

NOTICE IS HEREBY GIVEN THAT THE ELEVENTH ANNUAL GENERAL MEETING OF



WILL BE HELD ON THURSDAY, 7 JUNE 2007, AT 10H00 IN THE J B SUTHERLAND ROOM,  
AFROX HOUSE, 23 WEBBER STREET, SELBY, JOHANNESBURG.

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## AGENDA

1. To read the Notice convening the Annual General Meeting.
2. To adopt the Minutes of the Annual General Meeting held on Friday, 9 June 2006.
3. To adopt the Annual Report of the Board for the year ended 31 December 2006.
4. To adopt the Annual Financial Statements for the year ended 31 December 2006.
5. To re-appoint Advocate Buirski as the Disputes Committee.
6. To appoint the Auditors for the ensuing year.
7. To transact any other business of which due notice has been given by Thursday, 24 May 2007.

By order of the Board

A handwritten signature in black ink, appearing to read "Errol Gardiner". The signature is fluid and cursive, with a large initial "E" and "G".

**ERROL GARDINER**  
PRINCIPAL OFFICER

# ANNUAL REPORT OF THE BOARD OF TRUSTEES

We have pleasure in presenting our Report for the year ended 31 December 2006.

## OVERVIEW

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### MEDICAL SCHEMES INDUSTRY

The year 2006 was a much quieter year than the previous two years experienced in the Medical Aid industry. We would like to provide you with an update on current projects not yet finalised. Two “projects” launched by the Council for Medical Schemes in 2005 Risk Equalisation Fund (still in its shadow period in 2006) and the implementation of the ICD-10 coding system was still active in 2006. We also have an update on the Single Exit Pricing (SEP) on Medication, which was introduced in 2004. The Council for Medical Schemes announced the proposal of a revised benefit design structure for medical schemes. Although the latter did not have an impact on medical schemes and its members in 2006, it is looked at for future benefit structuring.

### RISK EQUALISATION FUND (REF)

As explained to you in the 2006 Annual General Meeting notice REF is a process to enhance medical schemes’ fairness and stability. The shadow process for this Fund took place during 2005 and 2006 and it would become effective in 2007. This has been postponed to take effect only in 2008, as the Fund has to be approved by Parliament before it can be implemented. The REF should ultimately benefit the financial position of the Scheme once implemented.

*Circular 25 – Council for Medical Schemes and previous AGM Notice (2006)*

### ICD-10 IMPLEMENTATION

Previously we have supplied you with information on the implementation of the ICD-10 coding system that is owned and supplied by the World Health Organization (WHO). All parties in South Africa have accepted the system, which provides necessary information, to the Council for Medical Schemes specifically regarding the Prescribed Minimum Benefit conditions. The coding system consists of five-character level codes, which was phased in from 2005 and should have been at the final stage of five characters on 1 January 2006. A task team monitored the implementation and conducted an evaluation on the progress. It was established that more time was needed in order to successfully conclude the implementation of phase three before the fourth phase could commence. The implementation was thus not finalised in 2006 and is ongoing at this stage. Most of the problems experienced with the implementation of the system in 2005, have been dealt with and only minimal “hick-ups” are experienced occasionally.

*Circular 21 – Council for Medical Schemes and previous AGM Notice (2006)*

### SINGLE EXIT PRICING (SEP) ON MEDICINE

The Medicine and Related Substances Act 101 of 1965, was published in *Government Gazette 26304* on 30 April 2004. The implementation of the revised principles of medicine purchasing, selling and pricing as described by the Act could be set out as follows:

- transparency of medicine pricing systems;
- discounting and bonus programmes prohibited from 2 May 2004;
- Single Exit Price (SEP) for each product to be set by the manufacturer by 2 June 2004 and;
- the dispensing fee added to the SEP replaces the current mark-up pricing method on pharmaceuticals from 2 August 2004.

The dispensing fee was at first set at 26% for a transaction under R100, and a flat fee of R26 to be charged on all transactions above R100. This resulted in major dissatisfaction, not only from the pharmacists, but also from members. Pharmacists complained that they could not survive with this dispensing fee and reacted by charging additional administration fees, which raised the medicine prices even further (in some instances, higher than before the introduction of the legislation). The case was taken to the Supreme Court of Appeal in 2005.

On 31 October 2006 the following dispensing fees were suggested:

- for a SEP of less than R75, the dispensing fee is suggested to be 33% plus R4;
- for a SEP of R75 or more, but less than R250, the dispensing fee is suggested to be 6% plus R25;
- for a SEP of R250 or more, but less than R1000, the dispensing fee is suggested to be 3% plus R33; and
- for a SEP of R1000 and more, the dispensing fee is suggested to be 1.5% plus R50.

The Pharmacists' view, however, is that the regulated dispensing fee would place some community pharmacies under crippling financial strain and that as many as 75% of pharmacies could be at risk of closing. The case is still pending in the Supreme Court of Appeal, and in the interim members of most medical schemes are still experiencing co-payments in respect of pharmacy administration fees.

*Department of Health and previous AGM Notice (2005)*

## **REVISED BENEFIT DESIGN STRUCTURE FOR MEDICAL SCHEMES**

The Council for Medical Schemes propose a movement away from the current silo-type options in existence towards the establishment of "scheme/common benefits" with a buy-up "supplementary benefit option". They recommend that a distinction be made between benefits that are common across all options at present and benefits that are not, or do not have to be common. This distinction would be achieved by requiring that common benefits being provided and priced by a scheme across the entire membership. Additional benefits should be purchasable on a voluntary basis by members, subject to the reasonable application of waiting periods.

The common benefits, which include Prescribed Minimum Benefits and other benefits like the hospital benefit (subject to community rated contribution), would be mandatory for all members joining the scheme. Supplementary benefits should be offered via "benefit buy-up options" each of which offers a specified set of benefits. Furthermore, these supplementary benefit options should be in respect of out-of-hospital services and that a fixed set of supplementary benefits options be permitted.

*Circular 8 – Council for Medical Schemes (2006)*

## **AFROX MEDICAL AID SOCIETY**

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### **Membership**

Following the sale by African Oxygen Limited of its healthcare subsidiary and the resignation of their members on 31 December 2005, the membership of the Society decreased. However, an actuarial review confirmed the sustainability of the Afrox Medical Aid Society.

### **Reserves**

In terms of the Medical Schemes Act, no reserves were transferred following the resignation of the healthcare members. This has resulted in the Society exceeding the minimum requirement of the 25% set by the Council for Medical Schemes by reporting a year end reserve ratio of 154.64%. The application for reserves for the benefit of the Society or its members is limited by the Medical Schemes Act, which requires that options within a scheme, must at least break even on an annual basis, from contributions received and benefits paid.

### **Benefits**

The requirement that scheme options have, to at least break even on an annual basis, means there is a direct correlation between contributions received and benefits offered in any one year. In an effort to provide benefits to all employees and pensioners of the company, your Society has continued to cross-subsidise the lower income members' contributions with those of members earning higher salaries.

Two independent actuarial valuations were conducted in 2006, both of which recommended very similar contributions and benefit structures and confirmed that the Society still offered 'value for money'. The Trustees, also, reviewed the current benefits agreeing not to reduce any of the major expense benefits or, like many schemes offer only Prescribed Minimum Benefits (PMBs) for chronic

diseases. In addition, for 2007, the Trustees agreed to include day-to-day benefits to replace the members' savings accounts.

### **Late Joiner Penalties (LJP)**

The recommendation by the Medical Schemes Act for LJP to be applied to members and beneficiaries is being applied by many schemes. Medical schemes, like all insurances, rely on cross-subsidisation, where the healthier membership cross-subsidises the less healthy. The introduction of LJP's was to prevent anti-selection, with members or beneficiaries joining, only when medical attention is required. This anti-selection is seen to be discriminatory to members who have been contributing, but not necessarily claiming benefits. LJP's are only applied to members or beneficiaries joining the Society who:

- are 35 years of age or older;
- do not have sufficient years of credible medical society cover as a member and/or beneficiary.

### **Medical Practitioner Costs**

Members are reminded that medical practitioners, both in- or out-of-hospital may charge rates that are above the Society rate for consultations and procedures. The Society rate is based on the National Health Reference Price List (NHRPL) rates, recommended by the Council for Medical Schemes.

Where possible, members are requested to obtain from practitioners their rates, before consultations or procedures.

The Trustees are conscious that members are experiencing unexpected costs after procedures or hospitalisation, because of this situation. Unless this is addressed by the industry as a whole, (similar to the pricing of medicine), the situation will continue or other benefits will need to be reduced to cover the additional cost of practitioners.

## **FINANCIAL OVERVIEW**

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### **Accumulated Funds**

A surplus of R8 226 042 was achieved during the year, after taking into account:

- Income from investments of R5 381 739;
- An operating surplus of R3 457 572 after deducting all expenses; and
- Other expenses R613 269.

The accumulated funds as at 31 December 2006 were R76 645 053.

The increase in reserves over 2006 meant that the Society had exceeded the minimum requirement of 25% set by the Council for Medical Schemes by reporting a yearend reserve ratio of 154.64%.

### **Risk Contribution Income (Excluding Savings)**

2006	R 55 811 324
2005	R162 083 458

### **Benefit Expenditure (Excluding Savings)**

2006	R 48 364 122
2005	R134 721 307

*Continued overleaf*

## Expenditure

Administration	2006	R 4 531 891
	2005	R11 618 246
Managed Care	2006	R 771 004
	2005	R 2 052 614

## Annual Comparisons

	2006	2005	2004
Managed care per member per month	R28	R19	R16
Administration cost per member per month	R138	R107	R91

## Membership

Membership of the Society decreased from 22 377 beneficiaries in 2005 to 7 079 in 2006.

	December 2006	December 2005
Total membership (Beneficiaries)	7 079	22 377
Principal members	2 879	9 335
Dependants	4 200	13 042
Average number of dependants per principal member	1.46	1.40

## VOTE OF APPRECIATION

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On behalf of the Afrox Medical Aid Society, we would like to express our thanks to the following people/organisations:

- The Company for their active support;
- Our members for their ongoing support;
- Our colleagues on the Board of Trustees for their support;
- The management and staff at Metropolitan Health Group for the manner in which they managed the Society;
- Our Medical Advisor, Dr G Dalziel, for his dedication and commitment;
- The external auditors, PricewaterhouseCoopers, for the efficient manner in which they conducted their audit;
- The healthcare consultants, Alexander Forbes, for their contribution;
- The Registrar of Medical Schemes and his staff for their co-operation and assistance during the year; and
- All service providers.



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CHAIRPERSON



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PRINCIPAL OFFICER

## AFROX MEDICAL AID SOCIETY

**Highlighted Financial information prepared from the audited  
Annual Financial Statements for the year ended 31 December 2006**

**Balance sheet as at 31 December 2006**

	2006 R	2005 R
<b>ASSETS</b>		
Non-current assets	89,210,774	79,412,995
Available-for-sale investments	89,210,774	79,412,995
<b>Current assets</b>	8,375,560	25,249,249
Trade and other receivables	4,720,479	19,090,107
Cash and cash equivalents	3,655,081	6,159,142
<b>Total assets</b>	97,586,334	104,662,244
<b>FUNDS AND LIABILITIES</b>		
Members' funds	88,697,701	72,542,343
Accumulated funds	76,645,053	68,419,011
Available-for-sale reserve	12,052,648	4,123,332
<b>Current liabilities</b>	8,888,633	32,119,901
Outstanding claims provision	1,996,046	9,390,880
Savings plan liability	4,231,123	15,478,428
Trade and other payables	2,661,464	7,250,593
<b>Total funds and liabilities</b>	97,586,334	104,662,244

**Income statement for the year ended 31 December 2006**

	2006 R	2005 R
<b>Gross contribution income</b>	57,359,372	181,102,638
Less: savings contributions	(1,548,048)	(19,019,180)
Risk contribution income	55,811,324	162,083,458
Risk transfer arrangement fees	(372,230)	(1,463,390)
<b>Net contribution income</b>	55,439,094	160,620,068
Realised gains	-	5,519,086
Investment income	5,381,739	3,843,115
Other income	192,303	143,752
<b>Net income</b>	61,013,136	170,126,021
<b>Gross claims</b>	(50,874,138)	(150,553,231)
Claims paid or charged to members savings accounts	3,057,238	17,253,865
Risk claims incurred	(47,816,900)	(133,299,366)
Claims recoveries from other risk transfer arrangements	223,782	630,673
Managed care: management services	(771,004)	(2,052,614)
<b>Net risk claims incurred</b>	(48,364,122)	(134,721,307)
Administration expenses	(4,531,891)	(11,618,246)
Finance costs	(349,394)	(1,858,173)
Expenses for asset management services rendered	(456,178)	(163,300)
Net impaired reversals/(losses)	914,491	(1,249,596)
<b>Expenses</b>	(52,787,094)	(149,610,622)
<b>Net surplus for the year</b>	8,226,042	20,515,399

**Cash flow statement for the year ended 31 December 2006**

	2006 R	2005 R
<b>Cash flows from operating activities</b>		
Cash flows generated from operations before working capital changes	2,279,205	14,420,334
Working capital changes		
- Decrease/(increase) in trade and other receivables	15,284,120	(3,992,544)
- (Decrease)/increase in trade and other payables	(4,589,129)	3,422,556
- (Decrease)/increase in outstanding claims provision	(7,394,834)	3,092,770
- (Decrease)/increase in savings plan liability	(11,247,305)	4,048,183
<b>Cash (utilised in)/generated from operations</b>	(5,667,943)	20,991,299
Finance costs	(349,394)	(1,858,173)
Purchase of available-for-sale financial assets	(1,868,463)	(104,755,471)
Proceeds from sale of available-for-sale financial assets	-	45,830,322
Investment income	5,381,739	3,475,351
Dividends received	-	204,464
<b>Net decrease in cash and cash equivalents</b>	(2,504,061)	(36,112,208)
Cash and cash equivalents at beginning of year	6,159,142	42,271,350
<b>Cash and cash equivalents at the end of the year</b>	<u>3,655,081</u>	<u>6,159,142</u>

**Statement of changes in funds and reserves for the year ended 31 December 2006**

	Accumulated funds R	Available- for-sale reserve R	Total members funds R
<b>Balance as at 1 January 2005</b>	48,391,339	3,635,605	52,026,944
Net surplus for the year	20,515,399	-	20,515,399
Unrealised gain on revaluation of available-for-sale financial assets	(5,519,86)	5,519,086	-
Realised gains on de-recognition of available-for-sale financial assets	5,031,359	(5,031,359)	-
<b>Balance as at 31 December 2005</b>	<u>68,419,011</u>	<u>4,123,332</u>	<u>72,542,343</u>
Net surplus for the year	8,226,042	-	8,226,042
Unrealised gain on revaluation of available-for-sale financial assets (up to date of disposal)	-	7,929,316	7,929,316
<b>Balance as at 31 December 2006</b>	<u>76,645,053</u>	<u>12,052,648</u>	<u>88,697,701</u>

Note: A full set of the Annual Financial Statements are available on request from the office of the Afrox Medical Aid Society and will be available for scrutiny at the Annual General Meeting.