2013

PROFMED ANNUAL INTEGRATED REPORT

Healthcare for Professionals

PROFMED

Notice OF ANNUAL GENERAL MEETING

Notice to members

Notice is hereby given that the 43rd Annual General Meeting of the members of Profmed will be held at Profmed Place, 15 Eton Road, Parktown, Johannesburg on Wednesday 4 June 2014 at 15:30.

Agenda

1. To receive and adopt the annual financial statements for the year ended 31 December 2013 (including the reports of the trustees, the auditors and the Profmed Audit Committee).

2. To re-appoint PricewaterhouseCoopers Inc. as the auditors of Profmed for 2014/15 in terms of rule 27 of the rules of Profmed.

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

4. To approve the remuneration of trustees at a rate of R2 500 per hour for the 2014/15 year.

5. To announce the appointment of one (1) trustee nominated in accordance with the rules of Profmed.

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

By order of the Board of Trustees.

Graham R Anderson
Principal Officer and Chief Executive

29 April 2014

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Chairman's REPORT

Dr Mohamed Bhikhoo
Chairman of the Board of Trustees

As a trustee of Profmed for the past eleven years, I have had the privilege, and sometimes the angst, of seeing Profmed through difficult but also successful times. Profmed is today in a healthier position than ever before and much of the success of Profmed can be attributed to the able and visionary leadership of the trustees and the chairmen who have served Profmed with pride, integrity and honour. In June 2013, Ms Esmé Prins-Van den Berg resigned as a trustee and Chairman of the Board to focus on her healthcare consulting business after serving on the Board for eleven years. I wish to take this opportunity to thank Esmé for the legacy she left both the Board and Profmed, and for the wealth of knowledge of the medical scheme industry she brought with her. We wish Esmé everything of the best for the future.

The Chairman's Report in the Annual Integrated Report for 2012 reported that Profmed was one of the few medical schemes that was growing in membership. I am pleased to report that this remained the case in 2013. Part of the Board of Trustees' strategy to ensuring the sustainability of Profmed is to grow the Scheme, and the membership growth achieved in 2013 is certainly encouraging.

This Annual Integrated Report once again presents outstanding results. The Board took the decision a number of years ago to keep the operating surplus to a minimum to ensure that members get the benefit of the Scheme's reserves. This set of results bears out that decision and once again provides assurance to members that Profmed is a healthy scheme. The Board of Trustees takes its fiduciary duties very seriously, in not only ensuring the financial soundness of the Scheme, but also in providing good quality, fair and transparent benefits for our valued members.

Of course, of equal importance is providing members with excellent service. Great strides have been made in implementing services and tools for our members to enhance their experience of Profmed. Some of these enhancements include the Chat facility on the website, the new Profmed mobi-app and our extended call centre hours. Claims are being paid quicker so that members, and providers, are not out of pocket, and the system is now functioning better than ever before. But we will not stop there. Profmed seeks to harness technology to make interaction with us and your experience of Profmed simpler and more convenient and we will communicate these developments as and when they become available.

Profmed is proud to be one of the few medical schemes to have contained contribution increases over the last few years within the lower quartile of the average of the industry while at the same time increasing benefits to our members. This was made possible by the prudent management of the Scheme's finances, transparent and astute governance practices, and a benefit model that is uncomplicated and designed to ensure Profmed meets the needs of our members at trying and difficult times in their lives. While we acknowledge the necessity for members to make healthy lifestyle choices, as a medical scheme our philosophy and function is to provide comprehensive medical cover when the unexpected occurs, in spite of healthy lifestyle choices. We unashamedly focus on benefits that provide cover for high-cost diseases and traumas, and treatment that is evidence-based and clinically appropriate. This evidence-based approach ensures that the funds entrusted to us by our members are spent in a cost-effective manner and equitably for all, while ensuring good outcomes.

Despite the challenges that face the medical scheme industry, the trustees are optimistic of Profmed's future and believe that the Scheme is well positioned to succeed and prosper. And I wish to thank my colleagues on the Board of Trustees for their dedication to Profmed and for the experience and skill they bring to the table. I also wish to thank the Principal Officer and staff of the Executive Office for their support.

Dr Mohamed Bhikhoo
Chairman

10 April 2014

Report SCOPE AND BOUNDARIES

This is Profmed's fourth Annual Integrated Report. Integrated reporting is acknowledged as an evolving journey and each year the Scheme aims to improve the report to make it more meaningful to our members and other stakeholders. This report aims to provide a concise overview of the Scheme, integrating and connecting important information about strategy, risks and opportunities and relating them to the financial, economic, social and environmental performance for the reporting period 1 January to 31 December 2013. Material and relevant issues that impact the Scheme have been identified to create this report.

Use of guidelines

Profmed's policies are aligned to the Medical Schemes Act 131 of 1998 and the recommendations set out in the King Report on Governance for South Africa (King III), incorporating guidance from the International Integrated Reporting Council. 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, future 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

PricewaterhouseCoopers Inc., the Scheme's external auditor, has audited the annual financial statements and their report is presented on page 23. The Scheme's independent actuaries have been consulted where estimates and projections are presented. The internal audit function of the Scheme's administrator performed a limited review of the non-financial information and qualitative data presented in this report. The Scheme was given a favourable rating in Global Credit Rating Co.'s independent assessment of the Scheme's claims-paying ability in the 2012 year.

1. Description of the medical scheme

Profmed is a restricted medical scheme that is open to professionals who have obtained a minimum of a four-year university degree or equivalent from a technical university, offering these individuals exclusive yet affordable medical cover. Profmed's medical and healthcare benefits, coupled with excellent service and attention to detail, are offered at affordable rates.

Profmed's vision is to address the healthcare needs of professionals through appropriate benefit design.

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 no. 1194.

1.2 Healthcare options offered by Profmed

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

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

2. Registered address and third-party service provider details

2.1 Registered office address and postal address

Profmed Place
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 no. Admin 37)
269 Von Willigh Avenue
Block D, Corporate Park 66
Die Hoewes
Centurion

Private Bag X1031
Lyttelton
0140.

2.3 Auditors

PricewaterhouseCoopers Inc.
2 Eglin Road
Sunninghill
Johannesburg

Private Bag X36
Sunninghill
2157.

2.4 Investment managers

Investec Wealth & Investment
(Financial Service Provider no. 8905)
100 Grayston Drive
Sandown
Sandton

P.O. Box 785700
Sandton
2146.

2.5 Actuaries

NMG Consultants and Actuaries Proprietary Limited
(Terminated 28 February 2013)

NMG House
411 Main Avenue
Randburg

P.O. Box 3075
Randburg
2125.

Towers Watson Proprietary Limited
(Appointed 1 March 2013)

1st Floor, 44 Melrose Boulevard
Melrose Arch
Johannesburg
2196

Postnet Suite 154
Private Bag X1
Melrose Arch
2076.

2.6 Attorneys

Knowles Husain Lindsay Incorporated

4th Floor, The Forum
2 Maude Street
Sandown
Sandton

P.O. Box 782687
Sandton
2146.

3. External environment

3.1 Economic environment

South African economic growth suffered in 2012 as a result of social unrest and the European crisis but accelerated moderately during 2013 due to improved global demand and accommodating macro-economic policies.

Rising interest rates and consumer inflation have an impact on the affordability of healthcare insurance. This hampers the rate at which the Scheme could grow. Profmed manages affordability carefully through limiting contribution increases, and appropriate benefit design.

3.2 Regulatory environment

The Competition Commission's inquiry into the private healthcare industry has commenced and is expected to last 18 to 24 months. It is unlikely that the inquiry will affect the Scheme in the period under review. Profmed is taking steps to ensure that it is fully prepared to participate in the Competition Commission inquiry.

A potential financial risk to the Scheme is the interpretation by the Council for Medical Schemes of Regulation 8 of the Medical Schemes Act, which stipulates 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 were 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 and to the medical scheme industry 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, which positions Profmed well to meet this challenge.

3.3 Competitive environment

Fierce competition exists in the medical scheme industry of South Africa and growth of the number of insured members as a whole is negligible. The majority of medical schemes that have seen growth in membership have done so through amalgamation. Profmed is one of the few medical schemes that has experienced steady organic membership growth for the past eight years. Competitive contribution rates as well as rich benefits ensure that Profmed remains the medical scheme of choice for professionals.

1. Management

1.1 Board of Trustees in office during the year under review

Dr MM Bhikhoo	Chairman
Mr RN Theunissen	Vice-Chairman
Dr AD Behrman	
Mr HP du Toit	
Ms MM Geringer (née Van Garderen)	
Prof WM Gumede	(appointed 29 August 2013)
Dr AP Newell	
Dr E Nkosi	
Ms EL Prins-Van den Berg	(resigned 5 June 2013)
Dr RD Shuttleworth	
Adv HB Smalberger	(elected 5 June 2013)
Dr EJ Thorburn	(resigned 5 June 2013).

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. 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, and considering information and explanations given by management and discussions with the external auditor on the results of the audit, which are 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 six times during 2013 (2012: six 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 16 to the annual financial statements.

	Board Meetings		Board Strategy Session		Executive Committee		Audit Committee		Governance, Strategy and Risk Committee		Medical Committee		Remuneration Committee		*Ad Hoc* Meetings
Name	**A**	**B**	**A**	**B**	**A**	**B**	**A**	**B**	**A**	**B**	**A**	**B**	**A**	**B**	**B**
Dr MM Bhikhoo	6	5	2	2	5	5	2†	2	3‡	3	4	4	2	2	46
Mr DC Arnold*													3	3	
Dr AD Behrman	6	6	2	2							4	4			2
Mr MJ Brown*							3	3					3	3	
Mr HP du Toit	6	6	2	2					4	4					4
Ms MM Geringer (née Van Garderen)	6	5	2	2			3	3	1	1					6
Prof WM Gumede	1	1	1	1					1	0					
Mr KG Mockler*							3	3					3	3	18
Dr AP Newell	6	6	2	2							4	4			9
Dr E Nkosi	6	6	2	2	2	2			4	4	2	2			1
Dr Y Omar Carrim*							3	2							
Ms EL Prins-Van den Berg	3	3	1	1	3	3	1†	1	1‡	1	2‡	1	1	1	30
Dr RD Shuttleworth	6	6	2	2	5	5					4	4			14
Adv HB Smalberger	3	3	1	1					3	3					3
Mr RN Theunissen	6	6	2	2	5	4	3	3	4	4					18
Dr EJ Thorburn	3	3	1	1							2	2			2

A – Total 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 auditor formally reports to the Committee on significant findings arising from auditing activities. The Audit Committee is satisfied that the Scheme has optimised the assurance coverage obtained from management and internal and external assurance providers in accordance with an appropriate combined assurance 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 administrator. 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 (re-appointed 6 June 2013)
Mr MJ Brown	Independent member (re-appointed 6 June 2013)
Ms MM Geringer (née Van Garderen)	Trustee
Dr Y Omar Carrim	Independent member (re-appointed 6 June 2013)
Mr RN Theunissen	Trustee.

The Chairman of the Board, the Principal Officer, the Chief Financial Officer of the administrator, and the 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 is assessed annually. The external and internal auditors meet separately with the Committee at least once a year without the presence of management. Management meets at least one a year with the Committee without the presence of the auditors.

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

- Examined and reviewed the Scheme's financial statements prior to submission to and approval by the Board, as well as the Annual Integrated Report;
- Reviewed the effectiveness of internal controls;
- Recommended to the annual general meeting, with the approval of the Board, the appointment of the external auditor, after considering the independence of the proposed auditor;
- Approved the external auditor's terms of engagement, the audit plan and audit fees;
- Approved the provision of all non-audit services by the external auditor;
- Reviewed the adequacy and effectiveness of the system for monitoring compliance with laws and regulations;
- Reviewed the performance of the internal audit function;
- Reviewed the finance function;
- Provided independent and objective oversight of the financial, operational and strategic risks.

4. Governance, Strategy and Risk Committee

The Scheme has an established Governance, Strategy and Risk (GSR) 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 its implementation of governance processes, the setting of strategic intent and assessment and management of risks and the impact thereof on the Scheme.

The GSR Committee comprised:

Dr E Nkosi (Chairman)	Trustee
Dr MM Bhikhoo	Chairman of the Board of Trustees (*ex officio*)
Mr HP du Toit	Trustee
Ms MM Geringer (née Van Garderen)	Trustee (outgoing 6 June 2013)
Prof WM Gumede	Trustee (incoming 21 November 2013)
Adv HB Smalberger	Trustee (incoming 6 June 2013)
Mr RN Theunissen	Trustee.

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

- Ensured that appropriate governance processes were in place and monitored compliance with all relevant legislative and regulatory requirements;
- 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;

- Identified and categorised industry and other business risks and monitored the management of the risks;
- Attended to other relevant matters referred to it.

The Committee is responsible for overseeing the accuracy and relevance of the Risk Register. Risks are identified by the Board and the Board committees and are analysed in terms of the likelihood of their occurrence and impact on the Scheme. The Committee assesses the rating of each risk and effectiveness of the mitigating controls. Section 1.3 of the Corporate Governance report provides further details in this regard.

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 to assist the Board of Trustees in ensuring the quality, integrity and reliability of the 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 GSR Committee. The Executive Committee comprised:

Dr MM Bhikhoo (Chairman)	Chairman of the Board of Trustees
Dr E Nkosi	Chairman of the GSR Committee
Dr RD Shuttleworth	Chairman of the Medical Committee
Mr RN Theunissen	Vice-Chairman of the Board of Trustees.

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;
- Monitored marketing and communication to, amongst others, 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, the rules of the Scheme, instructions of the Board and any other statutory/regulatory requirements or directives;
- Made recommendations to the Remuneration Committee in respect of remuneration of the Board, Board committees and the Principal Officer;
- Monitored the performance of the investment strategy adopted by the Board;
- Reviewed and monitored the performance of the asset managers and compliance with Annexure B to the Regulations in terms of the Medical Schemes Act 131 of 1998;
- Reviewed the performance of the Principal Officer;
- Apprised the Board of Trustees of the Principal Officer's performance appraisal by the Executive Committee and 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
Dr MM Bhikhoo	Chairman of the Board of Trustees (*ex officio*)
Dr AP Newell	Trustee
Dr E Nkosi	Trustee (incoming 6 June 2013)
Dr EJ Thorburn	Trustee (outgoing 6 June 2013).

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

- Reviewed the performance and quarterly reports of the managed healthcare providers;
- Reviewed and approved clinical protocols as proposed by the medical advisor as well as by the managed care providers;
- Considered *ex gratia* requests and reported any requests granted in the Medical Committee report to the Board;
- 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;
- Attended to any other relevant matters referred to it.

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.

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

Mr KG Mockler (Chairman)	Independent member (re-appointed 6 June 2013)
Mr DC Arnold	Independent member (re-appointed 6 June 2013)
Dr MM Bhikhoo (non-voting)	Chairman of the Board of Trustees
Mr MJ Brown	Independent member (re-appointed 6 June 2013).

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

- Recommended the general policy on executive management (which includes the Principal Officer), Board and committee remuneration;
- Recommended the remuneration package of the Principal Officer;
- Recommended the fees and other allowances and the policy with regard to the reimbursement of expenses relating to Board and Board committee members.

Remuneration Policy

The Remuneration Policy of the Board and committees recognises that most persons occupying such positions sacrifice income from their professional practices to do so. Accordingly, remuneration must be sufficient to attract the appropriate calibre of people to make themselves available.

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.

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. 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. Employees in a sales function also receive a variable monthly remuneration linked directly to their productivity. No long-term incentive schemes are available to employees.

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 and approved during the financial year.

The Scheme's investment objective is to achieve CPI + 3% per annum measured over a rolling three-year period and to perform in the top quartile measured against a peer group of medical scheme investment managers. 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 was to invest in selected discretionary portfolios.

Regulation 30 of the Medical Schemes Act, read with Annexure B, stipulates that medical schemes may invest only 40% of reserves in equities. In June 2011, the Council for Medical Schemes granted exemption to Profmed to invest up to 50% of its reserves in South African equities. Profmed has also received exemption to invest in the holding companies of medical scheme administrators.

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.

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 Schemes' interpretation. This poses a financial risk to the Scheme as there is no regulated tariff for providers.

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

Profmed is not compliant with the requirements of the Broad-Based Black Economic Empowerment Act, No. 53 of 2003, 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 become 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 exiting 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, three of the options had deficits. The Scheme took this factor into account when reviewing the 2014 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 Payment of claims within 30 days after receipt

In terms of Section 59(2) of the Medical Schemes Act 131 of 1998, a valid claim submitted to the Scheme should be paid out within 30 days after the day on which the claim is received. In limited instances claims were paid after 30 days mostly as a result of incorrect coding by service providers.

11.4 Investment in medical scheme administrators

In terms of Section 35(8) of the Medical Schemes Act 131 of 1998, a medical scheme shall not invest any of its assets in a medical scheme administrator. The Scheme, through one of its unit trust investments, has an investment in a medical scheme administrator's holding company. The Scheme has received exemption from this section of the Act.

11.5 Investment in a single property

In terms of Annexure B, read in conjunction with Regulation 30 of the Medical Schemes Act 131 of 1998, a medical scheme shall not have more than 2.5% of its assets invested in a single property. The Scheme's office building was 3.4% of its total assets at year-end. The Scheme has applied for exemption from this requirement.

11.6 Limitation of exposure to equities

Regulation 30 of the Medical Schemes Act, read with Annexure B, stipulates that medical schemes may invest only 40% of reserves in equities. In June 2011, the Council for Medical Schemes granted exemption to Profmed to invest up to 50% of its reserves in South African equities.

Strategy AND RESOURCE ALLOCATION

The Board of Trustees meets annually to determine the strategy of the Scheme. Risks that could impact the Scheme within the strategy period under review are taken into account when setting the strategy. The Governance, Strategy and Risk (GSR) Committee is responsible for overseeing the implementation of the strategy and regularly assesses the Scheme's performance against the defined strategy and reports to the Board on the Scheme's progress.

Profmed has a robust risk identification and monitoring process. Identified risks are evaluated and monitored quarterly by the Board of Trustees as well as the Audit Committee, Executive Committee and GSR Committee. Each of these forums provides input to the Risk Register relating to their spheres of responsibility. The Medical Committee does not review the Risk Register but provides input to the register on any matters of risk pertaining to its scope of responsibility.

The GSR Committee assesses the mitigation controls of each risk to ascertain the impact of the risk on the Scheme.

Profmed's key long-term strategy is to grow the membership base of the Scheme. By growing the membership base the risk pool will be enlarged, 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, 2 585 (2012: 2 457) new members joined and 1 853 (2012: 1 993) members resigned from the Scheme. Management continually seeks ways to improve member retention to minimise member attrition.

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 54.29%, which equates to R24 921 of reserves per member. The solvency ratio is placed under pressure by the eroding effects of medical inflation, resulting in annual contribution increases. The effect of growth is set out in the scenarios below.

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. 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.

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
2015	28 236	54.76%	27 128	56.92%
2017	29 376	55.11%	26 054	61.56%
2019	30 563	56.65%	25 022	67.41%

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
2015	30 450	50.91%	24 914	61.82%
2017	36 845	44.83%	20 180	78.12%
2019	44 582	41.21%	16 346	98.62%

The projections 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.

Profmed has allocated the following resources to achieve its long-term growth strategy:

- Incentivising independent brokers by means of legislated commission payments;
- Employment of broker consultants to support the independent brokers;
- Employment of consultants to drive direct sales;
- Utilising the services of a marketing agency to market its product.

The allocation of resources is carefully managed as part of the Scheme's non-healthcare expenditure.

Risks AND OPPORTUNITIES

The private healthcare industry in South Africa is highly sophisticated and is ranked as one of the best internationally in terms of access to care, healthcare outcomes and the use of advanced technology. The cost of providing this world class quality care, as well as the increasing burden of disease, is a major challenge for the healthcare funding industry globally. Medical inflation has outpaced consumer inflation for many years driven by various supply and demand factors. The Competition Commission's inquiry into the private healthcare industry may shed some light on the reasons for the high cost of private healthcare. The ageing membership of the Scheme, increasing benefit utilisation and increased burden of disease pose significant risks to the sustainability of the Scheme. However, Profmed has implemented an aggressive growth strategy within the Scheme's target market and the results of this are evident in that Profmed was one of the few medical schemes that grew in membership during the year under review and the average age of the new principal members joining Profmed was 31 years of age, which is significantly younger than the average age of Profmed's principal members of 49.

Medical scheme membership is voluntary in South Africa and schemes have to manage the risk of individuals opting to join a medical scheme only when they become ill. These individuals are primarily the young and healthy, which compromises the necessary cross-subsidisation in the industry.

Profmed is in the fortunate position that its Board of Trustees and executive management have a wealth of knowledge and experience in the healthcare industry. The Scheme has specialised data mining tools and, together with its administrator, carefully monitors these risks.

Many opportunities exist for Profmed in terms of growth. With healthy reserves, excellent administration system, a strong brand and rich benefits, Profmed is an excellent choice for graduate professionals.

Business MODEL

The business model of medical schemes creates value for stakeholders without a motive to derive profit.

The success of the Scheme's business model depends on product differentiation, affordability and service excellence. Medical schemes operate in a complex and challenging environment. Trustees have the responsibility of maintaining the fragile balance between competitive contribution rates, cost and sustainability. Risk management tools and refined benefit design techniques are utilised to provide access to quality healthcare while managing the cost and ensuring the sustainability of the Scheme.

Performance

1. Performance of the Scheme

The results of the Scheme's operations are set out on page 24 of the annual financial statements. For the period under review, the ratio of relevant healthcare expenditure as a percentage of net contribution income, was 85.09% (2012: 86.34%). Managed care service expenses were 2.23% (2012: 2.25%) of net contribution income, while administration expenditure (inclusive of impairment losses) was 10.20% (2012: 10.05%) of contribution income. The following table outlines how the Scheme performed against its budget for the 2013 year:

	Budget	Actual
Number of principal members	27 163	27 442
Number of beneficiaries	63 761	64 033
Gross underwriting result	R134 million	R146 million
Net underwriting result	R1 million	R13 million

Accumulated funds ratio

The accumulated funds ratio is calculated as follows:

	2013 R'000	2012 R'000
Total members' funds per Statement of Financial Position	**683 893**	579 750
Less: Reserve for unrealised investment gains	**(132 095)**	(95 821)
Accumulated funds per Regulation 29 of the Act	**551 798**	483 929
Annual contribution income per Statement of Comprehensive Income	**1 016 320**	931 155
Accumulated funds ratio calculated as the ratio of accumulated funds/gross annual contributions x 100	**54.29%**	51.97%
Minimum ratio required by Regulation 29 of the Act	**25.0%**	25.0%

Average premium increases with effect 1 January were as follows:

	2014	2013	2012
ProPinnacle	9.00%	9.26%	7.63%
ProSecure Plus	9.00%	9.28%	7.64%
ProSecure	9.00%	9.42%	7.18%
ProActive Plus	8.00%	8.10%	6.76%
ProActive	8.00%	7.94%	6.23%

2. Review of the accounting period's activities

2.1 Operational statistics per benefit option

	ProPinnacle	ProSecure Plus	ProSecure	ProActive Plus	ProActive	Total Scheme
2013						
Non-financial highlights						
Number of members at year-end	2 048	2 467	7 810	5 490	9 627	27 442
Average number of members for the year	2 066	2 485	7 802	5 457	9 537	27 347
Number of beneficiaries at year-end	4 080	5 141	17 808	12 259	24 745	64 033
Average number of beneficiaries for the year	4 143	5 194	17 898	12 190	24 741	64 166
Dependant ratio at year-end	0.99	1.08	1.28	1.23	1.57	1.33
Average age of beneficiaries per option	53.60	46.36	43.53	33.31	36.07	39.56
Pensioner ratio per benefit option (65 years and older)	35.96%	25.44%	19.62%	6.09%	7.98%	14.04%
Financial highlights						
Average net contributions per beneficiary per month	R3 422	R2 074	R1 629	R928	R779	R1 320
Average relevant healthcare expenditure per beneficiary per month	R3 537	R1 943	R1 495	R611	R548	R1 130
Average non-healthcare expenditure per beneficiary per month	R203	R194	R177	R182	R157	R173
Relevant healthcare expenditure as a percentage of gross contributions (claims ratio)	103.34%	93.71%	91.78%	65.80%	70.37%	85.62%
Non-healthcare expenditure as a percentage of gross contributions	5.92%	9.38%	10.87%	19.60%	20.11%	13.12%
2012						
Non-financial highlights						
Number of members at year-end	2 140	2 428	7 655	5 053	9 434	26 710
Average number of members for the year	2 181	2 428	7 686	4 916	9 522	26 733
Number of beneficiaries at year-end	4 313	5 139	17 964	11 306	24 950	63 672
Average number of beneficiaries for the year	4 424	5 146	18 115	10 987	25 262	63 934
Dependant ratio at year-end	1.02	1.12	1.35	1.24	1.64	1.38
Average age of beneficiaries per option	52.99	45.63	42.62	32.82	35.63	39.09
Pensioner ratio per benefit option (65 years and older)	34.11%	23.37%	17.87%	5.40%	7.40%	13.1%
Financial highlights						
Average net contributions per beneficiary per month	R3 117	R1 880	R1 471	R850	R718	R1 214
Average relevant healthcare expenditure per beneficiary per month	R3 111	R1 878	R1 397	R591	R466	R1 048
Average non-healthcare expenditure per beneficiary per month	R186	R178	R160	R168	R142	R158
Relevant healthcare expenditure as a percentage of gross contributions (claims ratio)	99.76%	99.92%	94.98%	69.55%	64.69%	86.33%
Non-healthcare expenditure as a percentage of gross contributions	5.96%	9.46%	10.87%	19.81%	19.78%	12.98%

2.2 Operational statistics for the Scheme

	2013	2012
Average accumulated funds and reserves per member	R24 921	R21 705
Investment return	16.5%	20.4%

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

2013	PMSA	MediKredit	Opticlear	Dental Risk Company	Total
Total claims received	R878 990 000	R150 425 000	R17 220 000	R67 337 000	R1 113 972 000
Impact of intervention	R198 504 000	R33 427 000	R11 132 000	R38 815 000	R281 878 000
Intervention % (of total)	22.6%	22.2%	64.65%	57.6%	25.3%
Cost to provide intervention	R78 888 000	R7 176 000	R446 000	R1 317 000	R87 827 000

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 26. 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 2013 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 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 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 2013 results.

Outlook

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.

The Board of Trustees and management of the Scheme are responsible for ensuring that administration of the Scheme is effective and that the administrator performs in line with strict service level agreements. Service levels are monitored quarterly by the Board and the Executive Committee in conjunction with the Principal Officer.

Profmed's risk management approach is broadenend by offering the Multiply Wellness Programme to its members. Voluntary participation in the programme encourages a healthy lifestyle, which is expected to have a positive impact on the Scheme's claims experience.

While there are a number of challenges facing the Scheme that could pose a threat to its future sustainability, the most important is that 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 has implemented an aggressive growth strategy within the Scheme's target market and the results of this are evident in that Profmed was one of the few medical schemes that grew in membership during the year under review and the average age of the new principal members joining Profmed was 31 years of age, which is significantly younger than the average age of Profmed's principal members of 49.

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 24 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 the standards in the 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 are responsible 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.

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

The Scheme's external auditor, PricewaterhouseCoopers Inc., has audited the annual financial statements and their report is presented on page 23.

The annual financial statements were approved by the Board of Trustees on 10 April 2014 and are signed on its behalf by:

Chairman

Trustee

Principal Officer

10 April 2014

Report
OF THE PROFMED AUDIT COMMITTEE

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

External auditor

The Committee satisfied itself that the auditor was independent. In consultation with management, the Committee agreed to the engagement letter, audit plan and audit fees for the year under review. It approved the terms of an agreement to carry out non-audit services.

Financial statements and accounting policies and practices

The Committee reviewed the accounting policies and practices and the financial statements and was satisfied that they were appropriate and complied with International Financial Reporting Standards (IFRS).

Integrated reporting

At its meeting on 17 March 2014, the Committee agreed to recommend to the Board the approval of the Annual Integrated Report, which includes the annual financial statements. The Board's statement on the going-concern status of the Scheme, which appears in the Statement of Responsibility on page 21, is supported by the Committee.

Governance of risk

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

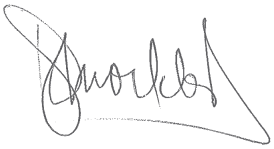
Internal audit

The Committee satisfied itself that the internal audit function of the administrator operated effectively. The annual audit plan relating to the Scheme was approved by the Committee.

Finance function

The Committee satisfied itself of the appropriateness of the expertise, adequacy of resources and experience of senior members of management of the Scheme and of the management of the administrator responsible for the finance function.

Information regarding the composition, attendance and responsibilities of the Audit Committee, together with the other information relating to its activities, is provided on page 7 of this report.



KG Mockler
Chairman: Audit Committee

17 March 2014

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 2013, 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 24 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 2013, and its financial performance and cash flows for the year then ended in accordance with International Financial Reporting Standards and in the manner required by the Medical Schemes Act, 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 Notes 18 and 26 to 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: GJ Kapp
Registered Auditor
Sunninghill

17 April 2014

Statement
OF FINANCIAL POSITION AS AT 31 DECEMBER 2013

	Notes	2013 R'000	2012 R'000
Assets			
Non-current assets		**568 114**	516 520
Property, plant and equipment	2	**19 539**	19 323
Available-for-sale financial assets	4	**548 575**	497 197
Current assets		**178 396**	120 805
Available-for-sale financial assets	4	**153 886**	105 595
Accounts receivable	5	**2 284**	1 817
Cash and cash equivalents	6	**22 226**	13 393
Total assets		**746 510**	637 325
Liabilities			
Current liabilities		**62 618**	57 575
Accounts payable	7	**23 537**	20 169
Outstanding claims provision	8	**39 081**	37 406
Total liabilities		**62 618**	57 575
Total net assets		**683 892**	579 750
Net assets			
Members' funds and reserves		**683 892**	579 750
Accumulated funds		**551 797**	483 929
Revaluation reserve		**132 095**	95 821
Members' funds and reserves		**683 892**	579 750

Statement
OF COMPREHENSIVE INCOME FOR THE YEAR ENDED 31 DECEMBER 2013

	Notes	2013 R'000	2012 R'000
Risk contribution income		**1 016 320**	931 155
Relevant healthcare expenditure	9	**(870 186)**	(803 947)
Risk claims incurred		**(870 186)**	(803 947)
Risk claims incurred	9	**(870 589)**	(804 164)
Third-party claim recoveries	9	**403**	217
Gross healthcare result		**146 134**	127 208
Managed care: Management services	10	**(22 631)**	(20 964)
Administration expenditure	11	**(103 675)**	(93 624)
Broker service fees	12	**(7 049)**	(6 279)
Net impairment losses on healthcare receivables		**(175)**	–
Net healthcare result		**12 604**	6 341
Other income		**60 036**	61 911
Investment income	13	**59 863**	61 834
Sundry income	14	**173**	77
Other expenditure		**(4 773)**	(4 412)
Asset management fees	15	**(4 773)**	(4 412)
Net surplus for the year		**67 867**	63 840
Other comprehensive income			
Items that may be reclassified into surplus or loss		**36 275**	52 185
Fair value adjustment on available-for-sale investments	4	**36 275**	52 185
Total comprehensive income for the year		**104 142**	116 025

Statement
OF CHANGES IN FUNDS AND RESERVES FOR THE YEAR ENDED 31 DECEMBER 2013

	Accumulated funds R'000	Revaluation reserve for available-for-sale financial assets R'000	Total members' funds and reserves R'000
Balance at 1 January 2012	420 090	43 636	463 725
Total comprehensive income for the year	63 840	52 185	116 025
Surplus for the year	63 840	–	63 840
Other comprehensive income	–	52 185	52 185
Balance at 31 December 2012	483 930	95 821	579 750
Total comprehensive income for the year	67 867	36 274	104 142
Surplus for the year	67 867	–	67 867
Other comprehensive income	–	36 274	36 274
Balance at 31 December 2013	551 797	132 095	683 892

Statement
OF CASH FLOWS FOR THE YEAR ENDED 31 DECEMBER 2013

	Notes	2013 R'000	2012 R'000
Cash flow from operating activities			
Cash generated/(utilised) from operations	17	**13 260**	(1 376)
Net cash generated/(utilised) from operating activities		**13 260**	(1 376)
Cash flow from investing activities			
Acquisition of property, plant and equipment	2	**(922)**	(19 116)
Proceeds on disposal of property, plant and equipment		**5**	–
Capital contribution	4	**(401 991)**	(45 339)
Proceeds from sale of investments	4	**392 542**	47 500
Disinvestment of investments to cash and cash equivalents		**(25 922)**	(24 260)
Interest	13	**26 870**	26 326
Dividends	13	**3 847**	4 338
Net rental income	13	**1 144**	428
Net cash utilised from investing activities		**(4 427)**	(10 551)
Net increase/(decrease) in cash and cash equivalents		**8 833**	(11 927)
Cash and cash equivalents at beginning of year		**13 393**	25 320
Cash and cash equivalents at end of year	6	**22 226**	13 393

1. Summary of accounting policies

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

1.1 Basis of preparation

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

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

1.2 Changes to accounting policy and disclosures

New and amended standards adopted by the Scheme:

Standard/Interpretation	Effective date	Expected impact
IFRS 12 – Disclosure of interests in other entities	1 January 2013	Increased disclosure
IFRS 13 – Fair value measurement	1 January 2013	Immaterial

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:

Standard/Interpretation	Effective date	Expected impact
IFRS 1 – First time adoption on government loans	1 January 2013	Immaterial
IFRS 7 – Financial Instruments: Disclosures – Asset and liability offsetting	1 January 2013	Immaterial
IAS 19 – Employee benefits	1 January 2013	Immaterial
IFRS 10 – Consolidated financial statements	1 January 2013	Immaterial
IFRS 11 – Joint arrangements	1 January 2013	Immaterial
IFRS 12 – Disclosures of interests in other entities	1 January 2013	Immaterial
IAS 27 – Separate financial statements	1 January 2013	Immaterial
IAS 28 – Associates and joint ventures	1 January 2013	Immaterial
IFRS 10 – Consolidated financial statements	1 January 2013	Immaterial
IFRS 11 – Joint arrangements	1 January 2013	Immaterial

Standards and interpretations not yet effective

The Scheme has chosen not to early adopt the following standards and interpretations, which have been published and are mandatory for the Scheme's accounting periods beginning on or after 1 January 2014 or later periods:

Standard/Interpretation	Effective date	Expected impact
IFRS 9 – Financial instruments	1 January 2015	Immaterial
IAS 32 – Financial instruments: Presentation	1 January 2014	Immaterial
IAS 39 – Financial instruments	1 January 2014	Immaterial
IAS 36 – Impairment of assets	1 January 2014	Immaterial
IFRS 10 – Consolidated financial statements	1 January 2014	Immaterial

1.3 Property, plant and equipment

Land and buildings comprise an office building which is partly owner occupied and stated at historical cost less the accumulated depreciation of the building. Land is not depreciated. Other property,

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

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

The estimated maximum useful lives of the assets are:

Buildings	30 years
Office furniture	10 years
Office equipment	3 years
Leasehold improvements	3 years
Vehicles	5 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 paragraphs below.

Accounts receivable

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

Accounts receivable from the Road Accident Fund

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

Available-for-sale financial assets

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 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 Structured entities

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

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

1.6 Impairment of financial assets

The Scheme assesses at each Statement of Financial Position date whether there is objective evidence that a financial asset or a group of financial assets is impaired. A financial asset is impaired if, and only if, there is objective evidence of impairment as a result of one or more events that occurred after the

initial recognition of the asset (loss event) and that loss event has an adverse impact on the estimated cash flows from the asset that can be reliably measured.

An asset is impaired if its carrying amount is greater than its recoverable amount. The recoverable amount of all assets, 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 asset is 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.

1.7 Derecognition of financial instruments

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

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

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

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

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

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

1.8 Offsetting of financial instruments

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

1.9 Cash and cash equivalents

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

1.10 Provisions

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

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

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

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

Outstanding claims provision

The outstanding claims provision comprises provisions for the Scheme's best estimate of the ultimate cost of settling all claims incurred but not yet reported as at the Statement of Financial Position date.

Claims outstanding are determined as accurately as possible based on a number of factors, which include previous experience in claims patterns, claims settlement patterns, changes in the nature and number of members according to trends in claims frequency, changes in the claims processing cycle and variations in the nature and average cost incurred per claim.

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

1.11 Member insurance contracts

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

1.12 Contribution income

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

1.13 Relevant healthcare expenditure

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

Risk claims incurred comprise:

- claims submitted and accrued for services rendered during the year;
- over- or under-provisions relating to prior year claims accruals;
- amounts paid or to be paid under service provider contracts for services rendered to members; 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.

1.14 Expenses for the acquisition of member insurance contracts

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

1.15 Investment income

Investment income comprises dividends and interest on cash and cash equivalents and other 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.

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

1.17 Unallocated funds

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

1.18 Segment reporting

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

1.19 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.

1.20 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. Property, plant, equipment and leasehold improvements

	Land and buildings R'000	Office equipment & software R'000	Office furniture R'000	Leasehold improvements R'000	Total R'000
31 December 2013					
Opening carrying amount	18 586	307	430	–	19 323
Acquisitions during the year	558	342	22	–	922
Disposals during the year	–	(22)	–	–	(22)
Depreciation charge	(439)	(178)	(67)	–	(684)
Closing carrying amount	18 705	449	385	–	19 539
Cost or valuation	19 238	1 451	738	–	21 427
Accumulated depreciation	(533)	(1 002)	(353)	–	(1 888)
Carrying amount	18 705	449	385	–	19 539
31 December 2012					
Opening carrying amount	–	219	315	18	552
Acquisitions during the year	18 679	266	171	–	19 116
Disposals during the year	–	–	–	–	–
Depreciation charge	(93)	(178)	(56)	(18)	(345)
Closing carrying amount	18 586	307	430	–	19 323
Cost or valuation	18 679	1 269	715	345	21 008
Accumulated depreciation	(93)	(962)	(285)	(345)	(1 685)
Carrying amount	18 586	307	430	–	19 323

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

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

	2013 R'000	2012 R'000
Available-for-sale financial assets		
- Non-current	**548 575**	497 197
- Current	**153 886**	105 595
Cash and cash equivalents	**22 226**	13 393
Accounts receivable		
- Loans and receivables	**385**	634
- Insurance receivables	**1 899**	1 183
Accounts payable		
- Financial liabilities measured at amortised cost	**3 073**	3 809
- Insurance payables	**54 107**	53 766

4. Available-for-sale financial assets

	Notes	2013 R'000	2012 R'000
Beginning of the year		**602 792**	497 764
Capital contribution		**401 991**	45 339
Withdrawals		**(389 921)**	(47 500)
Net realised gains	13	**28 002**	30 742
Asset management fees	15	**(4 773)**	(4 412)
Unrealised fair value gain: Revaluation reserve		**36 275**	52 185
Investment income			
- Interest	13	**24 248**	24 336
- Dividends	13	**3 847**	4 338
Fair value at the end of the year		**702 461**	602 792
Less: Available-for-sale financial assets – current		**(153 886)**	(105 595)
Available-for-sale financial assets		**548 575**	497 197

The Scheme's financial assets are categorised by measurement category below:

	2013 R'000	2012 R'000
Non-current		
Equity securities	**275 940**	235 733
Property equity securities	**35 931**	43 171
Bonds and cash instruments	**236 704**	218 293
Total non-current	**548 575**	497 197
Current		
Money market	**67 696**	19 552
Bonds and cash instruments	**86 190**	86 043
Total current	**153 886**	105 595

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 investments.

5. Accounts receivable

	2013 R'000	2012 R'000
Insurance receivables	**2 039**	1 283
Financial receivables	**248**	53
Receivable from administrator	**–**	337
Accrued interest	**137**	244
Sub-total: Accounts receivable	**2 424**	1 918
Impairment provision	**(140)**	(100)
Current portion	**2 284**	1 817

As at 31 December 2013, the carrying amounts of accounts receivable approximated their fair value. Interest is not charged on overdue balances.

6. Cash and cash equivalents

	2013 R'000	2012 R'000
Cash at bank and on hand	**4 121**	2 964
Short-term bank deposits	**18 105**	10 429
	22 226	13 393

The weighted average effective interest rate was 4.5% (2012: 4.80%) on call account balances.

7. Accounts payable

	2013 R'000	2012 R'000
Insurance liabilities		
Risk contributions received in advance	**2 641**	908
Reported claims not yet paid	**16 686**	14 216
Member and provider credit balances	**1 137**	1 236
Total liabilities arising from insurance contracts	**20 464**	16 360
Financial liabilities		
Sundry accounts payable	**3 073**	3 809
Total arising from financial liabilities	**3 073**	3 809
Total accounts payable	**23 537**	20 169

As at 31 December 2013, the carrying amounts of accounts payable approximated their fair value because of the short-term maturities of these liabilities.

8. Outstanding claims provision

	Notes	2013 R'000	2012 R'000
Analysis of movements in outstanding claims			
Balance at beginning of year		**37 406**	25 125
Payments in respect of prior year	9	**(40 258)**	(32 329)
Prior year under-provision	9	**(2 852)**	(7 204)
Adjustment for current year	9	**41 933**	44 609
Balance of the provision at year-end		**39 081**	37 406

Analysis of movements in provision arising from liability adequacy test

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

Process used to determine the assumptions

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

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

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

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

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

Assumptions

The outstanding claims provision is calculated based on claims processing patterns over the previous twenty-four months. Due to the large size of the Scheme membership base, no adjustment to the data is made for large claims. The assumptions that have the greatest effect on the measurement of the outstanding claims provision are the claims run-off periods for the most recent benefit years (split by discipline) for the in-hospital, chronic and day-to-day categories of claims. The run-off factor relates to the emergence and settlement patterns of claims and is expressed as the percentage of claims settled in respect of total claims expected to emerge in a specific service month. This factor is then used to project the remainder of the outstanding claims relating to the specified service month. These are used for assessing the outstanding claims provision for the 2013 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	
		2013 R'000	2012 R'000
Hospitalisation	1% lower	**1 386**	1 541
Chronic medication	1% lower	**439**	488

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

9. Relevant healthcare expenditure

	Notes	2013 R'000	2012 R'000
Current year claims paid		**868 914**	791 883
Movement in outstanding claims provision		**(1 675)**	12 281
Payments in respect of prior year	8	**(40 258)**	(32 329)
Under-provision in prior year	8	**2 852**	7 204
Adjustment for current year	8	**39 081**	37 406
Claims incurred		**870 589**	804 164
Less: Third-party claim recoveries		**(403)**	(217)
		870 186	803 947

10. Managed care: Management services

	2013 R'000	2012 R'000
Hospital pre-authorisation, case and disease management	**11 589**	10 569
Pharmacy benefit and clinical risk management services	**7 176**	6 648
Emergency medical transportation service	**1 058**	889
International travel cover management services	**601**	783
Optical benefit management	**446**	414
Dental benefit management	**1 317**	1 252
Trauma benefit management	**107**	91
Medical advisor	**337**	318
	22 631	20 964

11. Administration expenditure

	Notes	2013 R'000	2012 R'000
Actuarial fees		**757**	698
Association fees		**265**	259
Audit fees		**718**	692
Bank charges		**694**	634
Computer expenses		**398**	296
Council for Medical Schemes expenses		**696**	642
Depreciation		**684**	251
Eligibility services		**167**	237
Fees paid to the administrator		**67 300**	60 454
Internal audit fees		**33**	29
Internal broker consultants remuneration and expenses		**6 861**	6 777
Legal fees		**1 214**	799
Marketing and communication expenses		**8 495**	8 228
Multiply wellness programme		**3 036**	2 742
Office rental and related services		**151**	1 009
Principal Officer remuneration		**2 426**	2 123
Printing and stationery		**905**	561
Professional fees		**650**	51
Professional indemnity insurance premiums		**303**	206
Staff cost		**4 010**	3 815
Telephone, postage and fax		**750**	659
Travel, accommodation and conferences		**129**	87
Trustee remuneration and considerations	16	**2 884**	2 263
Other expenses		**149**	112
		103 675	93 624

12. Broker service fees

	2013 R'000	2012 R'000
Broker fees	**7 049**	6 279
Other distribution costs paid to brokers	**–**	–
	7 049	6 279

13. Investment income

	2013 R'000	2012 R'000
Available-for-sale – dividend income	**3 847**	4 338
Interest income	**26 870**	26 326
Available-for-sale financial assets	**24 248**	24 336
Call and current bank accounts	**2 622**	1 990
Net realised gains on available-for-sale financial assets	**28 002**	30 742
Net rental income	**1 144**	428
	59 863	61 834

14. Sundry income

	2013 R'000	2012 R'000
Prescribed amounts written to income	**172**	77
Profit on disposal of equipment	**1**	–
	173	77

15. Asset management fees

	2013 R'000	2012 R'000
Management fees	**4 773**	4 412
Performance fees	**–**	–
	4 773	4 412

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

16. Trustee and committee member remuneration

The following table records the remuneration paid to and consideration paid for trustees and other committee members during 2012 and 2013:

31 December	Fees for meeting attendance R	Fees for holding of office R	Fees for consultancy services R	Allowances R		Total remuneration R	Training R	Conference fees R	Travel and accommodation R	Other disbursements and reimbursements R	Total considerations R
2013											
Mr DC Arnold*	19 162					19 162			778		19 940
Dr AD Behrman	132 418					132 418	1 243		101 579		235 240
Dr MM Bhikhoo	405 915	80 000				485 915	15 258	3 000	22 754		526 927
Mr MJ Brown*	33 476					33 476			4 290		37 766
Mr HP du Toit	148 365					148 365	5 010		93 434		246 809
Ms MM Geringer (née Van Garderen)	146 033					146 033			2 062		148 095
Prof WM Gumede	33 950					33 950	5 360		691		40 001
Mr KG Mockler*	64 861		40 280			105 141			4 415		109 556
Dr AP Newell	159 588					159 588	5 360		1 094		166 042
Dr E Nkosi	159 690					159 690	450		5 995		166 135
Dr Y Omar Carrim*	9 466					9 466			1 573		11 039
Ms EL Prins-Van den Berg	218 450	69 275				287 725		1 881	8 831		298 437
Adv HB Smalberger	84 400					84 400	5 360		57 110		146 870
Dr RD Shuttleworth	221 225					221 225			159 611		380 836
Mr RN Theunissen	250 998	20 000				270 998	5 810		6 267		283 075
Dr EJ Thorburn	64 340					64 340			3 010		67 350
Total 2013	**2 152 338**	**169 275**	**40 280**			**2 361 893**	**43 851**	**4 881**	**473 494**		**2 884 118**
2012											
Mr DC Arnold*	9 621					9 621			386		10 007
Dr AD Behrman	80 745					80 745			73 046		153 791
Dr MM Bhikhoo	225 833	46 300				272 133			4 461		276 594
Mr MJ Brown*	44 417					44 417			4 236		48 653
Mr HP du Toit§	–					–			–		–
Ms MM Geringer (née Van Garderen)	126 540					126 540	1 926		992		129 458
Mr E Huggett	72 360					72 360			7 775		80 135
Mr KG Mockler*	62 787		30 200			92 987			5 074		98 061
Dr AP Newell	63 245					63 245	6 083		–		69 328
Dr E Nkosi	114 569					114 569			4 500		119 069
Dr Y Omar Carrim*	28 477					28 477			3 146		31 623
Ms EL Prins-Van den Berg	446 554	133 860				580 414		4 840	18 503		603 757
Dr RD Shuttleworth	160 223					160 223			136 803		297 026
Mr A Tait	72 360					72 360			1 523		73 883
Mr RN Theunissen	219 352					219 352			4 949		224 301
Dr EJ Thorburn	45 785					45 785			1 743		47 528
Total 2012	**1 772 866**	**180 160**	**30 200**			**1 983 226**	**8 009**	**4 840**	**267 136**		**2 263 214**

* Independent Board committee members
§ Appointed 22 November 2012

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

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

	Notes	2013 R'000	2012 R'000
Net surplus for the year		**67 867**	63 840
Adjustments for:			
Depreciation	2	**684**	345
Interest received	13	**(26 870)**	(26 326)
Dividend income	13	**(3 847)**	(4 338)
Realised gain on disposal of available-for-sale financial assets	13	**(28 002)**	(30 742)
Net rental income		**(1 144)**	(428)
Profit on the disposal of equipment	14	**(1)**	–
Increase in outstanding claims provision	9	**1 674**	12 281
Cash flows from operations before working capital changes		**10 360**	15 059
Changes in working capital		**2 900**	(16 435)
(Increase) in accounts receivable	5	**(468)**	(449)
Increase/(decrease) in accounts payable	7	**3 368**	(15 986)
Cash generated/(utilised) in operations		**13 260**	(1 376)

18. 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 Plus Tariff rates (approximately 200% 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 Plus Tariff rates (approximately 200% of the 2006 National Health Reference Price List with annual inflationary increases).
- **ProActive** – Comprehensive in-hospital benefits, and cover for prescribed minimum benefits.

The benefit options performed as follows:

	ProPinnacle R'000	ProSecure Plus R'000	ProSecure R'000	ProActive Plus R'000	ProActive R'000	Total R'000
2013						
Net contribution income	170 157	129 243	349 880	135 797	231 243	1 016 320
Relevant healthcare expenditure	(175 843)	(121 118)	(321 137)	(89 354)	(162 734)	(870 186)
Claims incurred	(175 843)	(121 118)	(321 316)	(89 354)	(162 958)	(870 589)
Third-party claim recoveries	–	–	179	–	224	403
Gross healthcare result	(5 686)	8 125	28 743	46 443	68 509	146 134
Managed care: Management services	(1 710)	(2 057)	(6 457)	(4 516)	(7 892)	(22 631)
Administration expenditure	(7 833)	(9 422)	(29 579)	(20 687)	(36 154)	(103 675)
Broker service fees	(532)	(641)	(2 011)	(1 407)	(2 458)	(7 049)
Net impairment losses on healthcare receivables	(13)	(16)	(50)	(35)	(61)	(175)
Net healthcare result	(15 774)	(4 011)	(9 354)	19 798	21 945	12 604
Average number of members during the year	2 066	2 485	7 802	5 457	9 537	27 347
2012						
Net contribution income	165 502	116 079	319 777	112 021	217 776	931 155
Relevant healthcare expenditure	(165 154)	(115 991)	(303 713)	(77 907)	(141 182)	(803 947)
Claims incurred	(165 371)	(115 991)	(303 713)	(77 907)	(141 182)	(804 164)
Third-party claim recoveries	217	–	–	–	–	217
Gross healthcare result	348	88	16 064	34 114	76 594	127 208
Managed care: Management services	(1 711)	(1 905)	(6 028)	(3 850)	(7 470)	(20 964)
Administration expenditure	(7 643)	(8 506)	(26 920)	(17 192)	(33 362)	(93 623)
Broker service fees	(513)	(571)	(1 805)	(1 153)	(2 237)	(6 279)
Net impairment losses on healthcare receivables	–	–	–	–	–	–
Net healthcare result	(9 519)	(10 894)	(18 689)	11 919	33 525	6 342
Average number of members during the year	2 181	2 428	7 686	4 916	9 522	26 734

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

19. Related party transactions

Administration agreement

Administration fees were paid to the administrator, 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.

Transactions with related parties

	Notes	2013 R'000	2012 R'000
Statement of Comprehensive Income			
Professional Medical Scheme Administrators			
Administration fees	11	**67 300**	60 454
Managed care fees	10	**11 589**	10 596
Statement of Financial Position			
Balance from Professional Medical Scheme Administrators		**–**	337

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

The administration agreement is in terms of the rules of the Scheme and in accordance with instructions given by the Board 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

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.

Key management personnel are defined as 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 means 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

	2013 R'000	2012 R'000
Statement of Comprehensive Income		
Remuneration	**5 310**	4 387
Contributions received	**430**	403
Claims incurred	**(132)**	(261)
Statement of Financial Position		
Contribution debtors	**–**	–
Claims reported not yet paid	**–**	–

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

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

20. Commitments

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

21. Subsequent events

There have been no adjusting or non-adjusting events that have occurred between the accounting date and the date of this report that affected the 2013 results.

22. Financial risk management

22.1 Financial risk factors

The Scheme's activities expose it to a variety of financial risks, including the effects of changes in the equity market price 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 Wealth & Investment BBB-
- Nedbank BBB
- Standard Bank BBB.

22.2 Market risk

a) Interest rate risk

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

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

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

	Up to 3 months R'000	4 – 12 months R'000	1 – 5 years R'000	Total R'000
2013				
Total exposure	99 715	54 171	236 705	390 591
2012				
Total exposure	49 031	56 564	–	105 595

The above amounts are classified as follows:

	Notes	2013 R'000	2012 R'000
Available-for-sale financial assets			
- Non-current		**236 704**	–
- Current	4	**153 886**	105 595
		390 590	105 595

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
2013				
Available-for-sale financial assets	77 210	69 398	561 140	553 328
2012				
Available-for-sale financial assets	56 720	52 716	476 810	472 806

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
2013					
Total exposure	–	–	–	311 871	311 871
2012					
Total exposure	–	–	–	278 904	278 904

22.3 Credit risk

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

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	2013 R'000	2012 R'000
Fully performing		**1 488**	635
Past due – 4 to 30 days		**475**	777
Past due – 31 days and older		**462**	561
Impairment provision		**(140)**	(100)
Total accounts receivable	5	**2 285**	1 817
Net impairment losses on healthcare receivables			–

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

	Notes	2013 R'000	2012 R'000
At 1 January		**100**	100
Increase in the provision for receivable impairment		**40**	–
At 31 December	5	**140**	100

22.4 Liquidity risk

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

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

22.5 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 could be 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 54.83% as at 31 December 2013 and 51.97% at 31 December 2012.

The accumulated funds ratio is calculated as follows:

	2013 R'000	2012 R'000
Total members' funds per Statement of Financial Position	**683 893**	579 750
Less: Reserve for unrealised investment gains	**(132 095)**	(95 821)
Accumulated funds per Regulation 29 of the Act	**551 798**	483 929
Annual contribution income per Statement of Comprehensive Income	**1 016 320**	931 155
Accumulated funds ratio calculated as the ratio of accumulated funds/gross annual contributions x 100	**54.29%**	51.97%

22.6 Investment risk

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

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

	Surplus (R'000)					
	Increase in market			Decrease in market		
	30%	15%	5%	5%	15%	30%
2013						
Equity portfolio	166 866	120 086	88 899	57 712	26 524	(20 256)
2012						
Equity portfolio	125 938	90 328	66 588	42 848	22 108	(16 502)

Fair values of financial assets by hierarchy level:

	Level 1 R'000	Level 2 R'000	Level 3 R'000	Reclassification
2013				
Available-for-sale financial assets	354 774	347 687	–	–
2012				
Available-for-sale financial assets	602 792	–	–	–

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.

22.7 Structured entities

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

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

Investee fund	Net asset value of investee fund	Fair value of Scheme's share of net asset of investee fund	% of Scheme's share of investee fund's net assets
Prudential Life Medical Aid Equity Fund	R188 million	R131 065 991	69.41%
Investec High Income Fund	R772 million	R65 745 798	8.51%
Nedgroup Investmets Core Income Fund	R15 billion	R150 875 804	0.96%

The strategy of the investee funds is to protect the capital of investors in an absolute sense, whilst providing income in excess of short-term bank deposit rates. The Scheme is not exposed to any further risks of financial loss beyond the fair value of its share in the investee funds as outlined in the preceding table. The Scheme's exposure to the Prudential Life Medical Aid Equity Fund is in excess of 50%. The Scheme did not consolidate the investee fund portfolio as the Scheme does not control the fund.

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

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

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

Outstanding claims provision

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

24. Insurance risk management

The primary insurance activity carried out by the Scheme 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 available to the members are structured to fall within the acceptable insurance risk levels specified. The annual business plan is structured around the insurance risk management policy.

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

The Scheme uses several methods to assess and monitor insurance risk exposure, both for individual types of risks insured and overall risks. These methods include internal risk measurement models, 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 below summarises the concentration of insurance risk, with reference to the carrying amount of the insurance claims incurred, by age group and in relation to the type of risk covered and benefits provided.

Concentration of insurance risk

Claims incurred for 2013 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	67 795	6 430	29 862	1 971	106 058
26 – 34	35 986	6 508	19 714	1 397	63 605
35 – 49	69 716	11 520	27 232	8 989	117 457
50 – 64	152 274	29 111	52 550	23 636	257 571
> 65	211 824	34 656	51 677	21 649	319 806
Total	537 595	88 225	181 035	57 642	864 497
Movement in the outstanding claims provision					9 703
Rectified benefits					(2 129)
Claims refunds					(403)
Other adjustments					(1 482)
Relevant healthcare expenditure (Note 9)					870 186

Claims incurred for 2012 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	62 773	5 954	27 650	1 976	98 354
26 – 34	33 321	6 026	18 254	1 427	59 029
35 – 49	64 552	10 667	25 215	9 463	109 897
50 – 64	140 994	26 955	48 657	25 589	242 196
> 65	196 134	32 089	47 849	22 823	298 894
Total	497 774	81 692	167 625	61 278	808 370
Movement in the outstanding claims provision					(5 077)
Rectified benefits					(302)
Claims refunds					(1 092)
Other adjustments					(301)
Relevant healthcare expenditure (Note 9)					803 947

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 acute medicines.

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

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

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

	Change in variable	2013 R'000	2012 R'000
Actual surplus		**67 866**	58 162
Surplus after change in claims experience	1% lower	**76 513**	66 201
Surplus after change in claims experience	1% higher	**59 218**	50 123

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.

25. 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, the member is obliged contractually to cede that payment to the Scheme to the extent that they have already been compensated. The outstanding claims at year-end amount to R4 024 202 (2012: R1 661 736).

26. Non-compliance matters

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

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

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

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

In terms of Annexure B read in conjunction with Regulation 30 of the Medical Schemes Act 131 of 1998, a medical scheme shall not have more than 2.5% of its investable assets invested in a single property. The

Scheme's office building is 3.4% of its total assets at year-end. The Scheme has applied to the Council for Medical Schemes for exemption from this requirement.

Regulation 30 of the Medical Schemes Act, read with Annexure B, stipulates that medical schemes may invest up to 40% of reserves in equities. Due to Profmed's reserves being well in excess of the statutory requirement, in June 2011 the Council for Medical Schemes granted exemption to Profmed to invest up to 50% of its reserves in South African equities.

Form of Proxy

Form of Proxy for the Profmed Annual General Meeting to be held at 15:30 on Wednesday 4 June 2014.

I, _____ , membership no. _____ ,

being a current and fully paid-up 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 Profmed Place, 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 2013 (including the reports of the trustees, the auditors and the Profmed Audit Committee)			
2.	Resolution for the re-appointment of the auditors			
3.	Resolution for the approval of the remuneration of trustees at a rate of R2 500 per hour for the 2014/15 year			
4.	Non-binding advisory vote to accept the Profmed Remuneration Policy			

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

Signed this _____ day of _____ 2014.

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-up 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 meeting.
3. The proxy form must be signed, dated and e-mailed to **profmedproxy2014@bdo.co.za** or faxed to **0862 338 308** by **12:00** on **Tuesday 3 June 2014**, the day prior to the scheduled annual general meeting. Hand-delivered or posted submissions will not be accepted. No proxy forms will be accepted after the deadline or at the annual general meeting.
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 on 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 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.

Profmed Place
15 Eton Road
Parktown
Johannesburg
2193

www.profmed.co.za