medihelp
medical scheme

2013
integrated annual report

contents

introduction

The financial information contained in this integrated annual report has been extracted from the consolidated audited financial statements of Medihelp. Should you require the complete set of financial statements, kindly phone Medihelp's Customer Care centre at 086 0100 678 and we will mail you a complete set of the financial statements. You are also welcome to obtain a set at Medihelp's administrator Strata Healthcare Management's offices at Arcadia at no cost.

medihelp: a quick overview as at 31 december 2013

Number of members	-	101 701
Number of lives covered	-	220 710
Average age of lives	-	36
GCR rating	-	AA–
Solvency ratio	-	30,37%
Pensioner ratio	-	12,1%
Number of claims processed	-	2 778 889
Hospital admissions authorised	-	61 905
Telephone calls answered	-	715 879
Written enquiries received	-	138 331

message by the chairman of the board of trustees

Introduction

I am pleased to report that the period under review has been very successful for Medihelp medical scheme. Medihelp has sustained its performance and excelled by consistently achieving net organic growth in a highly competitive industry, with principal members increasing from 100 333 in 2012 to 101 701 in 2013. The Scheme's profile has improved considerably by enrolling new members with an average age below that of the industry. We have also maintained a healthy solvency level of 30,37% which continues to significantly exceed the required solvency level of 25%.

The year 2013 will also be known as a momentous milestone in the Scheme's history by concluding a transaction to implement a new business model that Medihelp's members had already approved for the first time in 2003. This new direction is even more relevant when considering current healthcare industry trends. With only 87 medical schemes still in business by the end of 2013 and 23 open medical schemes competing for market share in the private sector, the market continues to shrink. Continued consolidations in the industry are a reflection of the pressure that schemes are under to remain sustainable. To remain relevant requires remaining in step with changes and challenges; in our case adapting a trusted recipe to entice and retain new business – which is why Medihelp chose to follow this direction.

New administration, new possibilities

The perseverance in finalising the transaction saw Medihelp disposing of its administration component to Strata Healthcare Management (Pty) Ltd. We believe that this new business model will contribute to Medihelp's continued viability. On 5 December 2013, the new administration company, Strata Healthcare Management, was accredited by the Registrar of Medical Schemes as an administrator. This meant that from 2 January 2014, Medihelp members were welcomed by the same voices and familiar faces of personnel under a new name.

This transition also allows me the opportunity to introduce the new Principal Officer of Medihelp, Heyn van Rooyen, as Anton Rijnen will take on the responsibility of CEO of Strata Healthcare Management in 2014. Heyn is no new-comer to Medihelp, and has been managing our National Sales team for the past 12 years. He joined Medihelp after a career in the South African Diplomatic Corps spanning 16 years which saw him serving in Washington DC, Montreal and Lisbon. We wish him every success in his new role.

Future focus

While Medihelp's strategies are influenced by industry trends, we always have the interests of the three main partners in the health triangle in mind: the funder, the service provider and the member. When implementing new innovations to address the many challenges we are faced with, one of the deciding factors we consider is the impact on all key stakeholders.

Accomplishing this remains a challenge within a highly regulated environment which to a large extent determines the cover we can provide.

The Council for Medical Schemes' Annual Report for 2012 was released on 3 September 2013 and gives an informative overview of the industry's performance amidst legislative, cost and behavioural patterns. In terms of benefit expenditure over the past 12 years, private hospitalisation, medical specialists and medicine remain the major cost drivers in the industry, with 75,8% of total healthcare benefit spend going to these three disciplines. Medical specialists have overtaken medicine expenditure in terms of costs following the introduction of PMB in 2004, to become the second-highest cost driver in the industry. Not surprisingly, medical schemes are focusing most of their efforts on these three disciplines when implementing risk management measures.

Medihelp will continue to follow a network approach with regard to various services, as well as selecting designated service providers to provide cost-effective, quality care to members and manage the cost of benefits particularly in the context of prescribed minimum benefits in view of the lack of pricing guidelines for providers. The networks that have been implemented are primarily aimed at managing the highest cost drivers. Guiding patients through the continuum of care will deliver results in terms of access, cost-efficiency and quality if this is managed as a seamless partnership between funders and providers, with patients accepting responsibility for their own health to optimise a healthy outcome.

As the scope of a medical scheme's business and the benefits provided are strictly regulated, one of the primary means of managing costs enforced on schemes has been through entering into relationships with providers and the direct payment of services at a predetermined fee, with electronic submission of claims and limited or no member involvement in the process. Where providers are not prepared to participate in the delivery of service at a predetermined or market-related fee, the negotiation responsibility has now been transferred to members. Members can now negotiate a fee with the service provider, who will in most cases require payment upfront or directly after rendering the service and the member is then reimbursed through the submission of a claim to the funder. The reimbursement process of members is being fast-tracked by schemes to ensure minimum discomfort to the member. Schemes also have the responsibility to inform and support members in the process, and to transform the member's role from that of a mere recipient of healthcare to an active participant in the management of medical costs.

Acknowledgements
Reading through the viability and management reports, as well as a summary of the financial statements of the Scheme contained in this report, members will agree that Medihelp performed exceptionally well in a volatile industry characterised by consistently increasing healthcare costs and the pressure of funding conditions related to prescribed minimum benefits (PMB).

Our achievements in 2013 were made possible by the prudent benefit utilisation of our members, who are taking greater responsibility for their health. Our product range – viable and stable benefit options that offer a range of healthcare cover choices – also continues to attract younger, healthier families. This trend continues to sustain and enhance our membership and risk profile.

I want to thank our members for their loyalty throughout 2013, especially with the approval and support of the ideal of changing Medihelp's business model. My sincerest thanks to all the members of the Board of Trustees for their commitment and the time, energy and experience they invest in ensuring Medihelp continues to provide in the healthcare needs of its members.

Thank you to Medihelp's advisers and intermediaries who continue to grow Medihelp with the desired profile members. You have become a major contributor to Medihelp's success. Thank you also to our healthcare providers, who ensure that our members enjoy the best care possible and are committed to the continuation of private healthcare in South Africa.

A warm thank you to Anton Rijnen, his executive team and the employees for the continued efficiency in offering members more than just medical cover, but also customer care which is known throughout South Africa. And where I have to bid you farewell, my best wishes accompany you and the team of Strata Healthcare Management. Thank you for the assurance that we can continue to rely on your innovation and commitment in the years to come.

Lastly, I thank our God, in whose power we continue to prosper.

Chris Klopper
Chairman of the Board of Trustees

overview by the principal officer

The end of 2013 is more than simply a date on which one of Medihelp's most remarkable years drew to a close – the date also heralds in a new and fourth era in the Scheme's history. During the first era, from 1905 to 1967 spanning 62 years, it was a voluntary medical scheme for civil servants; during the second era from 1967 to 1992 covering 25 years, it was a compulsory medical scheme for white civil servants; and during the third era of 21 years, commencing in 1992 until 2013, Medihelp was transformed to an open, private and voluntary medical scheme for all race and employer groups in the private sector.

The first chapter of a new and fourth era started on 1 January 2014. After 108 years of self-administration, the Scheme embarked on a new journey by separating the medical scheme from its administration and establishing Strata Healthcare Management. This fulfils an ideal of more than 10 years: changing the Scheme's business model to allow it to develop additional business opportunities and to offer a wider range of products and services to its members. The experience gained in administering Medihelp will now not only allow Strata Healthcare Management to offer Medihelp more value, but to also offer the same outstanding services to other medical schemes.

As this will be my last annual report as Principal Officer & CEO of Medihelp and I will take on the new role entrusted to me with Strata Healthcare Management, it allows me to reflect on the past few years' achievements and to close this chapter of Medihelp's history with pride and gratitude.

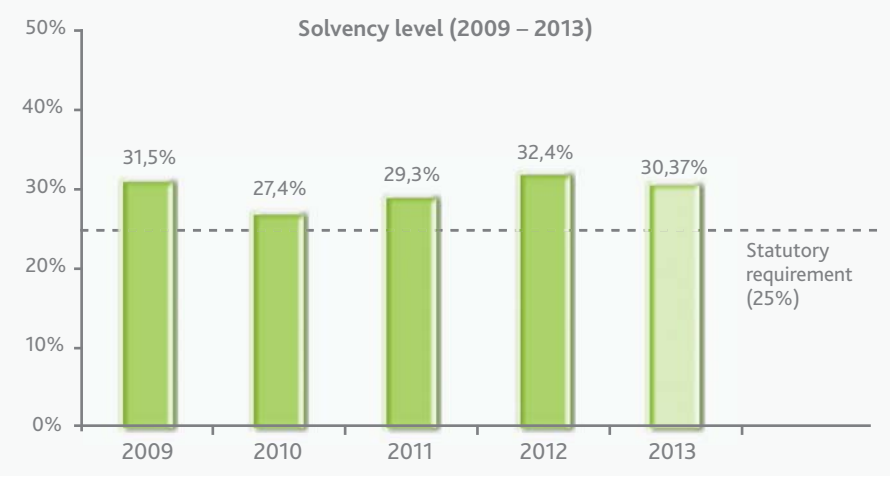
Healthy financial and risk profile

The most important indicator of the Scheme's viability is the AA– (AA minus) rating once again awarded to the Scheme by the independent and international credit rating company, Global Credit Rating. This is indicative of the general state of a scheme's finances and its ability to pay claims promptly and continuously. An AA– rating is the second-highest rating that a medical scheme can be awarded, and 2013 was the sixth consecutive year that the Scheme achieved this rating.

Continued healthy solvency ratio and accumulated funds

One of the reasons for this sound rating is our solvency ratio (which is calculated as the accumulated funds divided by the gross annual contributions) of 30,37%. Despite global financial uncertainties, Medihelp succeeded in maintaining a solvency level well above the minimum threshold of 25% required by the Medical Schemes Act, 1998 (Act No 131 of 1998).

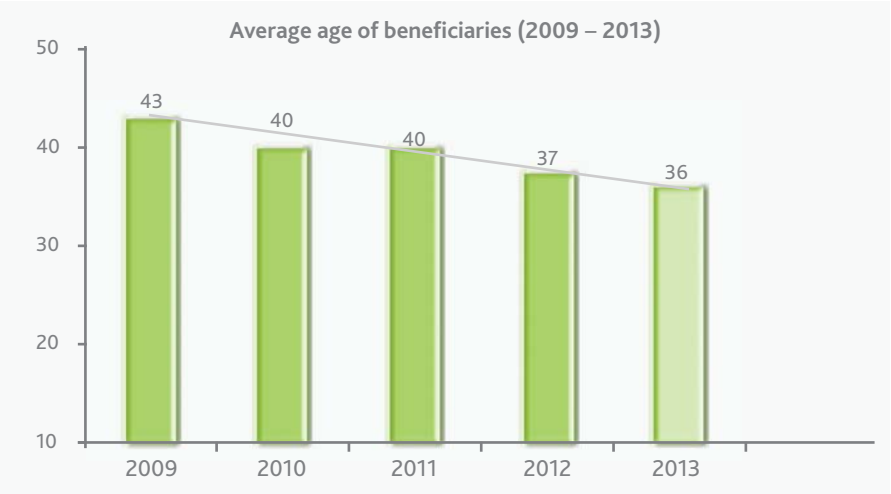
Translated into monetary terms, the accumulated funds per member remains very high, with the Scheme maintaining accumulated funds per member of over R10 000 in the previous two years.



Source: Medihelp Consolidated Financial Statements 2009 – 2013

Younger members, larger families ensure a healthier profile

Another important influence on the financial profile of a medical scheme is its risk profile, as schemes with older or smaller member bases typically have higher risk profiles. Medihelp's marketing and sales efforts therefore continued to focus on organic growth with a desired risk profile resulting in it being one of only a few medical schemes to have recorded organic growth in 2013 with almost 38 000 new lives joining the Scheme throughout the year. This resulted in a further decrease in average age from 2012 to 2013, whilst most other schemes are reporting an increase in average age.



Source: Medihelp Consolidated Financial Statements 2009 – 2013

The significant transformation of the Medihelp risk profile has also translated into an increase in the number of private individuals to more than 80%, an increase in corporate business and a more than 10% reduction in the Scheme's pensioner ratio. Medihelp's enhanced profile confirms its role in the delivery of healthcare cover in the private sector and adds to the long-term sustainability of the Scheme.

Benefits for 2013 enhanced and offered at market-related prices

The development and implementation of Medihelp's product and growth strategy is a continuous process, highly dependent upon actuarial input, the success of risk management initiatives, trends in the market, research conducted amongst members, input from intermediaries, market comparisons, as well as the performance and profile of current products. This intensive process aims to deliver sustainable options, of which the offering remains consistent in terms of price, benefits and experience.

Some of the enhancements to the 2013 range of benefit options included the following:

- ER24 replaced Netcare 911 as the Scheme's provider of emergency transport services. Medihelp re-evaluates all contracts during the course of a year to ensure that members continue to receive high quality services at the most competitive prices.
- With the removal of certain co-payments applicable to hospital procedures members' out-of-pocket expenses were reduced, enhancing the membership experience.
- The Scheme's preventive care benefits were augmented by the inclusion of bone mineral density tests and the removal of age limits which applied to cholesterol and blood glucose level tests, allowing wider access to these important screening tests.
- From 2013, Medihelp offers home confinement benefits separately from pregnancy and confinement benefits across most benefit options (excluding Unify), as well as unlimited benefits for normal confinements on the Necesse benefit option (previously limited to a set amount) and a generous limit on elective caesarean procedures (previously excluded).
- Another significant enhancement of the Necesse benefit option saw the removal of its overall annual limit.

In addition to these enhancements, Medihelp managed to once again announce an annual subscription increase at the end of 2013 in line with that of the industry. This was achieved by careful financial planning, prudent risk management and responsible utilisation of benefits by members. With the introduction of network versions of the popular Dimension Prime range of benefit options in 2013, the Scheme was able to offer these benefit options at a price differential of 10% lower than the non-network versions of these options, which was further enhanced with a 20% price differential in 2014.

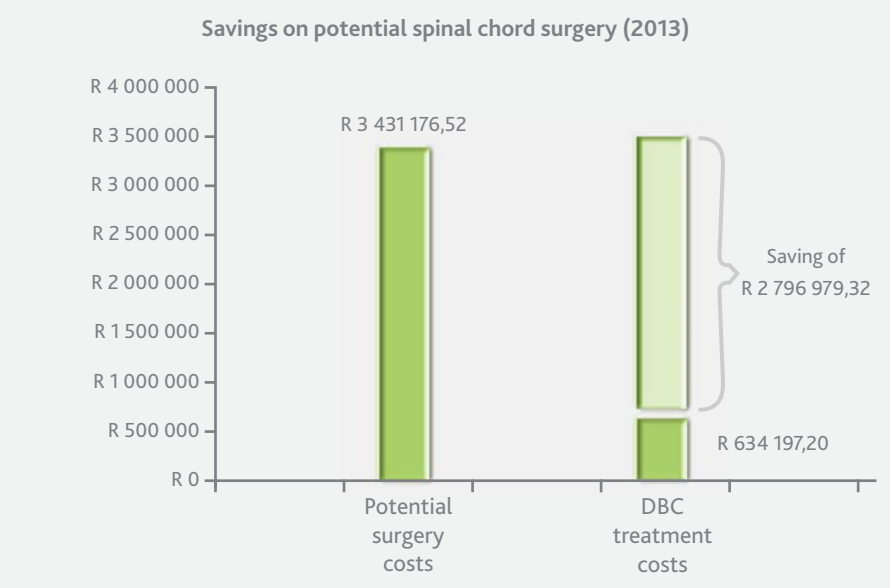
Managed healthcare initiatives

Easier access to benefits for CDL conditions

Whereas 2012 saw the introduction of a basket of care for all PMB-related hospital admissions, this initiative was extended in 2013 to encompass all Chronic Diseases List (CDL) conditions. This means that patients receive schedules of all services (for example consultations and diagnostic tests) which are approved for their specific CDL conditions, according to protocols. Patients no longer have to pre-authorise standard tests, consultations and services which form part of the published protocols for CDL conditions from 2013.

DBC programme

Another area in which Medihelp successfully utilises proven healthcare initiatives to manage cost is the Document Based Care back treatment programme (DBC programme). This programme offers an alternative to surgery for patients who adhere to specific clinical criteria. Of the 50 patients who were registered on this programme in 2013, only five were ultimately required to undergo surgery. The savings on potential surgery costs achieved by this interdisciplinary treatment programme amounted to almost R3 million:



Source: Medihelp Health Economics

Greater focus on networks

Tracking and guiding patients through the continuum of care will only deliver desired results in terms of access, cost-efficiency and quality if it becomes a seamless partnership between the funders and providers, with compliant patients accepting responsibility for their own health to optimise a healthy outcome. Medihelp has engaged with providers and obtained actuarial insights to assist in the journey to delivering seamless, appropriate care in the most cost-efficient manner.

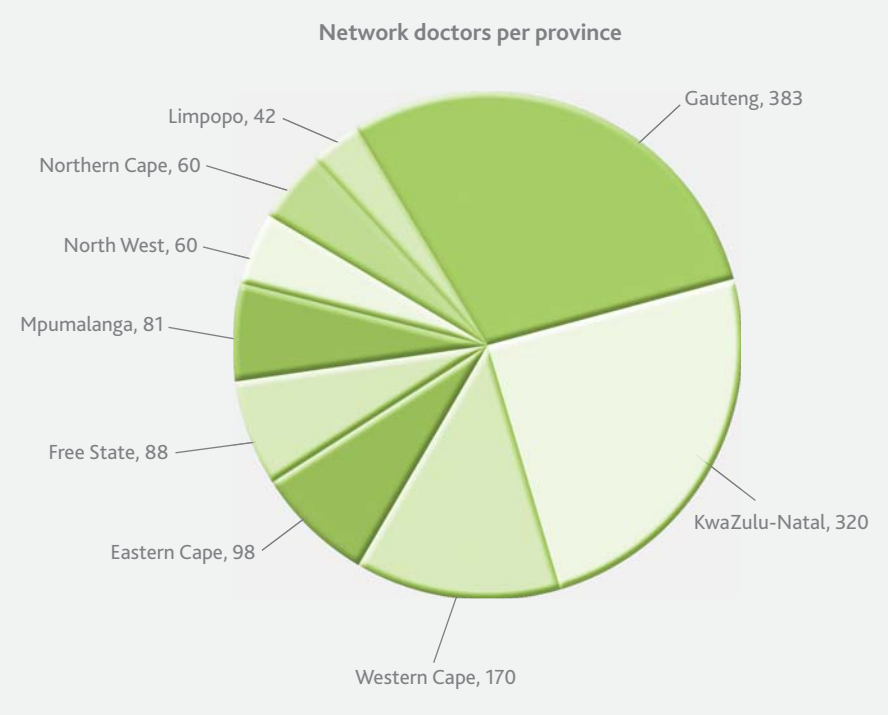
We firmly believe that risk management techniques such as directing members to networks of providers can accomplish the desired results and assist with benefit and risk management without compromising quality of care.

The network versions for the Dimension Prime range of benefit options were introduced in 2013 – by opting to remain within a hospital network for all hospital-related services, members of these network options are offered a 10% lower subscription than that of the freedom of choice option alternatives.

The Dimension Prime Network options that were introduced in 2013 have grown steadily and have been earmarked for more aggressive growth in 2014, with a 20% price differential. We are confident that the expansion of networks to other disciplines in future will provide members with a wider choice and increase the marketability of the products, elevating it to a higher performance level.

More than 1 700 pharmacies within Medihelp's Preferred Pharmacy Network continue to provide members with quality medicine while minimising out-of-pocket payments by members. These pharmacies have agreed to base their dispensing fees on the same model as that of the Scheme, ensuring members do not have additional co-payments on the dispensing of medicines (apart from the 20% standard co-payment which applies to all medicine).

General practitioners of the Necesse service provider network were reimbursed in 2013 based on a performance scale. This ensures that Necesse members receive the best healthcare at the most cost-effective rates. The distribution of the general practitioners of the Necesse service provider network is as follows:



Source: Medihelp Health Economics

Customer-focused engagement

To cater for Medihelp's transformed member profile and changes in consumer behaviour, we have established numerous digital platforms where active engagement takes place. This is aimed at –

- providing seamless interaction with real-time, relevant information on mobile phones, tablets and desktops;
- enabling informed decisions, regardless of the location of the stakeholder; and
- demystifying complex health terms and processes through the use of visual media.

Smartphone app
Apart from the dedicated websites that cater for the unique needs of each of our stakeholder groups, Medihelp has also developed applications for members and intermediaries, putting relevant Medihelp services in the palm of their hands.

Medihelp members were introduced to a smartphone application in June 2013 that utilises the Android service platform, and augmented these services by extending it to the iOS platform in October 2013. Since then, the app has attracted more than 3 000 members in over 15 000 login sessions, giving access to a range of services, including e-membership cards that can be sent to healthcare providers via Bluetooth technology. Members can also change their personal details by using the app, as well as submit claims by taking photos of it, or locating network and other service providers in their proximity.

Adviser app
Medihelp considers intermediaries to be essential contributors to our future sustainability. Apart from a secured online service, providing a competitive market offering and the support provided by our sales team, we invested in a digital enrolment platform, the adviser app, specifically designed to aid intermediaries in the advisory and sales process.

The application adheres to all applicable legislation and provides a secure, paperless environment for advisers to conduct business, including features like –

- an electronic application form with an e-signature,
- relevant product information, and
- direct uploading of all relevant supporting documentation to the Medihelp system.

The app is available for Android and iOS platforms.

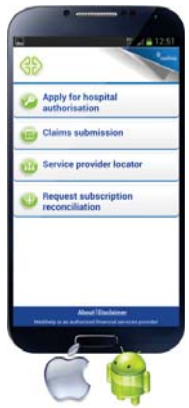
Secured sites
The members' secured web service, Medihelp Online, has also undergone extensive enhancements in 2013. Registration on Medihelp Online continues to grow, and currently almost 44 000 members use this function (an estimated 60% of web-enabled members).

The secured web services for service providers also underwent upgrading during June 2013, and currently almost 20 000 service providers are registered on the secured site (almost 50% of all healthcare providers).

Social media platforms
Members also engage with Medihelp on social media such as Facebook and Twitter, facilitating information sharing, interactive engagement on a variety of health-related topics and providing a constant inflow of stakeholder insights. On Facebook Medihelp boasts almost 10 000 likes.

Videos
The medical schemes industry is a complex environment to manage and grasp. It often entails complex processes and terminology a consumer may find difficult to understand. Medical schemes are presented with the challenge of delivering the message in a format that will not only create an understanding, but also buy-in and compliance. Medihelp has embarked on unpacking these topics in visual language through a series of communication aids ranging from published health articles and infographics to edu-videos and documentaries. The library of these materials and videos is available on Medihelp's website and the YouTube channel and include relevant topics such as generic medicine and interpreting the detail on members' claims statements. These edu-videos are supported by augmented reality. This software allows smartphone users to simply focus on specific print images to play the video – an alternative for people who prefer visual communication.

The fourth season of "'n Lewe met" was broadcast on kykNET between August and November 2013. Medihelp was the co-sponsor of this series, which focuses on conditions difficult to understand, but which impact on patients and their family's lives. More than 2,3 million viewers watched the series (almost 180 000 viewers per episode).



Thank you

If we look back on 2013 and indeed the last 108 years, one cannot but be thankful for the support that the Scheme has received in its years of self-administration. We are thankful to have been blessed by God and to have received His grace over the past 108 years in the organisation.

Over the years good corporate governance principles have been carried over from one generation to the next by a number of key role players, an important factor that explains why the Scheme has survived to be the oldest medical scheme in the history of South Africa. If we and those who succeed us were to continue this trend, a bright future would await both Medihelp and Strata Healthcare Management in continuing to play a key role in the healthcare industry of this wonderful country. There are too many to name, but to all those that I have known personally and that I have had the pleasure to work with, and who have served this organisation and continue to do so – I salute you.

I would like to thank the Board of Trustees for their years of guidance, support and leadership. I would also like to thank Medihelp's members, our hard-working healthcare providers and our devoted advisers and other partners for their continued support and loyalty.

I want to extend my thanks to Medihelp's employees who will follow me in 2014 on our next journey as an administration company.

The blessings and gifts bestowed on the Scheme by our Heavenly Father have resulted in Medihelp caring for millions of South Africans for over a century. Although I, my executive team and all the other Medihelp employees bid the Scheme farewell to serve Medihelp in a new capacity as administrator and managed healthcare organisation, I know that these blessings will continue – for Medihelp as well as for Strata Healthcare Management.

Anton Rijnen
Principal Officer

report of the board of trustees

1. Description of the medical scheme

1.1 Terms of registration

Medihelp is a self-administered not-for-profit open medical scheme registered with reference number 1149 in terms of the Medical Schemes Act, 1998 (Act No 131 of 1998) as amended.

1.2 Insurance contract options within Medihelp

The Scheme offered seven insurance contract options to employees of participating employers and members of the public during the period under review. These were:

- Medihelp Plus
- Dimension Elite
- Dimension Prime 3
- Dimension Prime 2
- Dimension Prime 1
- Necesse
- Unify

The Scheme provides cover for types of services that are categorised under core benefits and day-to-day services, of which the levels of cover differ per insurance contract. Types of services that qualify for core benefits include hospitalisation, prosthesis components, private nursing, emergency evacuation, blood transfusion, renal dialysis, technologist services, oxygen and oncology. Types of services that qualify for day-to-day benefits include consultations at general practitioners and specialists, radiology, pathology, dental, physiotherapy and optical services, medical, surgical and orthopaedic appliances, non-chronic and chronic medicine and supplementary health services out of hospital.

1.3 Savings plan

Members of the Dimension Prime 2 insurance contracts pay an agreed sum of approximately 22% of their gross contributions into a savings plan to help pay the members' portion of healthcare costs, up to a prescribed threshold.

Members earn interest on balances in their respective savings accounts at the end of each month which is based on the interest earned by a savings trust account. No administration fee is charged by the Scheme.

The liability to members in respect of the savings plan is reflected as a financial liability in the Consolidated Financial Statements, refundable in terms of regulation 10 of the Regulations under the Medical Schemes Act, 1998. Savings plan contributions are refundable when a member leaves the Scheme or transfers to an option within the Scheme which does not offer a savings plan.

2. Management

2.1 Board of Trustees in office during the year under review (in alphabetical order)

Mr JC Klopper	Chairman	Re-elected to the Board of Trustees and elected by the members of the Board of Trustees as Chairman on 20 June 2013
Mr HJ Koekemoer		Appointed to the Board of Trustees on 14 January 2013
Ms EM Malan		
Prof MJ van Staden		Term expired on 20 June 2013
Mr MJ Visser		Elected to the Board of Trustees on 20 June 2013
Dr HE Vosloo		
Mr PJ Vosloo	Vice-chairman	

A quorum was present for all meetings held during 2013.

All the Scheme's current trustees were elected by members. Mr HJ Koekemoer was appointed in the vacant position left by Mr EJ du Preez after he resigned. The term of office of Mr EJ du Preez would have expired on 26 June 2014, therefore Mr HJ Koekemoer's appointment is valid until 26 June 2014. Dr HE Vosloo's term of office will also expire on 26 June 2014.

2.2 Principal Officer

Mr AO Rijnen	Principal Officer & CEO of the Scheme Managing Director of MediMarketing (Pty) Ltd and MEDICHRON (Pty) Ltd

2.3 Registered office address and postal address

410 Steve Biko Road	PO Box 26004
Arcadia	ARCADIA
Pretoria	0007
0083	

2.4 Medical scheme administrator during the year

Medihelp is a self-administered scheme.

2.5 Investment managers

Investments are managed by skilled personnel of the Scheme under the guidance of the Investment Committee while the Allan Gray Life Domestic Balanced Portfolio is managed by Allan Gray Life:

Allan Gray Life Ltd	
2nd Floor	PO Box 51318
Granger Bay Court	V&A Waterfront
Beach Road	CAPE TOWN
V&A Waterfront	8002
Financial service provider number: 6663	

2.6 Auditors

PricewaterhouseCoopers Inc	
32 Ida Street	PO Box 35296
Menlo Park	MENLO PARK
Pretoria	0102
0102	

2.7 Attorneys

MacRobert Inc	
Cnr Justice Mahomed and Jan Shoba Streets	Private Bag X18
Brooklyn	BROOKLYN SQUARE
Pretoria	0075
0181	

Gildenhuys Lessing Malatji Inc	
GLMI House	PO Box 619
Harlequins Office Park	PRETORIA
164 Totius Street	0001
Groenkloof	
0027	

Dyason Attorneys	Private Bag X15
134 Muckleneuk Street West	BROOKLYN SQUARE
Nieuw Muckleneuk	0075
Pretoria	
0181	

3. Review of the accounting period's activities

3.1 Results of operations

The results of the year's activities are clearly set out in the Consolidated Financial Statements and the Board of Trustees believes no further clarification is needed.

3.2 Accumulated funds ratio

	Group		Scheme	
	2013 R	2012 R	2013 R	2012 R
Total members' funds per Consolidated Statement of Financial Position	1 279 558 401	1 306 351 905	1 279 507 720	1 306 283 245
Less: Reserve for unrealised investment gains	(209 943 584)	(166 364 587)	(209 943 584)	(166 364 587)
Fair value adjustment at date of transition to IFRS for property, plant and equipment included in the accumulated funds	(16 290 109)	(16 290 109)	(16 290 109)	(16 290 109)
Accumulated funds per regulation 29 of the Regulations under the Medical Schemes Act, 1998	1 053 324 708	1 123 697 209	1 053 274 027	1 123 628 549
Gross contributions	3 468 448 488	3 471 964 895	3 468 448 488	3 471 964 895
Accumulated funds ratio calculated as the ratio of accumulated funds/gross annual contributions x 100	30,37%	32,36%	30,37%	32,36%
Minimum ratio required by regulation 29 of the Medical Schemes Act	25,00%	25,00%	25,00%	25,00%

3.3 Operational statistics per insurance contract

	For the year ended 31 December 2013							
	Medihelp Plus	Dimension Elite	Dimension Prime 3	Dimension Prime 2	Dimension Prime 1	Necesse	Unify	Total
Average number of members during the accounting period	5 968	18 218	29 842	14 075	13 874	16 065	3 100	101 142
Number of members at the end of the accounting period	5 750	17 663	29 730	14 780	14 821	15 901	3 056	101 701
Average number of beneficiaries during the accounting period	8 589	32 117	72 937	32 785	32 901	29 489	10 173	218 991
Number of beneficiaries at the end of the accounting period	8 199	30 906	72 652	34 543	35 410	29 033	9 967	220 710
Dependants per member at the end of the accounting period	0,43	0,75	2,76	2,66	2,66	0,83	2,26	1,17
Risk contributions per average beneficiary per month	4 225,98	2 270,15	1 202,40	815,68	734,06	842,64	877,14	1 285,77
Relevant healthcare expenditure as a percentage of risk contributions	95,0%	84,6%	93,0%	93,4%	86,2%	98,8%	87,0%	90,9%
Relevant healthcare expenditure per average beneficiary per month	4 014,36	1 921,60	1 118,42	761,78	632,97	832,49	762,97	1 168,45
Non-healthcare expenses as a percentage of risk contributions *	13,4%	13,4%	13,4%	13,4%	13,4%	13,4%	13,4%	13,4%
Non-healthcare expenses per average beneficiary per month	564,54	303,26	160,63	108,96	98,06	112,57	117,18	171,76
Average age of beneficiaries	58	51	34	33	33	33	27	36
Pensioner ratio (beneficiaries > 65)	40,3%	30,0%	8,5%	8,9%	7,3%	7,1%	1,9%	12,1%

	For the year ended 31 December 2012							
	Medihelp Plus	Dimension Elite	Dimension Prime 3	Dimension Prime 2	Dimension Prime 1	Necesse	Unify	Total
Average number of members during the accounting period	11 206	20 553	28 449	12 660	12 326	16 783	3 332	105 309
Number of members at the end of the accounting period	6 678	19 819	28 495	12 978	12 814	16 263	3 286	100 333
Average number of beneficiaries during the accounting period	15 239	37 185	69 623	29 432	28 568	30 884	11 083	222 014
Number of beneficiaries at the end of the accounting period	9 684	35 551	69 957	30 255	29 923	30 042	10 803	216 215
Dependants per member at the end of the accounting period	0,45	0,79	1,46	1,33	1,34	0,85	2,29	1,15
Risk contributions per average beneficiary per month	3 972,33	1 988,17	1 082,32	731,26	672,84	770,98	813,95	1 276,47
Relevant healthcare expenditure as a percentage of risk contributions	92,6%	87,4%	96,0%	102,3%	88,9%	95,9%	81,7%	92,6%
Relevant healthcare expenditure per average beneficiary per month	3 679,77	1 737,97	1 039,23	748,38	597,88	739,39	664,75	1 181,76
Non-healthcare expenses as a percentage of risk contributions *	12,2%	12,2%	12,2%	12,2%	12,2%	12,2%	12,2%	12,2%
Non-healthcare expenses per average beneficiary per month	486,46	243,47	132,54	89,55	82,40	94,42	99,68	156,32
Average age of beneficiaries	56	49	33	33	33	32	25	37
Pensioner ratio (beneficiaries > 65)	38,2%	27,7%	7,6%	9,3%	7,7%	6,0%	1,9%	12,0%
Average accumulated funds per member at the end of the accounting period **	n/a	n/a	n/a	n/a	n/a	n/a	n/a	11 200
Return on investments as a percentage of investments	n/a	n/a	n/a	n/a	n/a	n/a	n/a	8,8%

* Non-healthcare expenses include administration expenditure, managed care: management services, broker service fees and net impairment losses.

** Accumulated funds are not apportioned per insurance contract.

3.4 Reserve accounts

Movements in the members' funds and reserve accounts are set out in the Consolidated Statement of Changes in Funds and Reserves on page 44. There were no unusual movements for the trustees to explain.

3.5 Outstanding claims

The basis of the calculation and the movement of the outstanding claims provision are set out in note 12 to the Consolidated Financial Statements and is consistent with prior years. There were no unusual movements for the trustees to explain.

3.6 Reporting in terms of International Financial Reporting Standards (IFRS)

The Board of Trustees applied all the applicable requirements of IFRS and the Medical Schemes Act, 1998 to the Consolidated Financial Statements.

4. Management of insurance risks

The primary insurance activity carried out by the Scheme assumes the cost of healthcare provision to members and their dependants that are directly subject to the health of the Scheme's members. As such, the Scheme is exposed to the uncertainty surrounding the timing and severity of claims under the contract.

The Scheme manages its insurance risk through benefit limits and sub-limits, approval procedures for transactions involving pricing guidelines, pre-authorisation and case management, service provider profiling, centralised management of risk transfer arrangements, as well as the monitoring of emerging issues. A team of forensic auditors investigates trends, service providers and members for possible fraudulent transactions on a continuous basis.

The Scheme uses several methods to assess and monitor insurance risk exposure both for individual and overall types of risks insured. These methods include internal risk measurement models, scenario analyses, managed healthcare protocols, reference pricing principles and programmes. The results of model and scenario analyses are used for benefit design and pricing purposes. The theory of probability is applied to the pricing and provisioning for a portfolio of insurance contracts. The principal risk is that the frequency and severity of claims will be greater than expected.

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

The Board of Trustees makes use of a Strategic Risk Register to manage risks to which the Scheme is exposed.

4.1 Risk transfer arrangements

The Scheme does not make use of commercial reinsurance cover and carries all risks from accumulated funds. This decision was taken after an actuarial model was used to determine the need for reinsurance cover and it was found to be unnecessary in view of the size of the Scheme. Commercial reinsurance cover would have resulted in an unjustifiable net expense for the Scheme.

The Scheme was party to risk transfer agreements with the following service providers during the year under review: ER24, UDIPA, Denis and PPN. Details regarding its nature, terms and conditions and results are disclosed in note 19 to the Consolidated Financial Statements.

4.2 Actuarial services

Medical schemes, like Medihelp, do not by definition have long-term liabilities to members, which is why the Board of Trustees is of the opinion that an actuarial valuation of the Scheme is not required. The role of actuaries at medical schemes is mainly to enhance risk management measures. The Scheme contracted The Health Monitor Company to perform the necessary actuarial functions during 2013.

The Health Monitor Company has been consulted regarding the determination of contribution and benefit levels. They also assisted in determining the assumptions used in the calculation of the outstanding claims provision, which are fully explained in the notes to the Consolidated Financial Statements.

The Scheme uses actuarial valuations in determining its liability regarding post-employment benefits in terms of the requirements of IAS 19, Post-Retirement Employee Benefits. The Health Monitor Company performed the valuation on the post-employment medical benefits. Simeka Consultants & Actuaries (Pty) Ltd performed the valuation on the pension benefits.

The Health Monitor Company
Ground Floor Block Central J
Central Park
400 16th Road
Midrand
1682

Private Bag X17
HALFWAY HOUSE
1685

Simeka Consultants & Actuaries (Pty) Ltd
Menlyn Woods Phase 2
Sprite Avenue
Faerie Glen
0043
Financial service provider number 13900

Private Bag X137
HALFWAY HOUSE
1685

5. Fidelity cover

Adequate fidelity cover exists in terms of the Medical Schemes Act, 1998.

6. Events after the reporting period

On 31 August 2011, the Board of Trustees of the Scheme approved the buy-out by Strata Healthcare Management (Pty) Ltd ("Strata Healthcare") of Medihelp's administration component as a going concern ("the Transaction"). Section 63 of the Medical Schemes Act, 1998 was followed in respect of the transfer of the administration component, pursuant to which Medihelp deposited with the Registrar of Medical Schemes an exposition document setting out the Transaction, which exposition document was confirmed by the Registrar on 25 September 2013. The Transaction entails the purchase by Strata Healthcare of the relevant assets and liabilities of the Scheme's administration component and the launching of an outsourced medical scheme administration and managed healthcare service by Strata Healthcare to the Scheme's members, with effect from 1 January 2014 ("the Effective Date"), subject to the accreditation of Strata Healthcare as an Administrator and Managed Care Organisation by the Council for Medical Schemes. Strata Healthcare applied for said accreditation which was approved on 5 December 2013.

The Scheme's employees will be transferred to Strata Healthcare on the Effective Date without interruption of the transferred employees' contracts of employment. In terms of the Transaction, employee-related liabilities (leave pay obligation, post-employment benefits and accrued long-term variable remuneration) will be transferred to Strata Healthcare (refer to note 10 to the Consolidated Financial Statements).

As of the Effective Date, Heyn van Rooyen will be employed as the Scheme's Principal Officer.

7. Investments in and loans to participating employers of members of the medical scheme and to other related parties

The Scheme holds investments in participating employers of medical scheme members (refer to paragraph 18.4 for non-compliance disclosure). The Scheme holds an investment in Curamed Holdings Limited, which forms part of a provider network that serves a number of members of the Scheme. Details are disclosed in note 28 to the Consolidated Financial Statements.

8. Related party transactions

Related party transactions are disclosed in note 28 to the Consolidated Financial Statements.

Trustee remuneration is disclosed in note 34 to the Consolidated Financial Statements.

9. Audit Committee

An Audit Committee was established in accordance with the provisions of the Medical Schemes Act, 1998 and is mandated by the Board of Trustees by means of written terms of reference to its membership, authority and duties.

The Committee consists of five members, two of whom are members of the Board of Trustees and the others are not officers of the Scheme. The committee met on three occasions during the course of the year. The meetings were also attended by the Principal Officer and CEO, external audit, internal audit and relevant senior management who have a standing invitation to attend these meetings:

6 February 2013
17 April 2013
27 August 2013

The meetings were attended by all members of the committee.

The committee reported to the Board of Trustees that:

- It has carried out its duties in terms of the Medical Schemes Act, 1998 and the Board of Trustees' written and approved Audit Committee Charter.
- The external auditors have confirmed their independence.
- It has carried out oversight of the risk and governance processes adopted and implemented by the Board of Trustees and management.
- The assurances provided by management, the internal auditors and the external auditors have satisfied the committee that internal controls are adequate and effective.
- It has reviewed the Scheme's Consolidated Financial Statements, reviewed the accounting policies, obtained assurances from the external auditors and recommended the approval of the Consolidated Financial Statements by the Board of Trustees.

At year-end the Committee comprised JFJ Scheepers (chairman), MJ Brown, JCE du Toit, MJ Visser and PJ Vosloo.

10. Investment Committee and Strategy

An Investment Committee was established and is mandated by the Board of Trustees by means of written terms of reference to its membership, authority and duties. This committee consists of three members who are members of the Board of Trustees and are not executive officers of the Scheme. The committee met on two occasions during the course of the year:

16 April 2013
13 November 2013

The meetings were attended by all members of the committee.

The purpose of the Investment Committee is to assist the Board of Trustees in fulfilling its responsibilities by ensuring that the relevant laws and regulations relating to the investment of excess funds are adhered to and to review the investment policy and Investment Committee Charter for approval by the Board of Trustees. The committee also provides an enabling environment for the proper administration of Medihelp's investments.

The Investment Committee discharged its responsibilities during 2013 as follows:

- A representative from Allan Gray Life was invited to both meetings held during the year, to present the performance of the Life Domestic Balanced Portfolio, and to answer questions relating to the portfolio. As a result, the committee ensured that the long-term investment was evaluated regularly to ensure maximum return.
- The performance of other short- and long-term investments were also evaluated via reports submitted and presented to the committee during meetings held.

The Scheme's investment objective is to maximise the return on its investments on a long-term basis at minimal risk. The investment strategy takes into consideration constraints imposed by legislation as well as those imposed by the Board of Trustees.

The mandate given by the Board of Trustees to the Investment Committee is to invest surplus funds in accordance with risk-minimising measures at institutions offering the highest possible returns. The Scheme invests in fixed deposits and has a long-term investment which is managed by Allan Gray Life (Domestic Balanced Portfolio). The majority of the portfolio managed by Allan Gray Life is invested in Listed Equities. The Scheme also owns an investment in Curamed Holdings Limited – refer to paragraph 18.1 of this Board of Trustees' report. The investment policy and the Investment Committee Charter are reviewed annually, taking into consideration compliance with the Medical Schemes Act, 1998, the Regulations to this Act and the Medihelp Rules. The risk and returns of the various investment instruments and the surplus of funds available are also taken into account.

At year-end the committee comprised PJ Vosloo (chairman), JC Klopper and HJ Koekemoer.

Investments in wholly-owned subsidiaries:

MediMarketing (Pty) Ltd

MediMarketing is a marketing company that was established to manage the recruitment of new members and the retention of the Scheme's existing members. MediMarketing's registered offices are situated on the Scheme's premises.

MEDICHRON (Pty) Ltd

MEDICHRON is a chronic pharmaceutical benefit management company which is dormant. MEDICHRON's registered offices are situated on the Scheme's premises.

11. Rule Committee

A Rule Committee was established and is mandated by the Board of Trustees by means of written terms of reference to its membership, authority and duties. This committee consists of three members who are members of the Board of Trustees and are not executive officers of the Scheme, and who possess in-depth knowledge of the Scheme's philosophy with regard to the Rules, the history of the Rules and the Scheme's operational processes and activities. Due to the implications of the Rules on the functioning of the Scheme and the liabilities that the Scheme can incur in this regard, the Rule Committee may co-opt persons with legal, financial and other expertise. The committee met on two occasions during the course of the year:

16 April 2013
28 August 2013

The meetings were attended by all members of the committee.

The committee's function is to make recommendations on rule amendments to the Board of Trustees, in order to support the Board in its responsibility to ensure that:

- The Rules of Medihelp comply with all legal and regulatory directives; and
- The Rules create an enabling environment for the proper administration of the affairs of Medihelp.

At year-end the committee comprised HJ Koekemoer(chairman), EM Malan and HE Vosloo.

12. Remuneration Committee

The role of the Remuneration Committee is to make recommendations to the Board of Trustees on the remuneration and benefits received by Medihelp's employees and on the honorarium that is payable to members of the Board.

The Remuneration Committee consists of two members of the Board of Trustees and two independent members. The Board members are EM Malan and HE Vosloo and the independent members are L Grubb and A van Wyk. A van Wyk is also the independent chairman of the Remuneration Committee. The Board of Trustees confirmed the reappointment of the independent members of the Remuneration Committee as well as the chairmanship of A van Wyk at its meeting of 3 August 2012. Their reappointment extended from 1 August 2012 to 31 December 2013 after which this committee ceased to exist due to the sale of business agreement (refer to paragraph 6 of this Board of Trustees' report). The committee met on three occasions during the course of the year:

11 April 2013
7 August 2013
13 November 2013

The meetings were attended by all members of the committee.

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

- Reviewed the remuneration, leave and performance management policies; and
- Recommended increases to the honorarium of members of the Board of Trustees, other independent members of committees and Medihelp employees.

At year-end the committee comprised A van Wyk (chairman), L Grubb, EM Malan and HE Vosloo.

13. Restructuring Committee

The Restructuring Committee was established and mandated by the Board of Trustees with written conditions regarding its membership, rights and responsibilities. At year-end the committee consisted of three members of the Board of Trustees. No executive manager of the Scheme formed part of the committee. The committee ceased to exist due to the sale of business agreement (refer to paragraph 6 of this Board of Trustees' report). The committee met on one occasion during the course of the year:

13 March 2013

The meeting was attended by all members of the committee.

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

- Assisted the Board of Trustees with the possible restructuring of the Scheme by selling the administration component thereof.
- Recommended the agreements to be signed by the Scheme and the buyer to the Board of Trustees for approval.
- Liaised, on behalf of the Scheme, with the Council for Medical Schemes regarding the proposed transaction.

At the time the committee met it comprised PJ Vosloo(chairman), JC Klopper and MJ van Staden.

14. Nominations Committee

The Nominations Committee was established and mandated by the Board of Trustees with written conditions regarding its membership, rights and responsibilities. This committee consists of two members, who are both members of the Board of Trustees and not executive officers of the Scheme. The committee met on two occasions during the course of the year:

6 February 2013
18 April 2013

These meetings were attended by all members of the committee.

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

- Ensured the establishment of a formal process for the nomination of trustees in terms of the registered Rules of the Scheme.
- Recommended the nomination of accepted candidates to the Board of Trustees for approval.

At year-end the committee comprised JC Klopper (Chairman) and MJ Visser.

15. Trustees of Medihelp Pension Fund

The Board of Trustees of the Scheme appointed three senior employees to represent the employer on the Board of Trustees of the pension fund and a further three members were elected from the ranks of the Scheme's employees who are also members of the pension fund. The trustees met on three occasions during the course of the year:

14 March 2013
6 June 2013
23 October 2013

The meetings were attended by all trustees.

At year-end the trustees of the pension fund were AO Rijnen (chairman), C Agenbach, B Hertzog, DE Klue, AF Schomper and GJ Wagner.

16. Claim against National Treasury

The National Treasury paid subsidies on behalf of state pensioners to Medihelp as their contribution or part thereof. During the past few years, National Treasury unilaterally deducted from the monthly subsidy payments of other members, amounts for past subsidies paid of pensioners who did not, in terms of the rules of National Treasury, qualify for subsidy any more. However, these pensioners enjoyed membership of Medihelp. Medihelp has issued summons against National Treasury for the repayment of the amount that was illegally deducted. Refer to the contingent asset disclosure in note 30 of the Consolidated Financial Statements.

17. Board of Trustees and committee meeting attendance and remuneration

The following schedule sets out the attendance at meetings of the Board of Trustees and attendance by members of committees of the Board of Trustees. Trustee remuneration is disclosed in note 34 to the Consolidated Financial Statements.

Trustee/committee member	Scheduled Board meetings	Special Board meetings	Audit Committee meetings	Investment Committee meetings	Rule Committee meetings	Remuneration Committee meetings	Restructuring Committee meetings	Nominations Committee meetings
Number of meetings for the year	6	4	3	2	2	3	1	2
Trustees								
JC Klopper	6	4	2	1		1	1	
HJ Koekemoer	5	3		2	2			
EM Malan	6	4			2	2		2
MJ van Staden	3	1		1	1		1	
MJ Visser*	3	3	1					
HE Vosloo	6	3			1	3		2
PJ Vosloo	6	4	3	2			1	
Independent members								
MJ Brown			3					
C du Toit			3					
L Grubb						3		
JFJ Scheepers			3					
A van Wyk						3		

*MJ Visser was elected to the Board of Trustees on 20 June 2013 and therefore only attended one Audit Committee meeting during 2013.

18. Non-compliance with the Medical Schemes Act

18.1 Aggregate fair value of investments not according to regulation 30(1) and Annexure B of the Medical Schemes Act, 1998

In terms of regulation 30(1) and Annexure B of the Medical Schemes Act, 1998 the maximum percentage of aggregate fair value of liabilities for investments in unlisted shares is 2,5%. Due to the substantial increase in the fair value of Curamed Holdings the Scheme exceeds this limitation, but the cost of the investment still falls within the 2,5% requirement. However, the Scheme's Board of Trustees classified this as a long-term strategic asset that will not be sold in the short term. The Scheme applied to the Council for Medical Schemes for exemption in terms of regulation 30(8) in November 2013. The Council for Medical Schemes confirmed that a meeting is scheduled for May 2014 where applications for exemptions will be considered.

18.2 Contribution income not received after three days of becoming due

In terms of section 26(7) of the Medical Schemes Act, 1998 all subscriptions or contributions must be paid directly to a medical scheme not later than three days after payment thereof becoming due. In this regard, rule 18(10) of the Rules of the Scheme stipulates that the Board of Trustees must take all reasonable steps to ensure that contributions are paid timeously to the Scheme in accordance with the Act and the Rules. In order to give effect to this stipulation, rule 11(6) determines the manner in which arrear subscriptions are dealt with. However, with regard to the application of section 26(7) of the Medical Schemes Act, 1998 it is important to note that the Scheme has no control over the timely payment of subscription to the Scheme. This issue was raised with the Registrar of Medical Schemes and the Scheme has received written confirmation from the Council for Medical Schemes that the legal obligation lies with the member/employer to pay subscription within the prescribed period.

18.3 Financial soundness of insurance contracts

In terms of section 33(2) of the Medical Schemes Act, 1998 each insurance contract must be self-supporting in terms of membership and financial performance and shall be financially sound. The Medihelp Plus, Dimension Prime 3, Dimension Prime 2 and Necesse insurance contracts operated at a deficit for the year ended 31 December 2013. Claim patterns for 2013 were not in line with previous years' trends. The insurance contracts will be subject to more stringent managed healthcare protocols in the 2014 financial year.

18.4 Investments in the business of or granting of loans to any medical scheme administrator

In terms of section 35(8)(c) of the Medical Schemes Act, 1998 a medical scheme shall not invest any of its assets in the business of or grant loans to any administrator. The Scheme holds investments in Liberty Holdings Limited, MMI Holdings Limited, Old Mutual PLC and Sanlam Limited through its investment portfolio in the Allan Gray Life Limited Domestic Balanced Portfolio ("the Portfolio") as well as its direct shareholding in Sanlam. Section 35(8)(a) states that a medical scheme shall not invest any of its assets in the business of or grant loans to an employer who participates in the medical scheme. The Scheme holds investments via the Portfolio in Gold Fields Limited, Murray & Roberts Holdings Limited and African Bank Investments Limited. It is the view of the trustees that these investments do not pose a risk to the Scheme. The Scheme applied to the Council for Medical Schemes for exemption in terms of regulation 30(8). Exemption was granted up until 25 March 2015 for investments held with asset managers who invest on behalf of the Scheme. The confirmation of exemption letter did not address the direct shareholding in Sanlam Limited. At reporting date, the Council for Medical Schemes has still not responded to various requests by the Scheme to provide feedback on the matter.

JC Klopper
Chairman

PJ Vosloo
Vice-chairman

23 April 2014

statement of responsibilities by the board of trustees

The trustees are responsible for the preparation, integrity and fair presentation of the Consolidated Financial Statements of the Group. The Consolidated Financial Statements have been prepared in accordance with International Financial Reporting Standards (IFRS) and the Medical Schemes Act, 1998 as amended and include amounts based on judgements and estimates made by management.

The trustees consider that in preparing the Consolidated Financial Statements they have used the most appropriate accounting policies, consistently applied and supported by reasonable judgements and estimates, and that all IFRS requirements that they consider to be applicable have been followed.

The trustees are responsible for ensuring that accounting records are kept. These records should disclose with reasonable accuracy the financial position of the Group to enable the trustees to ensure that the Consolidated Financial Statements comply with the relevant legislation.

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

The going-concern basis has been adopted in preparing the Consolidated Financial Statements. Based on forecasts and available cash resources, the trustees have no reason to believe that the Group will not be a going concern in the foreseeable future. These Consolidated Financial Statements support the viability of the Group.

The Group's external auditors, PricewaterhouseCoopers Incorporated, audited the Consolidated Financial Statements.

The Consolidated Financial Statements were approved by the Board of Trustees on 23 April 2014 and are signed on their behalf by:

JC Klopper
Chairman

PJ Vosloo
Vice-chairman

AO Rijnen
Principal Officer

statement of corporate governance by the board of trustees

The Board of Trustees is committed to the principles and practice of fairness, openness, integrity and accountability in all dealings with its stakeholders. The Medihelp Board of Trustees Charter, which includes the requirement that each trustee signs an Undertaking in terms of the Medihelp Code of Conduct, has been adhered to. The trustees are also committed to the principles of the Code of Corporate Practices and Conduct as set out in the King Report on Governance (King III).

Board of Trustees
The trustees meet regularly and monitor the performance of the Scheme. They address a range of key issues and ensure that discussions on items of policy, strategy and performance are critical, informed and constructive.

The Board of Trustees consists of six members who are elected by members at the Annual General Meeting. Trustees are elected and appointed for a three-year period and may be re-elected or re-appointed.

All trustees have access to the advice and services of the Principal Officer & CEO and, where appropriate, may seek independent professional advice at the expense of the Scheme to support them in their duties. In terms of the Board of Trustees Charter, trustees should ensure that an annual performance evaluation is completed to identify training needs of trustees. The Board of Trustees Charter also determines that the performance of all sub-committees is assessed on an annual basis to ensure the credibility of the committees. The Board of Trustees ensures that the performance of service providers is monitored in line with applicable service level agreements.

Internal control
The Board of Trustees maintains internal controls and systems designed to provide reasonable but not absolute assurance as to the integrity and reliability of the Consolidated Financial Statements and to safeguard, verify and maintain accountability for its assets. Such controls are based on established policies and procedures and are implemented by trained personnel with the appropriate segregation of duties.

The Medihelp Information Technology (IT) Governance Framework supports effective and efficient management of IT resources to facilitate the achievement of strategic objectives. The framework is applied in conjunction with the IT Governance Charter and aligned with best practices and standards. The IT Governance Report gives feedback on IT performance, security, investments, service levels and governance issues to the Board.

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

JC Klopper
Chairman

PJ Vosloo
Vice-chairman

AO Rijnen
Principal Officer

23 April 2014

corporate governance report

1. Introduction and general overview

This report on Medihelp's corporate governance provides a general overview of Medihelp's approach to good corporate governance. Medihelp's corporate governance aims to inspire trust with its members and other stakeholders inter alia by establishing good leadership, a balance of power, the protection of members' interests, and encouraging strategic conversation. Medihelp's bottom-line performance is governed by a competitive strategy, performance/risk management effectiveness, tone at the top and statutory/regulatory compliance.

2. The Board of Trustees (BOT)

The BOT consists of six trustees nominated by members and elected at the Annual General Meeting. There is no maximum number of meetings but normally five meetings are scheduled during a financial year. Special Board meetings are also held in addition to the scheduled meetings if required by circumstances. The Scheme's Rules stipulate that the BOT must meet at least once every three months. For more information on the trustees and their attendance of meetings, refer to page 30 of this integrated annual report.

The BOT have the following subcommittees as more fully described on pages 25 to 28 of this integrated annual report:

- Audit Committee
- Investment Committee
- Rule Committee
- Remuneration Committee
- Restructuring Committee
- Nominations Committee

Only the BOT may appoint members to subcommittees. The Board delegates specific tasks and ongoing roles to the mentioned committees in order to spread the work load, speed up research and debates, obtain the required additional expertise or act as a control measure over certain functions of the Board. The delegation of these tasks to Medihelp's subcommittees does not diminish the Board's responsibilities in these areas. Committees report back to the Board on their findings and recommendations, but authority for reaching the final decision rests with the Board.

All Board subcommittees are chaired by a member of that committee who is appointed by the BOT. The charters of the Audit Committee and the Remuneration Committee make provision for independent members to serve on these committees.

2.1 Decision-making by the BOT

All issues on which the BOT has to decide are formally presented in the Board pack to the Board for their consideration. These presentations are in the form of written submissions by the Principal Officer & CEO, Executive Managers and Senior Managers.

The submissions provide detailed background information on the issue which is then discussed, conclusions drawn within the context of the Scheme and a course of action recommended. The BOT then deliberates these submissions and a majority decision regarding the course of action is taken. The Principal Officer & CEO is then instructed to execute the decision of the BOT and where applicable, report back to the BOT.

Issues relating to the activities of the subcommittees of the BOT are first dealt with in the manner described above, after which the matter, together with a recommendation, is put to the BOT for deliberation and decision-making.

All meetings of subcommittees and the BOT are minuted and therefore all decisions taken by the BOT are accurately minuted and properly indexed.

The Scheme did not refuse any requests for information in terms of the Promotion of Access to Information Act, 2000 (Act No 2 of 2000).

2.2 Risk Management

As recommended in the King Report on Governance for South Africa 2009 (King III), Medihelp established a Risk Management Committee and a Risk Management Committee Charter was also approved in September 2010. This committee consists of the Executive Management. The Risk Management Framework for Medihelp has the following stated objective: "The purpose of the Risk Management Framework is to set out the guidelines within which the total process of risk management is to be dealt with by Medihelp, both from an internal and external perspective."

King III also recommended that appropriate processes should be put in place to address compliance as part of the broader risk management framework. The Scheme established a compliance function and approved the Compliance Charter in April 2012 with this objective: "The Compliance Charter defines the fundamental principles, roles and responsibilities of the Compliance function within Medihelp as well as its relationship with the Board of Trustees, executive management and the business and operational functions."

Medihelp's central source of guidance, advice and secretariat support to the BOT, Board Committees and within the Scheme on matters of ethics and good governance, is seated in the Legal & Commercial Advice Portfolio of Medihelp, and more specifically with the Senior Manager: Legal Advice & Secretariat Services.

At the Risk Management Committee meeting of 24 January 2012, it was decided by the Committee that Legal Advice and Secretariat Services may proceed to implement a Governance, Risk and Compliance (GRC) Model in Medihelp to help with the effective management of risk and the reaching of objectives.

3. Remuneration Policy

Medihelp has a performance-based remuneration philosophy. The organisation's strategy and key performance indicators are approved by the BOT annually. The organisation's key performance indicators provide for three levels of performance, which are verifiable. Individual performance is agreed on, managed and evaluated through a talent investment cycle.

The remuneration policy is designed to remunerate employees at market-competitive levels while taking into account the Scheme's financial ability. All employees receive both a fixed and a variable remuneration component. Fixed remuneration is reviewed on an annual basis to be aligned with adjustments in market trends. The median (50th percentile) of the market information for all job levels is set as the benchmark. Deviations from the 50th percentile are considered on merit, in line with the framework set out in the remuneration policy. The remuneration policy provides for specific interventions aimed at attracting and retaining key and scarce skills.
A short-term variable remuneration scheme for all staff and a long-term variable remuneration scheme for executive management are based on the organisation's key performance indicators. Both schemes are funded from better-than-budgeted financial performance. The provision for short-term variable remuneration for the 2013 financial year-end is R 18 927 512 (2012: nil).

Medihelp's BOT is paid a honorarium in terms of rule 17.19 of the Rules of Medihelp. The policy on the payment of a honorarium is approved by the Annual General Meeting and a fee is paid per Board meeting and subcommittee meeting attended by Board members. Medihelp uses the services of a human resource consultancy to advise the Scheme on market-related benchmarks and adjustments for Board and subcommittee members' honoraria.

The honoraria paid to the trustees are included in this integrated annual report under the heading "Trustees' remuneration" on pages 46 and 47. The benefits paid to employees who exercise general executive control and management of the Scheme, namely the Principal Officer & CEO and the Executive Managers, are disclosed in the Annual Financial Statements under "Related Party Transactions".

4. Report of the audit committee

In addition to the information presented on page 25 of this integrated annual report, the Audit Committee reports that:

- It has monitored the relationship between the external assurance providers and the Scheme;
- It has approved the internal audit plan, reviewed and commented on internal audit reports;
- It has oversight of the Scheme's financial reporting risks, internal financial controls, fraud risks as it relates to financial reporting, and Information Technology (IT) risks as it relates to financial reporting;
- It has recommended to the BOT the appointment of the external auditor; and
- A self-evaluation of the Audit Committee was performed.

4.1 Risk Management

The Audit Committee reviewed the BOT's risk evaluation and risk management plan and made recommendations thereon.

4.2 Corporate Governance

The Audit Committee reviewed the Principal Officer & CEO's governance report and made recommendations thereon.

4.3 Internal Audit

An in-house internal audit function is in place. Internal Audit, with the exception of the forensic component, is operating in accordance with a three-year audit plan, including a detailed plan for the first year, using an appropriate risk-based methodology. The Forensic Audit component is guided by the Medihelp Fraud and Corruption Policy and conducts investigations into matters reported through existing fraud reporting channels, as well as pro-active investigations in high-risk areas. Internal audit findings together with management comments and corrective actions instituted are periodically reported to the Audit Committee.

4.4 External Audit

The Audit Committee evaluated the work done by the external auditors and reviewed the audited Annual Financial Statements of the Scheme in conjunction with their management letter and audit report.

The Audit Committee concurs with and accepts the conclusions of the external auditors as contained in their report.

4.5 Compliance

External audit management and internal audit reports were reviewed to ensure that matters regarding compliance with laws and regulations, raised in the aforementioned management letters and reports, are timeously addressed and rectified.

The Scheme also established a compliance function and the Audit Committee considered the report from the compliance function.

4.6 Finance Function

From the various internal and external reports and a review of the qualifications and experience of the finance personnel it is evident that executive management consists of suitably qualified and industry experienced people.

The committee is satisfied that the policies and procedures implemented by management were sufficient to ensure that the accounting and information systems and related controls are adequate, effective and are in compliance with the requirements of the Council for Medical Schemes.

consolidated statement of financial position at 31 december 2013

	Notes	Group 2013 R	Group 2012 R	Scheme 2013 R	Scheme 2012 R
ASSETS					
NON-CURRENT ASSETS		374 065 466	363 845 075	374 065 466	363 845 176
Investments in subsidiaries	3.	-	-	-	101
Intangible assets	4.	-	26 517 716	-	26 517 716
Property, plant and equipment	5.	27 581 623	39 802 370	27 581 623	39 802 370
Available-for-sale financial assets	6.	346 483 843	297 524 989	346 483 843	297 524 989
CURRENT ASSETS		1 193 889 975	1 260 512 319	1 193 797 749	1 260 402 885
Trade and other receivables	7.	99 679 076	99 987 943	99 679 076	99 987 943
Advance account in debit	8.	1 017 788	1 017 788	1 017 788	1 017 788
Cash and cash equivalents	9.	1 046 910 184	1 159 506 588	1046 910 184	1 159 397 154
Scheme	9.	1 005 352 869	1 126 553 240	1 005 352 869	1 126 443 806
Personal medical savings account trust monies invested	9.	41 557 315	32 953 348	41 557 315	32 953 348
Assets of disposal groups classified as held-for-sale	10.	46 282 927	-	46 190 701	-
Total assets		1 567 955 441	1 624 357 394	1 567 863 215	1 624 248 061
MEMBERS' FUNDS AND LIABILITIES					
ACCUMULATED FUNDS		1 279 558 401	1 306 351 905	1 279 507 720	1 306 283 245
NON-CURRENT LIABILITIES					
Post-employment benefits	11.1	5 117 028	11 220 559	5 117 028	11 220 559
CURRENT LIABILITIES		283 280 012	306 784 930	283 238 467	306 744 257
Outstanding claims provision	12.	117 619 976	128 777 903	117 619 976	128 777 903
Personal medical savings account trust liability	13.	43 622 958	34 702 177	43 622 958	34 702 177
Advance accounts in credit	8.	7 854 734	7 854 734	7 854 734	7 854 734
Leave pay obligation	14.	57 137	11 480 000	57 137	11 480 000
Trade and other payables	15.	91 318 409	123 970 116	91 318 409	123 929 443
Liabilities associated with disposal groups classified as held-for-sale	10.	22 806 798	-	22 765 253	-
Total funds and liabilities		1 567 955 441	1 624 357 394	1 567 863 215	1 624 248 061

consolidated statement of comprehensive income
for the year ended 31 december 2013

	Notes	Group 2013 R	Group 2012 R	Scheme 2013 R	Scheme 2012 R
Risk contribution income	16.	3 378 855 329	3 400 735 579	3 378 855 329	3 400 735 579
		3 378 855 329	3 400 735 579	3 378 855 329	3 400 735 579
Relevant healthcare expenditure		(3 070 571 024)	(3 148 399 733)	(3 070 571 024)	(3 148 399 733)
Net claims incurred	17.	(3 055 847 026)	(3 128 644 259)	(3 055 847 026)	(3 128 644 259)
Risk claims incurred		(3 060 080 371)	(3 132 941 488)	(3 060 080 371)	(3 132 941 488)
Third-party claims recoveries		4 233 345	4 297 229	4 233 345	4 297 229
Net expense on risk transfer arrangements		(14 723 998)	(19 755 474)	(14 723 998)	(19 755 474)
Risk transfer arrangement fees/premiums paid	19.	(265 511 267)	(265 174 592)	(265 511 267)	(265 174 592)
Recoveries under risk transfer arrangements	19.	247 837 163	243 497 312	247 837 163	243 497 312
Net profit share arising from risk transfer arrangements	19.	2 950 106	1 921 806	2 950 106	1 921 806
Gross healthcare result		308 284 305	252 335 846	308 284 305	252 335 846
Managed care: Management services	18.	(68 163 432)	(68 558 548)	(68 163 432)	(68 558 548)
Broker service fees	20.	(49 606 626)	(46 650 223)	(49 606 626)	(46 650 223)
Administration expenditure	21.	(322 620 955)	(295 864 721)	(322 602 372)	(295 846 992)
Net impairment losses on healthcare receivables	22.	(11 001 481)	(5 403 034)	(11 001 481)	(5 403 034)
Net healthcare result		(143 108 189)	(164 140 680)	(143 089 606)	(164 122 951)
Other income		77 408 952	86 925 520	77 408 348	86 924 809
Investment income	24.	73 858 081	78 147 891	73 857 477	78 147 180
Scheme		72 076 242	76 609 281	72 075 638	76 608 570
Return on personal medical savings account trust monies invested		1 781 839	1 538 610	1 781 839	1 538 610
Sundry income	25.	3 550 871	8 777 629	3 550 871	8 777 629
Other expenditure		(3 542 089)	(3 075 754)	(3 542 089)	(3 075 754)
Asset management fees	6.	(1 759 144)	(1 528 374)	(1 759 144)	(1 528 374)
Interest paid	23.	(1 782 945)	(1 547 380)	(1 782 945)	(1 547 380)
Net deficit for the year		(69 241 326)	(80 290 914)	(69 223 347)	(80 273 896)
Other comprehensive income		42 447 822	49 333 162	42 447 822	49 333 162
Unrealised gain on fair value adjustment on available-for-sale financial assets	6.	43 578 997	49 932 641	43 578 997	49 932 641
Actuarial loss on post-employment benefit obligation	11.	(1 131 175)	(599 479)	(1 131 175)	(599 479)
Total comprehensive deficit for the year		(26 793 504)	(30 957 752)	(26 775 525)	(30 940 734)

consolidated statement of changes in funds and reserves for the year ended 31 december 2013

	Accumulated funds R	Group Revaluation reserve for available-for-sale financial assets R	Total members' funds R	Accumulated funds R	Scheme Revaluation reserve for available-for-sale financial assets R	Total members' funds R
Balance as at 1 January 2012	1 220 877 711	116 431 946	1 337 309 657	1 220 792 033	116 431 946	1 337 223 979
Comprehensive income						
Deficit for the year	(80 290 914)	-	(80 290 914)	(80 273 896)	-	(80 273 896)
Other comprehensive income	(599 479)	49 932 641	49 333 162	(599 479)	49 932 641	49 333 162
Fair value adjustment on available-for-sale financial assets	-	49 932 641	49 932 641	-	49 932 641	49 932 641
Actuarial loss on post-employment benefit obligation	(599 479)	-	(599 479)	(599 479)	-	(599 479)
Total comprehensive (deficit)/income for the year	**(80 890 393)**	**49 932 641**	**(30 957 752)**	**(80 873 375)**	**49 932 641**	**(30 940 734)**
Balance as at 31 December 2012	1 139 987 318	166 364 587	1 306 351 905	1 139 918 658	166 364 587	1 306 283 245
Balance as at 1 January 2013	1 139 987 318	166 364 587	1 306 351 905	1 139 918 658	166 364 587	1 306 283 245
Comprehensive income						
Deficit for the year	(69 241 326)	-	(69 241 326)	(69 223 347)	-	(69 223 347)
Other comprehensive income	(1 131 175)	43 578 997	42 447 822	(1 131 175)	43 578 997	42 447 822
Fair value adjustment on available-for-sale financial assets	-	43 578 997	43 578 997	-	43 578 997	43 578 997
Actuarial loss on post-employment benefit obligation	(1 131 175)	-	(1 131 175)	(1 131 175)	-	(1 131 175)
Total comprehensive (deficit)/income for the year	**(70 372 501)**	**43 578 997**	**(26 793 504)**	**(70 354 522)**	**43 578 997**	**(26 775 525)**
Balance as at 31 December 2013	1 069 614 817	209 943 584	1 279 558 401	1 069 564 136	209 943 584	1 279 507 720

trustees' remuneration

2013	Fees for Board of Trustees' meeting attendance R	Fees for subcommittee meeting attendance R	Telephone allowance R	Total remuneration R	Travel and accommodation R	Conference fees R	Total considerations R
HJ Koekemoer	121 352	54 952	1 100	177 404	-	-	177 404
HE Vosloo	153 508	72 804	1 200	227 512	59 717	-	287 229
PJ Vosloo	228 668	82 052	1 200	311 920	74 783	-	386 703
EM Malan	153 508	58 152	1 200	212 860	50 964	-	263 824
MJ van Staden*	57 040	36 402	600	94 042	4 204	-	98 246
MJ Visser*	96 468	12 666	600	109 734	-	-	109 734
JC Klopper	333 836	53 202	1 200	388 238	-	-	388 238
	1 144 380	**370 230**	**7 100**	**1 521 710**	**189 668**	**-**	**1 711 378**

*The term of office of MJ van Staden expired and MJ Visser was elected to the Board of Trustees on 20 June 2013.

2012	Fees for Board of Trustees' meeting attendance R	Fees for subcommittee meeting attendance R	Telephone allowance R	Total remuneration R	Travel and accommodation R	Conference fees R	Total considerations R
HJ Koekemoer**	47 932	49 361	600	97 893	6 260	-	104 153
EJ du Preez	131 215	77 758	1 200	210 173	13 107	-	223 280
HE Vosloo	131 215	65 648	1 200	198 063	48 869	-	246 932
PJ Vosloo	202 152	151 292	1 200	354 644	152 788	21 788	529 220
EM Malan**	83 283	29 076	600	112 959	41 996	-	154 955
MJ van Staden	142 895	108 651	1 200	252 746	9 786	-	262 532
JC Klopper	218 258	118 891	1 200	338 349	43 553	21 788	403 690
	956 950	**600 677**	**7 200**	**1 564 827**	**316 359**	**43 576**	**1 924 762**

**The term of office of HJ Koekemoer expired and EM Malan was elected to the Board of Trustees on 21 June 2012.

agenda for the annual general meeting

The agenda for Medihelp's AGM to be held in the Ruby Auditorium at the CSIR International Conference Centre, Meiring Naudé Road, Brummeria, Pretoria on Thursday, 26 June 2014 at 15:00 is as follows:

1. Opening
2. Issuing of ballot papers to proxies
3. Appointment of Medihelp's external auditors for 2014
4. Election of two members to the Board of Trustees
5. Rule amendments proposed by the Board of Trustees
6. Approval of the minutes of the AGM of 20 June 2013
7. Matters arising from the minutes of the previous AGM
   - 7.1 Item 9: Disposal of Medihelp's administration component as approved by the Annual General Meeting
8. Integrated annual report
9. Annual financial statements as at 31 December 2013
10. Inputs and proposals from the 2014 regional information sessions for the AGM
11. Announcement of the voting results
12. Closing

medihelp
medical scheme

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