

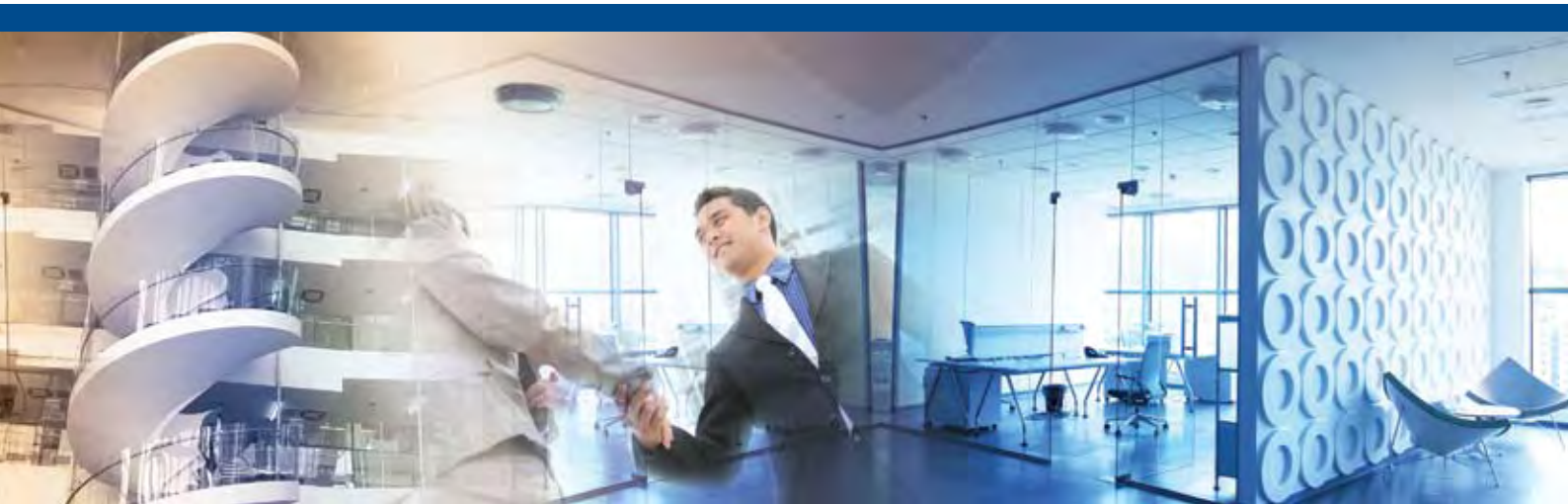


Discovery Health Medical Scheme

Annual financial statements for the
year ended 31 December 2008



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Discovery Health Medical Scheme

Registration no 331/1994

Statement of responsibility by the Board of Trustees

The Trustees are responsible for the preparation, integrity and fair presentation of the annual financial statements of Discovery Health Medical Scheme (the Scheme). The annual financial statements set out on pages 26 to 117 have been prepared in accordance with International Financial Reporting Standards and include amounts based on judgments and estimates made by management.

The Trustees consider that in preparing the annual financial statements they have used the most appropriate accounting policies, consistently applied and that all applicable International Financial Reporting Standards have been followed.

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

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

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

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

The Code of Corporate Practices and Conduct has been adhered to. The Scheme's external auditors, PricewaterhouseCoopers Incorporated, audited the annual financial statements, and their report is presented on pages 24 and 25.

The annual financial statements were approved by the Board of Trustees on 7 April 2009 and are signed on its behalf by:

M Van Der Nest
Chairman

D Moodley
Trustee

J Mathekga
Principal Officer

Statement of corporate governance by the Board Of Trustees

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

Board of Trustees

The Trustees meet regularly and monitor the performance of the Administrator. They address a range of key issues and ensure that discussion of items on policy, strategy and performance is critical, informed and constructive.

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

Internal control

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

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



M Van Der Nest
Chairman



D Moodley
Trustee



J Mathekga
Principal Officer



Discovery Health Medical Scheme

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Report of the Board of Trustees

The Board of Trustees presents its report for the year ended 31 December 2008

1. Governance and scheme information

1.1 Board of Trustees

The Board of Trustees of the Discovery Health Medical Scheme are responsible for ensuring adherence to principles of best corporate governance. The Scheme is committed to an open governance process that provides our members and other stakeholders with the assurance that the Scheme is managed ethically, within prudent risk parameters and in compliance with the Medical Schemes Act, 131 of 1998, as amended, and the rules of the Scheme. The Trustees are satisfied that the Scheme has in all material respects complied with the provisions and spirit of its rules and the Medical Schemes Act and its regulations. During the year under review, the Trustees of the Scheme were:

Name	Member elected	Position held	Qualification	Occupation
M Van Der Nest	Yes	Chairman	BA Law, LLB	Senior counsel
D Moodley	Yes	Trustee	MBA, MSC (Medicine) Sports Science, MBChB	President, Africa Unit Proudfoot Consulting Medical doctor Specialist
P Maserumule	Yes	Trustee	BA Law, LLB	Attorney, Maserumule Inc Former acting labour court judge
S Handler	Yes	Trustee	B.Com, FFA, FASSA	Chairman, Fundela Financial Education Trustee, Liberty Pension and Provident Funds. Non-executive chairman, Pioneer Financial Planning Group of Companies Non-executive independent director, Regent Life Assurance Company and Flagstone Reinsurance Company
N Sangweni	Yes	Trustee	MBChB (Natal) DOH (Wits) DCAM (IATA)	Occupational, travel and aviation medicine consultant Medical doctor Executive, South African Society of Travel Medicine
B Jacobson	Yes	Trustee	MBChB (Pretoria) Mmed (Haematology) (Wits) FRCS (Glasgow) PhD (Wits)	President, Southern African Society of Thrombosis and Haemostasis Head, Clinical Haematology. Department of Haematology, National Health Laboratory Service, The Charlotte Maxeke Johannesburg Academic Hospital Medical doctor
D Cohen	Yes	Trustee	B. Compt (Hons)	Director, RealJO Trading (Pty) Ltd and Lunga consulting Trustee, Ikageng Itireleng Property Trust

Report of the Board of Trustees

1. Governance and scheme information

1.2 Board proceedings

The Board of Trustees met seven times during 2008. Additional meetings are convened as and when necessary. The Trustees have full and unrestricted access to relevant information.

During the past financial year the attendance was as follows:

Name	31 Jan 2008	31 Mar 2008	15 May 2008	10 Jul 2008	3 Sep 2008	23 Oct 2008	27 Nov 2008
M Van Der Nest		✓	✓	✓	✓	✓	✓
D Moodley	✓	✓	✓	✓	✓	✓	✓
P Maserumule	✓	✓	✓	✓		✓	
S Handler	✓	✓	✓	✓	✓	✓	✓
N Sangweni	✓	✓	✓	✓	✓		✓
B Jacobson	✓	✓		✓	✓	✓	✓
D Cohen	✓	✓	✓	✓	✓	✓	✓



Discovery Health Medical Scheme

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Report of the Board of Trustees

1.3 Principal Officer

Jacky Mathekga

1.4 Registered office address and postal address

Discovery Health Medical Scheme	
16 Fredman Drive	PO Box 786722
Sandton	Sandton
2146	2146

1.5 Administrator of the Scheme

Discovery Health (Pty) Ltd	
155 West Street	PO Box 786722
Sandton	Sandton
2146	2146

1.6 Investment managers

RMB Asset Management (Pty) Ltd	
4 Merchant Place	PO Box 783414
1 Fredman Drive	Sandton
Sandton	2146
2146	

1.7 Auditors

PricewaterhouseCoopers Incorporated	
2 Eglin Road	Private Bag X36
Sunninghill	Sunninghill
2157	2157

1.8 Principal bankers

First National Bank	
4 First Place	PO Box 7791
BankCity	Johannesburg
Johannesburg	2000
2000	

Report of the Board of Trustees

2. Description of the scheme

2.1 Terms of registration

The Discovery Health Medical Scheme is a non-profit, open medical scheme registered in terms of the Medical Schemes Act, 131 of 1998, as amended.

2.2 Benefit options

The Scheme offered 14 benefit options to employers and members of the public for the 2008 year. These were:

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

	Core	Plus
Foundation	✓	
KeyCare	✓	✓



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Report of the Board of Trustees

2.3 Operational statistics

2008	Executive	Classic Comp	Classic Core	Classic Saver	Classic Priority	Essential Comp	Essential Core	Essential Saver
Number of members at the end of the accounting period	8,767	182,377	46,694	124,611	75,738	41,154	17,152	61,310
Number of beneficiaries at the end of the accounting period	21,243	447,614	100,440	272,210	173,929	94,612	38,385	140,798
Average number of members for the accounting period	8,701	183,956	45,783	120,653	74,294	41,788	16,587	60,701
Average number of beneficiaries for the accounting period	21,177	452,482	98,687	263,786	170,558	96,570	37,406	140,126
Average risk contributions per member per month (R)	6,364	2,570	1,479	1,438	1,689	2,327	1,284	1,310
Average risk contributions per beneficiary per month (R)	1,307	1,045	686	658	736	1,007	569	567
Average net claims incurred per member per month (R)	4,553	2,402	885	923	1,260	1,715	817	811
Average net claims incurred per beneficiary per month (R)	1,871	977	411	422	549	742	362	351
Average administration cost per member per month (R)	228	228	228	228	228	228	228	228
Average administration cost per beneficiary per month (R)	93	93	106	104	99	98	101	99
Average managed care: management services per beneficiary per month (R)	22	22	22	22	22	22	22	22
Beneficiaries per member at 31 December	2.42	2.45	2.15	2.18	2.30	2.30	2.24	2.30
Dependants per member at 31 December	1.42	1.45	1.15	1.18	1.30	1.30	1.24	1.30
Relevant healthcare expenditure as a percentage of risk contributions (%)	142.70	93.16	59.88	64.16	74.60	73.50	63.63	61.93
Non-healthcare expenditure as a percentage of risk contributions (%)	11.29	13.98	22.42	23.74	20.61	14.90	25.60	25.69

Report of the Board of Trustees

2.3 Operational statistics

2008	Essential Priority	Coastal Saver	Coastal Core	Foundation Core	KeyCare Plus	KeyCare Core	TOTAL
Number of members at the end of the accounting period	10,694	128,063	63,219	1,566	85,106	18,982	865,433
Number of beneficiaries at the end of the accounting period	23,602	302,189	140,879	3,457	163,407	30,698	1,953,463
Average number of members for the accounting period	10,471	127,101	61,846	1,661	79,772	17,323	850,636
Average number of beneficiaries for the accounting period	23,174	300,633	138,212	3,651	153,903	27,744	1,928,108
Average risk contributions per member per month (R)	1,580	1,164	1,101	1,054	947	626	1,629
Average risk contributions per beneficiary per month (R)	714	492	493	479	491	391	719
Average net claims incurred per member per month (R)	984	813	762	745	697	354	1,276
Average net claims incurred per beneficiary per month (R)	444	344	341	339	361	221	563
Average administration cost per member per month (R)	228	228	228	228	118	75	214
Average administration cost per beneficiary per month (R)	103	96	102	104	61	47	94
Average managed care: management services per beneficiary per month (R)	22	22	22	22	22	22	22
Beneficiaries per member at 31 December	2.21	2.36	2.23	2.21	1.92	1.62	2.26
Dependants per member at 31 December	1.21	1.36	1.23	1.21	0.92	0.62	1.26
Relevant healthcare expenditure as a percentage of risk contributions (%)	62.25	69.84	69.18	70.70	74.17	56.58	78.20
Non-healthcare expenditure as a percentage of risk contributions (%)	21.51	29.15	29.45	30.46	21.35	22.84	20.04



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Report of the Board of Trustees

2.3 Operational statistics

2007	Executive	Classic Comp	Classic Core	Classic Saver	Classic Priority	Essential Comp	Essential Core	Essential Saver
Number of members at the end of the accounting period	5,844	180,762	45,845	112,376	66,156	49,566	16,992	66,160
Number of beneficiaries at the end of the accounting period	14,177	446,860	98,365	246,303	152,461	118,432	38,440	154,864
Average number of members for the accounting period	5,474	184,775	44,712	108,336	63,899	50,488	16,557	65,807
Average number of beneficiaries for the accounting period	13,210	456,953	96,313	237,867	147,175	121,483	37,740	155,343
Average risk contributions per member per month (R)	2,869	2,353	1,343	1,300	1,540	2,172	1,174	1,212
Average risk contributions per beneficiary per month (R)	1,189	952	624	592	669	903	515	514
Average net claims incurred per member per month (R)	4,954	2,138	774	792	1,098	1,579	666	746
Average net claims incurred per beneficiary per month (R)	2,053	864	359	361	477	656	292	316
Average administration cost per member per month (R)	212	211	211	211	211	211	211	211
Average administration cost per beneficiary per month (R)	88	85	98	96	91	87	92	89
Average managed care: management services per beneficiary per month (R)	20	20	20	20	20	20	20	20
Beneficiaries per member at 31 December	2.43	2.47	2.15	2.19	2.30	2.39	2.26	2.34
Dependants per member at 31 December	1.43	1.47	1.15	1.19	1.30	1.39	1.26	1.34
Relevant healthcare expenditure as a percentage of risk contributions (%)	172.60	90.87	57.62	60.93	71.30	72.69	56.72	61.56
Non-healthcare expenditure as a percentage of risk contributions (%)	12.17	14.10	22.70	24.20	20.90	14.85	25.85	25.73

Report of the Board of Trustees

2.3 Operational statistics

2007	Essential Priority	Coastal Saver	Coastal Core	Foundation Core	KeyCare Plus	KeyCare Core	TOTAL
Number of members at the end of the accounting period	11,901	126,647	62,523	2,180	74,443	16,312	837,707
Number of beneficiaries at the end of the accounting period	27,010	302,005	139,754	4,805	144,928	26,380	1,914,784
Average number of members for the accounting period	11,684	125,830	60,697	2,334	67,899	13,741	822,232
Average number of beneficiaries for the accounting period	26,688	301,923	136,100	5,156	133,503	22,570	1,892,024
Average risk contributions per member per month (R)	1,473	1,069	1,002	952	873	579	1,499
Average risk contributions per beneficiary per month (R)	645	445	447	431	444	352	652
Average net claims incurred per member per month (R)	941	718	643	583	691	342	1,134
Average net claims incurred per beneficiary per month (R)	412	299	287	264	351	208	493
Average administration cost per member per month (R)	211	211	211	210	109	69	199
Average administration cost per beneficiary per month (R)	92	88	94	95	55	42	87
Average managed care: management services per beneficiary per month (R)	20	20	20	20	20	20	20
Beneficiaries per member at 31 December	2.27	2.38	2.24	2.20	1.95	1.62	2.29
Dependants per member at 31 December	1.27	1.38	1.24	1.20	0.95	0.62	1.29
Relevant healthcare expenditure as a percentage of risk contributions (%)	63.89	67.21	64.15	61.24	75.47	60.13	75.47
Non-healthcare expenditure as a percentage of risk contributions (%)	21.50	29.35	29.80	31.08	21.41	22.90	20.19



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2.4 Results of operations

The Scheme experienced another year of excellent overall performance with several multi-year strategies continuing to yield positive results. The Scheme continued to exhibit strong growth in 2008 with membership growing from 1.9 million lives to almost 2 million lives over the course of the year. Importantly, while the Scheme grew by 8.6% through new members joining, the rate of members leaving the Scheme was only 4.9%.

The Scheme generated a surplus of R997 million for the current year which takes the Scheme's statutory solvency level to 25.39%, R81 million higher than the 25% statutory solvency required by the Medical Schemes Act, 131 of 1998, as amended. The Scheme continues to exhibit a high level of financial strength and stability. This was confirmed by the upgrading of the credit rating to AA+, the highest possible rating in the industry, by independent credit rating agency Global Credit Ratings.

The results of the Scheme are set out in the financial statements on pages 26 to 117.

This outstanding overall performance is attributable to continued and effective risk management efforts, whilst ensuring that members experience quality care and receive value for money. The Scheme's hospital admission rate continued its decreasing trend in 2008 and the increase in cost per admission was also well controlled. Also, due to the expansion of the Scheme's GP Network and specialist Direct Payment Arrangements to cover more than 75% and 82% of members respectively, the members of the Scheme also experienced lower out-of-pocket payments.

Report of the Board of Trustees

2.5 Statutory scheme solvency

In terms of Regulation 29 (2) to the Medical Schemes Act 131 of 1998, as amended, the Scheme must maintain accumulated funds expressed as a percentage of gross annual contributions for the accounting period under review which may be no less than 25%. As at 31 December 2008, the Scheme's solvency margin stood at 25.39%.

The solvency margin is calculated on the following basis:

	2008 R'000	2007 R'000
Total members' funds per balance sheet	5,279,848	4,276,376
Less: cumulative unrealised net gain on remeasurement of investments to fair value	-	(28,653)
Accumulated funds per Regulation 29	5,279,848	4,247,723
Gross contribution income	20,796,701	18,468,378
Solvency margin = Accumulated funds / gross contribution income x 100	25.39%	23.00%

At 31 December 2008, the Scheme's regulatory capital exceeded the capital requirement imposed by the Regulator by R81 million.



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Report of the Board of Trustees

2.6 Reserve accounts

Movements in the reserves are set out in the statement of changes in members' funds.

2.7 Outstanding claims

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

2.8 Members' savings accounts

The Medical Savings Account (MSA) empowers members to manage their day-to-day expenses. Members pay an agreed sum, of up to 25% of their gross contributions, into this savings account. The full annual amount is made available for use immediately although members only contribute towards this monthly. The Medical Savings Account provides a variety of benefits to members for all medical expenses they may incur outside of hospital, such as dental care, optometry and medicines. The balance remaining in the Medical Savings Account at the end of each calendar year is carried over to the following year for the benefit of the member. The Scheme's liability to the members in respect of the savings account is reflected as a current liability in the financial statements (Note 8) and is repayable to members in terms of Regulation 10 of the Medical Schemes Act, 131 of 1998, as amended.

3. Key dimensions of the Scheme

Beyond the financial performance of the Scheme, the Trustees oversee appropriate management structures in order to ensure that the key dimensions of the Scheme are achieved. These key dimensions governing the Scheme's performance are dealt with below under the following headings:

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

3.1 Ensuring the Scheme has the ability to pay claims

The Scheme is confident of its ability to pay claims. To confirm this, the Scheme's credit rating for 2009 has been upgraded to AA+, the highest independent credit rating for a medical scheme in South Africa.

Report of the Board of Trustees

3. Key dimensions of the Scheme (continued)

3.2 Ensuring members are getting value for money

The Trustees believe value for money can be experienced at two levels. The first and most important for members is the overall cost and comprehensiveness of the Scheme benefits. The second is the level of charges for services obtained from service providers, relative to the service levels achieved. At both these levels, the Trustees are confident members are receiving value for money.

3.2.1 Member contributions and benefits provided

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

3.2.2 Administration fees

Administration fees have been steadily decreasing as a percentage of gross contributions from 14% in 2001 to 10.51% by the end of 2008. From 2007 to 2008 administration fees decreased from 10.73% to 10.51%. The Scheme is committed to continuing to reduce administration costs.

3.2.3 Contribution increases

Measured against its peers, the Scheme has had amongst the lowest increase in contributions in each of the last nine years. The net result of all activities over the year is the annual contribution increase to members. At the end of 2008, the headline increase was 12.8% and the average increase was 12.4% which falls within the guideline of CPIX plus 3%, which the Scheme has established as the long-term benchmark for contribution increases over recent years. The increase is also in line with the Council for Medical Schemes' guideline. This was one of the lowest increases among South African open medical schemes.



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Report of the Board of Trustees

3.3 Ensuring operational efficiency

3.3.1 Annual growth in membership

The Scheme continued to enjoy strong membership growth in 2008 and now covers almost 2 million lives.

The total membership per benefit option was as follows:

Benefit option	31 December 2008 Principal members	31 December 2008 Total lives	31 December 2008 Percentage of total lives	31 December 2007 Total lives
Executive	8,767	21,243	1.09	14,177
Classic Comprehensive	182,377	447,614	22.91	446,860
Classic Core	46,694	100,440	5.14	98,365
Classic Saver	124,611	272,210	13.93	246,303
Classic Priority	75,738	173,929	8.90	152,461
Essential Comprehensive	41,154	94,612	4.84	118,432
Essential Core	17,152	38,385	1.96	38,440
Essential Saver	61,310	140,798	7.21	154,864
Essential Priority	10,694	23,602	1.21	27,010
Coastal Saver	128,063	302,189	15.47	302,005
Coastal Core	63,219	140,879	7.21	139,754
Foundation Core	1,566	3,457	0.18	4,805
KeyCare Core	18,982	30,698	1.57	26,380
KeyCare Plus	85,106	163,407	8.36	144,928
Total	865,433	1,953,463	100.00	1,914,784

Report of the Board of Trustees

3.3 Ensuring operational efficiency (continued)

3.3.2 Key financial and service metrics

The Trustees continually monitor service levels. The volume of activity and the levels of service are impressive by any standards.

	2008	2007
Members' funds	R5,3 billion	R4,3 billion
Solvency ratio	25.39%	23.00%
Membership (lives)	1,95 million	1,91 million
Gross contribution income	R20,80 billion	R18,47 billion
Risk contribution income	R16,63 billion	R14,79 billion
Average net contributions per member per month	R1,629	R1,499
Average net claims per member per month	R1,276	R1,134
Average accumulated funds per member at year end	R6,207	R5,201
Average return on investments as a percentage of investments	12.07%	9.09%
Number of hospital events	456,955	448,039

2008	New Member Applications	Customer Service Call Centre	Claims Processing	Hospital and Walk In Centre visits
Volume	1009 lives per day	29,897 calls per day (2007) 28,551 calls per day (2008)	Average of 130,000 claims processed per working day	90,530 hospital patients were visited by Member Liaison Managers 56,051 members visited the four Walk In Centres
Average service delivery	80% of New Business applications are processed in less than 2 days	84.78% answered within 20 seconds	4.12 days from receipt to payment	The average waiting time at the Walk In Centres was one minute (00:00:59)
			0.33% error rate	Average member base research score out of 10 for Member Liaison Managers increased to 9.2



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Report of the Board of Trustees

3.3 Ensuring operational efficiency (continued)

3.3.3 Prudent financial management

The table below illustrates the very high level of financial control that the Scheme is achieving.

Year ended	December 2008 R'000	December 2007 R'000	December 2006 R'000
Gross contributions	R20,796,701	R18,468,378	R16,619,189
Total outstanding – excluding December contributions	R6,625	R10,150	R9,582
% outstanding	0.03%	0.05%	0.06%

3.3.4 Enhancing healthcare delivery in a difficult environment

The Trustees monitor the level of healthcare that the Scheme's healthcare providers provided to members and believe that the Scheme has managed the complex environment very effectively. The excellent financial performance of the Scheme was achieved despite the fact that the average age of the Scheme's members and beneficiaries has increased from 30.7 in 2001 to 33.2 years in 2008 with a pensioner ratio of 7.27%.

The Scheme's clinical risk management aims to balance access to high quality, affordable healthcare for all of the Scheme's members, while ensuring sustainability of the Scheme.

3.3.5 Due application of scheme rules

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

3.4 Ensuring statutory and regulatory compliance

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

The Scheme's auditors and Audit Committee, as well as the internal auditors and compliance officer, have an ongoing role in monitoring compliance and continually improving it to ensure we meet all the statutory and regulatory requirements.

In addition, the Trustees and the Council for Medical Schemes continue to monitor the Scheme's compliance within the broader regulatory framework through a joint task team.

Report of the Board of Trustees

4. Matters of non-compliance for the year ended 31 December 2008:

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

4.1 Statutory scheme solvency

In terms of Regulation 29 (2) to the Medical Schemes Act, 131 of 1998, as amended, the Scheme must maintain accumulated funds expressed as a percentage of gross annual contributions for the accounting period under review which may be no less than 25%.

During the year under review, the Scheme's accumulated funds expressed as a percentage of gross annual contributions, was in some months less than the statutory requirement of 25%. In line with the agreement reached with the Council for Medical Schemes during 2007 whereby the Scheme would build its reserves to reach 25% by 31 December 2008, the Scheme's statutory solvency margin was 25.39% as at 31 December 2008.

The build up of the solvency margin compared to the 2007 agreement is reflected in the following table:

	Solvency margin required per 2007 agreement	Solvency margin achieved
30 June 2007	21.00%	21.14%
31 December 2007	23.00%	23.00%
31 December 2008	25.00%	25.39%

4.2 Sustainability of benefit options

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

At 31 December 2008 the following options did not comply with Section 33 (2):

Option	Net underwriting deficit R'000	Net (deficit)/surplus R'000
Executive	(179,821)	(172,178)
Classic Comprehensive	(414,365)	(252,899)
Foundation Core	(326)	1,129

The Trustees continue to monitor the Executive and Classic Comprehensive options with a view to improving their sustainability. No new members are allowed to join the Foundation Core option as this option is being wound down.



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Report of the Board of Trustees

4. Matters of non-compliance for the year ended 31 December 2008 (continued):

4.3 Investments in employer groups

Section 35 (8)(a) of the Medical Schemes Act, 131 of 1998, as amended, states that a medical scheme shall not invest any of its assets in the business of an employer who participates or any administrator or any arrangement associated with a medical scheme. Due to the large number of the Scheme's employers being listed on the JSE, investments were made in certain of its employers listed on the JSE. The Council for Medical Schemes has granted the Scheme an exemption from this section of the Medical Schemes Act.

4.4 Broker fees paid before contributions are received

In terms of Regulation 28(5) to the Medical Schemes Act, 131 of 1998, as amended, the Scheme broker fees shall be paid monthly and on receipt by the Scheme of the relevant monthly contribution. In some instances brokers were compensated prior to receipt of the relevant monthly contribution. The Scheme has implemented additional controls to address this matter and the resulting instances where this requirement was contravened represents less than 0.5% of the total broker fees paid per month.

Report of the Board of Trustees

5. Investment Committee

The Investment Committee, established by the Board of Trustees, continues to invest excess funds in line with the Medical Schemes Act, 131 of 1998, as amended.

The Scheme's investment objectives are to maximise the return on its investments on a long-term basis at minimal risk, subject to any constraints imposed by legislation or the Trustees.

For the year ended 2008, the committee members were:

D Eriksson CA (SA) – Chairman

D Moodley (Member) MBA, MSC (Medicine) Sports Science, MBChB

P Maserumule (Member) BA Law, LLB

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

Name	11 Mar 2008	18 Jun 2008	14 Aug 2008	22 Oct 2008
D Eriksson	✓	✓	✓	✓
D Moodley	✓	✓	✓	✓
P Maserumule	✓	✓	✓	✓



Report of the Board of Trustees

6. Audit Committee

The responsibilities of the Audit Committee are:

- To assist in the execution of the Board's role of accountability;
- To ensure integrity, reliability and accuracy of accounting and financial reporting systems;
- To ensure that appropriate systems are in place for monitoring risk, control and compliance with laws and codes of conducts;
- To evaluate the adequacy of and effectiveness of the risk management, internal audit and compliance process;
- To maintain a transparent and appropriate relationship with the external auditors and set the principles of recommending the use of external auditors for non-audit services; and
- To review the scope, quality and cost of the statutory audit and the independence of the auditors. The committee had five members at 31 December 2008, two of whom are members of the Board of Trustees. In compliance with Section 36 (11) of the Medical Schemes Act, 131 of 1998, as amended, the majority of the members are not officers of the Scheme or of its Administrator. For the year ended 2008, the committee members were:
 - D Eriksson CA (SA) – Chairman
 - N Novick (Member) CA (SA)
 - S Green (Member) B.Sc B.Com (Hons)
 - JD Pema (Member) CA (SA), H.Dip Tax Law (resigned April 2008)
 - S Handler (Trustee Member) B.Com, FASSA, FFA
 - D Cohen (Trustee Member) B.Compt (Hons)

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

Report of the Board of Trustees

6. Audit Committee (continued)

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

Name	12 Mar 2008	26 Mar 2008	15 Apr 2008	16 Jun 2008	26 Aug 2008	18 Nov 2008
D Eriksson	✓		✓	✓	✓	✓
N Novick	✓	✓	✓	✓	✓	✓
S Green	✓	✓	✓	✓	✓	✓
JD Pema			n/a	n/a	n/a	n/a
S Handler	✓	✓	✓		✓	
D Cohen	✓	✓	✓	✓	✓	✓

7. Trustee and Sub-Committee remuneration

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

The remuneration payable to Trustees and Audit Committee members for the year ended 2008 is disclosed in Notes 19 and 16 respectively.

8. Subsequent events

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



Discovery Health Medical Scheme

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Report of the Board of Trustees

9. Going concern

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

10. Auditor independence

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

Details of fees paid to the external auditors for audit services are included in the annual financial statements. It is the Scheme's policy to ensure that it makes use of the most suitable organisation for any professional services it may require. These fees have also been disclosed and discussed with the Audit Committee.

11. The year ahead

The Scheme's average contribution increase in 2009 is 12.4%. The Scheme continues to deliver on its promise of sustainable, quality healthcare to its members. The exceptional financial performance is a result of continued development in risk management initiatives, its effective use of scale and the impact of making members healthier. The positive operating result positions the Scheme well to contain contribution increases in order to enhance the value that members receive for their contributions.

To achieve this target and maintain the contribution increases within the relevant guideline, the Scheme will continue to develop and implement various alternative reimbursement models with its service providers.

The Scheme's core purpose of making people healthier and enhancing and protecting their lives, remains the guiding principle. One of the ways that the Scheme achieves this is through its collaboration with Discovery Vitality using the Vitality HealthyFood™ benefit. This benefit aims to assist members in leading a healthy lifestyle and making healthy food choices by helping them to identify which healthy foods to buy. In addition, the Scheme benefits from the general incentive introduced by Discovery Vitality to make members healthier.

The Scheme continues to provide healthcare access to low income earners through the KeyCare Plans. KeyCare is the flagship low-income plan in South Africa today and has been growing faster than most other medical schemes in South Africa. Many employed but uninsured South Africans want medical scheme membership and have a source of funding, but the current lowest-cost plans in the market are still too expensive.

In response to this need, the Scheme has significantly reduced contributions for members earning below R5,500 a month. This offering is not at the expense of benefits on these plans, in fact KeyCare members will enjoy improved benefits in 2009, with enhancements to the Specialist, Antenatal and Mobility Devices benefits.

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

Report on the financial statements

We have audited the annual financial statements of Discovery Health Medical Scheme, which comprise the balance sheet as at 31 December 2008, the income statement, the statement of changes in funds and reserves and the cash flow statement for the year then ended, and a summary of significant accounting policies and other explanatory notes, as set out on pages 26 to 117.

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. This responsibility includes: designing, implementing and maintaining internal controls relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error; selecting and applying appropriate accounting policies; and making accounting estimates that are reasonable in the circumstances.

Auditor's Responsibility

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

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal controls relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal controls. 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.



Discovery Health Medical Scheme

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

Opinion

In our opinion, the financial statements present fairly, in all material respects, the financial position of the scheme as at 31 December 2008, and the 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.

Report on other legal and regulatory requirements

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

We draw attention to the detailed disclosures in note 32 with respect to three of the fourteen benefit options which were not self-sustaining during 2008 as required by S33(2) of the Medical Schemes Act 131 of 1998.

A handwritten signature in blue ink that reads "PricewaterhouseCoopers Inc."

PricewaterhouseCoopers Inc

Director: V Muguto

Registered Auditor

2 Eglin Road, Sunninghill,

Johannesburg

14 April 2009

Balance sheet

As at 31 December 2008

	Notes	2008 R'000	2007 R'000
Assets			
<i>Non-current assets</i>			
Financial assets at fair value through profit or loss	2	97,162	146,631
<i>Current assets</i>			
Financial assets at fair value through profit or loss	2	5,672,933	4,596,452
Trade and other receivables	3	815,293	793,921
Cash and cash equivalents	4	1,091,431	962,075
Total assets		7,676,819	6,499,079
Funds and liabilities			
<i>Members' funds</i>			
Accumulated funds		5,279,848	4,276,376
<i>Non-current liabilities</i>			
Members' trust funds	5	-	835
<i>Current liabilities</i>			
Outstanding claims provision	6	510,436	479,064
Derivative financial instruments	7	8,355	-
Members' savings accounts	8	1,430,744	1,291,449
Trade and other payables	9	446,488	451,033
Members' trust funds	5	948	322
Total funds and liabilities		7,676,819	6,499,079



Income statement for the year ended 31 December 2008

	Notes	2008 R'000	2007 R'000
Net contribution income	10	16,630,726	14,794,420
Net claims incurred	11	(13,021,903)	(11,188,524)
Claims incurred	11	(13,050,428)	(11,210,949)
Third party claim recoveries	11	28,525	22,425
Net income on risk transfer arrangements	12	16,656	23,830
Risk transfer arrangement fees	12	(86,532)	(157,033)
Recoveries from risk transfer arrangements	12	103,188	180,863
Relevant healthcare expenditure		(13,005,247)	(11,164,694)
Gross healthcare result		3,625,479	3,629,726
Managed care: management services	13	(505,087)	(457,930)
Broker service fees	14	(503,385)	(438,077)
Expenses for administration	25	(2,185,943)	(1,964,784)
Other operating expenses	15	(137,983)	(125,990)
Net healthcare result		293,081	642,945
Investment income	20	758,029	470,837
Net fair value (losses) / gains on financial assets at fair value through profit or loss	21	(20,933)	41,815
Sundry income	22	10,184	22,308
Other income		747,280	534,960
Expenses for asset management services rendered		(6,502)	(7,823)
Interest paid	23	(36,365)	(24,432)
Other expenditure		(42,867)	(32,255)
Net surplus for the year		997,494	1,145,650

Statement of changes in members' funds for the year ended 31 December 2008

	Note	2008 R'000 Accumulated funds	2007 R'000 Accumulated funds
Balance at beginning of the year		4,276,376	3,130,726
Net surplus for the year		997,494	1,145,650
Reserves transferred from other medical schemes	24	5,978	-
Balance at end of the year		5,279,848	4,276,376



Discovery Health Medical Scheme

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Cash flow statement for the year ended 31 December 2008

	Notes	2008 R'000	2007 R'000
CASH FLOWS FROM OPERATING ACTIVITIES			
Cash flows from operations before working capital changes	27	383,760	623,896
Working capital changes			
Increase in trade and other receivables		(69,169)	(148,939)
Increase in members' savings accounts		139,295	69,197
(Decrease) / increase in trade and other payables		(4,544)	6,200
Cash generated by operations		449,342	550,354
Purchases of financial assets		(1,198,500)	(1,398,479)
Proceeds from sale of financial assets		150,555	809,669
Interest received	27	751,564	462,476
Dividend income	20	6,991	10,011
Interest paid	23	(36,365)	(24,432)
Net cash flows from operating activities		123,587	409,599
CASH FLOWS FROM FINANCING ACTIVITIES			
Payments out of members' trust funds		(209)	(298)
Reserves transferred from other medical schemes	24	5,978	-
Net cash flows from financing activities		5,769	(298)
NET INCREASE IN CASH AND CASH EQUIVALENTS		129,356	409,301
Cash and cash equivalents at beginning of year		962,075	552,774
CASH AND CASH EQUIVALENTS AT END OF YEAR	4	1,091,431	962,075

Accounting policies for the year ended 31 December 2008

General Information

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

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

These annual financial statements were authorised for issue by the Board of Trustees on 7 April 2009.

1. Basis of preparation

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

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

The preparation of financial statements in conformity with IFRS requires the use of certain critical accounting estimates. It also requires management to exercise its judgment in the process of applying the Scheme's accounting policies. The areas involving a higher degree of judgment, or areas where estimates are significant to the annual financial statements, are disclosed in Note 31.

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

- financial instruments at fair value through profit or loss; and
- derivative financial instruments carried at fair value through profit or loss.

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



Discovery Health Medical Scheme

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Accounting policies

for the year ended 31 December 2008

1. Basis of preparation (continued)

New standards, amendments and interpretations effective in 2008 and relevant to the Scheme:

There were no new standards, amendments or interpretations issued during the year that were relevant to the Scheme.

New standards, amendments and interpretations effective in 2008 but not relevant to the Scheme:

The following new standards, amendments and interpretations are mandatory for accounting periods beginning on or after 1 January 2008 but are not relevant to the Scheme's operations:

Title	Nature of change	Effective for financial year ends commencing on or after
<p>IFRIC 12 – Service Concession Arrangements.</p> <p>Service concessions are arrangements whereby a government or other public sector entity grants contracts for the supply of public services to private sector operators. Control of the assets remains in public hands but the private sector is responsible for constructing, operating and maintaining the public sector infrastructure.</p> <p>This interpretation addresses how service concession operators should apply existing IFRSs to account for the obligations they undertake and rights they receive in these arrangements.</p> <p>The Scheme has not entered into any Service concession arrangements therefore this interpretation is not relevant to its operations.</p>	<p>IFRIC Interpretation</p>	<p>01 Jan 2008</p>
<p>IFRIC 13 – Customer Loyalty Programmes.</p> <p>This interpretation addresses accounting by entities that grant loyalty award credits to customers who buy other goods or services. Specifically, it explains how such entities should account for their obligations to provide free or discounted goods or services ('awards') to customers who redeem award credits. This interpretation requires the allocation of some of the proceeds of the initial sale to the award credits which is deferred as a liability and recognised as revenue only when they have fulfilled their obligations. They may fulfil their obligations by supplying awards themselves or engaging a third party to do so.</p> <p>The Scheme does not offer customer loyalty programmes, therefore this interpretation is not relevant to its operations.</p>	<p>IFRIC Interpretation</p>	<p>01 Jul 2008</p>

Accounting policies for the year ended 31 December 2008

1. Basis of preparation (continued)

New standards, amendments and interpretations effective in 2008 but not relevant to the Scheme (continued):

Title	Nature of change	Effective for financial year ends commencing on or after
<p>IFRIC 14 – IAS 19 - <i>Defined Benefit Assets and Minimum Funding Requirements.</i></p> <p>This interpretation provides general guidance on how to assess the limit in IAS 19 - <i>Employee benefits</i> on the amount of the surplus that can be recognised as an asset. It also explains how the pension asset or liability may be affected when there is a statutory or contractual minimum funding requirement.</p> <p>All employees of the Scheme are members of defined contribution funds. The Scheme does not offer defined benefit funds and therefore this interpretation is not relevant to its operations.</p>	IFRIC Interpretation	01 Jan 2008
<p>IFRIC 16 – <i>Hedges of a Net Investment in a Foreign Operation.</i></p> <p>This interpretation applies to an entity that hedges the foreign currency risk arising from its net investment in foreign operations and wishes to qualify for hedge accounting.</p> <p>Guidance is provided on:</p> <ul style="list-style-type: none"> • identifying the foreign currency risks that qualify as a hedged risk in the hedge of a net investment in a foreign operation; • where, within a group, hedging instruments that are hedges of a net investment in a foreign operation can be held to qualify for hedge accounting; and • how an entity should determine the amounts to be classified from equity to profit or loss for both the hedging instrument and the hedged item. <p>The Scheme does not have any investments in foreign operations therefore this interpretation is not relevant to its operations.</p>	IFRIC Interpretation	01 Oct 2008



Discovery Health Medical Scheme

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Accounting policies

for the year ended 31 December 2008

1. Basis of preparation (continued)

New standards, amendments and interpretations effective in 2008 but not relevant to the Scheme (continued):

Title	Nature of change	Effective for financial year ends commencing on or after
<p>IAS 39 – Financial Instruments: Recognition and Measurement and IFRS 7 – Financial Instruments: Disclosures.</p> <p>This amendment permits an entity to reclassify non-derivative financial assets (other than those designated at fair value through profit or loss by the entity upon initial recognition) out of the fair value through profit or loss category in particular circumstances.</p> <p>The amendment also permits an entity to transfer from the available-for-sale category to the loans and receivables category a financial asset that would have met the definition of loans and receivables (if the financial asset had not been designated as available-for-sale), if the entity has the intention and ability to hold that financial asset for the foreseeable future.</p> <p>The Scheme has no intention of reclassifying its non-derivative financial assets or transferring any financial assets into the loans and receivables category, therefore this amendment is not relevant to its operations.</p>	<p>Amendment to existing standard</p>	<p>01 Oct 2008</p>

Accounting policies

for the year ended 31 December 2008

1. Basis of preparation (continued)

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

The following new standards, amendments and interpretations are not yet effective for the current financial year.

The Scheme will comply with the new statements from the effective date.

Title	Nature of change	Effective for financial year ends commencing on or after
<p>IFRS 3 - Business Combinations (revised) and IAS 27 - Consolidated and Separate Financial Statements (amended).</p> <p>Medical schemes are included in the definition of mutual entities which was previously scoped out of IFRS 3. This amendment removes this exclusion and business combinations involving mutual entities are now within the scope of IFRS 3.</p> <p>In accounting for the merging or amalgamating of medical schemes the requirements set out in IFRS 3 must now be applied. Amongst others this requires applying the purchase method in accounting for these transactions.</p>	<p>Amendment to existing standard</p>	<p>01 Jul 2009</p>
<p>IAS 8 - Accounting Policies, Changes in Accounting Estimates and Errors.</p> <p>This amendment clarifies that the implementation guidance is not an integral part of a standard but is intended to assist in the application of standards rather than containing requirements that must be followed.</p> <p>This amendment is not expected to affect the Scheme's accounting treatment.</p>	<p>Amendment to existing standard</p>	<p>01 Jan 2009</p>



Accounting policies

for the year ended 31 December 2008

1. Basis of preparation (continued)

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

Title	Nature of change	Effective for financial year ends commencing on or after
<p>IFRIC 15 – Agreements for the Construction of Real Estate.</p> <p>The interpretation will standardise accounting practice for the recognition of revenue among real estate developers for sales of units, such as apartments or houses, “off plan”, ie before construction is complete.</p> <p>IFRIC 15 provides guidance on how to determine whether an agreement for the construction of real estate is within the scope of IAS 11 - <i>Construction Contracts</i> or IAS 18 - <i>Revenue</i> and when revenue from the construction should be recognised.</p> <p>The Scheme is not involved in the construction of real estate and therefore this interpretation is not relevant to its operations.</p>	<p>IFRIC Interpretation</p>	<p>01 Jan 2009</p>
<p>IFRIC 17 - Distributions of non-cash assets to owners.</p> <p>The interpretation clarifies that:</p> <ul style="list-style-type: none"> • a dividend payable should be recognised when the dividend is appropriately authorised and is no longer at the discretion of the entity; • an entity should measure the dividend payable at the fair value of the net assets to be distributed; • an entity should recognise the difference between the dividend paid and the carrying amount of the net assets distributed in profit or loss. <p>Section 26 (5) of the Medical Schemes Act 131 of 1998, as amended, prohibits the Scheme from paying dividends, therefore this interpretation is not relevant to the Scheme.</p>	<p>IFRIC Interpretation</p>	<p>01 Jul 2009</p>

Accounting policies

for the year ended 31 December 2008

1. Basis of preparation (continued)

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

Title	Nature of change	Effective for financial year ends commencing on or after
<p>IFRS 1 - First-Time Adoption of International Financial Reporting Standards and IAS 27 - Consolidated and Separate Financial Statements: Cost of an Investment in a Subsidiary, Jointly Controlled Entity or Associate.</p> <p>The amendment allows first-time adopters to use a deemed cost of either fair value or the carrying amount under previous accounting practice to measure the initial cost of investments in subsidiaries, jointly controlled entities and associates in the separate financial statements.</p> <p>The amendment also removed the definition of the cost method from IAS 27 and replaced it with a requirement to present dividends as income in the separate financial statements of the investor.</p> <p>The Scheme does not have investments in subsidiaries, jointly controlled entities or associates, therefore this amendment is not relevant to the Scheme.</p>	<p>Amendment to existing standard</p>	<p>01 Jan 2009</p>



Discovery Health Medical Scheme

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Accounting policies

for the year ended 31 December 2008

1. Basis of preparation (continued)

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

Title	Nature of change	Effective for financial year ends commencing on or after
<p>IFRS 2 - Share Based Payment.</p> <p>The amendment deals with two matters. It clarifies that vesting conditions are service conditions and performance conditions only. Other features of a share-based payment are not vesting conditions.</p> <p>It also specifies that all cancellations, whether by the entity or by other parties, should receive the same accounting treatment.</p> <p>The Scheme does not make any share-based payments therefore this amendment is not relevant to its operations.</p>	<p>Amendment to existing standard</p>	<p>01 Jan 2009</p>
<p>IFRS 5 - Non-current Assets Held for Sale and Discontinued Operations.</p> <p>This amendment deals with plans to sell the controlling interest in a subsidiary.</p> <p>The Scheme does not have any investments in subsidiaries therefore this amendment is not relevant to its operations.</p>	<p>Amendment to existing standard</p>	<p>01 Jul 2009</p>
<p>IFRS 7 - Financial Instruments: Disclosures.</p> <p>This amendment deals with presentation of finance costs.</p> <p>The Scheme does not have any borrowings incurring finance costs therefore this amendment is not relevant to its operations.</p>	<p>Amendment to existing standard</p>	<p>01 Jan 2009</p>

Accounting policies

for the year ended 31 December 2008

1. Basis of preparation (continued)

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

Title	Nature of change	Effective for financial year ends commencing on or after
<p>IAS 1 - Presentation of Financial Statements (revised).</p> <p>The main objective in revising IAS 1 was to aggregate information on the basis of shared characteristics. This led to the introduction of a statement of comprehensive income. This will enable readers to analyse changes in a company's equity resulting from transactions with owners in their capacity as owners separately from 'non-owner' changes. IAS 1 defines owners as holders of instruments classified as equity. The Scheme does not issue equity and consequently does not have owners, therefore these amendments are not relevant to the Scheme.</p> <p>The revisions include changes in the titles of some of the financial statements to reflect their function more clearly. The new titles are not mandatory for use in financial statements.</p> <p>The revision also introduces new requirements relating to the effect of income tax, reclassification adjustments and presentation of dividends. These changes are not relevant to the Scheme as it is exempt from Income tax and does not pay dividends.</p>	<p>Amendment to existing standard</p>	<p>01 Jan 2009</p>



Discovery Health Medical Scheme

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Accounting policies

for the year ended 31 December 2008

1. Basis of preparation (continued)

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

Title	Nature of change	Effective for financial year ends commencing on or after
<p>IAS 10 - Events after the Reporting Period.</p> <p>This amendment deals with dividends declared after the end of the reporting period.</p> <p>Section 26 (5) of the Medical Schemes Act 131 of 1998, as amended, prohibits the Scheme from paying dividends, therefore this amendment is not relevant to the Scheme.</p>	Amendment to existing standard	01 Jan 2009
<p>IAS 16 - Property, Plant and Equipment.</p> <p>This amendment deals with the recoverable amount and sale of assets held for rental.</p> <p>The Scheme does not have any items of Property, plant and equipment therefore this amendment is not relevant to its operations.</p>	Amendment to existing standard	01 Jan 2009
<p>IAS 18 - Revenue.</p> <p>This amendment replaces the term direct costs with transaction costs in respect of costs incurred in originating a loan.</p> <p>The Scheme has not originated any loans and therefore this amendment is not relevant to its operations.</p>	Amendment to existing standard	01 Jan 2009
<p>IAS 19 - Employee Benefits.</p> <p>This amendment deals with curtailments and negative past service costs, plan administration costs, replacement of the term 'fall due' and guidance on contingent liabilities.</p> <p>Employees of the Scheme are members of defined contribution funds under which the Scheme pays fixed contributions to a separate entity and has no further payment obligations. Therefore this amendment is not relevant to its operations.</p>	Amendment to existing standard	01 Jan 2009

Accounting policies

for the year ended 31 December 2008

1. Basis of preparation (continued)

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

Title	Nature of change	Effective for financial year ends commencing on or after
<p>IAS 20 - Accounting for Government Grants and Disclosure of Government Assistance.</p> <p>This amendment deals with government loans with a below-market rate of interest and consistency of terminology with other IFRSs.</p> <p>The Scheme has not received any grants or assistance from the government, therefore this amendment is not relevant to its operations.</p>	<p>Amendment to existing standard</p>	<p>01 Jan 2009</p>
<p>IAS 23 - Borrowing Costs.</p> <p>The main change is the removal of the option of immediately recognising as an expense borrowing costs that relate to assets that take a substantial period of time to get ready for use or sale.</p> <p>The Scheme does not have any borrowings and has not incurred any borrowing costs therefore this amendment is not relevant to its operations.</p>	<p>Amendment to existing standard</p>	<p>01 Jan 2009</p>
<p>IAS 27 - Consolidated and Separate Financial Statements (revised).</p> <p>This amendment requires the effects of all transactions with non-controlling interests to be recorded in equity if there is no change in control. They will no longer result in goodwill or gains and losses. The standard also specifies the accounting treatment when control is lost. Any remaining interest in the entity is re-measured to fair value and a gain or loss is recognised in profit or loss.</p> <p>The Scheme does not prepare consolidated financial statements therefore this amendment is not relevant to its operations.</p>	<p>Amendment to existing standard</p>	<p>01 Jan 2009</p>



Discovery Health Medical Scheme

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Accounting policies

for the year ended 31 December 2008

1. Basis of preparation (continued)

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

Title	Nature of change	Effective for financial year ends commencing on or after
<p>IAS 28 - Investments in Associates.</p> <p>This amendment deals with consequential amendments from changes to Business Combinations, required disclosures when investments in associates are accounted for at fair value through profit or loss and impairment of investments in associates.</p> <p>The Scheme does not have any investments in associates therefore this amendment is not relevant to its operations.</p>	<p>Amendment to existing standard</p>	<p>01 Jan 2009</p>
<p>IAS 29 - Financial Reporting in Hyperinflationary Economies.</p> <p>This amendment deals with the description of the measurement basis in financial statements and consistency of terminology with other IFRSs.</p> <p>The Scheme does not operate in a hyperinflationary economy therefore this amendment is not relevant to its operations.</p>	<p>Amendment to existing standard</p>	<p>01 Jan 2009</p>
<p>IAS 31 - Interests in Joint Ventures.</p> <p>This amendment deals with consequential amendments from changes to Business Combinations and required disclosures when interests in jointly controlled entities are accounted for at fair value through profit or loss.</p> <p>The Scheme does not have any interests in joint ventures therefore this amendment is not relevant to its operations.</p>	<p>Amendment to existing standard</p>	<p>01 Jan 2009</p>

Accounting policies

for the year ended 31 December 2008

1. Basis of preparation (continued)

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

Title	Nature of change	Effective for financial year ends commencing on or after
<p>IAS 32 - Financial Instruments: Presentation and IAS 1 - Presentation of financial statements - Puttable Financial Instruments and Obligations Arising on Liquidation.</p> <p>The amendment requires certain financial instruments that meet the definition of a financial liability, to be classified as equity.</p> <p>The amendment addresses the classification of some:</p> <ul style="list-style-type: none"> a) puttable financial instruments; and b) instruments, or components of instruments, that impose on the entity an obligation to deliver to another party a pro rata share of the net assets of the entity only on liquidation. <p>The Scheme does not have any puttable financial instruments or financial instruments that impose an obligation to deliver a pro rata share of the net assets of the Scheme on liquidation. Therefore this amendment is not relevant to its operations.</p>	<p>Amendment to existing standard</p>	<p>01 Jan 2009</p>
<p>IAS 34 - Interim Financial Reporting.</p> <p>This amendment deals with earnings per share disclosures in interim financial reports.</p> <p>The Scheme does not issue equity instruments therefore this amendment is not relevant to its operations.</p>	<p>Amendment to existing standard</p>	<p>01 Jan 2009</p>



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for the year ended 31 December 2008

1. Basis of preparation (continued)

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

Title	Nature of change	Effective for financial year ends commencing on or after
<p>IAS 36 - Impairment of Assets.</p> <p>Where fair value less cost to sell is calculated on the basis of discounted cash flows, this amendment requires disclosures equivalent to those for value-in-use calculations.</p> <p>The Scheme does not have assets that are in the scope of IAS 36 therefore these amendments are not relevant to its operations.</p>	Amendment to existing standard	01 Jan 2009
<p>IAS 38 - Intangible Assets.</p> <p>This amendment deals with advertising activities, promotional activities and the unit of production method of amortisation.</p> <p>The Scheme does not have any intangible assets therefore this amendment is not relevant to its operations.</p>	Amendment to existing standard	01 Jan 2009
<p>IAS 39 - Financial Instruments: Recognition and Measurement.</p> <p>This amendment deals with reclassification of derivatives into or out of the classification of at fair value through profit or loss, designating and documenting hedges at the segment level and applicable effective interest rate on cessation of fair value hedge accounting.</p> <p>The Scheme has no intention of reclassifying derivatives out of the fair value through profit or loss classification. The Scheme does not apply hedge accounting. Therefore these amendments are not relevant to its operations.</p>	Amendment to existing standard	01 Jan 2009

Accounting policies

for the year ended 31 December 2008

1. Basis of preparation (continued)

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

Title	Nature of change	Effective for financial year ends commencing on or after
<p>IAS 40 - Investment Property.</p> <p>This amendment deals with property under construction or development for future use as investment property, consistency of terminology with IAS 8 and investment property held under lease.</p> <p>The Scheme does not have investment property and is not currently developing property for future use as investment property therefore this amendment is not relevant to its operations.</p>	<p>Amendment to existing standard</p>	<p>01 Jan 2009</p>
<p>IAS 41 – Agriculture.</p> <p>This amendment deals with the discount rate for fair value calculations, additional biological transformation, examples of agricultural produce and products and point-of-sale costs.</p> <p>The Scheme is not involved in any activities relating to agriculture therefore this amendment is not relevant to its operations.</p>	<p>Amendment to existing standard</p>	<p>01 Jan 2009</p>



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Accounting policies

for the year ended 31 December 2008

2. Classification; recognition; presentation and derecognition of financial instruments

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

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

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

Offsetting financial instruments

Where a legally enforceable right 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.

Derecognition of financial assets and liabilities

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

Where the Scheme retains substantially all the risks and rewards of ownership of the financial asset, the Scheme continues to recognise the financial asset in its entirety and recognises a financial liability for the consideration received. In subsequent periods the financial liability is accounted for in terms of Accounting policy note 7.

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

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

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

Accounting policies

for the year ended 31 December 2008

3. Financial assets - initial and subsequent measurement

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

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

Financial assets at fair value through profit or loss

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

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

Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments that are not quoted in an active market. They are included in current assets, except for maturities greater than 12 months after the balance sheet date. These are classified as non-current assets. The Scheme's loans and receivables comprise Trade and other receivables and Cash and cash equivalents in the balance sheet (Accounting policy Notes 4 and 5 respectively).

4. Trade and other receivables

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

5. Cash and cash equivalents

In the cash flow statement, cash and cash equivalents comprise:

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

Cash and cash equivalents only include items held for the purpose of meeting short-term cash commitments rather than for investing or other purposes. Cash and cash equivalents have a maturity of less than three months and insignificant risk of changes in fair value.



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Accounting policies

for the year ended 31 December 2008

6. Impairment of financial assets

General

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

Financial assets carried at amortised cost

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

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

- Significant financial difficulty of service provider or member debtors;
- Breach of contract, such as nonpayment of member contributions when due and if these remain unpaid for extended periods;
- Default or delinquency in payments due by service providers and other debtors;
- Observable data indicating that there is a measureable decrease in the estimated future cash flows from other Scheme assets since the initial recognition of those assets, although the decrease cannot yet be attributed to the individual financial assets in the Scheme;
- Adverse changes in the payment status of members of the Scheme; or
- National or local economic conditions that correlate with nonpayment of debtor contributions.

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

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

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

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

Accounting policies

for the year ended 31 December 2008

7. Financial liabilities - initial and subsequent measurement

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

Trade payables

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

Members' savings accounts

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

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

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

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

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



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Accounting policies for the year ended 31 December 2008

8. Liabilities and provisions

Liabilities and provisions

The Scheme recognises liabilities, including provisions when:

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

Where the effect of discounting to present value is material, provisions are adjusted to reflect the time value of money.

Outstanding claims provision

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

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

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

9. Member insurance contracts

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

The contracts issued compensate the Scheme's members for healthcare expenses incurred and are detailed in Note 29.

10. Contribution income

Gross contributions comprise medical contributions and Medical Savings Account contributions.

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

Accounting policies for the year ended 31 December 2008

11. Relevant healthcare expenditure

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

11.1 Claims incurred

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

Net risk claims incurred comprise:

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

Net of:

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

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

11.2 Risk transfer arrangements

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

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

The claims incurred under member insurance contracts and the equivalent claims recoveries are presented in the income statement on a gross basis. Amounts recoverable under such contracts are therefore recognised in the same year as related claims. The claims incurred liability under risk transfer arrangements and the equivalent receivable are also presented in the balance sheet on a gross basis.

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



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for the year ended 31 December 2008

11. Relevant healthcare expenditure

11.2 Risk transfer arrangements

Amounts recoverable under risk transfer arrangements are assessed for impairment at each balance sheet date. These assets are deemed impaired if there is objective evidence, as a result of an event that occurred after its initial recognition, that the Scheme may not recover all amounts due and that the event has a reliably measurable impact on the amounts that the Scheme will receive under the risk transfer arrangement. The Scheme gathers the objective evidence that a risk transfer arrangement asset is impaired using the same process adopted for financial assets held at amortised cost. The impairment loss is also calculated following the same method used for these financial assets. These processes are described in Accounting policy Note 6.

12. Liability adequacy test

Liability adequacy tests are performed to ensure the adequacy of the member insurance contract liabilities as at the balance sheet date.

13. Managed care: management services fees

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

14. Broker service fees

Broker service fees are expensed as incurred.

15. Expenses for administration and other operating expenses

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

16. Investment income

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

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

Accounting policies

for the year ended 31 December 2008

17. Reimbursements from the Road Accident Fund

The Scheme grants assistance to its members in defraying expenditure incurred in connection with rendering of any relevant health service. Such expenditure may be in connection with a claim that is also made to the Road Accident Fund, administered in terms of the Road Accident Fund Act No. 56 of 1996. If the member is reimbursed by the Road Accident Fund, they are obliged contractually to cede that payment to the Scheme to the extent that they have already been compensated.

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

18. Unallocated funds

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

Unallocated funds that have legally prescribed, that is funds older than three years, are written back and are included under sundry income on the face of the income statement.

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

19. Employee benefits

Pension obligations

All employees of the Scheme are members of defined contribution funds. A defined contribution plan is a pension plan under which the Scheme pays fixed contributions into a separate entity. The Scheme has no legal or constructive obligations to pay further contributions if the fund does not hold sufficient assets to pay all employees the benefits relating to employee service in the current and prior periods. The Scheme has no further payment obligations once the contributions have been paid. Contributions to the defined contribution funds are recognised in the net surplus or deficit for the year in which they are incurred.

Other post-employment obligations

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

Leave pay accrual

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

Bonuses

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



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for the year ended 31 December 2008

20. Income tax

In terms of Section 10 (1)(d) of the Income Tax Act 58 of 1962, as amended, receipts and accruals of a benefit fund are exempt from normal tax. A medical scheme is included in the definition of a benefit fund and consequently the Scheme is exempt from income tax.

21. Allocation of income and expenditure to benefit options

The following items are directly allocated to benefit options:

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

The remaining items are allocated as detailed below:

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

Notes to the annual financial statements for the year ended 31 December 2008

	2008 R'000	2007 R'000
1. Accounting policies		
The accounting policies of the Scheme are set out on pages 30 to 53.		
2. Financial assets at fair value through profit or loss		
The Scheme's financial assets are summarised by measurement category as follows:		
Financial assets at fair value through profit or loss	5,770,095	4,743,083
Loans and receivables (Note 3)	15,458	18,543
Total financial assets	5,785,553	4,761,626
The non-current portion of financial assets is R97,162,138 (2007 - R146,631,388).		
The assets comprised in each of the categories are detailed below.		
Financial assets held at fair value through profit or loss		
Non-current assets	97,162	146,631
– Listed equities	97,162	146,631
Current assets	5,672,933	4,596,452
– Money market portfolio	5,672,933	4,591,028
– Derivative financial instruments held for trading	-	5,424
	5,770,095	4,743,083
Reconciliation of the balance at beginning of the year to the balance at the end of the year:		
At the beginning of the year	4,743,083	4,112,458
Acquisitions	1,198,500	1,398,479
Disposals	(150,555)	(809,669)
(Loss) / gain on revaluation of investments to fair value	(20,933)	41,815
At the end of the year	5,770,095	4,743,083



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Notes to the annual financial statements

for the year ended 31 December 2008

2. Financial assets at fair value through profit or loss (continued)

Instruments classified at fair value through profit or loss are held for trading.

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

In order to remove the market risk from the equity portfolio, the Scheme's asset managers entered into a futures contract whereby 2,222 (2007 - 2,214) Shareholder weighted index (Swix) 40 futures were sold at a level of 3,855 (2007 - 5,873). The multiplier for this contract was 10. The contract expires on 19 March 2009. This instrument is traded on SAFEX and settled daily. This arrangement covers 89% (2007 - 84%) of the Scheme's equity portfolio. The current year contract resulted in an unrealised loss of R8,354,720 compared to the unrealised gain of R5,424,300 in the prior year. The 2008 contract is disclosed in Note 7.

Section 35 (8)(a) of the Medical Schemes Act 131 of 1998, as amended, states that a medical scheme shall not invest any of its assets in the business of an employer who participates or any administrator or any arrangement associated with a medical scheme. Due to the large number of the Scheme's employers being listed on the JSE, investments were made in certain of its employers listed on the JSE. The Council for Medical Schemes has granted the Scheme an exemption from this section of the Medical Schemes Act.

Notes to the annual financial statements

for the year ended 31 December 2008

	2008 R'000	2007 R'000
3. Trade and other receivables		
Insurance receivables		
Contribution receivables	707,119	670,164
Contributions outstanding	712,156	676,969
Less: Provision for impairment	(5,037)	(6,805)
Member and service provider claims receivables	92,544	105,143
Amount due	210,808	194,213
Less: Provision for impairment	(118,264)	(89,070)
Other risk transfer arrangements	92	-
Recoveries due from other risk transfer arrangements	18,265	18,265
Less: Provision for impairment	(18,265)	(18,265)
Share of outstanding claims provision (Note 6)	92	-
Broker fee receivables	80	71
Amounts due from brokers	1,404	1,441
Less: Provision for impairment	(1,324)	(1,370)
Total receivables arising from insurance contracts	799,835	775,378
Loans and receivables		
Sundry accounts receivable	12,207	13,369
Interest receivable	3,251	5,174
Total receivables arising from loans and receivables	15,458	18,543
	815,293	793,921

At 31 December 2008 the carrying amounts of Trade and other receivables approximate their fair values due to the short-term maturities of these assets. Interest is not charged on overdue balances. The estimated future cash flow receipts have not been discounted as the effect would be immaterial.



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Notes to the annual financial statements for the year ended 31 December 2008

	2008 R'000	2007 R'000
4. Cash and cash equivalents		
Call accounts	591,875	696,057
Current accounts	407,181	231,350
Money market instruments	92,375	34,668
	1,091,431	962,075

At 31 December 2008 the carrying amounts of cash and cash equivalents approximate their fair values due to the short-term maturities of these assets.

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

Call account	876	1,057
Current account	100	100
	976	1,157

Notes to the annual financial statements for the year ended 31 December 2008

	2008 R'000	2007 R'000
5. Members' trust funds		
Mega reserves	948	1,157
Less:		
Current portion included in current liabilities	(948)	(322)
	<u>-</u>	<u>835</u>

These funds were transferred to Discovery Health Medical Scheme in 1999 from CNA Gallo Medical Scheme, in terms of Section 20 (c) of the Medical Schemes Act of 1967. The funds may only be used to subsidise the pensioner contributions and ex-gratia payments of those scheme members.

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



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Notes to the annual financial statements for the year ended 31 December 2008

	2008 R'000	2007 R'000
6. Outstanding claims provision		
Outstanding claims provision - not covered by risk transfer arrangements	510,344	479,064
Outstanding claims provision - covered by risk transfer arrangements	92	-
Provision arising from liability adequacy test	-	-
	510,436	479,064
<i>Analysis of movement in outstanding claims</i>		
Balance at beginning of year	479,064	544,896
Payments in respect of prior year	(531,864)	(460,495)
(Under) / over provision in prior year	(52,800)	84,401
Adjustment for current year	563,236	394,663
Covered by risk transfer arrangements	92	-
Not covered by risk transfer arrangements	563,144	394,663
Balance at end of year	510,436	479,064
<i>Analysis of outstanding claims provision</i>		
Estimated gross claims	557,955	525,456
Less:		
Estimated recoveries from savings plan accounts (Note 8)	(47,519)	(46,392)
Balance at end of year	510,436	479,064

Notes to the annual financial statements for the year ended 31 December 2008

	2008 R'000	2007 R'000
7. Derivative financial instruments		
Financial liabilities held at fair value through profit or loss		
Current liabilities		
– Derivative financial instruments held for trading	<u>8,355</u>	<u>-</u>
Reconciliation of the balance at beginning of the year to the balance at the end of the year:		
Derivative financial asset at the beginning of the year (Note 2)	5,424	-
Realised gain on derivative financial instruments transferred to listed equity portfolio	(53,180)	
Net gain on revaluation of derivative financial instruments to fair value	39,401	5,424
Gain on revaluation of derivative financial instruments to fair value	62,162	5,424
Loss on revaluation of derivative financial instruments to fair value	(22,761)	-
Derivative financial (liability) / asset at the end of the year	<u>(8,355)</u>	<u>5,424</u>

In order to remove the market risk from the equity portfolio, the Scheme's asset managers entered into a futures contract whereby 2,222 (2007 - 2,214) Shareholder weighted index (Swix) 40 futures were sold at a level of 3,855 (2007 - 5,873). The multiplier for this contract was 10. The contract expires on 19 March 2009. This instrument is traded on SAFEX and settled daily. This arrangement covers 89% (2007 - 84%) of the Scheme's equity portfolio. The current year's contract resulted in an unrealised loss of R8,354,720 compared to the unrealised gain of R5,424,300 in the prior year. The 2007 contract is disclosed in Note 2.



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Notes to the annual financial statements for the year ended 31 December 2008

	2008 R'000	2007 R'000
8. Members' savings accounts		
Balance on savings accounts at the beginning of the year	1,291,449	1,222,252
Add:		
Savings account contributions received or receivable	4,165,975	3,673,958
For the current year (Note 10)	4,165,975	3,673,958
Interest paid to members on savings accounts (Note 23)	36,293	24,402
Transfers received from other medical schemes	13,290	11,802
Less:		
Claims paid to or on behalf of members (Note 11)	(3,955,443)	(3,529,440)
Refunds on death or resignation	(120,820)	(111,525)
	1,430,744	1,291,449

The savings accounts contain a demand feature. In terms of Regulation 10 to the Medical Schemes Act 131 of 1998, as amended, any credit balance on a member's savings account must be taken as a cash benefit when the member terminates his or her membership of the Scheme or benefit option, and enrolls in another benefit option or medical scheme without a savings account or does not enroll in another medical scheme.

It is estimated that claims to be paid out of members' savings accounts in respect of claims incurred in 2008 but not recorded will amount to approximately R47,519,385 (2007 - R46,391,732) (Note 6).

As at 31 December 2008 the carrying amount of the members' savings accounts was deemed to be equal to their fair values, which is the amount payable on demand. The amounts were not discounted, due to the demand feature.

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

Notes to the annual financial statements for the year ended 31 December 2008

	2008 R'000	2007 R'000
9. Trade and other payables		
Insurance liabilities		
Contributions received in advance	10,709	10,303
Premium refunds due to employers	190	471
Reported claims not yet paid		
Balance at the beginning of the year	201,523	189,224
Movement for the year	(37,345)	12,299
Balance at the end of the year	164,178	201,523
Broker fee creditors	43,481	32,233
Accredited brokers	43,481	32,233
Other insurance liabilities	252	350
Total liabilities arising from insurance contracts	218,810	244,880
Financial liabilities		
Balance due to related party	221,275	198,938
Discovery Health (Pty) Ltd	221,275	198,938
Unallocated funds	3,982	2,956
Total accruals	2,421	4,259
General accruals	2,232	4,103
Leave pay accrual	189	156
Total arising from financial liabilities	227,678	206,153
	446,488	451,033

At 31 December 2008 the carrying amounts of Trade and other payables approximate their fair values due to the short-term maturities of these liabilities.



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	2008 R'000	2007 R'000
10. Net contribution income		
Gross contributions	20,796,701	18,468,378
Risk contributions	16,630,726	14,794,420
Members' savings account contributions (Note 8)	4,165,975	3,673,958
LESS:		
Members' savings account contributions (Note 8)	(4,165,975)	(3,673,958)
	16,630,726	14,794,420
11. Net claims incurred		
Current year claims	16,974,500	14,806,220
Claims not covered by risk transfer arrangements	16,871,312	14,625,357
Claims covered by risk transfer arrangements	103,188	180,863
Movement in outstanding claims provision	31,371	(65,831)
Under / (over) provision in prior year (Note 6)	52,800	(84,401)
Adjustment for current year	(21,429)	18,570
	17,005,871	14,740,389
Less:		
Claims charged to members' savings accounts (Note 8)	(3,955,443)	(3,529,440)
Claims incurred	13,050,428	11,210,949
Third party claim recoveries	(28,525)	(22,425)
	13,021,903	11,188,524

Notes to the annual financial statements for the year ended 31 December 2008

11. Net claims incurred (continued)

Risk transfer arrangements

During 2008 the Scheme had two risk transfer arrangements in place. The methodologies used to determine the claims covered by these arrangements are set out below.

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

The claims experience for members on the KeyCare Plus option for the 2008 benefit year was used as the basis for determining the claims under this arrangement. These claim amounts are adjusted to include a provision for outstanding claims and then converted to a Per Life Per Month (PLPM) rate using the membership on the KeyCare Plus option.

In order to determine the value of claims under this arrangement, the average 2008 PLPM rate is multiplied by the lives exposure for this arrangement's membership and reduced by the actual claims that the Scheme has paid under this arrangement.

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

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

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

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



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Notes to the annual financial statements for the year ended 31 December 2008

	2008 R'000	2007 R'000
12. Net income on risk transfer arrangements		
Other risk transfer arrangements:		
Capitation fees paid	(86,532)	(157,033)
Recoveries under risk transfer arrangements	103,188	180,863
Claims incurred in respect of related risk transfer arrangements	101,853	180,651
Recoveries received	1,335	212
	16,656	23,830
13. Managed care: management services		
Discovery Health (Pty) Ltd		
Clinical Claims Review	85,435	77,459
Clinical Policy Unit	13,107	11,883
Clinical Risk Management	95,386	86,481
Clinical Solutions (managed care systems)	8,495	7,702
Disease Management - Chronic Illness Benefit	51,698	46,871
HIV Case Management	41,504	37,629
Hospital Case Management	43,446	39,389
Hospital pre-authorisation	99,755	90,441
Network Management	54,368	49,292
Oncology Case Management	11,893	10,783
	505,087	457,930

Notes to the annual financial statements for the year ended 31 December 2008

	2008 R'000	2007 R'000
14. Broker service fees		
Brokers' fees	503,385	438,077
	<u>503,385</u>	<u>438,077</u>

In terms of Regulation 28 (5) to the Medical Schemes Act 131 of 1998, as amended, the Scheme broker fees shall be paid monthly and on receipt by the Scheme of the relevant monthly contribution. In some instances brokers were compensated prior to receipt of the relevant monthly contribution. The Scheme has implemented additional controls to address this matter and the resulting instances where this requirement was contravened represents less than 0.5% of the total broker fees paid per month.



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Notes to the annual financial statements for the year ended 31 December 2008

	2008 R'000	2007 R'000
15. Other operating expenses		
Airfares	4	(1)
Annual general meeting costs	75	3
Association fees	5,722	5,321
Audit fees	2,912	2,465
Audit services for the year ended 2006	-	969
Audit services for the year ended 2007	1,220	1,491
Audit services for the year ended 2008	1,640	-
Other services	52	5
Audit committee fees (Note 16)	525	361
Bank charges	6,687	6,454
Council for Medical Schemes	11,655	10,125
Debt collecting fees	930	777
Dispute committee fees	91	101
Electronic checking fees	53,338	43,015
Investment committee fees	106	-
Legal fees	460	316
Net impairment losses (Note 17)	47,938	33,931
Other expenses	1,001	251
Penalties	-	1
Principal Officer fees	2,332	2,600
Principal Officer office costs	389	104
Printing, postage and stationery	1,283	753
Professional fees	-	42
Staff costs (Note 18)	1,287	17,379
Sundry amounts written off	35	121
Trustees' remuneration and consideration expenses (Note 19)	1,213	1,871
	137,983	125,990

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	2008 R'000	2007 R'000
16. Audit committee fees		
Audit committee chairman - D. Eriksson	212	72
Audit committee member - N. Novick	190	111
Audit committee member - S. Green	119	97
Audit committee member - J. Pema (resigned April 2008)	4	81
	525	361
17. Net impairment losses		
Trade and other receivables		
Contributions that are not collectible	(1,618)	(307)
Movement in provision	(1,768)	(521)
Written off	150	214
Members' and service providers' portions that are not recoverable	49,609	35,506
Movement in provision	49,609	35,506
Amounts due by brokers that are not recoverable	(46)	(1,029)
Movement in provision	(46)	(1,029)
Recoveries due from other risk transfer arrangements	-	(8)
Movement in provision	-	(8)
Less:		
Previously written off receivables recovered	(7)	(231)
	47,938	33,931



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	2008 R'000	2007 R'000
18. Staff costs		
Salaries and bonuses	1,179	13,929
Pension costs - defined contribution plans	48	1,012
Medical and other benefits	27	2,487
Increase/(decrease) in leave pay accrual	33	(49)
	1,287	17,379

The decrease in staff costs during the current year is a result of certain staff members previously employed by the Scheme being transferred to the Administrator during 2007.

Notes to the annual financial statements for the year ended 31 December 2008

19. Trustees' remuneration and consideration expenses

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

31 December 2008	Sub-committee fees					Total
	Services as Trustee	Audit committee	Investment committee	Training	Fees for consultancy services	
	R'000	R'000	R'000	R'000	R'000	
M. Van Der Nest (Chairman)	169	-	-	-	-	169
D. Moodley	152	-	68	-	-	220
P. Maserumule	89	-	68	-	-	157
S. Handler	132	76	-	1	-	209
D. Cohen	132	115	-	1	-	248
N. Sangweni	105	-	-	-	-	105
B. Jacobson	105	-	-	-	-	105
Total	884	191	136	2	-	1,213

31 December 2007	Sub-committee fees					Total
	Services as Trustee	Audit committee	Investment committee	Training	Fees for consultancy services	
	R'000	R'000	R'000	R'000	R'000	
M. Van Der Nest (Chairman)	255	-	-	-	-	255
D. Moodley	185	-	64	-	-	249
P. Maserumule	129	-	48	-	-	177
S. Handler	164	40	-	1	-	205
D. Cohen	96	22	-	2	-	120
N. Sangweni	119	-	-	10	-	129
B. Jacobson	69	-	-	-	-	69
D. Eriksson*	195	97	85	-	-	377
R. Klein**	99	-	-	-	191	290
Total	1,311	159	197	13	191	1,871

* = Resigned

** = Term of office expired



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	2008 R'000	2007 R'000
20. Investment income		
Financial assets at fair value through profit or loss:	603,803	397,677
Dividend income	6,991	10,011
Interest income	596,812	387,666
Cash and cash equivalents interest income	154,226	73,160
Investment income per income statement	758,029	470,837
The Scheme's total interest income is summarised below.		
Financial assets not at fair value through profit or loss:		
Loans and receivables		
Interest received from Administrator (Note 22)	524	1,421
Other interest received (Note 22)	2	229
Cash and cash equivalents interest income	154,226	73,160
	154,752	74,810
Financial assets at fair value through profit or loss:		
Interest income	596,812	387,666
Total interest income	751,564	462,476

Notes to the annual financial statements for the year ended 31 December 2008

	2008 R'000	2007 R'000
21. Net fair value (losses) / gains on financial assets at fair value through profit or loss		
Net fair value gains on financial assets at fair value through profit or loss including derivatives:	39,401	42,285
- Equity securities	-	36,861
- Derivatives held for trading	39,401	5,424
Net fair value loss on financial assets at fair value through profit or loss including derivatives:	(60,334)	(470)
- Equity securities	(59,268)	-
- Money market	(1,066)	(470)
	<u>(20,933)</u>	<u>41,815</u>



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	2008 R'000	2007 R'000
22. Sundry income		
Fees recovered from members	441	450
Interest received from Administrator	524	1,421
Other interest received	2	229
Prescribed amounts written back	7,530	18,367
Stale cheques written back	1,687	1,841
	10,184	22,308
23. Interest paid		
Financial assets not at fair value through profit or loss:		
Interest paid on members' savings accounts (Note 8)	36,293	24,402
Interest paid other	52	30
Interest paid to Administrator	20	-
	36,365	24,432
24. Reserves transferred from other medical schemes		
Anglogold Medical Scheme	5,978	-
	5,978	-

The reserve transfer arises from an agreement reached between the Scheme, Discovery Health (Pty) Ltd and the Council for Medical Schemes relating to the 2004 amalgamation of Anglogold Medical Scheme.

Notes to the annual financial statements for the year ended 31 December 2008

25. Related party transactions

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

Parties with significant influence over the Scheme

Administrator:

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

Key management personnel and their close family members

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

Close family members include close family members of the Board of Trustees and Principal Officer.

Transactions with related parties

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



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for the year ended 31 December 2008

25. Related party transactions (continued)

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

	2008 R'000	2007 R'000
Income statement transactions		
<i>Compensation</i>		
Short-term employee benefits	(3,545)	(4,471)
<i>Contributions and claims</i>		
Gross contributions received	286	208
Claims paid from the Scheme	(22)	(118)
Claims paid from the Medical Savings Account	(74)	(40)
Healthcare provider fees paid	(62)	(194)
Balance sheet transactions		
Contribution debtors	16	15
Other debtors	-	10
Medical Savings Account balances	(17)	(16)
Trustee remuneration payable	(4)	(40)

Notes to the annual financial statements for the year ended 31 December 2008

25. Related party transactions (continued)

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

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

Transaction	Nature of transactions and their terms and conditions
Contributions received	This constitutes the contributions paid by the related party as a member of the Scheme, in their individual capacity. All contributions were on the same terms as applicable to other members.
Claims incurred	This constitutes amounts claimed by the related parties, in their individual capacity as members of the Scheme. All claims were paid out in terms of the rules of the Scheme, as applicable to other members.
Contribution debtors	This constitutes outstanding contributions receivable. The amounts are due immediately. No impairment provisions have been raised on these amounts.
Other debtors	This comprises the balance due to the Scheme as at 31 December 2007, on the Principal Officer's cellphone account. As at 31 December 2008 there was no balance due to the Scheme.
Medical Savings Account balances	The amounts owing to the related parties relate to Medical Savings Account balances to which the parties have a right. In line with the terms applied to third parties, the balances earn interest monthly at predetermined interest rates, on an accrual basis. The amounts are all current, and would need to be payable on demand should an appropriate claim be issued, or should the member resign from the Scheme, as applicable to other members.
Healthcare provider fees paid/payable	These constitute fees paid to healthcare providers (medical practitioners). Fees are paid on the same basis as applicable to third parties.



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Notes to the annual financial statements for the year ended 31 December 2008

25. Related party transactions (continued)

Transactions with entities that have significant influence over the Scheme

	2008 R'000	2007 R'000
Discovery Health (Pty) Ltd - Administrator		
Income statement transactions		
Administration fees paid	(2,185,943)	(1,964,784)
Interest received on monthly balances (Note 22)	524	1,421
Interest paid on monthly balances (Note 23)	(20)	-
Balance sheet transactions		
Balance due to Discovery Health (Pty) Ltd at year end (Note 9)	(178,694)	(160,279)
Discovery Health (Pty) Ltd - Managed care organisation		
Income statement transactions		
Managed care fees paid	(505,087)	(540,925)
Managed care: management services	(505,087)	(457,930)
Managed care: healthcare services	-	(82,995)
Balance sheet transactions		
Balance due to Discovery Health (Pty) Ltd at year end (Note 9)	(42,581)	(38,659)

Notes to the annual financial statements for the year ended 31 December 2008

25. Related party transactions (continued)

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

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

Administration agreement

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

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

Managed care agreements

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

Managed care: management services

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

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



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25. Related party transactions (continued)

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

Managed care agreements (continued)

Managed care: management services (continued)

The services provided by the managed care organisation include:

- Managed healthcare services as defined in the Medical Schemes Act 131 of 1998, as amended and the rules of the Scheme;
- Prospective review services including pre-authorisation and ensuring benefit availability;
- Concurrent case management services including managing each beneficiary's medical event on an individual case basis;
- Acute case management services including managing each beneficiary's treatment for severe medical conditions on at least a daily basis;
- On-site case management services including managing each beneficiary's medical treatment at the site where the treatment is provided in appropriate circumstances and auditing of clinical notes to assess coding accuracy;
- Disease case management services including managing each disease for which the Scheme provides benefits by determining the cost and incidence of each disease and suggesting appropriate measures to reduce the cost of treating the disease;
- Auditing and reviewing accounts received from service providers in respect of treatment provided to members and beneficiaries;
- Continually analysing and reporting on data including data on a case mixed adjusted basis in order to monitor both cost and utilisation of Scheme benefits with a view to identifying areas for intervention;
- Managing all contracts with service providers to the Scheme with the aim of reducing costs while maintaining and / or improving quality of service;
- Implementing, managing and reviewing reimbursement models and making recommendations on alternative reimbursement models; and
- Auditing and reviewing provider servicing behaviour with the aim of reducing costs while maintaining and / or improving the provision of appropriate levels of care.

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

2008	Executive R'000	Classic Comp R'000	Classic Core R'000	Classic Saver R'000	Classic Priority R'000	Essential Comp R'000	Essential Core R'000	Essential Saver R'000
Net contribution income	332,251	5,673,380	812,360	2,082,689	1,505,464	1,166,798	255,555	954,174
Net claims incurred	(475,421)	(5,302,876)	(486,441)	(1,336,270)	(1,123,131)	(859,951)	(162,606)	(590,905)
Claims incurred	(476,505)	(5,314,675)	(487,493)	(1,339,125)	(1,125,632)	(861,828)	(162,964)	(592,182)
Third party claim recoveries	1,084	11,799	1,052	2,855	2,501	1,877	358	1,277
Net income/(expense) on risk transfer arrangements								
arrangement fees	1,284	17,731	-	-	-	2,376	-	-
Risk transfer arrange fees	(3,222)	(50,655)	-	-	-	(7,223)	-	-
Recoveries from risk transfer arrangements	4,506	68,386	-	-	-	9,599	-	-
Relevant healthcare expenditure	(474,137)	(5,285,145)	(486,441)	(1,336,269)	(1,123,131)	(857,575)	(162,606)	(590,905)
Gross healthcare result	(141,886)	388,235	325,919	746,419	382,333	309,223	92,949	363,269
Managed care: management services	(5,548)	(118,532)	(25,852)	(69,101)	(44,679)	(25,297)	(9,799)	(36,707)
Broker service fees	(6,778)	(142,643)	(23,827)	(76,257)	(50,702)	(27,633)	(7,629)	(32,865)
Expenses for administration	(23,759)	(502,289)	(125,010)	(329,441)	(202,859)	(114,100)	(45,291)	(165,742)
Other operating expenses	(1,412)	(29,874)	(7,427)	(19,556)	(12,046)	(6,787)	(2,691)	(9,848)
Net healthcare result	(179,383)	(405,103)	143,803	252,064	72,047	135,406	27,539	118,107
Investment income	7,752	163,715	40,799	107,600	66,218	37,176	14,791	54,078
Net fair value losses on financial assets at fair value through profit or loss	(212)	(4,446)	(1,132)	(3,001)	(1,826)	(1,005)	(416)	(1,484)
Sundry income	104	2,197	548	1,446	890	499	199	726
Other income	7,644	161,466	40,215	106,045	65,282	36,670	14,574	53,320
Expenses for asset management services rendered	(67)	(1,402)	(350)	(923)	(568)	(319)	(127)	(464)
Interest paid	(372)	(7,860)	(1,957)	(5,159)	(3,176)	(1,786)	(709)	(2,595)
Other expenditure	(439)	(9,262)	(2,307)	(6,082)	(3,744)	(2,105)	(836)	(3,059)
Net surplus/(deficit) for the year	(172,178)	(252,899)	181,711	352,027	133,585	169,971	41,277	168,368



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

2008	Essential Priority R'000	Coastal Saver R'000	Coastal Core R'000	Foundation Core R'000	KeyCare Plus R'000	KeyCare Core R'000	Discounted options R'000	TOTAL R'000
Net contribution income	198,573	1,774,906	817,416	21,001	906,116	130,057	(14)	16,630,726
Net claims incurred	(123,609)	(1,239,509)	(565,461)	(14,847)	(667,290)	(73,586)	-	13,021,903
Claims incurred	(123,876)	(1,242,139)	(566,682)	(14,878)	(668,705)	(73,744)	-	(13,050,428)
Third party claim recoveries	267	2,630	1,221	31	1,415	158	-	28,525
Net income/(expense) on risk transfer arrangements	-	-	-	-	(4,735)	-	-	16,656
Risk transfer arrangement fees	-	-	-	-	(25,432)	-	-	(86,532)
Recoveries from risk transfer arrangements	-	-	-	-	20,697	-	-	103,188
Relevant healthcare expenditure	(123,609)	(1,239,509)	(565,461)	(14,847)	(672,026)	(73,586)	-	(13,005,247)
Gross healthcare result	74,964	535,397	251,955	6,154	234,091	56,471	(14)	3,625,479
Managed care: management services	(6,071)	(78,754)	(36,206)	(956)	(40,317)	(7,268)	-	(505,087)
Broker service fees	(6,364)	(71,016)	(25,624)	(636)	(27,359)	(4,052)	-	(503,385)
Expenses for administration	(28,590)	(347,047)	(168,869)	(4,534)	(112,832)	(15,580)	-	(2,185,943)
Other operating expenses	(1,698)	(20,624)	(10,032)	(270)	(12,919)	(2,799)	-	(137,983)
Net healthcare result	32,241	17,956	11,224	(242)	40,664	26,772	(14)	293,081
Investment income	9,333	113,213	55,119	1,474	71,255	15,506	-	758,029
Net fair value losses on financial assets at fair value through profit or loss	(258)	(3,105)	(1,531)	(39)	(2,035)	(443)	-	(20,933)
Sundry income	125	1,521	741	20	959	209	-	10,184
Other income	9,200	111,629	54,329	1,455	70,179	15,272	-	747,280
Expenses for asset management services rendered	(80)	(972)	(473)	(13)	(611)	(133)	-	(6,502)
Interest paid	(448)	(5,433)	(2,644)	(71)	(3,413)	(742)	-	(36,365)
Other expenditure	(528)	(6,405)	(3,117)	(84)	(4,024)	(875)	-	(42,867)
Net surplus/(deficit) for the year	40,913	123,180	62,436	1,129	106,819	41,169	(14)	997,494

Notes to the annual financial statements

for the year ended 31 December 2008

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

2007	Executive R'000	Classic Comp R'000	Classic Core R'000	Classic Saver R'000	Classic Priority R'000	Essential Comp R'000	Essential Core R'000	Essential Saver R'000
Net contribution income	94,241	5,217,671	720,797	1,690,491	1,181,064	1,316,090	233,164	957,324
Net claims incurred	(162,722)	(4,739,903)	(415,325)	(1,030,018)	(842,152)	(956,341)	(132,250)	(589,338)
Claims incurred	(163,171)	(4,749,603)	(416,141)	(1,032,012)	(843,875)	(958,255)	(132,517)	(590,468)
Third party claim recoveries	449	9,700	816	1,994	1,723	1,914	267	1,130
Net income/(expense) on risk transfer arrangements	60	(1,144)	-	-	-	(323)	-	-
Risk transfer arrangement fees	(736)	(43,709)	-	-	-	(7,087)	-	-
Recoveries from risk transfer arrangements	796	42,565	-	-	-	6,764	-	-
Relevant healthcare expenditure	(162,662)	(4,741,047)	(415,325)	(1,030,018)	(842,152)	(956,664)	(132,250)	(589,338)
Gross healthcare result	(68,421)	476,624	305,472	660,473	338,912	359,426	100,914	367,986
Managed care: management services	(1,604)	(110,985)	(23,392)	(57,773)	(35,746)	(29,506)	(9,166)	(37,730)
Broker service fees	(1,974)	(129,645)	(20,387)	(60,912)	(39,786)	(30,564)	(6,722)	(32,253)
Expenses for administration	(6,976)	(466,765)	(112,996)	(273,821)	(161,509)	(127,546)	(41,843)	(166,284)
Other operating expenses	(919)	(28,456)	(6,841)	(16,543)	(9,753)	(7,771)	(2,533)	(10,093)
Net healthcare result	(79,894)	(259,227)	141,856	251,424	92,118	164,039	40,650	121,626
Investment income	1,762	105,725	25,692	62,326	36,760	28,910	9,515	37,764
Net fair value gains / (losses) on financial assets at fair value through profit or loss	(195)	10,192	2,284	5,381	3,154	2,751	841	3,414
Sundry income	76	4,978	1,219	2,965	1,750	1,357	451	1,783
Other income	1,643	120,895	29,195	70,672	41,664	33,018	10,807	42,961
Expenses for asset management services rendered	(18)	(1,784)	(427)	(1,030)	(608)	(487)	(158)	(631)
Interest paid	(93)	(5,482)	(1,333)	(3,235)	(1,908)	(1,499)	(494)	(1,959)
Other expenditure	(111)	(7,266)	(1,760)	(4,265)	(2,516)	(1,986)	(652)	(2,590)
Net surplus/(deficit) for the year	(78,362)	(145,598)	169,291	317,831	131,266	195,071	50,805	161,997



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Notes to the annual financial statements for the year ended 31 December 2008

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

2007	Essential Priority R'000	Coastal Saver R'000	Coastal Core R'000	Foundation Core R'000	KeyCare Plus R'000	KeyCare Core R'000	Discounted options R'000	TOTAL R'000
Net contribution income	206,568	1,613,739	730,117	26,652	711,073	95,461	(32)	14,794,420
Net claims incurred	(131,975)	(1,084,553)	(468,370)	(16,321)	(562,939)	(56,339)	22	(11,188,524)
Claims incurred	(132,236)	(1,086,666)	(469,315)	(16,350)	(563,913)	(56,449)	22	(11,210,949)
Third party claim recoveries	261	2,113	945	29	974	110	-	22,425
Net income/(expense) on risk transfer arrangements	-	-	-	-	26,296	(1,059)	-	23,830
Risk transfer arrangement fees	-	-	-	-	(102,128)	(3,373)	-	(157,033)
Recoveries from risk transfer arrangements	-	-	-	-	128,424	2,314	-	180,863
Relevant healthcare expenditure	(131,975)	(1,084,553)	(468,370)	(16,321)	(536,643)	(57,398)	22	(11,164,694)
Gross healthcare result	74,593	529,186	261,747	10,331	174,430	38,063	(10)	3,629,726
Managed care: management services	(6,482)	(73,331)	(33,056)	(1,252)	(32,425)	(5,482)	-	(457,930)
Broker service fees	(6,605)	(63,032)	(21,847)	(777)	(20,691)	(2,882)	-	(438,077)
Expenses for administration	(29,529)	(317,955)	(153,399)	(5,893)	(88,835)	(11,433)	-	(1,964,784)
Other operating expenses	(1,786)	(19,297)	(9,281)	(363)	(10,296)	(2,067)	9	(125,990)
Net healthcare result	30,191	55,571	44,164	2,046	22,183	16,199	(1)	642,945
Investment income	6,713	72,210	34,890	1,331	39,247	7,992	-	470,837
Net fair value gains on financial assets at fair value through profit or loss	589	6,544	3,082	138	3,064	576	-	41,815
Sundry income	319	3,410	1,657	62	1,890	391	-	22,308
Other income	7,621	82,164	39,629	1,531	44,201	8,959	-	534,960
Expenses for asset management services rendered	(112)	(1,206)	(578)	(23)	(635)	(126)	-	(7,823)
Interest paid	(348)	(3,746)	(1,811)	(69)	(2,039)	(416)	-	(24,432)
Other expenditure	(460)	(4,952)	(2,389)	(92)	(2,674)	(542)	-	(32,255)
Net surplus/(deficit) for the year	37,352	132,783	81,404	3,485	63,710	24,616	(1)	1,145,650

Notes to the annual financial statements for the year ended 31 December 2008

	2008 R'000	2007 R'000
27. Cash flows from operations before working capital changes		
Net surplus for the year	997,494	1,145,650
Adjustments for:		
Increase / (decrease) in outstanding claims provision	31,371	(65,832)
Impairment losses	47,797	33,948
Interest received	(751,564)	(462,476)
Dividend income	(6,991)	(10,011)
Interest paid	36,365	24,432
Net fair value losses / (gains) on financial assets at fair value through profit or loss	20,933	(41,815)
Net fair losses on derivative financial instruments	8,355	-
	383,760	623,896

28. Post balance sheet events

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



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Notes to the annual financial statements

for the year ended 31 December 2008

29. Insurance risk management report

Nature and extent of risks arising from insurance contracts

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

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

Insurance risk

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

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

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

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

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

Hospital benefits

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

Chronic Illness Benefit

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

Day-to-day benefits

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

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

Notes to the annual financial statements

for the year ended 31 December 2008

29. Insurance risk management report (continued)

Insurance risk (continued)

Hospital Benefit risk

Frequency and severity of claims

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

A 1% increase or decrease in the admission rate is estimated to increase or decrease the Scheme's loss ratio by 0.56%. The introduction of new hospital technologies could also increase variability of claims. In some instances, the new technology has a beneficial impact on costs, whether in-hospital or consequent costs. In other instances the new technologies will increase costs.

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

1. The development of protocols around various high cost conditions, such as lower back surgery;
2. The "See Your Doctor First" initiative which requires members to see their doctor prior to an elective admission;
3. The amendment to the pre-authorisation length of stay benchmarks;
4. The work of the Clinical Policy Unit, which evaluates the effectiveness of new technologies and recommends whether the Scheme should cover these technologies or not.
5. Increased statistical and actuarial investigations and techniques to detect, manage and prevent fraud and over servicing.

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

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



Discovery Health Medical Scheme

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Notes to the annual financial statements

for the year ended 31 December 2008

29. Insurance risk management report (continued)

Insurance risk (continued)

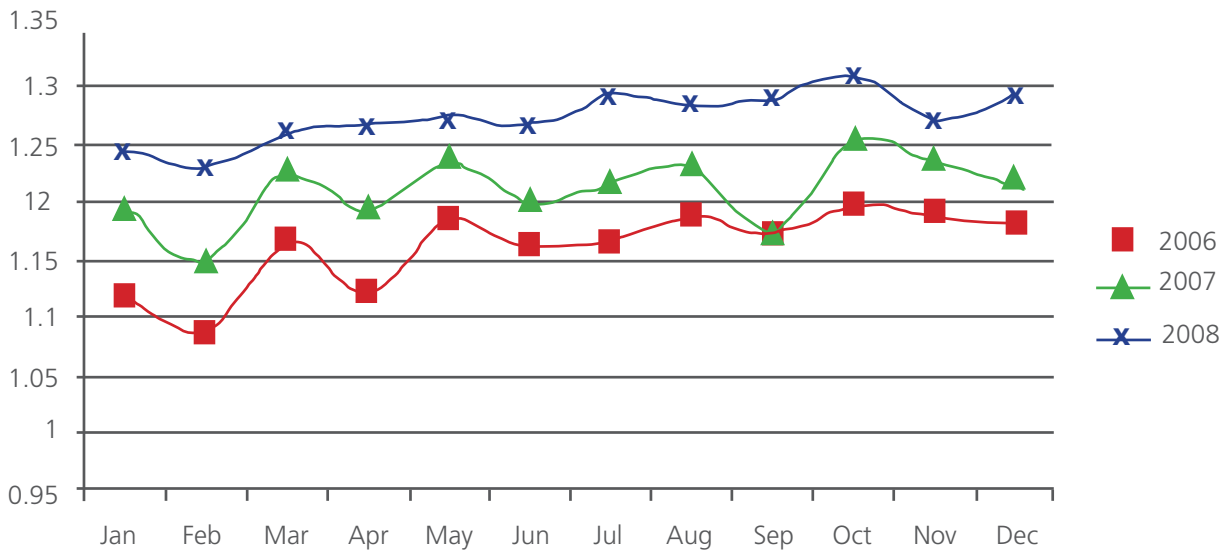
Chronic Illness Benefit (CIB) risk

Frequency and severity of claims

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

The following graphs indicate the change in the number of claimants over the past 3 years as well as the impact on the cost per claimant. These graphs are indexed to a value of 1 as at January 2006.

Chronic claimants per 1000



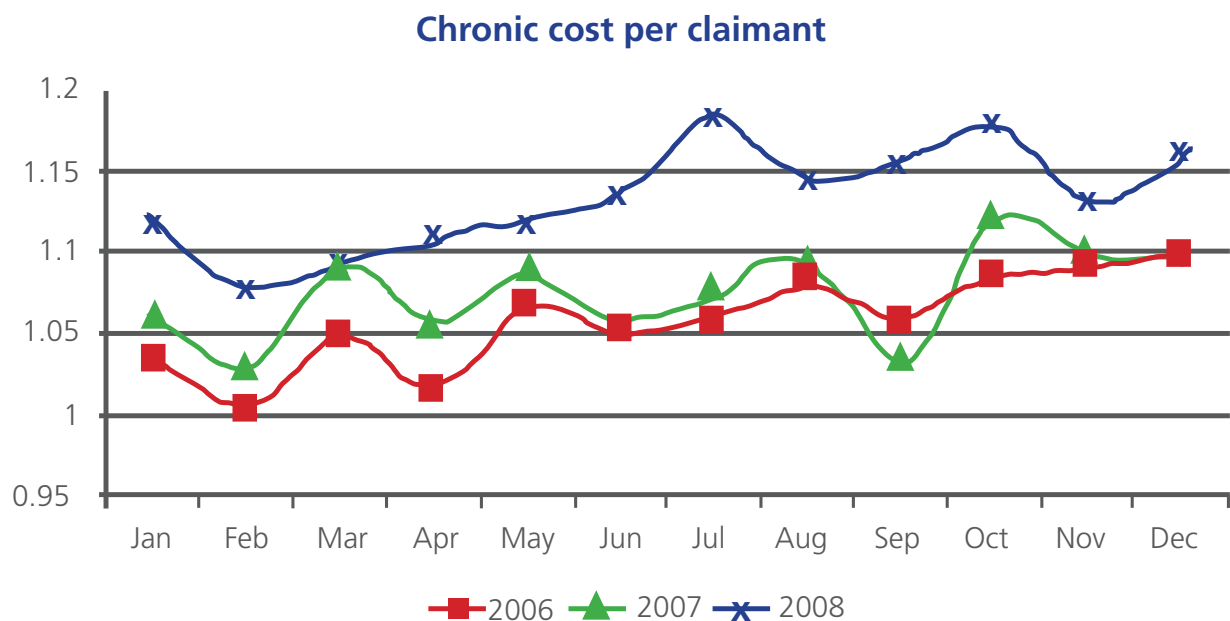
Notes to the annual financial statements for the year ended 31 December 2008

29. Insurance risk management report (continued)

Insurance risk (continued)

Chronic Illness Benefit (CIB) risk (continued)

Frequency and severity of claims



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

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



Discovery Health Medical Scheme

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Notes to the annual financial statements

for the year ended 31 December 2008

29. Insurance risk management report (continued)

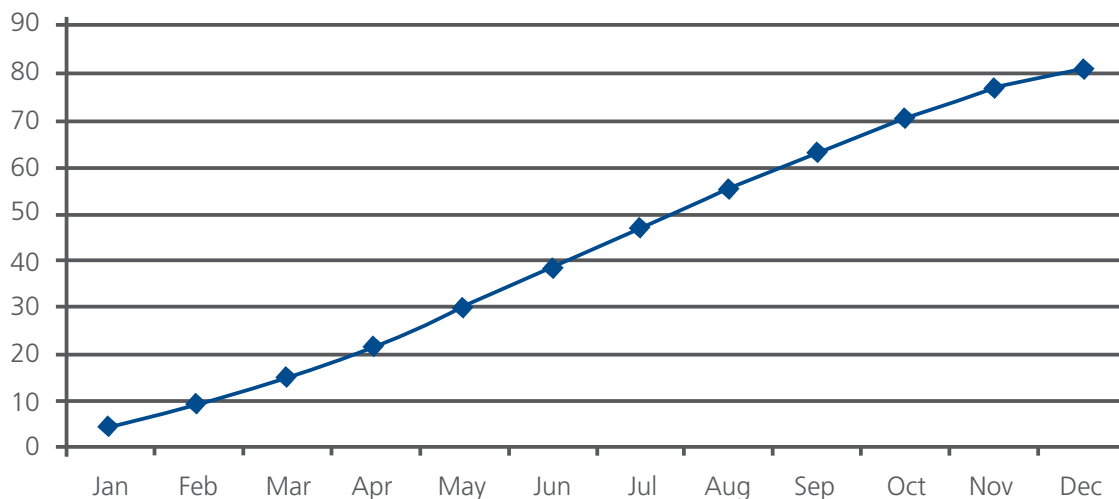
Insurance risk (continued)

Day-to-day benefit risk

Frequency and severity of claims

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

ATB Claimants per 1000 lives



Concentration of insurance risk

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

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

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

Notes to the annual financial statements for the year ended 31 December 2008

29. Insurance risk management report (continued)

Risk transfer arrangements

The Scheme has two risk transfer agreements with service providers to cover specific risks. The first risk transfer arrangement covers in-hospital and out-of-hospital benefits for certain members on the KeyCare Plus option. The second arrangement covers the treatment for Executive and Comprehensive plan members diagnosed with diabetes. (type I and II).

Risk in terms of risk transfer arrangements

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

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

Claims development

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

Liquidity risk

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

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



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29. Insurance risk management report (continued)

Risk management objectives and policies for mitigating insurance risk

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

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

The following factors affect the frequency and severity of claims:

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

Notes to the annual financial statements for the year ended 31 December 2008

29. Insurance risk management report (continued)

Outstanding claims provision

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

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

The estimation of the December 2008 outstanding claims provision was made in accordance with Professional Guidance Note 304 of the Actuarial Society. In accordance with this guidance note, we also checked whether the following factors would have any impact on the outstanding claims provision estimate:

1. The homogeneity of claims data;
2. The credibility of claims data;
3. Changes in emergence and settlement patterns;
4. The impact of seasonality;
5. The impact of re-opened or adjusted claims;
6. The impact of benefit limits and benefit changes;
7. External influences;
8. The demographic profile of the Scheme.

It was found that all of the above factors are adequately taken into account in the calculation methodology, but that some adjustment was necessary for changes in the emergence and settlement patterns experienced during the second half of 2008.

Based on the processing patterns and claims development up to the end of February 2009 in respect of treatment dates during 2008, the recommended provision for outstanding claims as at December 2008 is R510m.

Assumptions and the process used to determine the assumptions

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

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

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



Discovery Health Medical Scheme

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Notes to the annual financial statements

for the year ended 31 December 2008

29. Insurance risk management report (continued)

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

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

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

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

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

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

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

Notes to the annual financial statements for the year ended 31 December 2008

29. Insurance risk management report (continued)

Changes in assumptions and sensitivities to changes in key variables

There has been no change in the assumptions or the calculation methodology over the period. An improvement in the claims processing patterns has been observed as a result of an increase in the proportion of electronic claims submitted.

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

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

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

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

	Change in variable %	Impact on Outstanding claims provision 2008 R'000	Impact on Outstanding claims provision 2007 R'000
In-hospital claims incurred	1% increase in claims costs	88,743	76,946
Chronic claims incurred	1% increase in claims costs	10,553	9,113
Out-of-hospital risk claims incurred	1% increase in claims costs	30,621	25,108

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

Underwriting risk

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

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

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

One of the sensitivity tests performed in arriving at the estimate is to calculate the chain ladder on treatment-to-paid run-off patterns over the last 24 months and compare it to treatment-to-paid patterns over the last three months. Other reasonability checks are also performed, namely checks against the expected loss ratio taking into account the seasonality of claims, checks of pre-authorisation statistics relating to hospital admissions, as well as known hospital admission rates and consideration of the number of working days in recent months.



Discovery Health Medical Scheme

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Notes to the annual financial statements

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30. Financial risk management report

Overview

The Scheme is exposed to financial risk through its financial assets, financial liabilities and insurance liabilities. In particular the key financial risk is that the proceeds from its financial assets are not sufficient to fund the obligations arising from its insurance contracts. The most important components of financial risk are credit risk, liquidity risk, interest rate risk and market risk. The Scheme's overall risk management programme focuses on the unpredictability of financial markets and seeks to minimise potential adverse effects on the Scheme's statutory solvency requirement.

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

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

The following committees have been established by the Board of Trustees to assist in the implementation and monitoring of these risk management processes:

- Audit Committee;
- Investment Committee.

Credit risk

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

The Scheme's principal financial assets are cash and cash equivalents, trade and other receivables and investments. The Scheme's credit risk is primarily attributable to its trade and other receivables.

Trade and other receivables

Trade and other receivables comprise Insurance receivables and Loans and receivables.

The main components of Insurance receivables are in respect of:

- Receivables for contributions due from members;
- Receivables for amounts recoverable from service providers and members in respect of claims debt.

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;
- Performing credit checks on intermediary brokers;
- Suspending benefits on member accounts when contributions have not been received for 30 days;
- Terminating benefits on member accounts when contributions have not been received for 60 days;
- Ageing and pursuing unpaid accounts on a monthly basis.

The Scheme establishes an allowance for impairment that represents its estimate of incurred losses in respect of trade and other receivables and investments. The main components of this allowance are a specific loss component that relates to individually significant exposures, and a collective loss component established for groups of similar assets in respect of losses that have been incurred but not yet identified. The collective loss allowance is determined based on historical data of payment statistics for similar financial assets.

Notes to the annual financial statements for the year ended 31 December 2008

30. Financial risk management report (continued)

Credit risk (continued)

Investments

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

Exposure to credit risk

Trade and other receivables

The carrying amount of financial assets represents the maximum credit exposure. The maximum exposure to credit risk at the reporting date was:

	Carrying amount	
	2008 R'000	2007 R'000
Financial assets at fair value through profit or loss	5,770,095	4,743,083
Trade and other receivables	815,293	793,921
Insurance receivables	799,835	775,378
Loans and receivables	15,458	18,543
Cash and cash equivalents	1,091,431	962,075
	7,676,819	6,499,079

The main components of Insurance receivables are contribution receivables, member and service provider claims receivables. Contribution receivables are collected by means of debit orders or cash payments.

The maximum credit exposure to contribution receivables was:

Contribution receivables	707,119	670,164
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The maximum credit exposure to member and service provider claims receivables was:

Member claim receivables	37,889	46,624
Service provider claim receivables	54,655	58,519
	92,544	105,143



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Notes to the annual financial statements for the year ended 31 December 2008

30. Financial risk management report (continued)

Credit risk (continued)

Exposure to credit risk

Trade and other receivables (continued)

Impairment losses

The ageing of the components of Insurance receivables at year-end was:

Contribution debtors	Gross 2008	Impairment 2008	Gross 2007	Impairment 2007
	R'000	R'000	R'000	R'000
Not past due	516,662	-	553,586	-
Past due 4 - 30 days	193,262	-	113,404	-
Past due 31 - 60 days	1,040	-	1,303	-
Past due 61 - 90 days	411	-	1,513	-
91 days to more than one year	781	(5,037)	7,162	(6,805)
Total	712,156	(5,037)	676,969	(6,805)

Total member and service provider claims debtors	Gross 2008	Impairment 2008	Gross 2007	Impairment 2007
	R'000	R'000	R'000	R'000
Not past due	-	-	-	-
Past due 0 - 30 days	51,083	-	60,185	-
Past due 31 - 60 days	10,033	-	6,356	-
Past due 61 - 90 days	9,707	-	5,735	-
Past due 91 - 120 days	7,261	-	5,535	-
Past due 121 - 150 days	9,657	-	7,994	-
151 days to more than one year	123,067	(118,264)	108,409	(89,070)
Total	210,808	(118,264)	194,214	(89,070)

Notes to the annual financial statements for the year ended 31 December 2008

30. Financial risk management report (continued)

Credit risk (continued)

Exposure to credit risk

Trade and other receivables (continued)

Active member claims debtors	Gross 2008	Impairment 2008	Gross 2007	Impairment 2007
	R'000	R'000	R'000	R'000
Not past due	-	-	-	-
Past due 0 - 30 days	2,318	-	1,536	-
Past due 31 - 60 days	2,280	-	1,357	-
Past due 61 - 90 days	1,805	-	1,232	-
Past due 91 - 120 days	1,543	-	1,888	-
Past due 121 - 150 days	1,980	-	1,897	-
151 days to more than one year	24,570	(22,640)	23,883	(7,123)
Total	34,496	(22,640)	31,793	(7,123)

Withdrawn member claims debtors	Gross 2008	Impairment 2008	Gross 2007	Impairment 2007
	R'000	R'000	R'000	R'000
Not past due	-	-	-	-
Past due 0 - 30 days	5,086	-	3,550	-
Past due 31 - 60 days	4,719	-	3,159	-
Past due 61 - 90 days	4,643	-	4,114	-
Past due 91 - 120 days	5,042	-	4,449	-
Past due 121 - 150 days	5,853	-	4,672	-
151 days to more than one year	91,826	(91,136)	79,703	(77,693)
Total	117,169	(91,136)	99,647	(77,693)



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Notes to the annual financial statements for the year ended 31 December 2008

30. Financial risk management report (continued)

Credit risk (continued)

Exposure to credit risk

Trade and other receivables (continued)

Service provider claims debtors	Gross 2008	Impairment 2008	Gross 2007	Impairment 2007
	R'000	R'000	R'000	R'000
Not past due	-	-	-	-
Past due 0 - 30 days	43,679	-	55,099	-
Past due 31 - 60 days	3,034	-	1,841	-
Past due 61 - 90 days	3,259	-	389	-
Past due 91 - 120 days	676	-	(803)	-
Past due 121 - 150 days	1,824	-	1,424	-
151 days to more than one year	6,671	(4,488)	4,823	(4,254)
Total	59,143	(4,488)	62,773	(4,254)

Other risk transfer arrangements	Gross 2008	Impairment 2008	Gross 2007	Impairment 2007
	R'000	R'000	R'000	R'000
Not past due	-	-	-	-
Past due 0 - 30 days	-	-	-	-
Past due 31 - 60 days	-	-	-	-
Past due 61 - 90 days	-	-	-	-
Past due 91 - 120 days	-	-	-	-
Past due 121 - 150 days	-	-	-	-
151 days to more than one year	18,265	(18,265)	18,265	(18,265)
Total	18,265	(18,265)	18,265	(18,265)

Notes to the annual financial statements for the year ended 31 December 2008

30. Financial risk management report (continued)

Credit risk (continued)

Exposure to credit risk

Trade and other receivables (continued)

Broker fee debtors	Gross 2008	Impairment 2008	Gross 2007	Impairment 2007
	R'000	R'000	R'000	R'000
Not past due	-	-	-	-
Past due 0 - 30 days	94	-	349	-
Past due 31 - 60 days	166	-	(9)	-
Past due 61 - 90 days	257	-	(6)	-
Past due 91 - 120 days	90	-	3	-
Past due 121 - 150 days	(5)	-	106	-
151 days to more than one year	802	(1,324)	998	(1,370)
Total	1,404	(1,324)	1,441	(1,370)



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Notes to the annual financial statements for the year ended 31 December 2008

30. Financial risk management report (continued)

Credit risk (continued)

Exposure to credit risk

Trade and other receivables (continued)

The movement in the provision for impairment, for each class of financial asset, during the year was as follows:

	Trade and other receivables				Loans and receivables	Total
	Insurance receivables					
	Contribution debtors	Member and service provider claims debtors	Other risk transfer arrangements	Broker fee debtors		
	R'000	R'000	R'000	R'000	R'000	R'000
Balance as at 1 January 2007	7,326	65,729	18,273	5,852	-	97,180
Increase/(decrease) in provision for impairment	(521)	35,506	(8)	(1,029)	-	33,948
Amounts utilised during the year	-	(12,165)	-	(3,453)	-	(15,618)
Balance as at 31 December 2007	6,805	89,070	18,265	1,370	-	115,510
Balance as at 1 January 2008	6,805	89,070	18,265	1,370	-	115,510
Increase/(decrease) in provision for impairment	(1,768)	49,609	-	(46)	-	47,795
Amounts utilised during the year	-	(20,415)	-	-	-	(20,415)
Balance as at 31 December 2008	5,037	118,264	18,265	1,324	-	142,890

Based on past experience, the Scheme believes that no allowance is required in respect of Contribution debtors that are past due and outstanding for less than 90 days. For Member and service provider claims debtors and Broker fee debtors that are past due and outstanding for less than 180 days, past experience has indicated that no allowance is required.

The Scheme has not renegotiated the terms of receivables and does not hold any collateral or guarantees as security.

Notes to the annual financial statements for the year ended 31 December 2008

30. Financial risk management report (continued)

Credit risk (continued)

Exposure to credit risk

Investments

The Scheme limits its exposure to credit risk by investing in liquid securities and only with counterparties that have a credit rating of no less than F1 (short-term) and AA- (long-term) as rated by Fitch Ratings. Given these high credit ratings, the Trustees do not expect any counterparty to fail to meet its obligations. Annexure B to the Regulations of the Medical Schemes Act 131 of 1998, as amended, prescribes the credit limits per institution, which reduces the individual risk per institution. The utilisation of these credit limits are regularly monitored.

The table below shows the credit limit and balance of Cash and cash equivalents and money market instruments held at five major counterparties at year-end.

Counterparty	2008		2007	
	R'000 Credit limit	R'000 Balance	R'000 Credit limit	R'000 Balance
1	2,686,887	1,509,507	2,264,649	1,143,136
2	2,686,887	1,347,666	2,264,649	741,699
3	2,686,887	268,514	2,264,649	597,747
4	2,686,887	242,874	2,264,649	179,369
5	2,686,887	154,142	2,264,649	169,464

No credit limits were exceeded during the reporting period and the Trustees do not expect any losses from non-performance of these counterparties.



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Notes to the annual financial statements for the year ended 31 December 2008

30. Financial risk management report (continued)

Credit risk (continued)

Credit quality of financial assets

The credit quality of financial assets that are neither past due nor impaired can be assessed by reference to external credit ratings (if available) or to historical information about counterparty default rates:

	2008 R'000	2007 R'000
Insurance receivables		
Counterparties without external credit rating net of provision for impairment:		
Contribution debtors	707,119	670,164
Member and service provider claim debtors	92,544	105,143
Active member claim debtors	11,856	24,670
Withdrawn member claim debtors	26,033	21,954
Service provider claim debtors	54,655	58,519
Broker debtors	80	71
	799,743	775,378

Contribution debtors

On analysing the credit quality of contribution debtors the Scheme collected over 98% of these amounts in January. This indicates a high credit quality relating to these debtors. Consequently no additional disclosure of the credit quality is provided.

Active member claim debtors

These debtors are current members of the Scheme and are expected to have similar credit quality to the Contribution debtors. A provision for impairment covering 66% (2007 - 22%) of the total amount due has been raised.

Withdrawn member claim debtors

These amounts are due from members that have withdrawn from the Scheme. A provision for impairment covering 78% (2007 - 78%) of the total amount due has been raised and the Trustees are satisfied that this is adequate.

Notes to the annual financial statements for the year ended 31 December 2008

30. Financial risk management report (continued)

Credit risk (continued)

Credit quality of financial assets (continued)

	2008 R'000	2007 R'000
Cash and cash equivalents		
Counterparties with external credit ratings (Fitch's):		
F1+	1,063,212	952,666
Counterparties without external credit ratings	10,221	9,409
	1,073,433	962,075
Money market portfolio		
Counterparties with external credit ratings (Fitch's):		
Government	406,019	51,004
AAA	1,375,333	1,435,593
AA+	403,866	-
AA	301,889	991,971
AA-	775,462	271,736
A	-	61,270
F1+	2,307,186	1,427,288
F1	103,178	352,166
	5,672,933	4,591,028



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Notes to the annual financial statements

for the year ended 31 December 2008

30. Financial risk management report (continued)

Liquidity risk

Liquidity risk is the risk that the Scheme will not be able to meet its financial obligations as they fall due. The Scheme's approach to managing liquidity is to ensure, as far as possible, that it will always have sufficient liquidity to meet its liabilities when due, under both normal and stressed conditions, without incurring unacceptable losses or risking damage to the Scheme's reputation. The Scheme has complied with the requirements regarding the nature and categories of assets as prescribed by Section 35 and Regulation 30 of the Medical Schemes Act 131 of 1998, as amended.

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

As at 31 December 2008	Less than 1 year R'000	Between 1 and 2 years R'000	Between 2 and 5 years R'000
Members' trust funds	948	-	-
Members' savings accounts	1,430,744	-	-
Trade and other payables (Note 9)	227,678	-	-

As at 31 December 2007	Less than 1 year R'000	Between 1 and 2 years R'000	Between 2 and 5 years R'000
Members' trust funds	322	322	514
Members' savings accounts	1,291,449	-	-
Trade and other payables (Note 9)	206,153	-	-

Notes to the annual financial statements for the year ended 31 December 2008

30. Financial risk management report (continued)

Market risk

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

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

Currency risk

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

Price risk

The Scheme is exposed to equity securities price risk because of investments held by the Scheme and classified as at fair value through profit or loss. The Scheme is not exposed to commodity risk. To manage its price risk arising from investments in equity securities, the Scheme diversifies its portfolio. Diversification of the portfolio is done by the asset managers in accordance with the mandate set by the Scheme. Details of the Scheme's derivative strategy is set out in Note 2.

The Scheme's equity investments are publicly traded on the JSE.

Net surplus for the year would increase/decrease as a result of market gains/losses on equity securities classified as at fair value through profit or loss.



Discovery Health Medical Scheme

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Notes to the annual financial statements

for the year ended 31 December 2008

30. Financial risk management report (continued)

Market risk

Price risk (continued)

Sensitivity analysis

The futures contract referred to in note 2 protects 89% (2007 - 84%) of the Scheme's equity instruments. This contract effectively removes the price risk for this portion of the portfolio. The unprotected portion of the equity portfolio amounts to R10m (2007 - R24m). Changes to the market value are not expected to have a material impact on the Scheme's surplus or deficit and consequently a sensitivity analysis has not been disclosed.

Interest rate risk

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

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

As at 31 December 2008	0 - 3 Months R'000	3 - 12 Months R'000	> 12 Months R'000	Total R'000
Cash and cash equivalents	1,091,431	-	-	1,091,431
Money market instruments carried at fair value through profit or loss	-	5,672,933	-	5,672,933

As at 31 December 2007	0 - 3 Months R'000	3 - 12 Months R'000	> 12 Months R'000	Total R'000
Cash and cash equivalents	962,075	-	-	962,075
Money market instruments carried at fair value through profit or loss	-	4,591,028	-	4,591,028

Notes to the annual financial statements for the year ended 31 December 2008

30. Financial risk management report (continued)

Market risk

Interest rate risk (continued)

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

	2008 %	2007 %
Money market instruments carried at fair value through profit or loss	12.75%	10.22%
Cash and cash equivalents	12.54%	9.37%

The weighted modified duration of the money market instruments is 51 days (2007 - 68 days). The weighted average effective interest rate on short-term bank deposits (namely call account deposits) was 11.41% (2007 - 9.28%). These deposits have an average maturity of 21 days (2007 - 14 days).



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Notes to the annual financial statements for the year ended 31 December 2008

30. Financial risk management report (continued)

Market risk (continued)

Interest rate risk (continued)

Cash flow sensitivity analysis for interest bearing instruments.

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

Due to the short-term duration of these instruments, a reasonably possible change in interest rates is 150 basis points (2007 - 100 basis points). At the reporting date the effect of this change on the Scheme's accumulated funds and surplus is shown below. This analysis assumes that all other variables remain constant. The analysis was performed on the same basis for 2007.

31 December 2008	Surplus		Accumulated funds	
	150 Basis point Increase	150 Basis point Decrease	150 Basis point Increase	150 Basis point Decrease
	R'000	R'000	R'000	R'000
Money market instruments carried at fair value through profit or loss	73,867	(73,867)	73,867	(73,867)
Cash and cash equivalents	16,874	(16,874)	16,874	(16,874)
Cash flow sensitivity	90,741	(90,741)	90,741	(90,741)

31 December 2007	Surplus		Accumulated funds	
	100 Basis point Increase	100 Basis point Decrease	100 Basis point Increase	100 Basis point Decrease
	R'000	R'000	R'000	R'000
Money market instruments carried at fair value through profit or loss	39,686	(39,686)	39,686	(39,686)
Cash and cash equivalents	5,160	(5,160)	5,160	(5,160)
Cash flow sensitivity	44,846	(44,846)	44,846	(44,846)

Legal risk

Legal risk is the risk that the Scheme will be exposed to contractual obligations which have not been provided for. At 31 December 2008 the Scheme did not consider there to be any significant concentration of legal risk that had not been provided for.

Notes to the annual financial statements for the year ended 31 December 2008

30. Financial risk management report (continued)

Capital management

The Scheme is subject to the capital requirement imposed by Regulation 29 (2) to the Medical Schemes Act 131 of 1998, as amended which requires a minimum solvency ratio of accumulated funds expressed as a percentage of gross contributions to be 25%.

The Scheme's objectives when managing capital are to maintain the capital requirements of the Medical Schemes Act 131 of 1998, as amended and to safeguard the Scheme's ability to continue as a going concern in order to provide benefits for its stakeholders.

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

	2008	2007
	R'000	R'000
Total members' funds per balance sheet	5,279,848	4,276,376
Less: cumulative unrealised net gain on remeasurement of investments to fair value	-	(28,653)
Accumulated funds per Regulation 29	5,279,848	4,247,723
Gross contribution income	20,796,701	18,468,378
Solvency margin = Accumulated funds / gross contribution income x 100	25.39%	23.00%

At 31 December 2008, the Scheme's regulatory capital exceeded the capital requirement imposed by the Regulator by R81 million.



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Notes to the annual financial statements

for the year ended 31 December 2008

30. Financial risk management report (continued)

Fair value estimation

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

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

The members' savings accounts contain a demand feature. In terms of Regulation 10 to the Medical Schemes Act 131 of 1998, as amended, any credit balance on a member's savings account must be taken as a cash benefit when the member terminates his or her membership of the Scheme or benefit option, and enrolls in another benefit option or medical scheme without a savings account or does not enroll in another medical scheme. Therefore the carrying values of the members' savings accounts are deemed to be equal to their fair values, which is the amount payable on demand.

Investment risk

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

The Scheme's Investment Committee invests excess funds in line with the Medical Schemes Act 131 of 1998, as amended.

The Scheme's investment objectives are to maximise the return on its investments on a long-term basis at minimal risk, subject to any constraints imposed by legislation or the Board of Trustees. The Scheme continues to diversify its investment portfolio by investing in short-term deposits and money market and equity portfolios managed by Rand Merchant Bank Asset Managers.

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

To assist the Regulator in monitoring the Scheme's compliance with Annexure B of the Medical Schemes Act 131 of 1998, as amended, the Scheme submits monthly detailed investment schedules to the Council for Medical Schemes supplemented by the Scheme's asset managers' reports on a quarterly basis.

Notes to the annual financial statements for the year ended 31 December 2008

30. Financial risk management report (continued)

Investment risk (continued)

Breakdown of investments

Money market portfolio:

The Scheme's investment manager's mandate is for an "Active Cash" portfolio.

The portfolio will invest only in domestic fixed interest assets of investment grade quality.

The investments will be subject to a credit rating of no less than F1 (short-term) and AA- (long-term) as rated by Fitch Ratings.

The following credit guidelines shall be adhered to:

Rating	Total exposure	Maximum exposure per individual issuer
F1+	100%	20%
F1	25%	10%

The weighted modified duration of the portfolio and the modified duration of each individual instrument shall not exceed one year. The term of each individual instrument will not be limited.

The performance of the portfolio is measured against the Short Term Fixed Income Index (StefI).



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Notes to the annual financial statements for the year ended 31 December 2008

30. Financial risk management report (continued)

Investment risk (continued)

Breakdown of investments (continued)

Equity portfolio:

The Scheme's investment manager's mandate is to invest in a fully discretionary equity portfolio.

The portfolio may only be invested in South African equities, with cash held as working capital only.

The portfolio is prohibited from investing in Discovery Holdings Limited or its subsidiaries.

The assets of the portfolio must be invested in accordance with Annexure B of the Regulations to the Medical Schemes Act 131 of 1998, as amended.

The performance of the portfolio is measured against the JSE/FTSE Shareholder weighted index (SWIX).

The investments managed by the Investment Committee are split between the following in the annual financial statements:

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

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

Investments carried at fair value through profit or loss

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

	As at 31 December 2008 R'000	As at 31 December 2007 R'000
RMB asset management specialist equity portfolio	97,162	146,631
RMB asset management money market portfolio	5,672,933	4,591,028
RMB asset management specialist equity portfolio - Derivatives	(8,355)	5,424
Total	5,761,740	4,743,083

Cash and cash equivalents

Cash and cash equivalents are made up of the following:

	As at 31 December 2008 R'000	As at 31 December 2007 R'000
Deposits on call	591,875	696,057
Overnight deposits with financial institutions	407,181	231,350
Money market	92,375	34,668
Total	1,091,431	962,075

Notes to the annual financial statements

for the year ended 31 December 2008

30. Financial risk management report (continued)

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

For the year ended 31 December 2008	Financial assets at fair value through profit and loss		Loans and receivables	Insurance receivables and (payables)	Financial liabilities at amortised cost	Total carrying amount	Fair value amount
	designated upon initial recognition	classified as held for trading					
	R'000	R'000	R'000	R'000	R'000	R'000	R'000
Investments							
– Listed equities	-	97,162	-	-	-	97,162	97,162
– Money market portfolio	-	5,672,933	-	-	-	5,672,933	5,672,933
– Derivatives held for trading	-	(8,355)	-	-	-	(8,355)	(8,355)
Cash and cash equivalents	-	-	1,091,431	-	-	1,091,431	1,091,431
Trade and other receivables	-	-	15,458	799,835	-	815,293	815,293
Members' savings accounts	-	-	-	(1,430,744)	-	(1,430,744)	(1,430,744)
Trade and other payables	-	-	-	(218,810)	(227,678)	(446,488)	(446,488)
Members' trust funds							
– Current portion	-	-	-	(948)	-	(948)	(948)
	-	5,761,740	1,106,889	(850,667)	(227,678)	5,790,282	5,790,282



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Notes to the annual financial statements

for the year ended 31 December 2008

30. Financial risk management report (continued)

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

For the year ended 31 December 2007	Financial assets at fair value through profit and loss		Loans and receiv- ables	Insurance receivables and (payables)	Financial liabilities at amortised cost	Total carrying amount	Fair value amount
	designated upon initial recognition	classified as held for trading					
	R'000	R'000	R'000	R'000	R'000	R'000	R'000
Investments							
– Listed equities	-	146,631	-	-	-	146,631	146,631
– Money market portfolio	-	4,591,028	-	-	-	4,591,028	4,591,028
– Derivatives held for trading	-	5,424	-	-	-	5,424	5,424
Cash and cash equivalents	-	-	962,075	-	-	962,075	962,075
Trade and other receivables	-	-	18,543	775,378	-	793,921	793,921
Members' savings accounts	-	-	-	(1,291,449)	-	(1,291,449)	(1,291,449)
Trade and other payables	-	-	-	(244,880)	(206,153)	(451,033)	(451,033)
Members' trust funds							
– Non-current portion	-	-	-	(835)	-	(835)	(835)
– Current portion	-	-	-	(322)	-	(322)	(322)
	-	4,743,083	980,618	(762,108)	(206,153)	4,755,440	4,755,440

Notes to the annual financial statements for the year ended 31 December 2008

31. Critical accounting estimates and judgments

Critical accounting estimates and assumptions

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

Outstanding claims provision

The critical estimates and judgments relating to the outstanding claims provision are set out under Note 29.

Other risk transfer arrangements

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

Impairment of assets

The critical estimates made by the Scheme are set out under Note 30 and judgments relating to the impairment of assets are set out under Note 6 of the Accounting policies.



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Notes to the annual financial statements for the year ended 31 December 2008

32. Material non-compliance matters

Statutory Scheme solvency

In terms of Regulation 29 (2) to the Medical Schemes Act 131 of 1998, as amended, the Scheme must maintain accumulated funds expressed as a percentage of gross annual contributions for the accounting period under review which may be no less than 25%.

During the year under review, the Scheme's accumulated funds expressed as a percentage of gross annual contributions was, in some months less than the statutory requirement of 25%. In line with the agreement reached with the Council for Medical Schemes during 2007 whereby the Scheme would build its reserves to reach 25% by 31 December 2008, the Scheme's statutory solvency margin was 25.39% as at 31 December 2008.

The build up of the solvency margin compared to the 2007 agreement is reflected in the following table:

	Solvency margin required per 2007 agreement	Solvency margin achieved
30 June 2007	21.00%	21.14%
31 December 2007	23.00%	23.00%
31 December 2008	25.00%	25.39%

Sustainability of benefit options

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

At 31 December 2008 the following options did not comply with Section 33(2):

Option	Net underwriting deficit R'000	Net (deficit)/surplus R'000
Executive	(179,821)	(172,178)
Classic Comprehensive	(414,365)	(252,899)
Foundation Core	(326)	1,129

The Trustees continue to monitor the Executive and Classic Comprehensive options with a view to improving their sustainability. No new members are allowed to join the Foundation Core option as this option is being wound down.



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