial assets		
– Non-current	358 447	209 770
– Current	139 317	218 500
Cash and cash equivalents	25 320	23 024
Accounts receivable		
– Loans and receivables	818	1 645
– Insurance receivables	691	494
Accounts payable		
– Financial liabilities measured at amortised cost	4 023	2 121
– Insurance payables	57 258	55 998

4. Available-for-sale financial assets

	Notes	2011 R'000	2010 R'000
Beginning of the year		428 270	362 530
Capital contribution		46 100	16 500
Withdrawals: Day-to-day cash management		–	(1 747)
Net realised gains	14	–	13 346
Asset management fees	16	(2 597)	(2 208)
Unrealised fair value gain: Revaluation reserve		6 974	18 440
Investment income			
– Interest	14	19 017	21 183
– Dividends	14	–	226
Fair value at the end of the year		497 764	428 270
Less: Available-for-sale financial assets – current		(139 317)	(218 500)
Available-for-sale financial assets		358 447	209 770
The Scheme's financial assets are categorised by measurement category below:			
Equity securities		213 956	170 252
Property equity securities		42 314	32 043
Money market		114 555	94 688
Bonds and cash instruments		126 939	131 287
Total		497 765	428 270

Available-for-sale financial instruments are denominated in RSA Rand. Money market instruments redeemable in three months or less are classified as cash and cash equivalents. None of the available-for-sale financial assets are past due. At the end of the current financial year there was no objective evidence of impairment of the equity investments.

5. Accounts receivable

	2011 R'000	2010 R'000
Contributions outstanding	104	114
Receivable from service providers	379	279
Recoveries from members	208	101
Deposits and prepaid expenses	196	327
Sundry debtors	–	229
Accrued interest	583	1 089
Sub-total: Accounts receivable	1 470	2 139
Impairment provision	(100)	(100)
Current portion	1 370	2 039

As at 31 December 2011, the carrying amounts of accounts receivable approximated their fair value. Interest is not charged on overdue balances.

6. Cash and cash equivalents

	2011 R'000	2010 R'000
Cash at bank and on hand	3 101	3 479
Short-term bank deposits	22 219	19 545
	25 320	23 024

The weighted average effective interest rate was 5.88% (2010: 5.91%) on current and call account balances.

The current bank account has a general cession of R86 839 with regards to a lease deposit paid in the form of a bank guarantee. The Council for Medical Schemes provided written exemption on 29 June 2009 from Section 35(6)(a) of the Medical Schemes Act 131 of 1998.

7. Accounts payable

	2011 R'000	2010 R'000
Insurance liabilities		
Net contributions received in advance	93	405
Reported claims not yet paid	31 163	32 377
Member and provider credit balances	876	688
Total liabilities arising from insurance contracts	32 132	33 470
Financial liabilities		
Sundry accounts payable	4 023	2 121
Total arising from financial liabilities	4 023	2 121
Total accounts payable	36 155	35 591

As at 31 December 2011, the carrying amounts of accounts payable approximated their fair value because of the short-term maturities of these liabilities.

8. Outstanding claims provision

	Notes	2011 R'000	2010 R'000
Analysis of movements in outstanding claims			
Balance at beginning of year		22 528	31 851
Payments in respect of prior year	10	(20 538)	(29 764)
Over-provision in prior year written back	10	(1 990)	(2 087)
Adjustment for current year	10	25 126	22 528
Balance at end of year		25 126	22 528

Analysis of movements in provision arising from liability adequacy test

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

Process used to determine the assumptions

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

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

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

The actual method or blend of methods used varies by benefit year being considered, categories of claims and observed historical claims development. To the extent that historical claims development information is used, it is assumed that the historical claims development pattern will occur again in the future. There are reasons why this may not be the case, which, insofar as they can be identified, have been allowed for by modifying the methods. Such reasons include:

- changes in processes that affect the development and recording of claims paid and incurred;
- changes in composition of members and their dependants;
- random fluctuations, including the impact of large losses; and
- legislative changes, e.g. expansion of the definition of a prescribed minimum benefit (PMB)/Chronic Disease List (CDL).

Assumptions

The outstanding claims provision is calculated based on claim processing patterns over the previous twenty-four months. Due to the large size of the Scheme membership base, no adjustment to the data is made for large claims. The assumptions that have the greatest effect on the measurement of the outstanding claims provision are the claims run-off periods for the most recent benefit years (split by discipline) for the in-hospital, chronic and day-to-day categories of claims. The run-off factor relates to the emergence and settlement patterns of claims and is expressed as the percentage of claims settled in respect of total claims expected to emerge in a specific service month. This factor is then used to project the remainder of the outstanding claims relating to the specified service month. These are used for assessing the outstanding claims provision for the 2011 benefit year. Due to the fact that 98% of claims are paid within three months of the date of service, no allowance for discounting of claims costs is made.

Changes in assumptions and sensitivities to changes in key variables

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

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

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

	Change in variable %	**Change in liability 2011 R'000**	Change in liability 2010 R'000
Hospitalisation	1% slower	**1 289**	1 599
Chronic medication	1% slower	**168**	215

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

9. Net contribution income

	2011 R'000	2010 R'000
Net contribution income	**866 699**	761 802

10. Relevant healthcare expenditure

	Notes	**2011 R'000**	2010 R'000
Current year claims paid		**712 220**	646 462
Movement in outstanding claims provision		**2 598**	(9 323)
Payments in respect of prior year	8	**(20 538)**	(29 764)
Over-provision in prior year	8	**(1 990)**	(2 087)
Adjustment for current year	8	**25 126**	22 528
Claims incurred		**714 818**	637 139
Less: Third-party claim recoveries		**(1 092)**	(584)
		713 726	636 555

11. Managed care: Management services

	2011 R'000	2010 R'000
Hospital pre-authorisation, case and disease management	**9 723**	8 567
Pharmacy benefit and clinical risk management services	**6 389**	5 724
Emergency medical transportation service	**424**	339
Travel insurance	**1 313**	1 103
Optical benefit management	**389**	386
Dental benefit management	**895**	710
Trauma benefit management	**70**	69
Medical advisor	**178**	144
	19 381	17 042

12. Administration expenditure

	Notes	2011 R'000	2010 R'000
Audit fees		650	596
Actuarial fees		656	634
Association fees		260	252
Bank charges		482	605
Internal broker consultants		6 721	6 105
Computer expenses		125	115
Council for Medical Scheme expenses		542	450
Depreciation		300	295
Entertainment		7	18
Fees paid to the administrator		58 028	52 586
Internal audit fees		28	28
Legal fees		133	480
Marketing expenses		5 648	4 435
Office rental		934	719
Principal officer remuneration		2 081	1 872
Printing and stationery		799	927
Professional fees		21	138
Professional indemnity insurance premiums		217	202
Eligibility services		221	205
Repairs and maintenance		7	14
Staff cost		3 479	3 141
Telephone, postage and fax		1 570	1 079
Travel, accommodation and conferences		215	91
Trustee remuneration and considerations	17	1 774	1 831
Other expenses		288	304
		85 185	77 222

13. Broker service fees

	2011 R'000	2010 R'000
Broker fees	5 531	4 588
Other distribution costs paid to brokers	–	–
	5 531	4 588

14. Investment income

	2011 R'000	2010 R'000
Available-for-sale – dividend income	–	226
Interest income	20 471	21 183
– Available-for-sale financial assets	19 017	18 964
– Call and current bank accounts	1 454	2 219
Net realised gains on available-for-sale financial assets	–	13 346
	20 471	34 755

15. Sundry income

	2011 R'000	2010 R'000
Prescribed amounts written to income	73	214
Profit on the disposal of equipment	7	1
	80	215

16. Asset management fees

	2011 R'000	2010 R'000
Management fees	2 597	2 016
Performance fees	–	192
Current year expense	2 597	2 208

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

17. Trustee and committee remuneration

The following table records the remuneration and consideration paid to trustees and other committee members during 2011:

31 December 2011	Fees for meeting attendance	Fees for holding of office	Fees for consultancy services	Allowances	Total remuneration	Training	Conference fees	Travel and accom-modation	Other disbursements and reimbursements	Total considerations
Dr AD Behrman	R66 230				R66 230	R705		R62 566		R129 501
Dr JB Bekker	R29 620				R29 620			R51 861		R81 481
Dr MM Bhikhoo	R140 900	R46 300			R187 200	R705		R3 500		R191 405
Mr M Brown*	R41 984				R41 984			R3 372		R45 356
Mr E Huggett	R94 050				R94 050	R2 405		R7 163		R103 618
Mr KG Mockler*	R55 432		R36 400		R91 832			R3 970		R95 802
Dr E Nkosi	R96 850				R96 850	R705		R4 392		R101 947
Dr Y Omar Carrim*	R19 921				R19 921			R2 134		R22 055
Ms EL Prins-Van den Berg	R281 303	R68 700			R350 003	R4 277	R3 850	R17 379		R375 509
Dr RD Shuttleworth	R99 760				R99 760	R705		R105 846		R206 311
Mr A Tait	R80 290				R80 290	R705		R1 400		R82 395
Mr RN Theunissen	R162 190				R162 190	R2 255		R5 057		R169 502
Dr EJ Thorburn	R91 230				R91 230	R705		R4 265		R96 200
Ms MM van Garderen	R70 030				R70 030	R1 948		R1 340		R73 318
Total	R1 329 790	R115 000	R36 400		R1 481 190	R15 115	R3 850	R274 245		**R1 774 400**

* Independent Board committee members

Trustee appointment, election and resignation dates are disclosed in the Report of the Board of Trustees.

17. Trustee and committee remuneration *(continued)*

The following table records the remuneration and consideration paid to Trustees and other committee members during the 2010:

31 December 2010	Fees for meeting attendance	Fees for holding of office	Fees for consultancy services	Allowances	Total remuneration	Training	Conference fees	Travel and accom-modation	Other disbursements and reimbursements	Total considerations
Dr AD Behrman	R70 355				R70 355			R76 643		R146 998
Dr JB Bekker	R90 965				R90 965	R2 743		R60 512		R154 220
Dr MM Bhikhoo	R170 038	R25 970			R196 008	R3 110		R4 788		R203 906
Mr M Brown*	R20 800		R3 480		R24 280			R2 400		R26 680
Mr E Huggett	R87 525				R87 525	R1 500		R9 504		R98 529
Mr KG Mockler*	R56 180		R31 900		R88 080			R5 208		R93 288
Dr E Nkosi	R93 485				R93 485			R4 440		R97 925
Dr Y Omar Carrim*	R15 600				R15 600			R1 980		R17 580
Ms EL Prins-Van den Berg	R194 165	R55 650			R249 815	R7 554	R147	R17 142		R274 658
Dr RD Shuttleworth	R88 665				R88 665	R1 500		R79 203		R169 368
Mr A Tait	R90 995				R90 995			R2 352		R93 347
Mr RN Theunissen	R200 115				R200 115	R6 054		R6 330		R212 499
Dr EJ Thorburn	R142 525	R26 500			R169 025		R5 952	R7 092		R182 069
Dr HS van Riet	R26 620				R26 620			R33 523		R60 143
Total	R1 348 033	R108 120	R35 380		R1 491 533	R22 461	R6 099	R311 117		**R1 831 210**

* Independent Board committee members

Trustee appointment, election and resignation dates are disclosed in the Report of the Board of Trustees.

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

	Notes	2011 R'000	2010 R'000
Net surplus/(deficit) for the year		60 826	59 103
Adjustments for:			
Depreciation	2	300	350
Interest received	14	(20 471)	(21 183)
Dividend income	14	–	(226)
Realised gain on disposal of available-for-sale financial assets	14	–	(13 346)
Profit on the disposal of equipment	15	(7)	(1)
Increase/(decrease) in outstanding claims provision	10	2 598	(9 323)
Cash flows from operations before working capital changes		43 247	15 374
Changes in working capital		1 194	12 295
Decrease in accounts receivable	5	630	688
Increase in accounts payable	7	564	11 607
Cash utilised in operations		44 441	27 669

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

The Scheme offers five benefit options, which have the following principal features:

- **ProPinnacle** – Comprehensive in-hospital cover in private wards, and comprehensive chronic and day-to-day cover. GP and specialist costs covered at Profmed Premium Tariff rates (approximately 300% of the 2006 National Health Reference Price List with annual inflationary increases).
- **ProSecure Plus** – Comprehensive in-hospital cover and private ward rates for maternity confinement. Chronic and day-to-day medical expenses and cover over and above the prescribed minimum benefits. In-hospital GP and specialist costs covered at Profmed Premium Tariff rates (approximately 300% of the 2006 National Health Reference Price List with annual inflationary increases).
- **ProSecure** – Comprehensive cover in-hospital, and chronic and day-to-day medical expenses and cover over and above the prescribed minimum benefits.
- **ProActive Plus** – Comprehensive in-hospital benefits, and cover for prescribed minimum benefits. In-hospital GP and specialist costs covered at Profmed Premium Tariff rates (approximately 300% of the 2006 National Health Reference Price List with annual inflationary increases).
- **ProActive** – Comprehensive in-hospital benefits, and cover for prescribed minimum benefits.

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

2011	ProPinnacle R'000	ProSecure Plus R'000	ProSecure R'000	ProActive Plus R'000	ProActive R'000	Total R'000
Net contribution income	165 014	106 809	298 307	88 326	208 243	866 699
Relevant healthcare expenditure	(163 971)	(106 178)	(261 786)	(61 295)	(120 496)	(713 726)
Claims incurred	(164 152)	(106 203)	(262 221)	(61 295)	(120 947)	(714 818)
Third-party claim recoveries	181	25	435	–	451	1 092
Gross healthcare result	1 043	631	36 521	27 031	87 747	152 973
Managed care: Management services	(1 711)	(1 776)	(5 627)	(3 116)	(7 151)	(19 381)
Administration expenditure	(7 519)	(7 804)	(24 730)	(13 696)	(31 436)	(85 185)
Broker service fees	(488)	(507)	(1 606)	(889)	(2 041)	(5 531)
Net impairment losses on healthcare receivables	–	–	–	–	(4)	(4)
Net healthcare result	(8 675)	(9 456)	4 558	9 330	47 115	42 872
Average number of members during the year	2 298	2 385	7 557	4 185	9 607	26 032

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

2010	ProPinnacle R'000	ProSecure Plus R'000	ProSecure R'000	ProActive Plus R'000	ProActive R'000	Total R'000
Net contribution income	157 712	91 036	261 204	64 397	187 453	761 802
Relevant healthcare expenditure	(153 417)	(92 165)	(228 369)	(43 983)	(118 621)	(636 555)
Claims incurred	(153 417)	(92 180)	(228 429)	(44 016)	(119 097)	(637 139)
Third-party claim recoveries	–	15	60	33	476	584
Gross healthcare result	4 295	(1 129)	32 835	20 414	68 832	125 247
Managed care: Management services	(1 646)	(1 567)	(4 986)	(2 294)	(6 549)	(17 042)
Administration expenditure	(7 457)	(7 100)	(22 593)	(10 395)	(29 677)	(77 222)
Broker service fees	(443)	(422)	(1 342)	(618)	(1 763)	(4 588)
Net impairment losses on healthcare receivables	(5)	(5)	(16)	(7)	(21)	(54)
Net healthcare result	(5 256)	(10 223)	3 898	7 100	30 822	26 341
Average number of members during the year	2 435	2 319	7 378	3 395	9 692	25 219

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

20. Related party transactions

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

Administration fees were paid to the administrator, Professional Medical Scheme Administrators (Proprietary) Limited, a wholly-owned subsidiary of PPS Insurance Company Limited. Administration fees were charged in line with market-related rates on an arm's length basis.

Transactions with related parties

	Notes	**2011 R'000**	2010 R'000
Statement of Comprehensive Income			
Professional Medical Scheme Administrators	12	**58 028**	52 586
Statement of Financial Position			
Balance due to Professional Medical Scheme Administrators		**–**	–

The terms and conditions of the transactions with related parties 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.

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 Principal Officer. The disclosure deals with full-time personnel that are compensated on a salary basis (Principal Officer), and part-time personnel that are compensated on a fee basis (Board of Trustees). Close family members include close family members of the Board of Trustees and Principal Officer.

Transactions with related parties' key management personnel (Board of Trustees and Principal Officer) and their close family members

	2011 R'000	2010 R'000
Statement of Comprehensive Income		
Remuneration	**3 869**	3 703
Contributions received	**403**	396
Claims incurred	**(309)**	(211)
Statement of Financial Position		
Contribution debtors	**–**	–
Claims reported not yet paid	**–**	–

20. Related party transactions *(continued)*

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

Transaction	Nature of transactions and terms and conditions thereof
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 debtor	This constitutes outstanding contributions receivable. The amounts are due immediately. No impairment provisions have been raised on these amounts.
Claims reported not yet paid	These are claims that have been reported, but not yet paid due to the fact that the Scheme's year-end fell between the claims payment runs. All claims are settled within 30 days of being received, as applicable to third parties or other members.

21. Commitments

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

22. Subsequent events

There have been no adjusting or non-adjusting events that have occurred between the accounting date and the date of this report that affected the 2011 results.

23. Guarantees

The Scheme did not receive guarantees from third parties in terms of Section 33(3) of the Medical Schemes Act. The current bank account has a general cession of R86 839 with regards to a lease deposit paid in the form of a bank guarantee. The Council for Medical Schemes provided written exemption from Section 35(6)(a) of the Medical Schemes Act 131 of 1998 on 29 June 2009.

24. Financial risk management

24.1 Financial risk factors

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

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

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

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

- ABSA Bank A-
- FirstRand Holdings BBB+
- Investec Private Bank BBB.

24.2 Market risk

a) Interest rate risk

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

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

The Scheme's investment manager's mandate is to invest 60% to 80% in money market portfolios. The portfolio invests in bonds and cash instruments.

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

	Up to 3 months R'000	4 - 12 months R'000	1 - 5 years R'000	Total R'000
2011				
Total exposure	117 418	47 219	–	164 637
2010				
Total exposure	188 271	53 253	–	241 524

The above amounts are classified as follows:

	Notes	2011 R'000	2010 R'000
Available-for-sale financial assets			
– Non-current	4	–	–
– Current	4	164 637	241 524
		164 637	241 524

Interest rate risk sensitivity analysis

A change of 100 basis points in interest rates at the reporting date would have increased/(decreased) accumulated funds and the surplus by the amounts shown below. The analysis assumes that all other variables remain constant. The analysis was performed from the date that the current asset managers were appointed.

	Surplus or deficit (R'000)		Accumulated funds (R'000)	
	100bp increase	100bp decrease	100bp increase	100bp decrease
2011				
Available-for-sale financial assets	62 729	59 105	421 812	418 365
2010				
Available-for-sale financial assets	61 363	56 844	361 523	357 003

24. Financial risk management *(continued)*

b) Currency risk

All of the Scheme's investments and benefits are Rand-denominated and therefore do not have significant net currency risk.

c) Price risk

The Scheme is exposed to equity securities price risk because of investments held by the Scheme and classified in the Statement of Financial Position as Available-for-sale financial assets. The Scheme is not exposed to commodity risk. To manage the price risk arising from investment in equity securities, the Scheme diversifies its portfolio within the limits prescribed by the Medical Schemes Act and Regulations.

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

	Up to one month R'000	1 - 3 months R'000	4 - 12 months R'000	1 - 5 years R'000	Total R'000
2011					
Total exposure	–	–	–	256 269	256 269
2010					
Total exposure	–	–	–	195 015	195 015

24.3 Credit risk

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

The receivables are in respect of:

- contributions due from members;
- amounts recoverable from service providers and accrued interest.

The Scheme manages credit risk by:

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

The amounts presented in the Statement of Financial Position are net of provision for impairment, estimated by the Scheme's management, based on prior experience and the current economic environment. The credit risk on liquid funds is limited because the counter-parties are banks with high credit ratings assigned by international credit-rating agencies. There is no significant concentration of credit risk with respect to receivables, as the Scheme has a large number of members who are nationally dispersed.

Exposure to credit risk

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

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

	Notes	2011 R'000	2010 R'000
Fully performing		818	1 645
Past due – 4 to 30 days		522	107
Past due – 31 days and older		69	287
Impairment provision		100	100
Total accounts receivable	5	1 509	2 139
Net impairment losses on healthcare receivables		4	54

Movements on the impairment provision of accounts receivable are as follows:

	Notes	2011 R'000	2010 R'000
At 1 January		100	100
Reduction in the provision for receivable impairment		–	–
At 31 December	5	100	100

24.4 Liquidity risk

The Scheme manages liquidity risk by monitoring cash flows. The Scheme is exposed to daily calls on its available cash resources mainly from claims. Liquidity risk is the risk that cash may not be available to pay obligations when they are due at a reasonable cost.

The availability of funding through liquid-holding cash positions with various financial institutions ensures that the Scheme has the ability to fund the day-to-day operations of the Scheme. The 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.

24.5 Capital management

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 risk is that there are insufficient reserves to provide for adverse variations on actual and future experience. The Medical Schemes Act 131 of 1998, as amended, requires a minimum ratio of accumulated funds expressed as a percentage of gross premiums to be 25%. The Scheme's accumulated funds ratio was 48.47% as at 31 December 2011 and 47.16% at 31 December 2010.

24. Financial risk management *(continued)*

The accumulated funds ratio is calculated as follows:

	2011 R'000	2010 R'000
Total members' funds per Statement of Financial Position	463 764	395 925
Less: Reserve for unrealised investment gains	(43 636)	(36 662)
Accumulated funds per Regulation 29 of the Act	420 128	359 263
Annual contribution income per Statement of Comprehensive Income	866 699	761 802
Accumulated funds ratio calculated as the ratio of accumulated funds/gross annual contributions x 100	48.47%	47.16%

24.6 Investment risk

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

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

	Surplus (R'000)					
	Increase in market			Decrease in market		
	30%	15%	5%	5%	15%	30%
2011						
Equity portfolio	114 827	87 827	69 827	51 827	33 827	11 131
2010						
Equity portfolio	182 289	142 203	115 478	95 249	81 514	60 912

Fair values of financial assets by hierarchy level:

	Level 1 R'000	Level 2 R'000	Level 3 R'000	Reclassification
2011				
Available-for-sale financial assets	497 764	–	–	–
2010				
Available-for-sale financial assets	428 270	–	–	–

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

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

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

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

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

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

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

Outstanding claims provision

The outstanding claims provision is a provision made for the estimated cost of healthcare benefits that had occurred before the year-end, but that had not been reported to the Scheme by that date. This provision is determined as accurately as possible based on a number of factors, which include previous experience in claims patterns, claims settlement patterns, changes in the nature and number of members according to trends in claims frequency, changes in the claims processing cycle, and variations in the nature and average cost incurred per claim. Refer to Note 8.

26. Insurance risk management

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

The Board of Trustees has developed and approved a documented policy for the acceptance and management of insurance risk to which the Scheme is exposed. Reference has also been made to the requirements of the Medical Schemes Act 131 of 1998, as amended, in compiling the insurance risk management policy. This policy is reviewed annually and the benefit options provided to the members are structured to fall within the acceptable insurance risk levels specified. The annual business plan is structured around the insurance risk management policy.

The Scheme manages its insurance risk through benefit limits and sub-limits, approval procedures for transactions that involve pricing guidelines, pre-authorisation and case management, protocols as well as the monitoring of emerging legislative, environmental and actuarial issues.

The Scheme uses several methods to assess and monitor insurance risk exposure, both for individual types of risks insured and overall risks. These methods include internal risk measurement models, comparison of budgeted versus actual claims on a regular basis, sensitivity analyses, scenario analyses and stress testing. The theory of probability is applied to the pricing and provisioning for a portfolio of insurance contracts, using established actuarial principles. The principal risk is that the frequency and severity of claims is greater than expected. Insurance events are, by their nature, random, and the actual number and size of events during any one year may vary from those estimated using established statistical techniques.

The table overleaf summarises the concentration of insurance risk, with reference to the carrying amount of the insurance claims incurred, by age group and in relation to the type of risk covered and benefits provided. Where appropriate, prescribed minimum benefits (PMBs) and non-PMB claims have been split.

26. Insurance risk management *(continued)*

Concentration of insurance risk

Claims incurred for 2011 service year:

Age grouping (in years)	In-hospital R'000	Chronic R'000	Day-to-day R'000	Other R'000	Total R'000
< 26	62 800	3 859	20 094	5 570	92 324
26 – 34	41 271	3 827	9 558	2 291	56 946
35 – 49	72 342	7 904	19 118	6 097	105 460
50 – 64	153 659	23 857	38 715	18 091	234 322
> 65	154 499	22 960	28 065	18 246	223 771
Total	484 572	62 407	115 549	50 295	712 823
Movement in the outstanding claims provision					2 598
Rectified benefits					(302)
Claims refund					(1 092)
Other adjustments					(301)
Relevant healthcare expenditure (Note 10)					713 726

Claims incurred for 2010 service year:

Age grouping (in years)	In-hospital R'000	Chronic R'000	Day-to-day R'000	Other R'000	Total R'000
< 26	58 388	3 865	20 064	2 538	84 856
26 – 34	35 915	2 670	8 500	581	47 667
35 – 49	73 848	6 605	18 542	2 163	101 157
50 – 64	138 659	21 119	38 140	6 185	204 103
> 65	152 829	21 443	28 929	5 517	208 718
Total	459 640	55 702	114 175	16 984	646 501
Movement in the outstanding claims provision					(9 323)
Rectified benefits					29
Claims refund					(584)
Relevant healthcare expenditure (Note 10)					636 555

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

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

Day-to-day benefits cover the cost (up to 100% of the Scheme tariff) of all out-of-hospital medical attention, such as visits to general practitioners and dentists and prescribed non-chronic medicines.

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

All the contracts are annual in nature and the Scheme has the right to change the terms and conditions of the contracts at renewal. Management information including contribution income and claims ratios by option, target market and demographic split, is reviewed monthly. There is also an underwriting review programme that reviews a sample of contracts on a quarterly basis to ensure adherence to the Scheme's objectives.

The table below indicates how sensitive the Scheme's results are to changes in the claims experience:

	Change in variable	2011 R'000	2010 R'000
Actual surplus/(deficit)		**60 827**	59 103
Surplus after change in claims experience	1% lower	**67 964**	65 469
Surplus after change in claims experience	1% higher	**53 690**	52 737

Risk transfer arrangements

The Scheme did not reinsure any of the risks it underwrites in order to control its exposure to losses and protect capital resources. The Scheme did not have any capitation agreements with any providers of service.

Claims development

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

27. Contingent asset

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 (RAF), administered in terms of the Road Accident Fund Act No. 56 of 1996. If the member is reimbursed by the RAF, they are obliged contractually to cede that payment to the Scheme to the extent that they have already been compensated. The outstanding amount at year-end amounts to R1 313 189 (2010: R2 818 646).

28. Non-compliance matters

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

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

Section 26(1)(b) of the Act states that: "Any medical scheme registered under this Act shall – (b) assume liability for and guarantee the benefits offered to its members and their dependants in terms of its rules". Regulation 8(1) of the Act states that: "Subject to the provisions of this regulation, any benefit option that is offered by a medical scheme must pay in full, without co-payment or the use of deductibles, the diagnosis, treatment and care costs of the prescribed minimum benefit conditions." Profmed paid PMBs in excess of the Scheme rules for the latter part of the 2011 financial period in order to comply with the Council for Medical Scheme's interpretation of Regulation 8(1).

Form of Proxy

Form of Proxy for the Profmed Annual General Meeting to be held at 15h30 on Wednesday 6 June 2012.

I, _____ , membership no. _____,

being a current and fully-paid member of Profmed, hereby appoint _____,

membership no. _____, or failing him the Chairman of the meeting, as my proxy to attend, and speak, and vote on a poll for me and on my behalf at the meeting of Profmed to be held at 15 Eton Road, Parktown, Johannesburg, and at any adjournment thereof, as follows:

No.	Business	In favour of	Against	Abstain
1.	Resolution for the adoption of the Annual Financial Statements for the year ended 31 December 2011 (including the reports of the trustees and the auditors)			
2.	Resolution for the re-appointment of the auditors			
3.	Confirmation of remuneration of trustees			

Indicate instruction to proxy by way of a cross x in the relevant space provided above.

Signed this _____ day of _____ 2012.

Signature: _____

Notes

1. A member entitled to attend and vote is entitled to appoint a proxy to attend, speak and, on a poll, vote in his stead, provided such proxy is also a current and fully-paid member of Profmed.
2. Resolutions referred to in this form are those that must, in accordance with the Rules of Profmed, be taken at an annual general meeting and voted upon by all those present at such an annual general meeting.
3. The proxy form must be signed, dated and e-mailed to proxy2012@profmed.co.za or faxed to 011 628 8907 by **12h00 on Tuesday 5 June 2012**, the day prior to the scheduled annual general meeting. Hand-delivered or posted submissions will not be accepted.
4. The signatory may insert the name of any Profmed member whom the signatory wishes to appoint as his/her proxy in the blank spaces provided for that purpose at the top of the proxy form.
5. The completion and lodging of this Form of Proxy will not preclude the signatory from attending the meeting and speaking and voting in person to the exclusion of any proxy appointed in terms hereof should such signatory wish to do so.
6. If the signatory does not indicate in the appropriate place on the face of this form how he/she wishes to vote in respect of any resolution, his/her proxy shall be entitled to vote as he/she deems fit in respect of that resolution whether or not express reference is made to the nature of such a resolution in this form.

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