MEDICLINIC
INTERNATIONAL

INTEGRATED ANNUAL REPORT

for the year ended 31 March 2013

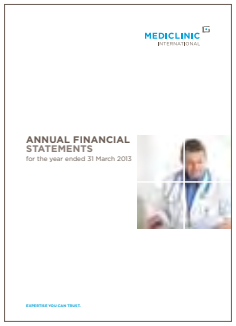
EXPERTISE YOU CAN TRUST.

CONTENTS

VIEW THIS REPORT ONLINE:
www.mediclinic.com

MORE INFORMATION

This integrated annual report is published as part of a set of reports in respect of the financial year ended 31 March 2013, all of which are available on the Company's website at www.mediclinic.com.



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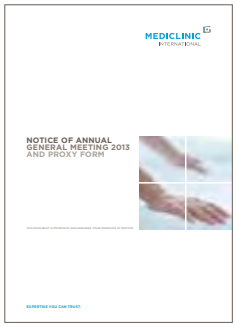
Annual Financial Statements 2013



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Notice of Annual General Meeting 2013 and Proxy Form

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Sustainable Development Report 2013

PDF

Application of King III Principles 2013

REPORT PROFILE

SCOPE, BOUNDARY AND REPORTING CYCLE

This integrated annual report of Mediclinic International presents the economic, social and environmental performance, as well as the financial results of the Mediclinic Group for the financial year ended 31 March 2013 and covers all our operations in Southern Africa, Switzerland and the United Arab Emirates. Cognisance should be taken of the fact that the majority of the Group's operations is situated in Southern Africa (with 52 hospitals), compared to our operations in Switzerland (with 14 hospitals) and in the United Arab Emirates (with 2 hospitals and 8 clinics). There are therefore variances in the level of detail provided in this integrated annual report and the detailed Sustainable Development Report. Although the Group's operations in Switzerland are relatively small compared to Southern Africa, the Swiss operations contributed 40% to the Group's attributable income and therefore considered to have a material impact on the Group's ability to create and sustain value.

The integrated annual report is available on the Company's website at www.mediclinic.com. Printed copies are available on request from the Company Secretary.

REPORTING PRINCIPLES

The contents included in the integrated annual report are deemed to be useful and relevant to our stakeholders, which the Group, with due regard to our stakeholders' expectations through our continuous engagement, deems relevant or material, or which may influence the perception or decision-making of our stakeholders. The information provided aims to provide our stakeholders with a good understanding of the financial, social, environmental and economic impacts of the Group to enable them to evaluate the ability of Mediclinic to create and sustain value for our stakeholders.

This integrated annual report was prepared in accordance with the International Financial Reporting Standards, the Listings Requirements of the JSE Limited, as well as the Companies Act, 71 of 2008, as amended, where relevant. The Company's reporting on sustainable development was done in accordance with the third revision guidelines of the Global Reporting Initiative ("GRI G3.1"). The Company has applied the majority of the principles contained in the King Report on Governance for South Africa 2009 ("King III") – all the King III principles which the Company has not applied are explained, where applicable, in the integrated annual report, also stating for what part of the year any non-compliance had occurred. An index on the application of the King III principles is published on the Company's website at www.mediclinic.com. The Company has also considered and applied many of the recommendations contained in the discussion papers and the latest consultation draft on integrated reporting issued by the Integrated Reporting Committee of South Africa and the International Integrated Reporting Committee. We have prepared a more succinct integrated annual report by only including an abridged version of the Group's Sustainable Development Report and the annual financial statements. The detailed report and financial statements are available on the Company's website at www.mediclinic.com.

SIGNIFICANT EVENTS DURING REPORTING PERIOD

As communicated to shareholders and published on SENS and in the media, the following significant events occurred during the period under review:

The Company raised R5 billion through a rights offer in terms whereof 174 641 984 new Mediclinic shares were issued on 8 October 2012 at R28.63 per share, bringing the total number of issued shares to 826 957 325 ordinary shares.

The Company further successfully implemented a comprehensive refinancing of the Group's debt with new long-term, committed debt facilities across the Group's operating platforms.

The Company acquired the minority interest of 49.63% held in Emirates Healthcare to own 100% of Emirates Healthcare, the Group's operations in the UAE, with effect from 17 October 2012. Emirates Healthcare has subsequently rebranded to Mediclinic. The Group's operations in the UAE are therefore referred to in this report as Mediclinic Middle East.

EXTERNAL AUDIT AND ASSURANCE

The Group's consolidated annual financial statements as well as the abridged consolidated annual financial statements were audited by the Group's independent external auditors, PricewaterhouseCoopers Inc., in accordance with International Standards of Auditing. The report of the external auditors in respect of the abridged consolidated annual financial statements is included on page 120.

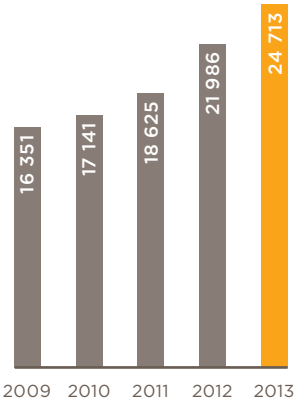
Various other voluntary external accreditation, certification and assurance initiatives are followed in the Group, complementing the Group's combined assurance model, as covered throughout the integrated annual report. We believe that this adds to the transparency and reliability of information reported to our stakeholders. Please refer to **Figure 3** of the abridged Sustainable Development Report for further details.

CONTACT US

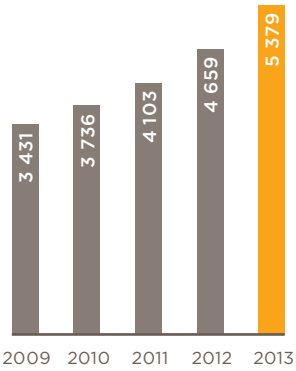
We welcome the opinions and suggestions of all our stakeholders. Please see the contact details included on pages 113 and 132.

PERFORMANCE HIGHLIGHTS

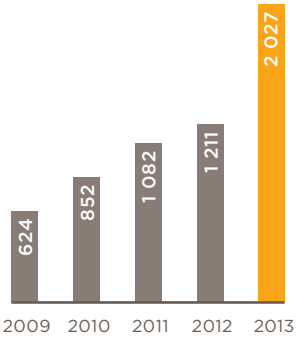
NORMALISED REVENUE (R'm)



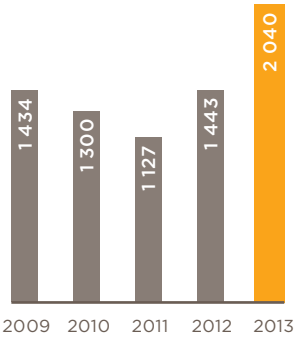
NORMALISED EBITDA (R'M)



NORMALISED HEADLINE EARNINGS (R'M)



CAPITALISED INVESTMENTS (PROJECTS AND EQUIPMENT) (R'M)



GROUP REFINANCING AND R5 BILLION RIGHTS OFFER SUCCESSFULLY CONCLUDED

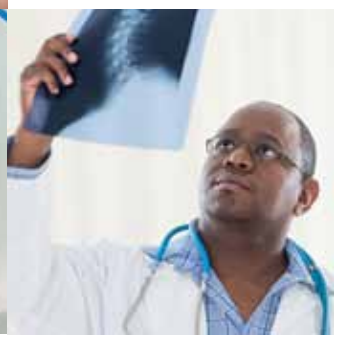
BASIC NORMALISED HEADLINE EARNINGS PER SHARE INCREASED BY **53%** TO **273.2** CENTS

BUY-OUT OF EMIRATES HEALTHCARE MINORITIES

NORMALISED GROUP EBITDA MARGIN INCREASED FROM **21.2%** TO **21.8%**

STRONG PERFORMANCE BY ALL THREE OPERATING PLATFORMS

TOTAL DIVIDEND PER ORDINARY SHARE INCREASED TO **85.8** CENTS
(2012: 78.0 CENTS)



PERFORMANCE HIGHLIGHTS continued

FINANCIAL		2013	2012	% change
Normalised revenue	R'm	**24 713**	21 986	12%
Normalised EBITDA	R'm	**5 379**	4 659	15%
Cash generated from operations	R'm	**5 577**	4 266	31%
Normalised headline earnings	R'm	**2 027**	1 211	67%
Total assets	R'm	**56 774**	50 195	13%
Shareholders' equity	R'm	**17 379**	10 116	72%
Return on shareholders' equity	%	**11.7%**	12.0%	(3%)
Normalised headline earnings per ordinary share – basic	cents	**273.2**	178.3	53%
Normalised headline earnings per ordinary share – diluted	cents	**265.7**	172.1	54%
Total distribution per ordinary shares	cents	**85.8**	78.0	10%
Net asset value per ordinary share	cents	**2 764.9**	1 609.4	72%
Adjusted net asset value per ordinary share*	cents	**2 863.4**	2 238.9	28%
Share performance:				
– Closing price at year end	cents	**6 420**	3 750	75%
– Market capitalisation	R'bn	**53.1**	24.5	117%
Capital expenditure on projects, new equipment and replacement of equipment	R'm	**2 040**	1 443	28%
– Southern Africa	R'm	**694**	523	17%
– Switzerland	R'm	**1 239**	869	37%
– United Arab Emirates	R'm	**107**	51	11%

* *The adjusted net asset value per ordinary share excludes the valuation of the derivative financial instruments and the Swiss pension liability.*

OPERATIONAL	2013	2012
Number of hospitals in operation	**68**	68
– Southern Africa	**52**	52
– Switzerland	**14**	14
– United Arab Emirates	**2**	2
Number of clinics in operation (UAE only)	**8**	8
Number of licensed/registered beds	**9 305**	9 191
– Southern Africa	**7 436**	7 378
– Switzerland	**1 487**	1 479
– United Arab Emirates	**382***	334
Number of licensed/registered theatres	**340**	340
– Southern Africa	**254**	254
– Switzerland	**76**	76
– United Arab Emirates	**10**	10

* *Includes 27 day beds available at Mediclinic Middle East's eight clinics.*

PERFORMANCE HIGHLIGHTS continued

SOCIAL		2013	2012
Number of employees*		**23 475**	21 981
– Southern Africa		**14 927**	13 846
– Switzerland		**6 508**	6 321
– United Arab Emirates		**2 040**	1 814
Staff turnover rate			
– Southern Africa		**9.8%**	10.6%
– Switzerland		**15.1%**	16.0%
– United Arab Emirates		**9.5%**	11.1%
Training spent as approximate % of payroll			
– Southern Africa		**4%**	4%
– Switzerland		**4.2%**	not measured
– United Arab Emirates		**0.3%**	0.3%
Spent on corporate social investment			
– Southern Africa**	R'm	**5.8**	5.0
– Switzerland	CHF'm	**1.7**	1.6
– United Arab Emirates	AED'm	**0.4**	0.4
BBBEE (South Africa only)			
– BBBEE scorecard contributor level		**4**	3
– % black employees		**64%**	63%
– % black management employees		**22%**	22%

* *See organisational chart on page 6.*

** *Excludes various donations at hospital level and significant donations to academic institutions (see Sustainable Development Report published on the Company's website).*

ENVIRONMENTAL		2013	2012
Ranking in Carbon Disclosure Project		**joint 4th**	43rd
Total carbon emissions (CO_2e)*	Tonnes		
– Southern Africa (as per CDP 2011 and CDP 2012)		**188 824**	186 437
– Switzerland (per 2010 and 2011 calendar years)		**9 879**	9 100
Total energy usage	Gigajoules	**908 952**	874 178
– Southern Africa		**624 948**	626 149
– Switzerland (per 2010 and 2011 calendar years)		**219 302**	195 000
– United Arab Emirates (hospitals only)		**64 702**	53 029

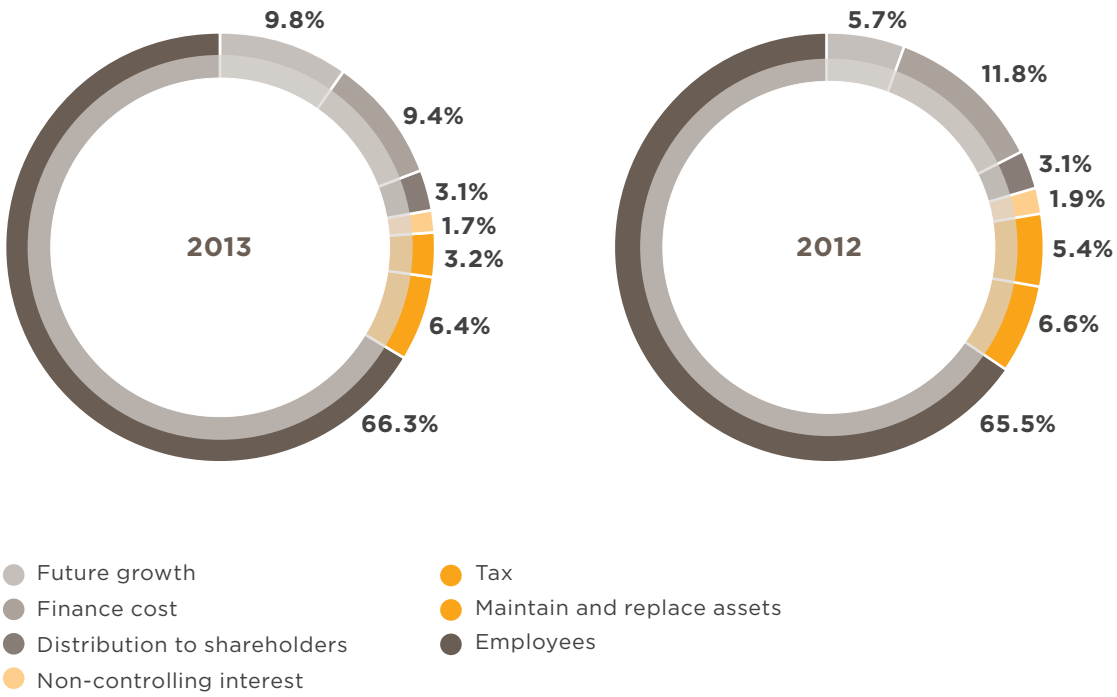
* *The carbon emissions by Mediclinic Southern Africa and Hirslanden are not directly comparable as they follow different management measures.*

OTHER	2013	2012
Inclusion in JSE SRI Index	**Yes**	Yes

VALUE ADDED STATEMENT

	2013 R'm	%	2012 R'm	%
VALUE CREATED				
Normalised revenue	**24 713**		21 986	
Cost of materials and services	**(9 149)**		(8 195)	
Finance income	**68**		85	
	15 632	**100.0**	13 876	100.0
DISTRIBUTION OF VALUE				
To employees as remuneration and other benefits	**10 369**	**66.3**	9 091	65.5
Tax and other state and local authority levies (excluding VAT)	**506**	**3.2**	749	5.4
To suppliers of capital				
– Non-controlling interests	**259**	**1.7**	263	1.9
– Finance cost on borrowed funds	**1 472**	**9.4**	1 642	11.8
– Distributions to shareholders	**488**	**3.1**	436	3.1
	13 094	**83.7**	12 181	87.7
VALUE RETAINED				
To maintain and replace assets	**999**	**6.4**	910	6.6
Income retained for future growth	**1 539**	**9.8**	785	5.7
	2 538	**16.2**	1 695	12.3

DISTRIBUTION OF VALUE



COMMITTED TO MANAGING OUR BUSINESS IN A SUSTAINABLE WAY, CREATING LONG-TERM SHAREHOLDER VALUE AND ENTRENCHING MEDICLINIC AS A LEADER IN THE GLOBAL HEALTHCARE INDUSTRY

MEDICLINIC INTERNATIONAL

COUNTRY OF OPERATION		
South Africa and Namibia	Switzerland	United Arab Emirates
BRAND OR TRADING NAME		
MEDICLINIC	HIRSLANDEN	ميديكلينيك MEDICLINIC
HOSPITALS AND CLINICS IN OPERATION		
Operates 49 private hospitals throughout South Africa and three in Namibia, with 7 436 beds in total.	Operates 14 private hospitals with 1 487 beds in Switzerland.	Operates two hospitals and eight clinics with 382 beds in Dubai in the United Arab Emirates.
NUMBER OF EMPLOYEES		
14 927 (18 594 full-time equivalents, which include agency staff)	6 508 (which include full-time and part-time permanent employees)	2 040
NATURE OF OWNERSHIP		
100% owned through wholly owned subsidiary (with some group companies partly owned and doctor shareholding in hospital investment companies).	100% owned through wholly owned subsidiaries.	100% owned through wholly owned subsidiaries.

WHO WE ARE

Mediclinic International, founded in 1983, is an international private hospital group with operations in South Africa, Namibia, Switzerland and the United Arab Emirates, and listed on the JSE, the South African securities exchange, since 1986. The Group's head office is based in Stellenbosch, South Africa.

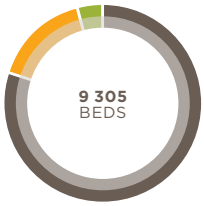
WHAT WE DO

We are a private hospital group focused on providing acute care, specialist-orientated, multidisciplinary hospital services and related service offerings. We place science at the heart of our care process by providing evidence-based care of the highest standard. Our patients receive controlled and customised treatment, orchestrated by a team of world-class specialists devoted to delivering the best possible clinical outcomes in multidisciplinary facilities that are of a world-class standard. Our core purpose is to enhance the quality of life of our patients by providing comprehensive, high-quality hospital services in such a way that the Group will be regarded as the most respected and trusted provider of hospital services by patients, doctors and funders of healthcare.

OUR VISION

To be respected internationally and preferred locally.

- SOUTHERN AFRICA **52** (76%)
- SWITZERLAND **14** (21%)
- UAE **2** (3%)



- SOUTHERN AFRICA **7 436** (80%)
- SWITZERLAND **1 487** (16%)
- UAE **382** (4%)

- SOUTHERN AFRICA **14 927** (63%)
- SWITZERLAND **6 508** (28%)
- UAE **2 040** (9%)

OUR BUSINESS MODEL

We offer multidisciplinary, specialist-orientated private healthcare facilities. We have built our reputation and our brand by our proven commitment to ensuring a high standard of discipline, independence, ethics, equity, social responsibility, accountability, cooperation and transparency.

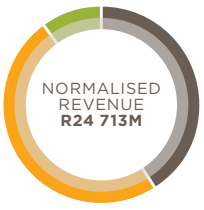
We assume accountability for clinical outcomes as far as possible. We acknowledge that our success will not come from growth in volumes, but from the improved value of our services and best possible clinical outcomes. That is why much focus is placed on our clinical governance framework (refer to the Clinical Services Report for more information) and patient satisfaction levels. Another vital element in our delivery of quality clinical outcomes is the quality of our nursing care. We therefore continue to invest in the training and development of our staff, offering competitive remuneration and generally looking after the well-being of our staff.

Our focus is on providing the best possible facilities, with technology of an international standard. We therefore continue to invest capital in our facilities for state-of-the-art equipment, expansions, upgrades and maintenance.

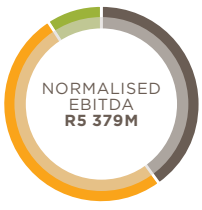
Our business model varies slightly in the three jurisdictions within which we operate. In Southern Africa our operations are supported by specialists who are not employed by the Group, but operate independently. This is a regulatory limitation in terms of the Health Professions Council of South Africa, which prohibits the employment of doctors by private hospitals, although permission has been obtained to appoint doctors in our emergency units. In Switzerland some of the supporting doctors are employed, whilst in Dubai the majority of the supporting doctors are employed.

We listen to our stakeholders. Building sound long-term business relationships is one of the foundations of the continued success of our business.

Our business model has resulted in consistent earnings growth, quality service delivery, manageable risks, and generally a business that sustains growth and value to all our stakeholders.

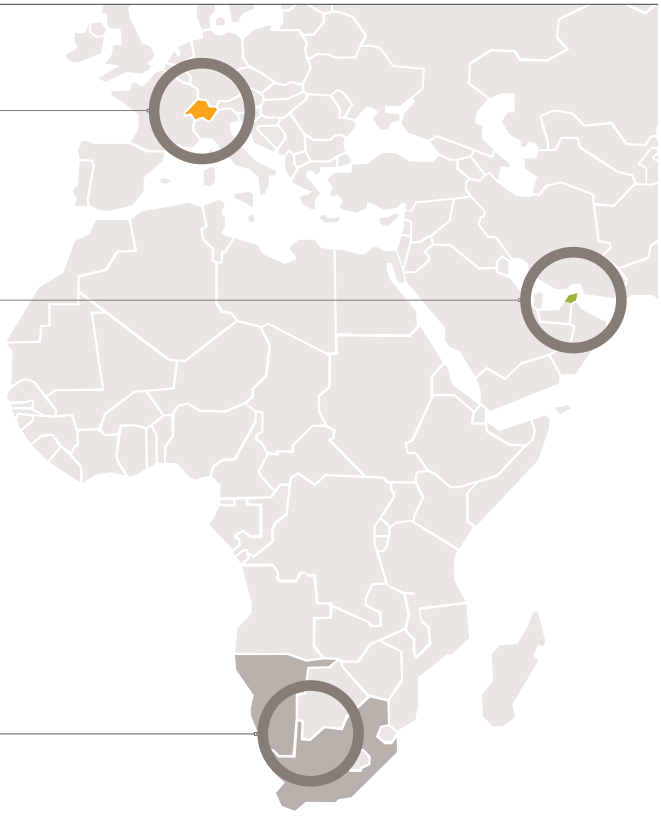


- SOUTHERN AFRICA **R10 185** (41%)
- SWITZERLAND **R12 043** (49%)
- UAE **R2 485m** (10%)



- SOUTHERN AFRICA **R2 169m** (40%)
- SWITZERLAND **R2 716m** (51%)
- UAE **R495m** (9%)

- SOUTHERN AFRICA **R906m** (45%)
- SWITZERLAND **R802m** (40%)
- UAE **R232m** (11%)
- CORPORATE **R87m** (4%)



SWITZERLAND

FIND OUT MORE ABOUT OUR SWISS OPERATIONS ON PAGE **42**

UNITED ARAB EMIRATES

FIND OUT MORE ABOUT OUR UAE OPERATIONS ON PAGE **48**

SOUTHERN AFRICA

FIND OUT MORE ABOUT OUR SOUTHERN AFRICAN OPERATIONS ON PAGE **36**

NUMBER OF EMPLOYEES	NUMBER OF HOSPITALS	NUMBER OF BEDS
23 475	**68**	**9 305**

HOW WE GOVERN OUR BUSINESS

Our governance structures are focused on maintaining and building a sustainable business and support our commitment to being a responsible corporate citizen in every country and community in which the Group does business. The key elements of our governance structures include:

- ensuring good clinical outcomes and quality healthcare (see the Clinical Services Report for more information);
- maintaining strict principles of corporate governance, integrity and ethics (see the Corporate Governance Report for more information);
- effective risk management and internal controls (see the Risk Management Report for more information);
- engaging with our stakeholders and responding to their legitimate expectations (see the stakeholder engagement section in the detailed Sustainable Development Report published on our website);
- managing our business in a sustainable manner (see the abridged Sustainable Development Report for more information); and
- offering our employees competitive remuneration packages based on the principles of fairness and affordability (see the Remuneration Report for more information).

BOARD OF DIRECTORS

NON-EXECUTIVE CHAIRMAN

E de la H (Edwin) Hertzog
(63)

M.B.Ch.B., M.Med., F.F.A. (SA)

Appointed in 1983 as Managing Director, in 1990 as executive Vice-chairman and in 1992 as executive Chairman of the Company. Retired in August 2012 from his executive role, but remained on the Board as non-executive Chairman. Other directorships include Distell, Remgro and Total (SA).

EXECUTIVE DIRECTORS >

DP (Danie) Meintjes
(56)

Chief Executive Officer
B.Pl. (Hons)

Joined the Group in 1985 and appointed in 1996 as a director of the Company. Seconded to Dubai in 2006 and appointed as the Chief Executive Officer of Emirates Healthcare in 2007. Appointed as the Company's Chief Executive Officer since April 2010.

CI (Craig) Tingle
(54)

Chief Financial Officer
B.Sc. (For), B.Compt. (Hons), CA(SA)

Appointed in 1992 as the Financial Director of the Company. After his resignation as the Financial Director in 1999, he stayed on as a non-executive director until 2005 when he was appointed as the Chief Financial Officer of the Company's operations in Dubai. Appointed as the Company's Chief Financial Officer since September 2010.

CA (Ronnie) van der Merwe
(50)

Chief Clinical Officer
M.B.Ch.B., D.A. (SA), F.C.A. (SA)

Joined the Group in 1999 as head of the Clinical Information Department. Currently the Chief Clinical Officer of the Company. Appointed as an executive director of the Company in 2010.

INDEPENDENT NON-EXECUTIVE DIRECTORS CONTINUED

RE (Robert) Leu
(66) *(Swiss)*

Master in Economics, Ph.D., Professor in Economics

Executive director of the Department of Economics at the University of Bern in Switzerland. Appointed as an independent non-executive director of the Company in 2010.

N (Nandi) Mandela
(44)

B.Soc.Sc., Associate in Management (AIM)

Director of Linda Masinga & Associates, a town planning and consultancy firm. She is also the founder and director of New Ground Investments (Pty) Ltd and Natholigugu Investments (Pty) Ltd. Appointed as an independent non-executive director with effect from 13 September 2012.

TD (Trevor) Petersen
(57)

B.Comm (Hons), CA(SA)

Former managing partner of the Cape Town office of PricewaterhouseCoopers Inc. and former chairman of PwC Western Cape and the South African Institute of Chartered Accountants. He currently serves on the University of Cape Town Council and is also a director of Petmin Limited. Appointed as a non-executive director with effect from 13 September 2012.

AA (Anton) Raath
(57)

B.Comm., CA(SA)

Chief Executive Officer of Glacier, a subsidiary of Sanlam. Appointed as a director of the Company in 1996.

OUR FOCUS IS ON PROVIDING THE BEST POSSIBLE FACILITIES, WITH TECHNOLOGY OF AN INTERNATIONAL STANDARD

EXECUTIVE DIRECTORS CONTINUED

KHS (Koert) Pretorius
(50)

Chief Executive Officer: Mediclinic Southern Africa
B.Compt., MBL

Joined the Group in 1998 and appointed as a director of the Company in 2006. Appointed as the Chief Executive Officer of Mediclinic Southern Africa in 2008.

TO (Ole) Wiesinger
(50) *(German)*

Chief Executive Officer: Hirslanden
Ph.D., Postgraduate Studies in Health Economics

Joined the Hirslanden group in 2004. Appointed as the Chief Executive Officer of Hirslanden and a director of the Company in 2008.

INDEPENDENT NON-EXECUTIVE DIRECTORS >

DK (Desmond) Smith
(65)

Lead Independent Director
B.Sc., FASSA

Chairman of the Reinsurance Group of America (RGA) and Sanlam. Appointed in 2008 as a director of the Company. Also appointed as the Lead Independent Director of the Company in 2010.

JA (Alan) Grieve
(60) *(Scottish)*

B.A. (Hons), CA

Director of Corporate Affairs of Richemont, as well as the Chief Executive Officer of Reinet Investments Manager SA and Reinet Fund Manager SA. Appointed as an independent non-executive director with effect from 13 September 2012.

NON-EXECUTIVE DIRECTORS*

JJ (Jannie) Durand
(46)

B.Acc. (Hons), M.Phil. (Management Studies), CA(SA)

Chief Executive Officer of Remgro. Appointed as a director of the Company in June 2012. Other directorships include Capevin Holdings, Discovery Holdings, Grindrod, Invenfin, Kagiso Tiso Holdings, Rainbow Chicken and Sabido Investments.

MK (Kabs) Makaba
(59)

M.B.Ch.B., Intermediate Diploma in Personnel Management and Training, Certificate in Small Business Management

Chief Executive Officer of Faranani Health Solutions and director of Phodiso Holdings and Ubelele Holdings. Appointed as a director of the Company in 2008.

PJ (Pieter) Uys
(50)

B.Sc. (Eng), M.Sc. (Eng), MBA

Investment Manager at Remgro and previous CEO of Vodacom. Appointed as a director of the Company with effect from 1 April 2013.

COMPANY SECRETARY

GC (Gert) Hattingh
(48)

B.Acc. (Hons), CA(SA)

Joined Mediclinic in 1991 as group accountant. Various managerial positions held throughout the Mediclinic Group. Appointed as Company Secretary since 2000 and Group Services Executive since 2011.

* *Please refer to the explanation why these directors are not regarded as independent on page 87 (Figure 1) of the Corporate Governance Report.*

OUR VISION

TO BE RESPECTED INTERNATIONALLY AND PREFERRED LOCALLY

WE WILL BE RESPECTED INTERNATIONALLY FOR:

- Delivering measurable quality clinical outcomes
- Continuing to grow as a successful international healthcare group
- Enforcing good corporate governance
- Acting as a responsible corporate citizen

WE WILL BE PREFERRED LOCALLY FOR:

- Delivering excellent patient care
- Ensuring aligned relationships with doctor communities
- Being an employer of choice, appointing and retaining competent staff
- Building constructive relationships with all stakeholders
- Being a valued member of the community

Our relentless focus on patient needs will create long-term shareholder value and establish Mediclinic International as a leader in the global healthcare industry.

EXPERTISE YOU CAN TRUST.

OUR VALUES

THE MEDICLINIC GROUP AND ITS EMPLOYEES SUPPORT THE FOLLOWING CORE VALUES:

CLIENT ORIENTATION

In our behaviour we:

- reflect the image of the Company
- deliver the right service in the right place at the right time
- regard everyone who is dependent on our outputs as our client
- determine and meet the expectations of our clients
- measure our clients' satisfaction regularly
- respect our clients' right to confidentiality
- personally accept responsibility for client service

TEAM APPROACH

In our behaviour we:

- promote positive team behaviour
- ensure the participation of all role players in problem solving
- set common goals
- exhibit responsible, fair, honest and effective leadership and followership

MUTUAL TRUST AND RESPECT

In our behaviour we:

- share information to the benefit of the Company
- listen with empathy
- communicate openly and honestly
- exhibit respect for the individual and his or her dignity
- respect personal and company property
- solve problems on a win-win basis
- greet and acknowledge one another
- maintain an ethical standard

PERFORMANCE DRIVEN

In our behaviour we:

- set objectives and give regular performance feedback
- ensure that each individual knows what the standards are and what is expected
- give recognition to whom it is due
- offer each employee the opportunity to develop to his or her full potential
- eliminate activities that do not add value
- promote continuous improvement in productivity
- base all appointments and promotions on competence and performance
- accept mentorship as a management task

WE CONTINUE TO GROW THE BUSINESS WITH STRONG OPERATIONAL GROWTH

CREATING SHAREHOLDER VALUE

- We will continue to optimise operations by growing the business of our existing hospitals and extracting efficiencies in key business processes.
- We will continue to invest in incremental growth opportunities based on sound investment principles and to demonstrate efficiency and diligence in the planning and execution of such opportunities.

BUILDING A CULTURE THAT PROVIDES GROWTH AND DEVELOPMENT OPPORTUNITIES FOR STAFF AND ENCOURAGES TEAM WORK

- We will continue to maintain a corporate culture that provides a good working environment, training and skills development that assist to attract and retain a talented workforce.
- We will continue to aim to be the employer of choice, recognising that market competition for talent is increasing.

STRATEGIC DOCTOR ALIGNMENT

- We will continue to focus on improving our partnership relationship with our doctor community with a vision to ensure an aligned delivery process within private healthcare in the best interest of our patients.

DEVELOPING AN INTERNATIONAL HOSPITAL GROUP

- We will continue to develop core competencies across the various platforms to ensure that international healthcare best practice is followed.
- We will continue to develop in-house skills that drive cost savings and synergies across existing and future platforms.
- We will position ourselves as a leading international hospital group.

MANAGING RISK AND REGULATORY CHANGE PROACTIVELY

- We will continue to meticulously manage our risks supported by our enterprise-wide risk management processes.
- We will continue to focus on proactive health policy research and active engagement to influence regulatory and legislative bodies.

LEADING AS A RESPONSIBLE CORPORATE CITIZEN

- We will continue to manage our business in a sustainable manner, upholding the highest ethical and professional standards, with continuous engagement with our stakeholders.
- We maintain focused on managing our social and environmental impacts, in particular with regard to the quality and safety of our patient care; addressing the shortage of nurses and general skills shortage; BBBEE of our South African operations; our corporate social investment and community involvement and the effective management of our environmental impacts in order to monitor and minimise the Group's impacts.

CONTINUOUSLY IMPROVING QUALITY CARE

- We will continue to strive to be trusted and respected by patients, doctors and nurses.
- We will continue to focus on firmly embedding our clinical quality processes that ensure patient safety.
- We will continue to benchmark our clinical outcome statistics and to incrementally reduce adverse events.
- We will continue to meet the independent accreditation standards of our hospitals.
- We will continue with initiatives to improve our independently monitored patient satisfaction levels.

INVESTMENT CASE

DEFENSIVE LONG-TERM INDUSTRY

- The healthcare sector provides a strongly defensive investment as demand is relatively unaffected by economic cycles.
- The demand for private healthcare is likely to continue to grow due to population growth, ageing population, consumerism, technological advancement and the burden of disease.

PURE HOSPITAL AND RELATED HEALTHCARE SERVICES PLAYER

- Mediclinic is a long-term investor in and manager of acute care, specialist-orientated, multidisciplinary hospitals.
- Mediclinic has an extensive property portfolio in prime real estate areas that provides valuable operational flexibility and a strong asset underpin to its business.

QUALITY CARE

- Mediclinic's sustainable competitive advantage lies in the continuous focus on patient safety, excellence in clinical governance and delivering measurable, cost-effective quality care.

STRONG TRACK RECORD

- Mediclinic has consistently delivered stable and strong operational growth for more than two decades.
- Mediclinic has a track record of investing in satisfactory return projects and has demonstrated the ability to integrate and extract value from acquisitions.
- Mediclinic is led by an experienced and proven management team with an average tenure of 20 years at corporate level.
- Remgro, Mediclinic's largest shareholder, maintained a long-term commitment over Mediclinic's entire history.

OPERATIONAL EFFICIENCY

- Mediclinic has consistently expanded or maintained its operating margin through its focus on cost-effective quality care.
- Mediclinic has always sustained the high quality and highly cash generative nature of its earnings.
- Mediclinic constantly pursues the implementation of best practice to enhance the overall performance of the group.
- Mediclinic has a proven record of growing revenue and maintaining margins despite historical changes in healthcare regulations.

SUSTAINABILITY

- Mediclinic is committed to managing its business in a sustainable way, upholding the highest standard of ethics and corporate governance practices. Through our business integrity, we maintain and improve the confidence, trust and respect of our stakeholders.
- Mediclinic values its employees by following fair labour practices, offering competitive remuneration and investing in the training and development of its employees; it respects the communities within which the Group operates and contributes to the well-being of society; and it manages the Group's impacts on the environment.

INTERNATIONAL PRESENCE

- Mediclinic is well positioned as a trusted provider of hospital services in the developing and developed markets in which it operates (Southern Africa, Europe and the United Arab Emirates).
- Mediclinic has a leading position in all the markets in which it operates.
- Mediclinic's presence in diverse geographies mitigates country-specific risk.

SEVEN-YEAR REVIEW

	CAGR[#]	2013 IFRS R'm	2012 IFRS R'm	2011 IFRS R'm	2010 IFRS R'm	2009 IFRS R'm	2008 IFRS R'm	2007 IFRS R'm
INCOME STATEMENTS								
Revenue	28.9%	**24 562**	21 986	18 625	17 141	16 351	9 579	5 364
Normalised EBITDA	29.3%	**5 379**	4 659	4 103	3 736	3 431	2 062	1 152
Past service cost		**35**	14	33	97	–	–	–
Pre-acquisition tariff provision (2012: Impairment charges 2011: includes related insurance proceeds)		**(151)**	(4)	50	–	–	–	–
EBITDA		**5 263**	4 669	4 186	3 833	3 431	2 062	1 152
Depreciation		**(980)**	(890)	(726)	(705)	(672)	(336)	(146)
Amortisation/impairment of goodwill		**(19)**	(20)	(12)	(13)	(12)	(5)	–
Operating profit	27.2%	**4 264**	3 759	3 448	3 115	2 747	1 721	1 006
Other gains and losses		**531**	(26)	13	28	–	–	–
Income from associates		**2**	1	4	7	2	–	1
Finance income		**68**	85	61	41	67	49	44
Finance cost		**(5 166)**	(1 642)	(1 491)	(1 524)	(1 602)	(685)	(88)
Finance cost excluding one-off charges		**(1 472)**	(1 642)	(1 491)	(1 524)	(1 602)	(685)	(88)
Derecognition of Swiss interest rate swap		**(3 531)**	–	–	–	–	–	–
Accelerated recognition of capitalised financing fees		**(163)**	–	–	–	–	–	–
(Loss)/profit before tax		**(301)**	2 177	2 035	1 667	1 214	1 085	963
Income tax expense		**(442)**	(693)	(654)	(481)	(502)	(364)	(270)
(Loss)/profit for the year		**(743)**	1 484	1 381	1 186	712	721	693
Attributable to:								
Equity holders of the Company		**(1 002)**	1 221	1 177	1 058	636	610	582
Non-controlling interests		**259**	263	204	128	76	111	111
		(743)	1 484	1 381	1 186	712	721	693
Headline (loss)/earnings		**(1 007)**	1 222	1 110	1 028	624	608	581
Normalised headline earnings	23.2%	**2 027**	1 211	1 082	852	624	608	581
STATEMENTS OF FINANCIAL POSITION								
ASSETS								
Property, equipment and vehicles		**40 233**	34 808	30 409	28 046	32 479	30 972	3 124
Intangible assets		**7 279**	6 350	5 565	5 243	6 293	6 101	419
Other investments and loans		**19**	663	712	26	32	34	46
Deferred income tax assets		**244**	212	210	220	178	123	120
Derivative financial instruments		**100**	–	33	–	–	43	–
Current assets		**8 899**	8 162	6 608	4 829	4 892	4 326	1 780
Total assets		**56 774**	50 195	43 537	38 364	43 874	41 599	5 489
EQUITY								
Equity attributable to owners of parent		**17 379**	10 116	9 489	6 650	7 091	8 560	2 068
Non-controlling interests		**796**	1 288	1 071	966	898	807	752
LIABILITIES								
Long-term interest-bearing borrowings		**25 359**	22 864	20 414	20 667	24 349	23 266	996
Deferred income tax liability		**6 227**	5 303	4 773	4 399	5 162	5 088	5
Retirement benefit obligations		**501**	823	383	346	997	639	129
Derivative financial instruments		**85**	3 739	2 170	2 331	2 512	595	–
Provisions		**687**	361	271	185	229	190	–
Current liabilities		**5 740**	5 701	4 966	2 820	2 636	2 454	1 539
Total equity and liabilities		**56 774**	50 195	43 537	38 364	43 874	41 599	5 489
STATEMENTS OF CASH FLOWS								
Cash generated from operating activities	29.4%	**5 577**	4 266	4 179	3 800	3 346	1 517	1 187
Net finance income/(cost)		**(1 509)**	(1 525)	(1 368)	(1 396)	(1 438)	(419)	(44)
Tax paid		**(514)**	(525)	(495)	(444)	(522)	(360)	(306)
Cash flow from operating activities		**3 554**	2 216	2 316	1 960	1 386	738	837
Cash flow from investment activities		**(537)**	(1 055)	(2 563)	(1 271)	(1 380)	(16 898)	(672)
Cash flow from financing activities		**(2 839)**	(735)	688	(542)	125	16 461	43
Cash distributions to minorities		**(206)**	(111)	(59)	(55)	(54)	(41)	(40)
Distributions to shareholders		**(488)**	(436)	(398)	(374)	(339)	(189)	(178)
Proceeds from issuance of ordinary shares		**4 896**	–	1 331	–	–	4 472	–
Movement in borrowings		**(2 945)**	(214)	(208)	(155)	547	12 219	248
Refinancing transaction costs		**(615)**	–	–	–	–	–	–
Settlement of interest rate swap		**(1 633)**	–	–	–	–	–	–
Acquisition of non-controlling interest		**(1 971)**	–	–	–	–	–	–
Other		**123**	26	22	42	(29)	–	13
Net movement in cash and bank overdrafts		**178**	426	441	147	131	301	208
Opening balance of cash and bank overdrafts		**1 981**	1 447	967	941	787	357	149
Exchange rate fluctuations on foreign cash		**541**	108	39	(121)	23	129	–
Closing balance of cash and bank overdrafts		**2 700**	1 981	1 447	967	941	787	357

[#] *Compounded Annual Growth Rate*

SEVEN-YEAR REVIEW continued

	CAGR#	2013	2012	2011	2010	2009	2008	2007
STATISTICS AND PERFORMANCE PER PLATFORM								
Mediclinic Southern Africa								
Number of hospitals		**52**	52	52	52	51	51	50
Licensed beds		**7 436**	7 378	7 103	7 035	6 855	6 776	6 845
Licensed theatres		**254**	254	253	252	248	248	243
Normalised revenue (R'm)	11.3%	**10 185**	9 423	8 632	7 680	6 792	6 056	5 364
Normalised EBITDA (R'm)	11.1%	**2 169**	1 957	1 837	1 651	1 458	1 302	1 152
Normalised EBIT (R'm)	11.1%	**1 887**	1 701	1 608	1 445	1 281	1 143	1 006
Normalised EBITDA margin (%)		**21.3%**	20.8%	21.3%	21.5%	21.5%	21.5%	21.5%
Hirslanden								
Number of hospitals		**14**	14	14	13	13	13	
Licensed beds		**1 487**	1 479	1 457	1 365	1 334	1 301	
Licensed theatres		**76**	76	76	71	71	64	
Normalised revenue (R'm)	14.3%	**12 043**	10 732	8 659	8 335	8 737	6 185*	
Normalised EBITDA (R'm)	14.6%	**2 716**	2 350	2 026	1 953	1 961	1 373*	
Normalised EBIT (R'm)	15.1%	**2 112**	1 794	1 593	1 516	1 507	1 046*	
Normalised EBITDA (CHF'm)	6.2%	**300**	278	285	266	245	222	
Normalised EBIT (CHF'm)	6.6%	**233**	212	224	206	188	169	
Normalised EBITDA margin (%)		**22.6%**	21.9%	23.4%	23.4%	22.5%	22.2%*	
Mediclinic Middle East								
Number of hospitals		**2**	2	2	2	2	1	
Licensed beds		**382**	334	336	336	321	120	
Licensed theatres		**10**	10	10	10	10	4	
Normalised revenue (R'm)	38.8%	**2 485**	1 831	1 334	1 126	822	482	
Normalised EBITDA (R'm)	58.2%	**495**	352	240	132	(7)	50	
Normalised EBIT (R'm)	77.0%	**382**	254	164	57	(60)	22	
Normalised EBITDA (AED'm)	52.4%	**214**	174	122	62	(3)	26	
Normalised EBIT (AED'm)	71.9%	**165**	125	84	27	(25)	11	
Normalised EBITDA margin (%)		**19.9%**	19.2%	18.0%	11.8%	(0.9%)	10.3%	
Share ratios								
Headline earnings per ordinary share (cents)								
Basic		**(135.6)**	179.9	184.2	180.8	111.5	144.5	162.2
Diluted		**(131.9)**	173.7	176.3	171.7	105.6	133.6	147.2
Normalised headline earnings per ordinary share (cents)								
Basic	9.1%	**273.2**	178.3	179.6	149.9	111.5	144.5	162.2
Diluted	10.3%	**265.7**	172.1	171.9	142.4	105.6	133.6	147.2
Distribution per ordinary share (cents)	8.0%	**85.8**	78.0	73.0	73.0	68.6	61.2	54.1
Net asset value per ordinary share (cents)	29.9%	**2 764.9**	1 609.4	1 516.7	1 181.4	1 265.5	1 527.5	575.5
Adjusted net asset value per ordinary share (cents)**	30.7%	**2 863.4**	2 238.9	1 903.1	1 639.4	1 752.2	1 657.6	575.5
JSE								
Market capitalisation (R'bn)		**53.1**	24.5	18.9	16.0	12.7	11.7	9.9
Price (cents per share)								
31 March		**6 420**	3 750	2 900	2 700	2 150	1 970	2 510
Highest		**6 548**	4 199	3 150	2 765	2 575	2 695	2 860
Lowest		**3 601**	2 810	2 325	1 865	1 535	1 811	1 740
Number of shares traded (000)		**125 013**	118 734	98 979	101 801	116 798	131 057	78 700
Price-earnings ratio		**(47.3)**	19.2	15.7	14.7	19.3	13.6	15.5
Normalised price-earnings ratio		**23.5**	19.4	16.1	17.8	19.3	13.6	15.5
Number of shares								
Ordinary shares issued (000)		**826 957**	652 315	652 315	593 014	593 014	394 338	394 338
Weighted average for basic earning per share (000)		**741 858**	679 152	602 467	568 721	559 336	421 437	357 606
Weighted average for diluted earnings per share (000)		**762 862**	703 651	629 488	598 656	590 999	455 748	394 107
Exchange rates								
Average rate (Swiss franc)	R/CHF	**9.05**	8.45	7.11	7.35	8.01	6.18*	
Closing rate (Swiss franc)	R/CHF	**9.69**	8.50	7.42	6.93	8.32	8.14	
Average rate (UAE dirham)	R/AED	**2.32**	2.03	1.96	2.13	2.41	1.94	
Closing rate (UAE dirham)	R/AED	**2.52**	2.09	1.85	2.00	2.58	2.20	

* *The Group consolidated Hirslanden's results from the effective date of its acquisition, 26 October 2007. The figures are provided for a full year for comparative purposes.*

** *The adjusted net asset value per ordinary share excludes the valuation of the derivative financial instruments and the Swiss pension liability.*

Edwin Hertzog
Chairman

SUCCESSFUL IN UTILISING ATTRACTIVE GROWTH OPPORTUNITIES IN SOUTHERN AFRICA, SWITZERLAND AND THE UAE

GROUP PERFORMANCE

As chairman of Mediclinic International it is indeed my privilege to oversee a leading international healthcare company that has grown from infancy in 1983 to the Group we know today with 68 hospitals and 8 clinics, employing over 23 000 staff members across Southern Africa, Switzerland and the United Arab Emirates.

We have seen the Company's market capitalisation increase from R170 million at listing on the JSE Limited in 1986 to R53 billion at year end. During this time our Group revenue has increased from R100 million for the year ended 31 March 1987 to R24 562 million for the year under review, equating to a compounded annual growth rate (CAGR) of 23.6% since 1987. Similarly, our normalised earnings before interest, tax, depreciation and amortisation (EBITDA) delivered a CAGR of 29.3% and normalised headline earnings delivered a CAGR of over 128% since 1987. This compares favourably to the performance of the FTSE JSE Top 40 Index, of which we are a constituent today.

As we continue our pattern of consistent growth we remain firmly committed to our vision to be respected internationally and preferred locally. Our relentless focus on patient needs should continue to create long-term shareholder value and entrench Mediclinic International as a leader in the global healthcare industry.

After a 30-year stint of serving originally as the CEO of the Group and then as its executive chairman, I reached the retirement age of 63 years and became the Group's non-executive chairman at the end of August 2012. The continued management of the Group is unaffected by my change in role.

PROSPECTS

Healthcare is globally a growth industry based on supportive factors such as the ageing population, better diagnostic methods, improved clinical outcomes, new technologies and better informed patients. Our Group has been successful in utilising attractive growth and development opportunities within this industry in Southern Africa, Switzerland and Dubai.

However, the affordability of healthcare remains a universal challenge and health authorities tend to control and regulate the private sector to try and address greater accessibility. Although the healthcare delivered by public sector providers is often more expensive, this is seldom acknowledged and it remains the private providers that come under frequent attack. This is most likely due to the fact that a great amount of costs in the public sector are hidden from public scrutiny. Furthermore, on the income side, the public health authorities often ignore the substantial amount of taxation paid by private healthcare providers to, *inter alia*, support the public health facilities.

In Switzerland the Group still has to deal with many regulatory uncertainties such as the exact tariffs for hospitals in certain cantons as well as the patient case loads that will be allowed for specific hospitals.

In South Africa the Competition Commission is set to initiate an inquiry into the private healthcare sector within the year. Mediclinic is engaging with the Commission's representatives and has discussed the draft Terms of Reference as well as the envisaged process with them. The inquiry should be finalised by December 2014.

Fortunately Southern Africa, Switzerland and the United Arab Emirates have proved to be more stable and progressive than many other countries and territories. Furthermore, within these three geographic platforms, the Group's management teams have proved themselves to be competent and adaptable. The facilities of the Group are also well established and attractive expansion opportunities remain available.

We therefore have good reason to believe that the Group will continue with its consistent growth pattern.

DIRECTORATE MATTERS

During the period under review, the following changes to the Board were approved, as previously announced.

Following the tragic passing away of Mr Thys Visser on 26 April 2012, Mr Jannie Durand, Chief Executive Officer of Remgro, was appointed as a non-executive director of the Company with effect from 7 June 2012. Remgro owns 43.4% of Mediclinic's issued shares through a wholly owned subsidiary.

Mr Joseph Cohen, Ms Zodwa Manase, Dr Mamphela Ramphele and Prof Wynand van der Merwe retired as directors of the Company at the annual general meeting on 26 July 2012. Mr Chris van den Heever also resigned as a director on 1 February 2013. The Board is thankful to them for the significant contribution they have made over a long period to the Group.

As referred to above, I have retired from my executive role with effect from 31 August 2012, but remain on the Board as non-executive chairman.

Mr Alan Grieve, Ms Nandi Mandela and Mr Trevor Petersen were appointed as independent non-executive directors of the Company with effect from 13 September 2012. Subsequent to year end, Mr Pieter Uys, Investment Manager at Remgro, was appointed as a non-executive director of the Company with effect from 1 April 2013.

APPRECIATION

My sincere thanks to every person in the Mediclinic team who has contributed to the ongoing success of the Group during the last year. They include our directors, management, doctors, nurses and other hospital as well as office staff.

The support of patients who preferred our services is much appreciated, while I would also like to thank our shareholders for the confidence bestowed in us.

Edwin Hertzog
Non-executive Chairman

Danie Meintjes
Chief Executive Officer

SIGNIFICANT INVESTMENTS WERE MADE TO GROW CAPACITY AT EACH OPERATING PLATFORM

We are delighted to report that our operations delivered thoroughly satisfactory performances across our business operations in Southern Africa, Switzerland and the United Arab Emirates (UAE). The Group financial results were also strong and supported by the successful elective refinancing of the Group's debt, the R5 billion rights offer concluded in October 2012 and the subsequent buy-out of minority interests in Emirates Healthcare (hereinafter referred to as Mediclinic Middle East).

BUSINESS ENVIRONMENT

REGULATORY ENVIRONMENT

Rising healthcare costs and the concomitant affordability of healthcare remain a global concern in both the public and private healthcare sectors. Cost drivers include ageing populations, new technology, consumerism and the increasing prevalence of certain complex diseases. The healthcare sector therefore remains a particular focus area for governments, with different countries employing different views and approaches on regulations and other means of reform. Mediclinic recognises that affordability should remain a key focus area as we continuously strive to become more cost-efficient without compromising patient safety.

In Switzerland, significant regulatory changes introduced by the revised Swiss Health Insurance Act were implemented with effect from 1 January 2012. Although a number of uncertainties remain, Hirslanden succeeded in meeting the associated challenges and embedding the required changes.

The South African government maintains its commitment to implement the National Health Insurance system at an uncertain future date. The Competition Commission is set to initiate an inquiry into the private healthcare sector within the 2013 calendar year.

In the UAE, specifically in Dubai, regulatory changes have been less prominent, although regulatory developments, specifically relating to healthcare funding, are expected in the next few years.

Further information on the regulatory changes and capital investments is reported in the Operational Reviews of each of the operating platforms.

ECONOMIC ENVIRONMENT

According to the United Nations' "World Economic Situation and Prospects 2013" the global economy is still struggling to recover after the global financial crisis, and global economic growth has weakened further during 2012. Weakness in major developed economies continued, with several European countries being in recession and a notable weakening of the economy of the United States during 2012. The economies in developing Asia have also weakened as China and India's economies slowed down.

The Group's three operating platforms in Southern Africa, Switzerland and the UAE, each with different economic interdependencies on countries and regions in the world, represent a well-diversified investment portfolio with a vibrant mix of developing to developed economies. South Africa's economic performance has decelerated in recent years but remains positive, the Swiss economy is remarkably stable and the UAE is growing fairly strongly.

The rand depreciated from R7.66 to R9.23 against the US dollar, against which the UAE dirham is pegged, and from R8.50 to R9.69 against the Swiss franc during the year under review. The South African Reserve Bank's Monetary Policy Committee expects the rand to remain sensitive to both domestic and global developments and the exchange rate to remain volatile. Most analysts expect the rand to appreciate during the year, although the degree of dispersion is indicative of uncertainty.

As in the past, the Group continued its participation in numerous relevant discussion and lobbying activities and remains confident about the business environment in all three operational platforms. This is confirmed by the significant capital expenditure investments made during the year under review and planned for the next financial year, as discussed in more detail in the Operational Reviews.

STRATEGIC PRIORITIES

The following specific strategic objectives were set for the Group for the year under review:

- developing a refinancing plan with an implementation schedule ("refinancing");
- refocusing on meeting patient needs;
- delivering measurable quality clinical outcomes;
- maintaining financial performance; and
- continuing to grow as a successful international healthcare Group.

We are pleased to report the following progress against each of these strategic objectives.

BUY-OUT OF MINORITY INTEREST IN EMIRATES HEALTHCARE SUCCESSFULLY CONCLUDED DURING THE YEAR

PERFORMANCE AGAINST OBJECTIVES

REFINANCING

A key objective for the year was the completion of the elective refinancing of the Group's Swiss and South African debt.

Although the refinancing only needed to be concluded by October 2014, there were a number of compelling reasons to be proactive and conclude this earlier. Firstly, a substantial portion of the Swiss debt could be refinanced at attractive rates with substantial interest savings while also allowing for debt facilities for continued capital investments. Secondly, the South African debt and equity markets were strong and allowed for a substantial successful capital raise and the refinancing of the South African debt at attractive interest rates, also allowing for debt facilities for Southern African growth. Thirdly, the opportunity to invest further in the Middle East had arisen and needed to be coordinated with the South African fund raising and Middle East refinancing.

All these activities were successfully concluded during October 2012. Further information is reported in the Chief Financial Officer's Report.

REFOCUSING ON PATIENT NEEDS

Meeting patient needs is a principal priority for the Group and it is gratifying to report that the three operating platforms performed very well in this regard, with the following patient satisfaction indices achieved:

Mediclinic Southern Africa:	76% (2012: 76%)
Hirslanden (Switzerland):	87% (2012: 93%)
Mediclinic Middle East:	93% (2012: 89%)

(Note: The measurement methodologies differ between operational platforms and are not directly comparable. The Swiss measurement methodology also differs from the prior year and is thus not comparable.)

Accurate and comparable patient satisfaction data is important for benchmarking purposes. For this reason we are in the process of finalising a proposal to use a single independent specialist provider to measure patient satisfaction for all three operating platforms that will also give us the ability to benchmark results with international industry norms in the future.

Mediclinic Southern Africa formally established a focused programme to improve the overall patient experience in our hospitals. The Patient Journey Project involves a multidisciplinary team, under the leadership of a dedicated manager and will focus on the following three areas:

- leadership development and the entrenchment of a values-driven organisation as a basis to drive the patient experience;
- skills development for all frontline staff to help create an empathetic rapport with our patients; and
- an in-depth streamlining of multiple organisational processes to focus on the patient perspective.

DELIVERING MEASURABLE QUALITY CLINICAL OUTCOMES

Patient safety is non-negotiable and is the responsibility of top management who needs to ensure that the necessary structures, processes and standards are in place to ensure a safe clinical environment at each of our hospitals. We aim to ensure that the responsibilities for patient safety are clearly defined, that the organisational culture supports patient safety and that there are clear patient safety objectives. A Chief Clinical Officer and a multidisciplinary clinical governance committee support the executive committees of the respective platforms in order to fulfil their duties.

Despite the complexities and challenges related to the measurement of clinical outcomes, our Group embarked on a journey to implement structures and processes to measure and compare key clinical indicators at all three operating platforms. We are very pleased to report that we have made good progress in this regard, with noticeable improvements on most of the clinical indices.

Any initiative to improve the quality of clinical care needs the support and engagement of the treating physicians. For this reason our Group is actively involved with various programmes to better engage with our supporting physicians. Due to the different clinical models in the operating platforms the engagement models will differ between the countries. In Southern Africa the structure of the clinical committees at each hospital was revisited and improved. Representatives of the hospital clinical committees now also meet annually to discuss the more strategic clinical issues on a national basis.

Further information is reported in the Clinical Services Report.

MAINTAINING FINANCIAL PERFORMANCE

Increasing operational efficiency and ensuring the effective use of our capital structure are always high priorities. During the year under review we achieved the following:

- increased bed occupancy levels at all three operating platforms;
- increased normalised EBITDA margin; and
- significantly increased normalised earnings per ordinary share.

Further information on the financial performance of the Group and the individual operating platforms is reported in the Chief Financial Officer's Report.

CONTINUING TO GROW AS A SUCCESSFUL INTERNATIONAL HEALTHCARE GROUP

It is pleasing to report that the Group managed to increase its investment in Emirates Healthcare from 50.4% to 100%, which was subsequently rebranded to Mediclinic. During the year a further investment of AED213m was approved to expand the very successful Mediclinic City Hospital in Dubai with a further 34 beds and a modern high-tech oncology treatment unit. The expanded capacity will also be used to de-bottleneck specific pressure areas in the hospital.

Significant investments were also made to expand our capacity at each of the other operating platforms. The details of the specific expansion projects are listed in the operating platforms' Operational Reviews. The most significant of these investments is the addition of the south wing to Klinik Hirslanden in Zurich. This expansion includes 72 beds and eight ICU beds, increasing the total capacity of the hospital to 351 beds. The new wing was commissioned in May 2013.

Being part of an international healthcare Group creates opportunities to transfer knowledge and skills and as such the Swiss and UAE operating platforms are actively cooperating to transfer clinical expertise in the areas of oncology, bariatric surgery, neurosurgery and radio-oncology.

We concluded a formal process to strategically re-align the international Group's organisational structures to be more nimble and efficient. In the process we addressed the structures at the operating platform and the international level after an in-depth analysis performed by international advisors. The changes included the streamlining of board and sub-committee structures at platform level, the appointment of discipline-specific cross-platform synergy teams with defined governance structures, the streamlining of regional management structures in Mediclinic

CONTINUED FOCUS ON DELIVERING MEASURABLE QUALITY CLINICAL OUTCOMES

Southern Africa and the gradual standardisation and centralisation of support services at Hirslanden. A new organisational blueprint for Mediclinic Southern Africa, of which the main outcomes are focusing on more integrated clinical services and aligning the company to be more patient centred, focusing on efficiency and effectiveness, was approved in December 2012. During the next year we will focus on the detailed design and implementation at all levels of the organisation.

A decision was taken to standardise a single IT solution for the Group's back-office functions. Significant savings were achieved by negotiating a global contract with a reputable vendor. This solution was successfully implemented in Mediclinic Middle East, while Mediclinic Southern Africa will start the roll-out in the 2014 financial year. Hirslanden, which is already using the solution, will focus on standardisation at the platform level.

Using the Group's scale to unlock synergies is a specific focus area for the Group. We consequently appointed a Group Procurement Manager in May 2013 to coordinate the procurement processes for high-volume and major capital products on a Group basis.

GROUP PERFORMANCE

As reported earlier, we are pleased with the performance of the Group, in particular with the performance of Hirslanden against the background of major regulatory changes that were implemented during 2012.

On a Group level the positive leveraging impact of the Group's refinanced capital structure has benefited financial results. Both the Swiss franc and the US dollar, to which the UAE dirham is pegged, have appreciated significantly against the rand over the last five years.

SOUTHERN AFRICA

Mediclinic Southern Africa contributed 41% of the Group's normalised revenue and 40% of its normalised EBITDA (2012: 43% and 42% respectively).

We are pleased to report a 4% growth in bed days sold by Mediclinic Southern Africa measured against the growth of 2% in medical aid membership.

The shortage of qualified human resources, specifically in the medical disciplines, remains a challenge. We will continue to invest in the training of nurses through our six well-established nursing schools.

An agreement was reached with one of our empowerment partners, Phodiso, to extend their lock-in period by two years to the end of 2018. The transaction involved the refinancing of existing third party bank facilities and a cash distribution arising on the sale of rights offer entitlements on the October 2012 rights issue. The transaction was supported by the substantial value that exists in the applicable BEE structure.

SWITZERLAND

Hirslanden contributed 49% of the Group's normalised revenue and 51% of its normalised EBITDA (2012: 49% and 50% respectively).

We are pleased to report a 2.6% increase in Hirslanden's inpatient admissions.

The major regulatory changes that were implemented during 2012 are now well embedded in the administrative systems and the local management performed particularly well to manage the associated risks. Although there are still uncertainties, specifically around the management of highly specialised medicine, the overall impact of the regulatory changes was limited. We see a strong increase in the number of general insured patients due to the listing status of 13 of our 14 hospitals.

UNITED ARAB EMIRATES

Mediclinic Middle East (formerly Emirates Healthcare) contributed 10% of the Group's normalised revenue and 9% of its normalised EBITDA (2012: 8% and 8% respectively).

Mediclinic Middle East maintained its strong performance with an increase of 13% in inpatient hospital admissions and a 14% growth in the clinics' outpatient consultations. Mediclinic City Hospital is now operating at full capacity and the performance of the clinics has been pleasing.

The global economic crisis had no negative impact on Mediclinic Middle East's activities. It contributed towards the lowering of costs in the region, including a significant reduction in accommodation costs, making Dubai a more affordable place to live. The recent unrest in some Middle Eastern countries has also resulted in an increased influx of people to Dubai, as the United Arab Emirates is seen as a safe haven in the region.

OUTLOOK

Affordability of healthcare remains a global concern and we can expect continuous focus from regulatory authorities to ensure access to healthcare by the broader population. The private healthcare industry has a key role to play in the delivery of healthcare, supplementary to that provided by governments.

Despite the regulatory uncertainties, specifically in Switzerland and Southern Africa, we remain optimistic about our role in delivering cost-effective quality healthcare in the markets that we serve. This is further confirmed by the substantial capital investments we are making in all three our operating platforms. We are optimistic that the CHF80m investment at the flagship Klinik Hirslanden in Zurich will create new momentum for future growth at this new facility.

In Southern Africa the construction of the new 174-bed Mediclinic Centurion hospital has started and commissioning is scheduled for the second half of 2014. Additional capacity will also be created at several of our hospitals in South Africa.

The newly approved expansion at Mediclinic City Hospital in Dubai will add new high-tech radio-oncology facilities and will be a first in the private healthcare market in Dubai. These facilities will be commissioned during the 2015 financial year.

Meeting the needs of our patients in the most cost-effective way will remain a key priority for our Group and we will keep investing as required to improve the patient experience across our facilities.

I would like to thank the thousands of patients for their trust in Mediclinic, as well as our supporting doctors, nursing staff, management and all other staff for their contributions towards the success we achieved during the year.

Danie Meintjes
Chief Executive Officer

GROUP REFINANCING AND R5 BILLION RIGHTS OFFER SUCCESSFULLY CONCLUDED

INTRODUCTION

The Group delivered strong financial results and growth for 2013, despite continuing challenging global economic conditions.

GROUP OVERVIEW

GROUP FINANCIAL PERFORMANCE

The Group uses normalised revenue, normalised operating profit before interest, tax, depreciation and amortisation ("normalised EBITDA"), normalised headline earnings and normalised basic headline earnings per share as non-IFRS (International Financial Reporting Standards) measures in evaluating performance and as a method to provide shareholders with clear and consistent reporting. These non-IFRS measures are defined as reportable EBITDA, headline earnings and basic headline earnings per share in terms of accounting standards, excluding one-off items.

Craig Tingle
Chief Financial Officer

RESULTS OVERVIEW

Group normalised revenue increased by 12% to R24 713m (2012: R21 986m) for the year under review. Normalised EBITDA was 15% higher at R5 379m (2012: R4 659m).

FIGURE 1: EBITDA RECONCILIATION (R'M)

	2013	2012
EBITDA	**5 263**	4 669
Adjusted for:		
Past service cost	**(35)**	(14)
Impairment of property and equipment	**–**	4
Pre-acquisition tariff provision	**151**	–
Normalised EBITDA	**5 379**	4 659

The leveraging effect of the capital structure of the Group enhanced financial performance and resulted in basic normalised headline earnings per share growth of 53% to 273.2 cents (2012: 178.3 cents) compared to the normalised EBITDA growth of 15%. The Group's normalised EBITDA margin increased from 21.2% to 21.8% at year end. An adjustment was made to the prior year's earnings per share in terms of IFRS, as detailed in the paragraph 'Weighted average number of shares adjustment' below.

During the period under review, a number of one-off items relating to the refinancing of the Group's debt occurred. Details of a number of corporate activities were released on SENS during the year and a summarised SENS announcement was released on 17 October 2012. The announcements reported on the successful elective refinancing of the Group's debt and the successful conclusion of a R5 billion rights offer, as well as the conclusion of the buy-out of the minority interest in Emirates Healthcare (which has subsequently been rebranded to Mediclinic and referred to as Mediclinic Middle East hereinafter). The one-off charges amount to R3 215m (R2 946m after tax) and comprise the following:

- the derecognition of the mark-to-market liability relating to the Hirslanden interest rate swap of R3 531m (R3 311m after tax);
- accelerated amortisation charges of capitalised financing expenses of R163m (R129m after tax);
- loan breakage charges of R54m (R39m after tax) relating to existing South African debt;
- Swiss stamp duty of R41m (R41m after tax), partially offset by a realised gain of R574m (R574m after tax) on foreign exchange forward contracts.

In addition, the Group results also include the following one-off items (refer to **Figure 1**):

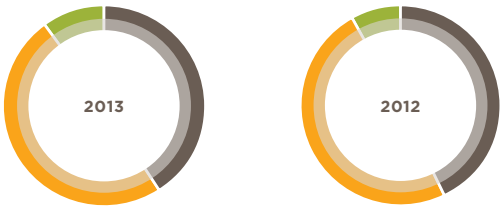
- a pre-acquisition Swiss tariff provision charge of R151m (R115m after tax); and
- a past service cost credit of R35m (R27m after tax) due at one of the Group's pension funds.

Before taking these adjustments into account, reported EBITDA increased by 13% to R5 263m (2012: R4 669m). Including the one-off items, headline earnings declined by 182% to a loss of R1 007m (2012: profit of R1 222m) and basic headline earnings per ordinary share decreased by 175% to a loss of 135.6 cents (2012: profit of 179.9 cents).

The average rand/Swiss franc (CHF) exchange rate was R9.05 compared to R8.45 for the comparative period and the average UAE dirham (AED) was R2.32 compared to R2.03 for the comparative period. These movements in the exchange rates had a positive effect on the reported results, as detailed under Hirslanden's and Mediclinic Middle East's financial performance sections.

The total dividend per share for the period under review is 85.8 cents (2012: 78.0 cents).

FIGURE 2: NORMALISED REVENUE (R'M)



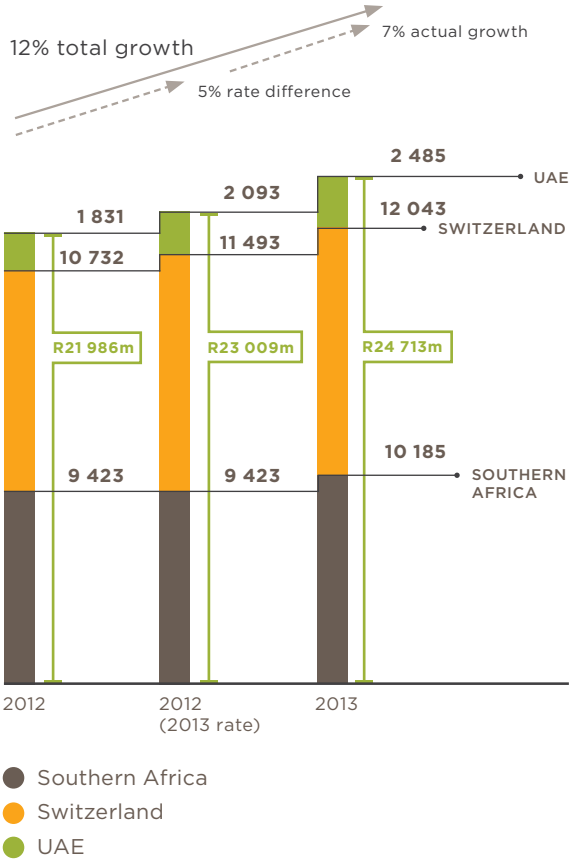
SOUTHERN AFRICA
R10 185 (41%)
SWITZERLAND
R12 043 (49%)
UAE
R2 485 (10%)

TOTAL R24 713M

SOUTHERN AFRICA
R9 423 (43%)
SWITZERLAND
R10 732 (49%)
UAE
R1 831 (8%)

TOTAL R21 986M

FIGURE 3: NORMALISED REVENUE GROWTH (R'M)



WEIGHTED AVERAGE NUMBER OF SHARES ADJUSTMENT

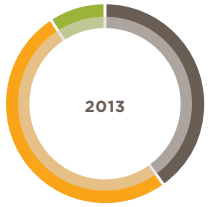
In terms with IAS 33 paragraph 26, an adjustment to the weighted average number of shares in issue for the period under review and the prior year is required, since the rights offer share price of R28.63 per share was less than the market value on the last day to trade in shares in order to participate in the rights offer. Consequently, the basic headline earnings per share for the prior year decreased by 15.0 cents and basic normalised headline earnings per share for the prior year decreased by 14.7 cents.

REVENUE

The geographical composition of the Group's revenue for 2013 and 2012 is shown in **Figure 2**.

As shown in **Figure 3**, normalised revenue increased by 12% to R24 713m (2012: R21 986m).

FIGURE 4: NORMALISED EBITDA (R'M)



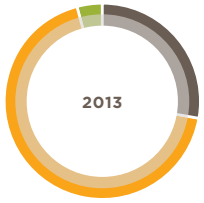
- SOUTHERN AFRICA **R2 169** (40%)
- SWITZERLAND **R2 716** (51%)
- UAE **R495** (9%)

TOTAL R5 379M

- SOUTHERN AFRICA **R1 957** (42%)
- SWITZERLAND **R2 350** (50%)
- UAE **R352** (8%)

TOTAL R4 659M

FIGURE 6: NORMALISED FINANCE COST (R'M)



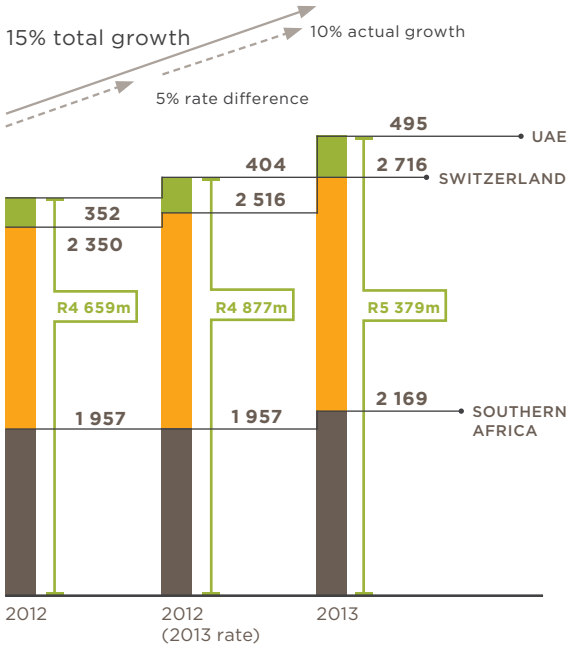
- SOUTHERN AFRICA **R422** (28%)
- SWITZERLAND **R1 023** (68%)
- UAE **R63** (4%)

TOTAL R1 508M

- SOUTHERN AFRICA **R369** (22%)
- SWITZERLAND **R1 244** (76%)
- UAE **R29** (2%)

TOTAL R1 642M

FIGURE 5: NORMALISED EBITDA GROWTH (R'M)



- Southern Africa
- Switzerland
- UAE

NORMALISED EBITDA

The Group's normalised EBITDA margin increased from 21.2% to 21.8% in 2013. The EBITDA margins of the Group's platforms were 21.3% for Mediclinic Southern Africa, 22.6% for Hirslanden and 19.9% for Mediclinic Middle East.

The geographical composition of the Group's normalised EBITDA for 2013 and 2012 is shown in **Figure 4**.

As shown in **Figure 5**, normalised EBITDA increased by 15% to R5 379m (2012: R4 659m).

FINANCE COST

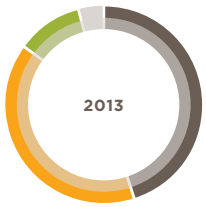
Finance cost includes the following items:

- R3 531m (2012: Rnil) derecognition of the Swiss interest rate swap;
- R163m (2012: Rnil) accelerated recognition of capitalised financing expenses; and
- R89m (2012: R81m) amortisation of capitalised financing expenses.

The capitalised financing expenses are amortised over the terms of the relevant loans in line with future cash payments as prescribed in IAS 39 Financial Instruments.

The geographical composition of the Group's finance cost for 2013 is shown in **Figure 6**.

FIGURE 7: NORMALISED HEADLINE EARNINGS (R'M)



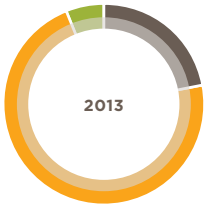
- SOUTHERN AFRICA **R906** (45%)
- SWITZERLAND **R802** (40%)
- UAE **R232** (11%)
- CORPORATE **R87** (4%)

TOTAL R2 027M

- SOUTHERN AFRICA **R787** (65%)
- SWITZERLAND **R296** (25%)
- UAE **R114** (9%)
- CORPORATE **R14** (1%)

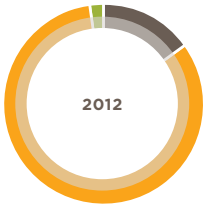
TOTAL R1 211M

FIGURE 8: DEBT (R'M)



- SOUTHERN AFRICA **R5 817** (22%)
- SWITZERLAND **R18 997** (72%)
- UAE **R1 556** (6%)

TOTAL R26 370M



- SOUTHERN AFRICA **R3 631** (15%)
- SWITZERLAND **R20 723** (83%)
- UAE **R440** (2%)

TOTAL R24 794M

CONTRIBUTION TO GROUP NORMALISED HEADLINE EARNINGS

The geographical composition of the Group normalised headline earnings for 2013 and 2012 is shown in **Figure 7**.

CASH FLOW

The Group's cash flow continued to be strong. The Group converted 104% (2012: 92%) of normalised EBITDA into cash generated from operations. Cash and cash equivalents increased from R2 099m at 31 March 2012 to R2 705m at year end.

INTEREST-BEARING BORROWINGS

Interest-bearing borrowings increased from R24 794m at 31 March 2012 to R26 370m at year end, mainly as a result of the change in the closing rand/CHF exchange rate. The closing rand/CHF exchange rate moved from R8.50 at 31 March 2012 to R9.69 at year end. It is important to note that the foreign debt of the Group's Swiss and Middle Eastern operations, amounting to R20 553m, is matched with foreign assets in the same currencies. The foreign debt also has no recourse to the Southern African operations' assets, as stipulated by the South African Reserve Bank, as well as applicable financing arrangements

The geographical composition of the Group's debt at 31 March 2013 is shown in **Figure 8**.

ASSETS

Property, equipment and vehicles increased from R34 808m at 31 March 2012 to R40 233m at year end and intangible assets increased from R6 350m at 31 March 2012 to R7 279m at year end. These increases are mainly a result of the change in the closing rand/CHF and the rand/AED exchange rate, as mentioned above.

Other investments and loans decreased from R790m at 31 March 2012 to R17m at year end, mainly due to the sale of the investment grade bond portfolio. The investment in money market funds was converted to cash.

TREASURY SHARES

During the year 75 857 (2012: 418 823) of treasury shares were utilised in terms of the executive share option scheme, 636 275 (2012: 691 599) of the treasury shares were utilised in terms of the management incentive scheme and 440 000 shares (2012: 300 000) were acquired during the year.

FOREIGN EXCHANGE RATES

The rand experienced substantial volatility during the year against both the Swiss franc (CHF) and the United States dollar, to which the UAE dirham is pegged at AED3.6725.

GROUP NORMALISED EBITDA MARGIN INCREASED FROM 21.2% TO 21.8%

The average rand/Swiss franc (CHF) exchange rate was R9.05 compared to R8.45 for the comparative period and the average UAE dirham (AED) was R2.32 compared to R2.03 for the comparative period. These movements in the exchange rates had a positive effect on the reported results, as detailed under Hirslanden's and Mediclinic Middle East's financial performance sections.

Accounting convention requires the Group to convert its offshore balance sheets at the year-end spot rate, while its offshore income statements are converted at the average rate for the year. The difference between the spot rates and the average rates results in distortions, when ratios between the statement of financial position and the income statement items are calculated in rand. The spot rate should therefore also be used for translating, for example, EBITDA, when calculating such ratios.

Exchange rate movements also had a significant impact on the statement of financial position. The resulting currency translation difference, which is the amount by which the Group's interest (including non-controlling interests) in the equity of the two foreign platforms increased as a result of the spot rate's movement, amounted to R1 705m (2012: R1 405m) and was credited to the statement of comprehensive income.

REFINANCING

During October 2012, the comprehensive, elective refinancing of the Group's debt, with new long-term debt facilities across the Group's platforms was successfully completed.

Although the existing Swiss facility would only mature in October 2014, the board elected to raise equity and refinance all Group debt at the current opportune time, recognising the significant benefits to Mediclinic, namely:

- to take advantage of the favourable equity market in South Africa through a fully underwritten rights offer;
- to take advantage of current favourable debt market conditions in all the platforms to secure attractive terms;
- to benefit from the record low Swiss interest rates to fix the cost of the new Swiss facilities at attractive rates for their entire duration; and
- to provide flexibility to pursue strategic growth and development opportunities.

R5 billion of new equity was raised through a rights offer of 174 641 984 new Mediclinic shares at an issue price of R28.63 per share in the ratio of 26.77263 new Mediclinic shares for every 100 shares held. The rights offer was fully underwritten by a subsidiary of Remgro Limited.

The new Swiss debt funding comprises approximately CHF2.1 billion property-backed facilities without recourse to the Group's Southern African operations:

- CHF1.5 billion first lien facility with a partially amortising repayment profile over five years and priced at Swiss Libor plus a margin of 2.0%;
- CHF0.3 billion second lien facility with a bullet maturity in June 2018, priced at Swiss Libor plus a margin of 3.5%;
- CHF0.3 billion third lien facility with a bullet maturity in June 2018, priced at Swiss Libor plus a margin of 2.0%;
- the existing swap was restructured into an extended at-the-money swap with a maturity and profile matching the new first and second lien facilities; and
- the total blended cost of the new Swiss funding is now approximately 2.3% and results in substantial future finance cost savings.

BASIC NORMALISED HEADLINE EARNINGS PER SHARE INCREASED BY 53% TO 273.2 CENTS

The new South African debt funding comprises five-year senior facilities of R4.2 billion and a five-year preference share facility of R2.0 billion, all priced at favourable rates and at costs below the existing facilities.

The Dubai operations raised a USD172m facility as well as Group equity to facilitate the buy-out of the minority interests in Mediclinic Middle East and to provide capital for expansion. The facility has a partially amortising profile over 54 months and is without recourse to the Group's South African operations.

HIRSLANDEN PENSION FUNDS

Hirslanden provides defined contribution pension plans in terms of Swiss law to employees, the assets of which are held in separate trustee-administered funds. These plans are funded by payments from employees and Hirslanden, taking into account the recommendations of independent qualified actuaries. Because of the strict definition of defined contribution plans in IAS 19, in terms of IFRS, these plans are classified as defined benefit plans, since the funds are obliged to take some investment and longevity risk in terms of Swiss law.

The IAS 19 pension liability was valued by the actuaries at the end of the year and amounted to R188m (CHF19m) (2012: R471m (CHF55.4m)), included under "Retirement benefit obligations" in the Group's statement of financial position. However, the pension funds were, for Swiss statutory purposes, estimated to be 110% (2012: 105%) funded at 31 March 2013. From an economic and legal point of view, this amount as calculated in terms of IAS 19 does not lead to a liability for Hirslanden at 31 March 2013.

The pension liability resulted in an amount of R135m (CHF15m) being credited (2012: R413m (CHF49m) charged) to the consolidated statement of comprehensive income for the year. An amount of R122m (CHF13.3m) (2012: R114m (CHF13.5m)), which is the employer's contribution exceeding the current service cost, was credited to the consolidated income statement. In addition, a one-off past service cost credit of R35m (CHF4m) was made relating to the lowering of a conversion rate at one of the Swiss pension funds.

DERIVATIVE FINANCIAL INSTRUMENTS

The Group uses floating-to-fixed interest rate swaps to hedge against interest movements which have the economic effect of converting the interest-bearing borrowings to fixed interest rate borrowings. The Group applies hedge accounting and therefore fair value movements are booked to the consolidated statement of comprehensive income.

During the year, the Group restructured the Swiss interest rate swap. As a result the fair value liability of the Group's interest rate swaps decreased from R3 739m at 31 March 2012 to R50m at year end and an amount of R3 203m (2012: R1 126m charged) was credited to the consolidated statement of comprehensive income.

OPERATIONS IN SOUTHERN AFRICA

MEDICLINIC SOUTHERN AFRICA

The Southern African group revenue increased by 8% to R10 185m (2012: R9 423m) for the year under review. Normalised EBITDA was 11% higher at R2 169m (2012: R1 957m), as illustrated in **Figure 9**.

FIGURE 9: MEDICLINIC SOUTHERN AFRICA REVENUE (R'M)

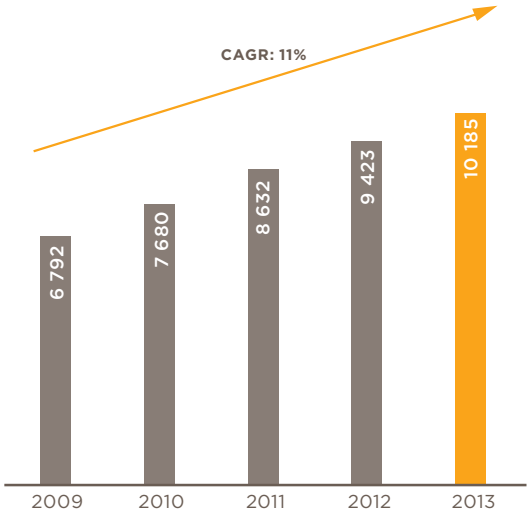
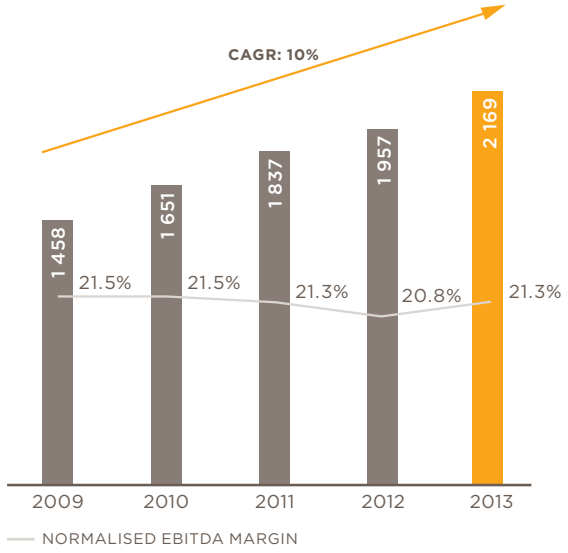


FIGURE 10: MEDICLINIC SOUTHERN AFRICA NORMALISED EBITDA (R'M)



After incurring depreciation charges of R282m (2012: R256m), net finance charges of R369m (2012: R328m), taxation of R442m (2012: R434m) and deducting the interest of minority shareholders in the attributable income of the Southern African group amounting to R170m (2012: R152m), the Southern African operations contributed R906m (2012: R787m) to the normalised attributable income of the Group.

Figure 10 shows Mediclinic Southern Africa's EBITDA performance over recent years.

The normalised EBITDA margin of the Southern African operations increased from 20.8% to 21.3%.

Mediclinic Southern Africa's cash flow continued to be strong as it converted 113% (2012: 97%) of normalised EBITDA into cash generated from operations.

Cash and cash equivalents increased from R821m at 31 March 2012 to R1 305m at year end.

Interest-bearing borrowings increased from R3 631m at 31 March 2012 to R5 817m at year end as part of the refinancing of the Group's debt.

OPERATIONS IN SWITZERLAND
HIRSLANDEN

Hirslanden's reported results for 2013 were affected by exchange rate movements. The average rand/CHF exchange rate for the year increased from R8.45 in 2012 to R9.05 in 2013.

Hirslanden's normalised revenue increased by 12% (5% at constant foreign exchange rates) to R12 043m (CHF1 330m) (2012: R10 732m (CHF1 270m)) for the year under review. Normalised EBITDA was 16% higher (8% higher at constant foreign exchange rates) at R2 715m (CHF300m) (2012: R2 350m (CHF278m)).

After incurring depreciation charges of R604m (CHF67m) (2012: R556m (CHF66m)), net finance charges of R1 014m (CHF112m) (2012: R1 239m (CHF147m)), tax of R297m (CHF33m) (2012: R260m (CHF31m)) and income from associate of R2m (CHF0.2m) (2012: R1m (CHF0.1m)), Hirslanden contributed R802m (CHF88m) (2012: R296m (CHF34m)) to the attributable income of the Group.

FIGURE 11: HIRSLANDEN NORMALISED REVENUE (CHF'M)

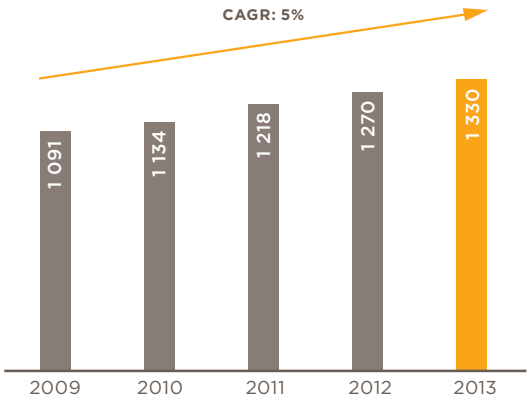
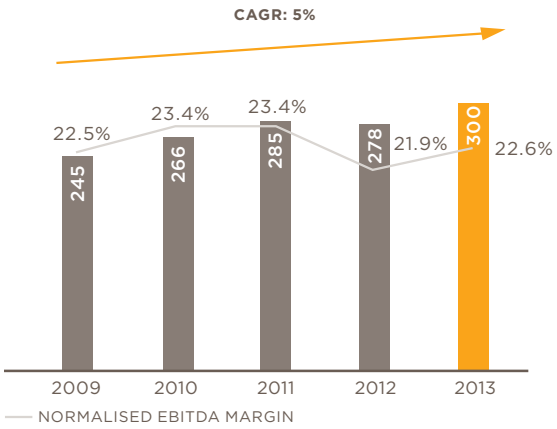


FIGURE 12: HIRSLANDEN EBITDA GROWTH AND PERFORMANCE (CHF'M)



Hirslanden's revenue performance is set out in **Figure 11**.

The normalised EBITDA margin of Hirslanden increased from 21.9% to 22.6%.

Hirslanden converted 93% (2012: 84%) of normalised EBITDA into cash generated from operations.

Cash and cash equivalents decreased from R588m (CHF69m) at 31 March 2012 to R536m (CHF55m) at year end.

Interest-bearing borrowings decreased from R20 723m (CHF2 438m) at 31 March 2012 to R18 997m (CHF1 960m) at year end, mainly due to the refinancing of Swiss debt, counteracted by the increase in the closing rand/CHF exchange rate.

Hirslanden's historical normalised EBITDA performance, excluding one-off items, is set out in **Figure 12**.

OPERATIONS IN UNITED ARAB EMIRATES

MEDICLINIC MIDDLE EAST

Mediclinic Middle East's reported results for 2013 were affected by exchange rate movements. The average rand/AED exchange rate for the year increased from R2.03 in 2012 to R2.32 in 2013.

Mediclinic Middle East's normalised revenue increased by 36% (19% at constant foreign exchange rates) to R2 485m (AED1 072m) (2012: R1 831m (AED902m)) for the year under review. Mediclinic Middle East's historical revenue performance is set out in **Figure 13**.

Normalised EBITDA increased by 41% (23% at constant exchange rates) to R495m (AED214m) (2012: R352m (AED174m)).

After incurring depreciation charges of R113m (AED49m) (2012: R98m (AED48m)), net finance charges of R63m (AED27m) (2012: R27m (AED14m)) and the sharing of minority shareholders in the attributable income of Mediclinic Middle East amounting to R87m (AED38m) (2012: R113m (AED56m)), Mediclinic Middle East contributed R232m (AED100m) (2012: R114m (AED56m)) to the attributable income of the Group.

FIGURE 13: MEDICLINIC MIDDLE EAST REVENUE (AED'M)

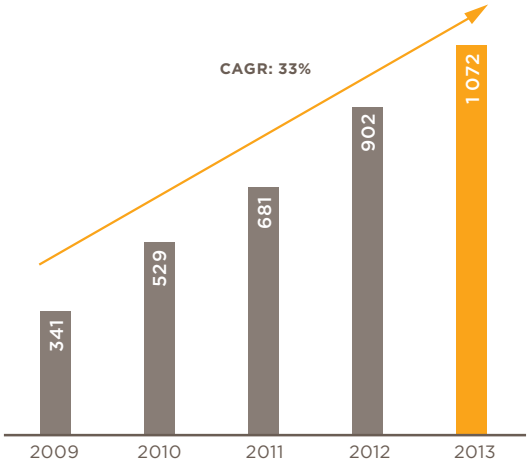
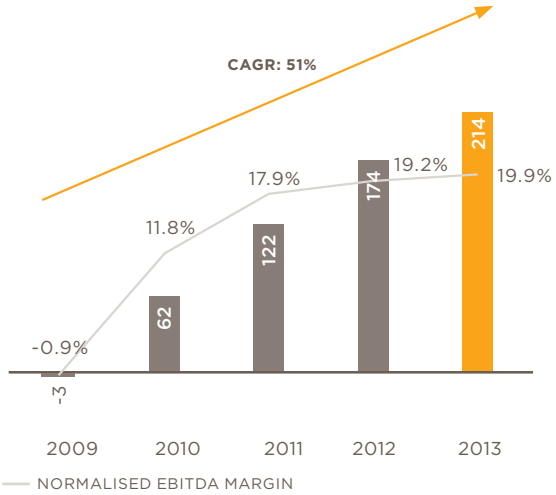


FIGURE 14: MEDICLINIC MIDDLE EAST NORMALISED EBITDA GROWTH AND MARGIN (AED'M)



The normalised EBITDA margin of Mediclinic Middle East increased from 19.2% to 19.9%.

Mediclinic Middle East converted 125% (2012: 119%) of normalised EBITDA into cash generated from operations.

Cash and cash equivalents increased from R325m (AED155m) at 31 March 2012 to R629m (AED250m) at year end. Interest-bearing borrowings increased from R440m (AED210m) at 31 March 2012 to R1 556m (AED619m) at year end, mainly because of the refinancing and buy-out of Mediclinic Middle East's minority interests.

Mediclinic Middle East's historical EBITDA performance is set out in **Figure 14**.

GROUP DIVIDEND POLICY

The Group's dividends are based on and dictated by the performance of the Southern African operations.

RISK MANAGEMENT

Risk management receives top priority throughout the Group. The Group-wide risk management policy is benchmarked against the international Committee of Sponsoring Organisations of the Treadway Commission framework and complies with the recommendations of the King III report.

The Group's risk management process is summarised in the Risk Management Report and the abridged Sustainable Development Report included in this integrated annual report, and notes 3.1 and 3.3 to the annual financial statements published on the Company's website.

ACCOUNTING POLICIES

The annual financial statements have been prepared in accordance with IFRS. The accounting policies are based on reasonable judgements and estimates, are in accordance with IFRS and are consistent with those applied in the prior year.

Craig Tingle
Chief Financial Officer

OPERATIONAL REVIEW: SOUTHERN AFRICA

Koert Pretorius
Chief Executive Officer: Mediclinic Southern Africa

www.mediclinic.co.za

BUSINESS ENVIRONMENT

South Africa's economic performance has been weaker than expected in recent years with the annual gross domestic product growth rate decelerating to 2.5% in 2012. In contrast, the South African private healthcare sector has maintained a positive, gradual, long-term growth trajectory.

The medical schemes market, which accounts for approximately 90% of Mediclinic Southern Africa's revenue, grew to 8.6 million beneficiaries in September 2012, from 8.5 million a year earlier. The average annual increase in scheme membership over the last decade was approximately 2%, largely due to the establishment of the Government Employees Medical Scheme (GEMS) in 2006.

The medical scheme industry has remained financially sound, although total solvency levels decreased slightly to 30.2% at September 2012 from 32.6% at December 2011. The total accumulated reserves for all medical schemes increased from R35.0 billion to R35.4 billion over this period.

Although the number of scheme beneficiaries has shown consistent growth, the number of schemes has continued to decline over the years, reducing from 144 in 2000 to 93 in 2012. The three largest schemes cover more than 50% of all scheme beneficiaries. This consolidation in schemes is also seen in the administrator market, with three of the largest administrators accounting for approximately 80% of scheme members. This trend in consolidation is likely to continue.

The membership mix shows very interesting trends from a hospital perspective. A relatively higher growth in scheme membership occurred in the age bands of 45 to 49 and over 85. The absolute number of dependants who are registered for chronic medication benefits also increased year-on-year. This contributes to the sustained increase in the number of bed days sold by the group.

Within the broader health sector context, the government maintains its commitment to achieve universal coverage through a National Health Insurance (NHI) system. A White Paper on the NHI

BUILDING PROJECTS IN PROGRESS WILL ADD 139 ADDITIONAL BEDS DURING THE YEAR AHEAD

NUMBER OF EMPLOYEES **14 927**	NUMBER OF BEDS **7 436**
NUMBER OF HOSPITALS **52**	NUMBER OF THEATRES **254**

is expected to be published during the year ahead and Mediclinic will continue to engage with both government and other relevant stakeholders on the most appropriate design and mechanisms to pursue universal coverage within the South African context.

The shortage of human resources in healthcare remains a critical challenge for the sector. This has been acknowledged by the Minister of Health. The Minister has proposed various initiatives to address this problem, such as expanding the capacity of medical schools and the reopening of nursing colleges.

The Competition Commission is set to initiate an inquiry into the private healthcare sector within the year. Mediclinic is engaging with the Commission's representatives and the draft Terms of Reference and the envisaged process have been discussed. The Commission stated that it wishes to finalise the inquiry by December 2014.

BUSINESS PERFORMANCE

The 8% revenue growth was achieved through a 3.5% increase in bed days sold and a 4.6% increase in the average income per bed day. Medical cases continued increasing at a higher rate than surgical cases. The number of patients admitted increased by 2.4%, while the average length of stay increased by 1.1%.

The normalised EBITDA margin of the Southern African operations increased from 20.8% to 21.3%.

During the period under review the Southern African operations invested the following amounts:

- R445m (2012: R293m) in capital projects and new equipment to enhance its business;
- R249m (2012: R230m) to replace existing equipment; and
- R282m (2012: R274m) to repair and maintain property and equipment, which was charged through the income statement.

BED DAYS SOLD **+3.5%**	REVENUE **+8%**
AVERAGE INCOME PER BED DAY **+4.6%**	PATIENT SATISFACTION LEVEL **76%**

For the next financial year the budget is:

- R765m for capital projects and new equipment;
- R276m for replacing existing equipment; and
- R279m for repairs and maintenance.

Incremental EBITDA resulting from capital projects in progress or approved is budgeted to amount to R42m and R83m in 2014 and 2015 respectively.

The number of licensed hospital beds increased from 7 378 to 7 436 during the year under review.

Patient satisfaction levels as measured independently remained stable at 76%.

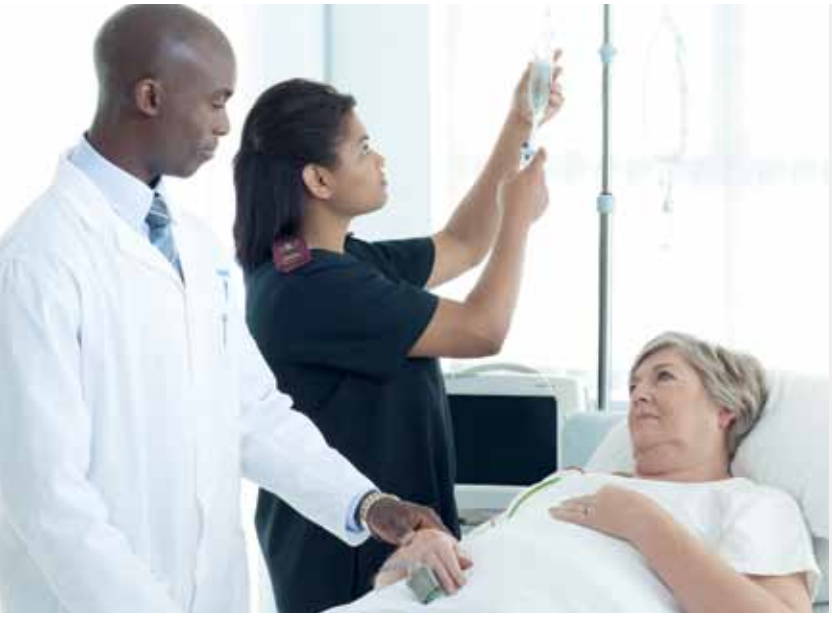
BUILDING PROJECTS

During the past year a number of building projects were completed at various hospitals, creating 58 additional beds as well as new consulting rooms and involving a number of facility upgrades.

Building projects in progress, which should be completed during the next financial year, will add 139 additional beds as well as new consulting rooms, a cardiology unit and a number of facility upgrades.

The number of licensed beds is expected to increase from 7 436 to 7 575 during the next financial year.

Several building projects in progress should be completed during the 2015 financial year, of which the establishment of the new Mediclinic Centurion (174 beds) is the most significant development.



PATIENT EXPERIENCE

Mediclinic Southern Africa formally established a focused programme to improve the overall patient experience in our hospitals. The Patient Journey Project involves a multidisciplinary team, under the leadership of a dedicated manager, and will focus on the following three areas:

- leadership development and the entrenchment of a values-driven organisation as a basis to drive the patient experience;
- skills development for all frontline staff to help create an empathetic rapport with our patients; and
- an in-depth streamlining of multiple organisational processes to focus on the patient perspective.

NEW MANAGEMENT STRUCTURE

Mediclinic International concluded a formal process to strategically re-align the Group's organisational structures to be more nimble and efficient. In the process it addressed the structures at operating platform level after an in-depth analysis performed by international advisors. The changes at Mediclinic Southern Africa level included the streamlining of board – and sub-committee – as well as regional management structures. A new organisational blueprint, of which the main outcomes are focusing on more integrated clinical services and aligning the company to be more patient-centred focusing on efficiency and effectiveness, was approved in December 2012. During the next year we will focus on the detailed design and implementation at all levels of the organisation.

SIGNIFICANT CONTRIBUTION TO BE MADE TO PUBLIC HEALTH ENHANCEMENT FUND ANNUALLY

SUSTAINABILITY

PEOPLE

Recruiting and retaining high-quality medical professionals is fundamental to Mediclinic Southern Africa's sustainability. There remains an ongoing shortage of nurses in South Africa. In the short term Mediclinic Southern Africa has addressed this by recruiting nurses from India. The longer-term solution is to increase local training.

Mediclinic Southern Africa's training and development function is registered as a Private Higher Education Institution and presents a Diploma in General Nursing Science and a Diploma in Operating Room Practice to promote that training of skilled healthcare personnel and thus sustain quality outcomes in providing healthcare. Mediclinic also has provisional registration, until December 2015, to present Enrolled Nursing programmes.

A total of 520 learners completed undergraduate programmes and 70 learners completed postgraduate programmes during the 2012 academic year. A further 978 learners completed in-house structured programmes.

The formal management succession process is well established in Mediclinic Southern Africa and the talent review committee is satisfied that adequate provision has been made for the expected retirement of senior executives over the next five years.

SOCIETY

The Mediclinic Corporate Social Investment (CSI) programme makes a meaningful impact on the communities we support.

As a company we are driven by the need for continuous improvement and for finding ways in which we can increase our impact on disadvantaged communities.

Our CSI programme is based on three tiers:

- Tier 1
  Tier 1 involves partnering with the government (Department of Health/public hospitals) to provide the community with much needed surgical support in various disciplines where the Department of Health may have need. During the period under review our activities included the following:
  - A "Saturday Surgeries" project undertaken with the Red Cross War Memorial Children's Hospital via The Children's Hospital Trust to the value of R217 000, where 87 children benefited. The project was aimed at reducing the waiting list for surgical procedures at the hospital.
  - As part of the World Breast Cancer Awareness month, a mammography screening partnership with Pink Drive and the KwaZulu-Natal Department of Health, where 150 women benefited. The project was aimed at reducing the waiting list for screening at three hospitals.

- Tier 2
  This tier focuses on enhancing the role of accredited community organisations by providing monetary and product support. The four focus areas are education, sport, health and welfare. In this regard we have supported 52 accredited community organisations with monetary support of R2.75m. In-kind donations (of linen, beds and the like) were also made to the value of R300 000.

- Tier 3
  Tier 3 offers a platform for Mediclinic employees to make a difference by volunteering their time, expertise and knowledge to community organisations.

The projects conducted under each of these pillars are a reflection of Mediclinic Southern Africa's ongoing commitment to play a positive role in making a difference in the lives of local communities.

In November 2012, the Minister of Health announced a social compact for health improvement entered into between Mediclinic together with other leading private sector healthcare companies and the National Department of Health. The social compact led to the establishment of the Public Health Enhancement Fund (PHEF), which has raised funding of R40 million for activities in 2013. R20 million has been approved to provide bursaries to 100 undergraduate medical students in 2013.

A further R10 million is earmarked to support master's and PhD studies and the balance to support the Academy for Health Leadership and Management in Health. The PHEF is a non-profit organisation that has committed to investing a fixed annual sum over a fixed-term period to develop and strengthen South Africa's healthcare system. Mediclinic Southern Africa has committed to contributing 0.75% of its net profit after tax to this fund annually.

ENVIRONMENT

Mediclinic Southern Africa is committed to minimising its environmental impact and to ensure that its environmental management systems and practices are aligned with international best practices, based on the ISO 14001:2004 Specification for Environmental Systems. Its performance is assessed by National Quality Assurance London.

Thirty nine of Mediclinic Southern Africa's 52 hospitals are now ISO 14001 certified. All 52 hospitals have now been ISO 14001 trained to follow the same environmental management practices and are also subject to annual internal audits.

Mediclinic Southern Africa achieved joint fourth ranking in the Carbon Disclosure Leadership Index of the Carbon Disclosure Project 2012 for the Top 100 companies on the JSE. The Carbon Disclosure Leadership Index focuses on climate change governance, risk management, performance, transparency and data management.

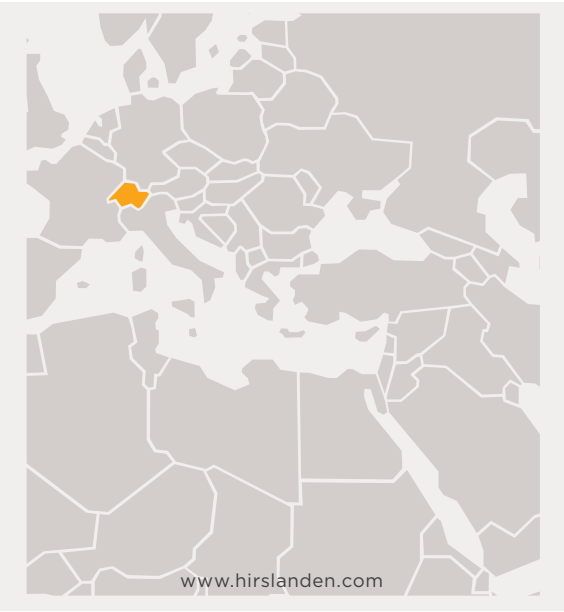
OUTLOOK

There are many attractive growth opportunities in Southern Africa, both through the expansion of Mediclinic Southern Africa's existing hospitals and through building new hospitals. At the same time, medical scheme membership continues to grow. There will always be room to improve operational efficiencies, while benefits may also be derived, for instance, from leveraging technology such as clinical information systems.

Skills shortages are an ongoing challenge that Mediclinic Southern Africa is addressing through increased training. Potential regulatory changes also create some uncertainties which are part of our healthcare operating environment. We continue to monitor the regulatory position so that we can play an appropriate role in decision-making.

OPERATIONAL REVIEW: SWITZERLAND

Ole Wiesinger
Chief Executive Officer: Hirslanden



BUSINESS ENVIRONMENT

Hirslanden remains the largest private hospital group in Switzerland, with its primary competitor being the Swiss public hospital sector.

Although the Swiss economy grew at a slower rate than in the previous year, it still appears strong when compared with its European neighbours. Minor deflation was experienced while the level of unemployment remained stable at low levels. Switzerland thus remains attractive to foreign workers and professionals, also in healthcare.

The year under review was the first full 12 months regulated by the revised Swiss Health Insurance Act (KVG) introducing fundamental changes in the Swiss health sector not seen since the KVG's establishment in 1996, and presenting numerous legal and political uncertainties. As reported before, the changes involved:

- the introduction of fixed fees for inpatient services based on the new Swiss Diagnosis Related Grouping (DRG);
- a new hospital financing system which redefines the funding ratios of the cantons versus the health insurance companies; and
- the revision of the hospital planning that led to new hospital lists, defining those hospitals that are eligible to treat generally insured patients. Many rules were introduced provisionally or at very short notice, some even with backdated effect. Hirslanden succeeded in meeting the challenge of interpreting these rules most appropriately from both a strategic and operational point of view, while simultaneously contributing to the group's growth strategy.

The above mentioned challenges not only confronted Hirslanden, but all Swiss hospitals. Hirslanden had been well prepared to meet these challenges, with all 14 hospitals amongst the first in Switzerland to render accounts according to the new system. With regard to supplementary (private/semi-private) insurance, Hirslanden managed to conclude contractual agreements with health insurers.

SUCCEEDED IN MEETING REGULATORY CHALLENGES, WHILE CONTRIBUTING TO THE GROUP'S GROWTH STRATEGY

NUMBER OF EMPLOYEES **6 508**	NUMBER OF BEDS **1 487**
NUMBER OF HOSPITALS **14**	NUMBER OF THEATRES **76**

As previously reported, despite the fact that the new system is operational, there are still a number of areas that have not been finalised and remain uncertain:

- the applicable base rate per canton of the DRG pricing;
- hospital lists in some cantons are still under debate or being legally challenged;
- restrictions in cantonal legislation could impact the business;
- highly specialised medicine (HSM) developments can have an impact on the future patient profile of some hospitals; and
- cantons subsidising public hospitals.

Prior to the new hospital financing system's coming into force, approximately a third of Hirslanden's patients had only general insurance. This proportion increased to 39.6% during the year under review, from 32.2% during the prior year, mainly due to the fact that 13 of the 14 Hirslanden hospitals have been included on the cantonal hospital lists, with the obligation to admit patients with general insurance. Hirslanden, however, continues to position its hospitals as leading operators in the supplementary insurance segment by aiming, firstly, to differentiate itself from its competitors and, secondly, to differentiate between insurance categories. Hirslanden believes that it is the definer of quality leadership and therefore market differentiation, firstly via the medical service offered to the patients and, secondly by providing the highest standards of (non-medical) patient care. This high quality includes swift access to treatment, leadership in cutting-edge medical technology, having the best experts in medical fields and a measurable excellence of (non-medical) patient care. In order to further maintain the public's experience of the added value of supplementary insurance without creating differences in medical service quality, Hirslanden has re-launched its Hirslanden Privé programme. This means that all hospital departments which come into contact with privately insured patients can offer care tailored to the individual needs of the patients.

INPATIENT ADMISSIONS **+2.6%**	NORMALISED REVENUE **+5%**
AVERAGE INCOME PER CASE **+2%**	PATIENT SATISFACTION LEVEL **87%**

BUSINESS PERFORMANCE

The 5% normalised revenue growth was achieved through inpatient admissions increasing by 2.6% during the reporting period, while the average length of stay decreased slightly and the average revenue per case increased by 2.0%, due to higher acuity levels.

The normalised EBITDA margin of Hirslanden increased from 21.9% to 22.6%.

During the period under review, Hirslanden invested the following amounts:

- R741m (CHF82m) (2012: R456m (CHF54m)) on capital projects and new equipment to enhance its business;
- R498m (CHF55m) (2012: R413m (CHF49m)) on replacing existing equipment; and
- R317m (CHF35m) (2012: R292m (CHF35m)) on repairing and maintaining property and equipment, which was charged through the income statement.

For the next financial year the budget is:

- CHF58m for capital projects and new equipment;
- CHF52m for replacing existing equipment; and
- CHF34m for repairs and maintenance.

Incremental EBITDA resulting from capital projects in progress or approved is budgeted to amount to CHF6m and CHF13m in 2014 and 2015 respectively.

The number of fully operational inpatient beds increased to 1 487 (2012: 1 479) during the period under review, due to an additional eight inpatient beds that were opened at Klinik St. Anna early 2013.

BUILDING PROJECTS

Investment in repairs and maintenance, new and replacement equipment and expansion projects are essential for Hirslanden to maintain its leadership in quality healthcare. Hirslanden is known for its use of cutting-edge medical technology, thereby enabling it to maintain its position as a preferred employer

and partner of choice for the leading experts in the various medical fields.

Building projects completed during the period under review were:

- The Group's largest construction project, the new wing (Enzenbühl Trakt) at Klinik Hirslanden in Zurich, was substantially completed during the period under review, and formally opened during May 2013. With a total area of around 16 710 square metres, the wing will house doctors' practices, specialised centres of medical competence, a modern intensive care unit, operating theatres and an additional 72 inpatient beds and eight ICU beds. A whole floor will be dedicated to Hirslanden Privé (the private insurance offering). The new wing is state-of-the-art in terms of comfort and care, and also, with the integration of a whole range of centres of medical competence and inter-disciplinary teams, positions Klinik Hirslanden well towards becoming even more of a private hospital with the character of a traditional Swiss university hospital.
- At Klinik Stephanshorn, the health centre was opened as planned in September 2012. The centre consists of five doctor practices and a walk-in emergency.

The major ongoing expansion projects are as follows:

- Klinik Stephanshorn will open its new intensive care unit (ICU) during July 2013. The creation of an ICU is especially important for the hospital to obtain the inclusion of certain medical services on the canton of St. Gallen's hospital list, expected to become effective at the beginning of 2014.
- A new centre at Berne main station, offering basic medical care, specialist and emergency consultation and other services, will be opened in August 2013.

EXTENSIVE EXPANSION OF KLINIK HIRSLANDEN IN ZURICH SUCCESSFULLY COMMISSIONED

Hirslanden is also investing in structural maintenance and innovative medical technology:

- At Klinik St. Anna in Lucerne, around 70 rooms have been renovated in the last three years. All of the hospital's wards will have been brought up to the newest standards by 2015.
- For the treatment of tumours, TrueBeam linear accelerators were installed at the radiotherapy unit at Klinik Hirslanden in Zurich, and the radio-oncology unit at Clinique Bois-Cerf in Lausanne. The cutting-edge technology device enables both conventional radiation and stereotactical radiotherapy, with a precision of less than one millimetre.
- A *da Vinci* robot, a system for minimally invasive surgical treatment, was brought into service at Klinik Beau-Site in Berne in February 2013. It is now the third unit of this type in the Hirslanden group.

The number of licensed beds is expected to increase from 1 487 to 1 561 during the next financial year.

NEW MANAGEMENT STRUCTURE

Hirslanden improved its organisational structure to better exploit the benefits available to the group. Since September 2012, all corporate services have been assigned to one member of the group's executive committee, with another member representing the 14 hospitals. At the same time, the number of group management members was reduced by one.

The new organisational structure will relieve the hospitals from some administrative responsibilities, which will enable them to concentrate more on their core activity, namely the provision of quality medical care. It will also enable the corporate services at head office to be more efficient, with synergies that benefit all 14 hospitals.

SUSTAINABILITY

QUALITY

The quality management of Hirslanden is based on a strong process orientation underpinned by ISO 9001:2008 certification of all hospitals. The outcome measurement and publication of all Swiss hospitals is regulated by the Swiss Association of Quality Assurance (ANQ). Hirslanden performed well compared to public hospitals and the group's public quality report is also still more transparent than those of other Swiss hospitals.

PEOPLE

As elsewhere in the world, healthcare in Europe is challenged by a significant shortage of nurses. Hirslanden is therefore continuously expanding its engagement in the training and education of medical staff. With modern working conditions and regular employee satisfaction surveys, Hirslanden further aims to maintain a low staff turnover rate and long-term staff commitment. In the future, with centres of expertise specialised in remuneration and employer branding, Hirslanden will continue to position itself as an employer of choice in the healthcare industry.

As one of the largest employers in the Swiss healthcare industry, Hirslanden is strongly active in training, and employs 700 apprentices and students in 27 professional groups (e.g. in State Certification, Degree and Post-degree). Of the apprentices and students, 599 are in medical profession areas. There are also 89 assistant doctors who have completed a part of their medical doctor studies in one of the group's hospitals.

ENVIRONMENT

Strict and comprehensive environmental legislation and regulations apply in Switzerland, with which Hirslanden fully complies, ensuring that the group maintains the highest degree of environmental protection.

Klinik Hirslanden, Klinik Im Park and, as of 2013, Klinik Stephanshorn were recognised as CO_2-reduced businesses by the Swiss Energy Agency for the Economy on behalf of the Swiss Federal Office of Energy. This achievement recognises the contracted commitment to reduce CO_2 emissions within operations.

The new wing at Klinik Hirslanden in Zurich fulfils the stipulations of the MINERGIE® standards for buildings, and has been issued the provisional MINERGIE® certificate (valid until completion of construction). This certificate of construction is a non-compulsory building standard enabling the rational use of energy and a broad use of replaceable energy sources with simultaneous improvement of quality of life, guarantee of competitiveness and reduction in environmental impact.

The Engineering Services teams at the hospitals, under the guidance of the group's Head of Real Estate, are responsible for managing the group's environmental impacts, and continue to focus on improving existing measures. A new position within this department has been filled, to assume responsibility for managing, *inter alia*, the group's energy projects. The environment manager project leader formed a Sustainability and Environment Management working group in 2012. This group has evaluated proposals to strengthen the vision, basic values and strategy in the area of ecological sustainability.

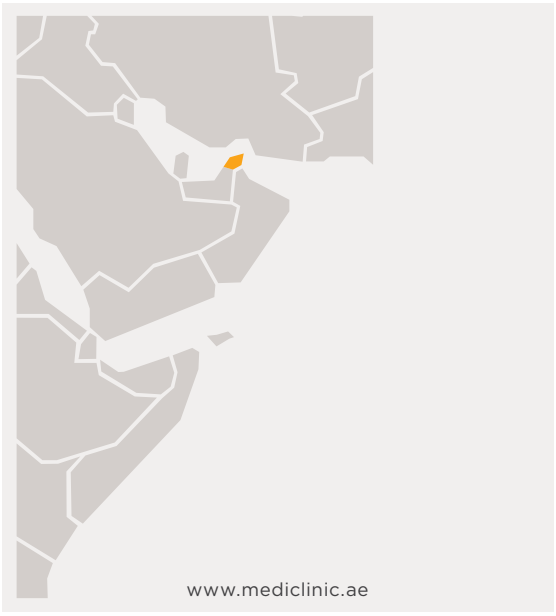
OUTLOOK

As reported previously, public private partnerships (PPPs) are implicit in Hirslanden's strategy. Hirslanden is actively seeking opportunities for such partnerships, which are mutually beneficial to both parties. A current PPP is the radiotherapy centre at the hospital in Männedorf, of which construction commenced at the beginning of 2013, with the unit's inauguration due in 2014. This will create comprehensive radiation treatment, with a linear accelerator that will allow tumours to be treated during outpatient treatment sessions.

Hirslanden further continues to see significant growth potential in its existing hospitals and is following a consistent and sustainable strategy, investing approximately 10% of its revenue in maintenance, replacement, expansion and acquisitions.

OPERATIONAL REVIEW: UNITED ARAB EMIRATES

David Hadley
Chief Executive Officer: Mediclinic Middle East



www.mediclinic.ae

BUSINESS ENVIRONMENT

Economic sentiment in the United Arab Emirates (UAE) is arguably more positive at our reporting date than at any time in the past four years. The real gross domestic product is estimated to have risen to 4.5% in 2012 (according to the UAE Minister of Economy), up from 3.4% in 2011. This is reported to be a direct result of consistently high oil prices, a surge in tourist numbers and increased activity in the trade, manufacturing, construction and real estate industries. Dubai International Airport recorded a 13% rise in passengers in 2012, up to 57.7 million, making it the world's third busiest airport.

The Middle East region continues to see conflict and unrest, particularly in Syria and Egypt, but the UAE remains a safe haven for investors and represents a stable and peaceful business environment. Mediclinic Middle East continues to monitor the situation in Iran closely. A new pipeline carrying the bulk of Abu Dhabi's oil to the east coast of the UAE opened in August 2012. This pipeline bypasses the strategically sensitive Straits of Hormuz and reduces the UAE's economic dependence on the volatile area controlled by Iran.

The healthcare sector in the UAE has grown at an unprecedented rate over the past few years. The compound annual growth between 2011 and 2014 is predicted at 16% by RNCOS, a leading industry research agency. This growth is driven by an increasing population and the marked prevalence of lifestyle diseases such as diabetes, heart disease and cancer.

Mediclinic International acquired the 49.6% minority interests in Emirates Healthcare held by the Varkey Group and General Electric during October 2012 and launched the Mediclinic brand in the Middle East (replacing Emirates Healthcare) in December 2012. The refinancing and successful buy-out of the minority interests, followed by the rebranding of Emirates Healthcare to Mediclinic Middle East was the main focus of our activities during the period under review.

There are challenges ahead in the form of the opening of competing facilities and tariff reform, but Mediclinic Middle East is well placed to manage these.

MEDICLINIC MIDDLE EAST NOW WHOLLY OWNED WITH BUY-OUT OF MINORITIES DURING THE YEAR

NUMBER OF EMPLOYEES **2 040**	NUMBER OF BEDS **382**
NUMBER OF HOSPITALS **2**	Number of theatres **10**
NUMBER OF CLINICS **8**	

BUSINESS PERFORMANCE

The 19% revenue growth was achieved through inpatient hospital admissions increasing by 13%, while hospital outpatient consultations and visits to the emergency units increased by 8%. Clinic outpatient consultations increased by 14%.

The normalised EBITDA margin of Mediclinic Middle East increased from 19.2% to 19.9%.

As mentioned previously, Mediclinic International bought out the minority interests in Emirates Healthcare at a cost of USD225m. The buy-out was financed partly from the Mediclinic International rights issue of October 2012, and partly through additional debt raised by Mediclinic Middle East. This additional debt gave us the opportunity to refinance the entire platform. Emirates Healthcare was rebranded and relaunched in December 2012, with a major media and patient education campaign designed to minimise confusion, bring an end to the fragmented EHL/Welcare brand and begin the move forwards to a unified Mediclinic brand. This effort will continue in the next financial year. Other achievements during the period under review included the launch of Mediclinic Beach Road, approval for the North Wing expansion and other significant development projects at Mediclinic City Hospital, as well as major ICT projects such as the implementation of a hospital information system at Mediclinic Welcare Hospital and a unified electronic medical records system across the group.

During the period under review Mediclinic Middle East invested the following amounts:

- R62m (AED27m) (2012: R26m (AED13m)) on capital projects and new equipment to enhance its business;
- R45m (AED19m) (2012: R25m (AED12m)) to replace existing equipment; and
- R43m (AED19m) (2012: R35m (AED17m)) to repair and maintain property and equipment, which was charged through the income statement.

For the next financial year the budget is:

- AED88m on capital projects and new equipment;
- AED8m for replacing existing equipment; and
- AED17m for repairs and maintenance.

The number of licensed beds is 382, which includes 27 day beds available at the clinics.

Patient satisfaction levels improved from 89% to 93%, against a target of 90%.

INPATIENT ADMISSIONS **+13%**	REVENUE **+19%**
OUTPATIENT CONSULTATIONS **+14%**	PATIENT SATISFACTION LEVEL **93%**

BUILDING PROJECTS

Following the closure of Emirates Diagnostic Clinic, Mediclinic Middle East launched a new clinic, Mediclinic Beach Road. The new clinic significantly expands the primary healthcare offering of the group. Mediclinic Beach Road opened in December 2012.

Mediclinic City Hospital opened its second floor as a dedicated outpatient department and the remaining corporate staff members were relocated from the 7th floor of Mediclinic City Hospital to Mediclinic Dubai Mall, allowing for 30 additional beds, increasing the operational bed capacity of the hospital by 15%.

The land exchange of the Creek plot for the vacant plot adjacent to Mediclinic City Hospital was approved by Dubai Healthcare City. It is planned to develop the adjacent plot as an extension to the hospital at an estimated cost of AED213m, which will include a state-of-the-art oncology unit developed in association with Hirslanden, an expanded reference laboratory servicing the entire Mediclinic Middle East, a day surgery unit, a rehabilitation centre and Mediclinic Middle East's corporate offices, which will relocate from Mediclinic Dubai Mall, freeing up additional clinical space there. The expected completion date of the project is in the second quarter of 2015 (calendar year).

The development of Mediclinic Middle East's first clinic in Abu Dhabi, Mediclinic Corniche, is ongoing and this should open in the Corniche area in the last quarter of 2013 (calendar year), laying a platform for future growth in this emirate.

SUSTAINABILITY

PATIENT TRUST

Winning patient trust is paramount to the success of Mediclinic Middle East's business. The increase in inpatient and outpatient admissions and consultations respectively is a clear indication that the group is achieving this. The group endeavours to communicate with patients through many different channels to ensure that information is relayed quickly, accurately and at the convenience of the patient or prospective patient. These channels include patient satisfaction surveys, free health checks, seminars and talks and the

positioning of Mediclinic Middle East doctors as figures of authority through media appearances and social media. In addition, Mediclinic Middle East's mobile application was launched in May 2012 and up to the end of the period under review has been downloaded by more than 5 000 users.

PEOPLE

Mediclinic Middle East has undergone rapid expansion in terms of employee numbers, with a 12.5% increase in staff during the period under review. It looks to attract and retain the very best professionals with market-related salaries and benefits, including life insurance and permanent disability benefits, comprehensive training, open communication and sound management practices. Staff turnover has dropped from 11.1% in the previous period to 9.5% in the period under review.

Mediclinic Middle East organises continued medical education sessions both at an individual facility level and a corporate level for its employed and community-based doctors.

COMMUNITY

Mediclinic Middle East is committed to working with the community in which it operates to facilitate better awareness and understanding of health issues and to provide assistance to the less fortunate. Corporate social investment initiatives run by the group have included charity campaigns using Facebook, free health screenings, health talks and awareness campaigns on particular health topics.

Mediclinic Middle East also actively supports members of its medical staff who wish to volunteer their services in regions affected by conflict or natural disasters.

Individual units work at a local level to support causes of their choice, but at a corporate level Mediclinic Middle East takes part in major community events such as World Health Day, World Heart Day and World Diabetes Day, with free health check-ups for the general public at locations across Dubai.

Mediclinic has budgeted AED500 000 for community initiatives in the year ahead, the same as in the period under review.

ENVIRONMENT

Mediclinic Middle East is aware of its environmental responsibilities and each facility works individually to minimise its environmental impact, no matter how big or small the initiative. The 'Go Green' committee at Mediclinic City Hospital continues to be active with more departments participating, installation of education boards, community clean-ups and inter-departmental recycling competitions. Electricity consumption at Mediclinic City Hospital increased by only 2%, despite a 20% increase in bed days sold. The electricity usage at Mediclinic Welcare Hospital increased by only 0.63%.

OUTLOOK

Mediclinic Middle East is positive about the outlook for the next financial year. Mediclinic City Hospital's North Wing expansion is expected to break ground in June 2013 and will provide an exciting focus for the group's activities in the year ahead.

The expansion into Abu Dhabi is also a very positive initiative for the group as it seeks to expand its footprint, and it continues to look actively for further opportunities for expansion both in the UAE and elsewhere in the Middle East.

The next financial year will also see the opening of a new paediatric ICU at Mediclinic City Hospital, the first of its kind in the UAE, and the expansion of the hospital's accident and emergency department. Development work will also take place at Mediclinic Al Qusais to build new doctors' rooms.

A FURTHER INVESTMENT OF AED213M TO EXPAND THE SUCCESSFUL MEDICLINIC CITY HOSPITAL IN DUBAI

Mediclinic Middle East is also looking forward to working in closer collaboration with Hirslanden in the areas of oncology, bariatric surgery, neurosurgery and tele-radiology.

We do expect far-reaching developments in the Dubai healthcare sector in the foreseeable future. These include a greater focus on medical regulations and a revised tariff structure, as well as the introduction of mandatory health insurance. Details of timelines and proposals are uncertain but Mediclinic Middle East will continue to be an active participant in these initiatives.

The economic climate in the UAE, combined with the group's enviable reputation for quality healthcare and a focus on engaging with community-based doctors to increase referrals and the expansion of social media activity into new channels, should all assist Mediclinic Middle East to grow at a satisfactory rate, despite increased competition.

CONTINUED FOCUS ON PATIENT SAFETY, EXCELLENCE IN CLINICAL GOVERNANCE AND DELIVERING MEASURABLE, COST-EFFECTIVE QUALITY CARE

CLINICAL SERVICES REPORT

INTRODUCTION

Mediclinic provides a wide range of clinical services throughout its operating platforms. The majority of services are provided in specialist-orientated acute care inpatient community hospitals of average size. Highly specialised services are provided by a number of hospitals in larger metropolitan areas, and these hospitals also serve as referral centres, while more generic services are provided in smaller hospitals in outlying towns.

Delivery models differ between the three operating platforms. Most doctors working at Mediclinic Middle East facilities are employed by the Group, whereas the majority of doctors practise independently at Hirslanden's and Mediclinic Southern Africa's hospitals.

Mediclinic strives to ensure that the clinical services provided throughout the organisation are efficient, effective, appropriate, evidence-based and in line with modern technological advances. This is a formidable task, and is approached by way of clinical governance, clinical information management and clinical services development. Clinical governance focuses on ensuring patient safety and quality improvement. Clinical information management enables clinical performance measurement and deals with systems that support the clinical care process at hospital level, including electronic patient records. Clinical services development deals with developing new coordinated care models, investigating new services lines and keeping abreast of technological developments.

It is important to note that all indicators are reported per calendar year to ensure completeness and consistency, as a significant time lag needs to be provided for in the collection of clinical data.

ACHIEVEMENTS

- *The Best Care… Always!* campaign in South Africa progresses with marked reductions in healthcare-associated infections (HAIs) and continued implementation of changes to address HAIs.
- A new state-of-the-art cardiac electrophysiology laboratory established at Mediclinic Panorama – the second cardiac electrophysiology laboratory in Mediclinic Southern Africa.
- Piloting the application of an internal model for accrediting Hirslanden competence centres at different levels.
- The successful introduction of the concept of patient-centred care at Hirslanden.
- A *da Vinci* robot, a system for minimally invasive surgical treatment, was brought into service at Klinik Beau-Site in Berne in February 2013, being the third unit of this type within the Hirslanden group.
- A diagnostic nuclear medicine department was successfully commissioned at the Mediclinic City Hospital in Dubai.
- The development of clinical key performance indicators that will be included in the annual doctors' performance review process at Mediclinic Middle East.

SPECTRUM OF SERVICES

The services offered by Mediclinic range from routine procedures and medical treatment plans to highly specialised, complex and technologically advanced treatment modalities. The majority of cases are elective in nature, but in Mediclinic Southern Africa a significant portion is unscheduled, emergency and trauma related.

Day-case services are becoming more prevalent across all facilities, and emergency, unscheduled and scheduled outpatient services are provided at the majority of the Group's hospitals. Scheduled and unscheduled outpatient services are provided at outpatient facilities in Dubai and Switzerland. Radiology and laboratory services are provided at all hospitals, either by independent practices or by Mediclinic, while oncology and radiotherapy services are provided at selected hospitals.

FIGURE 1: SPECTRUM OF SERVICES – MEDICLINIC SOUTHERN AFRICA (2012)

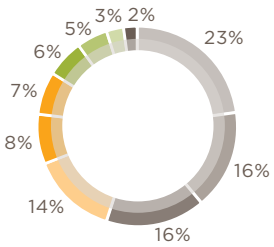


FIGURE 2: SPECTRUM OF SERVICES – HIRSLANDEN (2012)

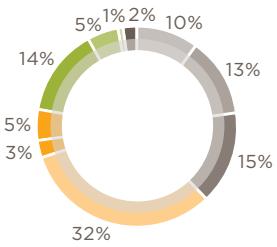
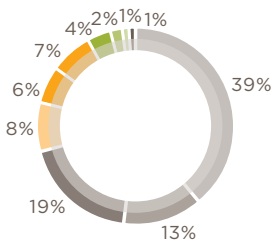


FIGURE 3: SPECTRUM OF SERVICES – MEDICLINIC MIDDLE EAST (2012)



- Internal medicine
- General surgery
- Obstetrics and gynaecology
- Orthopaedics
- ENT and ophthalmology
- Urogenital
- Cardiac and vascular
- Neurology
- Oral and maxillofacial
- Other

VOLUME CONTRIBUTION

MEDICLINIC SOUTHERN AFRICA

Figure 1 illustrates the contribution per discipline in terms of number of patients admitted to Mediclinic Southern Africa's hospitals in 2012. Internal medicine was the most prominent contributor (23%), followed by general surgery (16%), obstetrics and gynaecology (16%) and orthopaedic services (14%).

HIRSLANDEN

Figure 2 illustrates the contribution per discipline in terms of the number of patients admitted to Hirslanden's hospitals in 2012. Orthopaedics was the most prominent contributor (32%), followed by obstetrics and gynaecology (15%), cardiac and vascular (14%), general surgery (13%) and internal medicine (10%).

MEDICLINIC MIDDLE EAST

Figure 3 illustrates the contribution per discipline in terms of the number of patients admitted to Mediclinic Middle East's hospitals in 2012. Internal medicine (39%), obstetrics and gynaecology (19%) and general surgery (13%) were the most prominent contributors in 2012 followed by orthopaedics (8%) and urogenital (7%).

FIGURE 4: AVERAGE INPATIENT LENGTH OF STAY (2012) (CALENDAR DAYS)

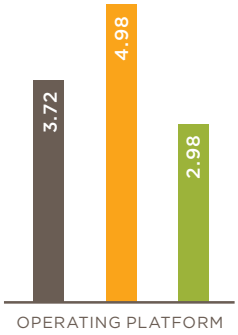
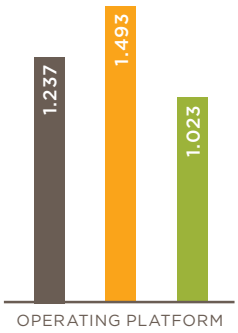


FIGURE 5: CASE MIX INDEX (2012)



- Mediclinic Southern Africa
- Hirslanden
- Mediclinic Middle East

LENGTH OF STAY

(ALL OPERATING PLATFORMS)

The average inpatient length of stay (calendar days) for the Group's three operating platforms in 2012, as indicated in **Figure 4** indicates a significant variation from 2.98 in Mediclinic Middle East to 4.98 days in Hirslanden to Mediclinic Southern Africa with 3.72 days. These variations in inpatient length of stay can be contributed to the mix and severity of the patient population treated by the different operating platforms and should be viewed in combination with the case mix of the operating platforms as illustrated in **Figure 5**.

CASE MIX INDEX

(ALL OPERATING PLATFORMS)

Mediclinic uses various methodologies and grouping systems to measure and compare case mix differences (i.e. differences in clinical risk, complexity and resource utilisation of patients over time and between entities). The methodologies used assign a case weight to each patient which is used to adjust for the differences in patient profiles. **Figure 5** shows the case mix index of the three operating platforms. The indices are based on patient diagnosis, age and gender information consolidated between the operating platforms, using the Mediclinic Southern Africa inpatient case weights.

CLINICAL GOVERNANCE

Mediclinic strives to provide internationally comparable quality care in a safe environment at all times. Quality and safety are actively promoted through a comprehensive clinical governance programme consisting of focus areas in leadership and accountability, healthcare workforce, infrastructure and environment, clinical care management and clinical performance measurement. The Group is following a unified approach to clinical governance by adhering to certain important principles, namely a non-punitive system of self-governance at hospital level, a focus on measurable improvement targets and the involvement of the entire hospital team.

All three operating platforms use a comprehensive standardised clinical risk register as a starting point in clinical governance. Innovative control measures are being developed, implemented and improved all the time, and the operating platforms freely share their challenges and achievements with one another.

LEADERSHIP AND ACCOUNTABILITY

Leadership is indispensable in the promotion of quality and safety of patient care. The executive committees of the respective operating platforms are ultimately accountable for patient safety. These bodies aim to ensure that the responsibilities for patient safety are clearly defined, that the culture supports patient safety and that there are clear patient safety objectives. Each executive committee is supported by a chief clinical officer and a multidisciplinary clinical governance committee in order to fulfil its duties, and all operating platforms use clinical key performance indicators to measure clinical performance.

MEDICLINIC SOUTHERN AFRICA

Mediclinic Southern Africa's hospitals are divided into five regions with a clinical manager and clinical information specialist at each. Eight nursing specialist committees assist the hospitals with expertise in clinical governance, critical care, emergency care, mother and child care, operating room care, paediatrics, documentation and policy. Each hospital has a multidisciplinary clinical hospital committee that drives quality and safety at hospital level and promotes cooperation between doctors, nursing staff and management. Each hospital also has a clinical risk manager who is responsible, *inter alia*, for infection prevention and control.

HIRSLANDEN

Every Hirslanden hospital has a quality manager, an infection control specialist, a critical incident manager as well as several subcommittees for quality, infection control and critical incident reporting. The Clinical Services department at the Hirslanden head office coordinates the activities of the sub-committees, and clinical key performance indicators monitor their activities. The affiliated doctors are integrated into this structure by established boards in several specialities.

Hirslanden promotes quality and safety in patient care by subscribing to the European Foundation for Quality Management (EFQM). The EFQM Excellence Model is a non-prescriptive framework based on nine criteria. The five 'Enabler' criteria are concerned with what an organisation does and how it is done. The four 'Results' criteria measure organisational achievements. The main objective of this model is to add value to patients and other stakeholders of the business. Every hospital underwent a self-assessment utilising the criteria of the EFQM Excellence Model in the year under review in order to identify areas of improvement.

MEDICLINIC MIDDLE EAST

Clinical services at Mediclinic Middle East are coordinated by the Clinical Forum, a multidisciplinary committee comprised of the senior clinical leaders (medical, nursing, pharmacy, hospital and clinical directors), which meets monthly.

Both Mediclinic Middle East hospitals have a full-time medical director coordinating the activities of all the doctors in the facility, and each has an active and functioning clinical hospital committee. These committees are multidisciplinary, with excellent cooperation between doctors, nurses and management. Each committee has six subcommittees covering infection control, clinical risk management, credentialling, research, patient safety and pharmaceutical use.

QUALITY AND SAFETY OF CARE ARE ACTIVELY PROMOTED THROUGH A COMPREHENSIVE CLINICAL GOVERNANCE PROGRAMME

Each of the eight multidisciplinary outpatient clinics also has a practising clinician as its medical director. The medical director is responsible for all the clinical aspects of the clinic and forms an integral part of the operating platform's clinical management structure.

HEALTHCARE WORKFORCE

Quality and safety of patient care are very reliant on a well-trained, skilled and experienced healthcare workforce. Recruitment practices, credentialling of healthcare professionals, performance surveillance and continuous professional development are some of the most important aspects in ensuring a capable healthcare workforce.

MEDICLINIC SOUTHERN AFRICA

In South Africa and Namibia all practising doctors must be in possession of full registration in their specific fields of speciality with the Health Professions Council of South Africa and Namibia respectively. Hospitals follow a specific credentialling process to evaluate doctors who apply for admission rights, and in many hospitals the clinical hospital committees assist with the process. A professional performance surveillance system has been developed to continuously evaluate clinical service levels. Areas of concern are identified early and a process to deal with impaired practitioners has been developed.

Mediclinic Southern Africa is actively involved in training. Numerous different courses are presented and the company spends approximately 4% of payroll on training. This ranges from formal basic training in nursing to continuous professional development of healthcare professionals by providing various training courses, sponsoring international conference attendance and hosting training workshops.

Mediclinic Southern Africa has developed and implemented an integrated nursing staffing model in all its hospitals over the last two years. This software solution measures workload in nursing units and forecasts the optimal number and skill mix of staff required. The optimal deployment of nursing and support staff is motivated using an evidence-based approach.

The Mediclinic Southern Africa Nursing Executive has been appointed as the private sector representative on the National Department of Health Technical Advisory Committee to assist with the development of Human Resources Health Staffing Norms for the public sector hospitals in South Africa, a project which will run over a number of years.

HIRSLANDEN

There are strict entry criteria for doctors to become affiliated to Hirslanden hospitals. Applicants must be qualified specialists having held leading positions in other hospitals for at least two years. A comprehensive credentialling process, assisted by a clinical committee, is followed. The recruitment and credentialling of nursing staff is a rigorous process that includes a trial period of three months during which three formal assessments take place. Healthcare education is highly regulated in Switzerland, and Hirslanden participates by offering 599 healthcare apprenticeships and 89 positions for further training.

The continuous training of nurses is coordinated by training managers in every hospital, and resuscitation training takes place on an ongoing basis.

MEDICLINIC MIDDLE EAST

Mediclinic Middle East has to follow a thorough credentialling process when recruiting new doctors and nursing staff. The Dubai Health Authority (DHA) and the Centre for Planning and Quality in Dubai Healthcare City do primary source verification to validate the qualifications of all doctors and nurses applying for a licence to practise. Once a licence has been approved by the relevant regulating body, Mediclinic Middle East continues with the rest of the recruitment and credentialling process. Successful candidates receive specific clinical privileges based on qualifications and experience, which are reviewed biannually by hospital clinical subcommittees.

Doctors are regularly assessed by way of a clinical performance management system in which different competencies are assessed and graded. Nursing staff are evaluated twice a year and succession planning for key nursing staff is performed on an ongoing basis. Both hospitals conduct in-house continued medical education for their doctors and have a dedicated budget to support external training for doctors. The training department conducts various mandatory courses internally as well as for several other institutions outside the Mediclinic Middle East group. These courses include training in life support.

INFRASTRUCTURE AND ENVIRONMENT

Hospitals are high-risk environments in which complex treatment processes are executed using sophisticated equipment and techniques. It is a business imperative to ensure a safe environment for patients and healthcare workers. At all three operating platforms patient safety and quality care aspects are carefully considered in the development of facilities, the procurement of medical equipment, and the maintenance of infrastructure.

The management of infrastructure and the environment in which patients are treated is further enhanced by the participation of the operating platforms in various accreditation and certification initiatives. Accreditation involves a quality-assurance process under which the structures and processes of healthcare facilities are examined by an independent accrediting agency to determine whether applicable quality management standards have been met. Certification is received through internal and external audits of approved standards. Patients receiving treatment in an accredited or certified facility have the peace of mind that quality and safety standards have been achieved and are being continuously monitored.

MEDICLINIC SOUTHERN AFRICA

Mediclinic Southern Africa chose the Council for Health Services Accreditation of Southern Africa, an organisation whose standards have been accredited by the International Society for Quality in Healthcare, to accredit its hospitals. The process in the South African and Namibian health sectors is entirely voluntary, and Mediclinic Southern Africa was the first private hospital group in South Africa to enrol its hospitals in 1996. To date 33 of the 36 participating Mediclinic Southern Africa facilities have received accreditation status.

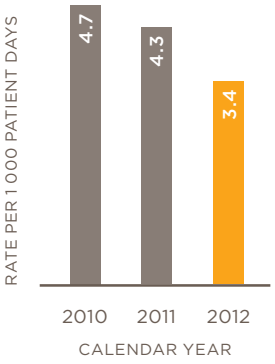
HIRSLANDEN

Hirslanden hospitals participate in ISO 9001:2008 certification in cooperation with the Swiss Association for Quality and Management Systems. The initiative focuses on processes and is embraced by EFQM objectives. All 14 hospitals are currently certified.

MEDICLINIC MIDDLE EAST

Hospital accreditation is a mandatory requirement of the Dubai Healthcare City Authority (DHCA) and the DHA. The DHCA appointed the Joint Commission International (JCI) as the sole accreditation body for the first re-accreditation cycle that is due in June 2013. Both hospitals will go through the re-accreditation process in June 2013 and the clinics will undergo their first JCI accreditation during the same period.

FIGURE 6: HEALTHCARE-ASSOCIATED INFECTIONS – MEDICLINIC SOUTHERN AFRICA (2010 – 2012)



In addition to the JCI accreditation, the laboratory of Mediclinic City Hospital also achieved the very prestigious College of American Pathologists accreditation in 2009, re-accredited in 2011 and will undergo the biannual re-accreditation in August 2013. Mediclinic City Hospital laboratory also obtained ISO 15189:2009 certification in 2010 and will undergo re-certification in 2013.

CLINICAL CARE MANAGEMENT

The numerous treatment plans that are executed in each hospital every day consist of countless interdependent and interrelated clinical care processes that by their nature are error prone. Hospitals face many clinical risks, the most prominent of which are HAIs and hospital adverse events. These and other clinical risks are managed through different control measures and continuous process re-engineering.

HAIs are infections that occur in patients during the process of care in a hospital or healthcare facility, and that were not present or incubating at the time of admission. These also include infections acquired in hospital but appearing after discharge. HAIs have become a major international challenge because of a significant increase in antimicrobial resistance. All operating platforms are therefore strongly focused on infection prevention and control.

An adverse event is defined as any event which causes harm to a patient while in the care of the hospital. A near miss is any event which could have caused harm, damage or loss, but which was prevented from happening by design or good fortune. All operating platforms make use of hospital event management systems in which all events are reported and analysed, and corrective action taken to prevent recurrence.

MEDICLINIC SOUTHERN AFRICA

HEALTHCARE-ASSOCIATED INFECTIONS

Mediclinic Southern Africa operates a robust and comprehensive infection prevention and control surveillance programme using the US Centres for Disease Control and Prevention as a reference point. All infections are categorised as either community acquired or healthcare-associated. This process is supported by a national electronic surveillance system to which all positive laboratory results are imported and cases then managed. The system monitors organism profiles, resistance patterns and outbreaks of organisms. Positive laboratory reports are imported hourly and pre-defined alerts are triggered when certain epidemiologically important pathogens are cultured. The services of independent microbiologists and infection prevention and control specialists are regularly utilised in order to ensure continuous improvements in the infection prevention and control programme. **Figure 6** reflects the HAI rate per 1 000 patient days, in line with international reporting trends. There was a significant decrease in the HAI rate in 2012.

Southern Africa, as in many other parts of the world, is facing significant challenges with the emergence of multi-drug resistant organisms such as carbapenem resistant enterobacteriaceae (more specifically NDM-1 and OXA-48), *clostridium difficile* as well as vancomycin resistant enterococci. It is also concerning that patients with multi-drug resistant organisms such as methicillin-resistant *staphylococcus aureus* and extended spectrum beta lactamase are mostly already colonised on admission to healthcare facilities.

The added burden of communicable diseases such as pulmonary tuberculosis makes patients with resistant organisms very challenging to accommodate and manage in the hospital setting. These patients all need to be isolated with the necessary precautions to prevent transmission to other patients.

FIGURE 7: DEVICE-ASSOCIATED AND SURGICAL SITE INFECTIONS – MEDICLINIC SOUTHERN AFRICA (2011 – 2012)

Best Care... Always!

Mediclinic Southern Africa is driving three major initiatives to reduce HAIs. The first initiative is an active and ongoing participation in the national *Best Care... Always!* campaign. Mediclinic Southern Africa is a founding member of this campaign and has committed all 52 hospitals to the initiative. The campaign focuses on the prevention of surgical site and three types of device-associated infections, as well as antimicrobial stewardship. Hospitals are actively implementing evidence-based interventions shown to reduce these types of HAI.

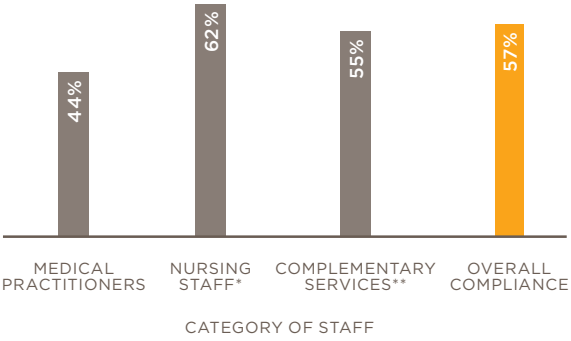
Figure 7 shows a significant reduction in infection rates in 2012 as compared to 2011.

Hand hygiene

The second initiative focuses on the improvement of hand hygiene in order to prevent the transmission of infections. Hand hygiene compliance is monitored continuously, and an annual hand hygiene compliance audit is conducted at all hospitals. All categories of healthcare workers are evaluated.

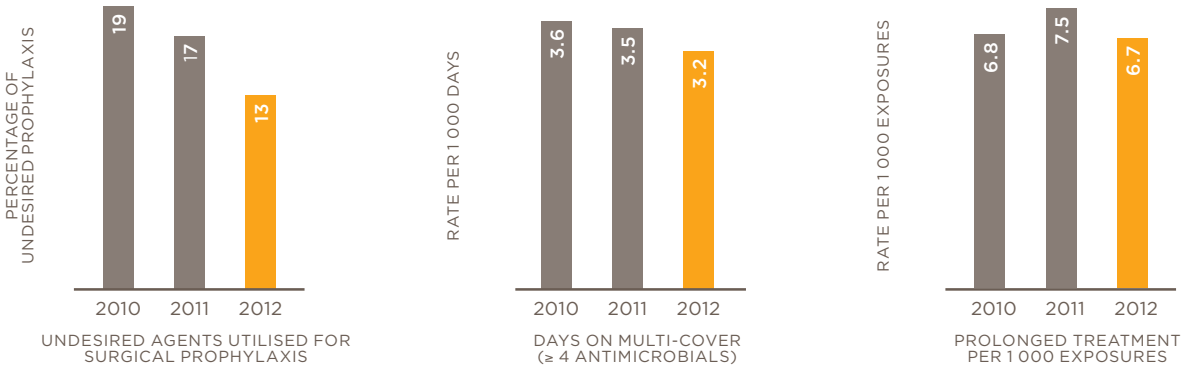
Figure 8 demonstrates the percentage of hand hygiene compliance per category of healthcare worker as well as the overall compliance in Mediclinic Southern Africa in 2012. The overall compliance of 57.3% is comparable to results from other parts of the world. According to the *Guidelines for Hand Hygiene in Healthcare* published by the World Health Organisation in 2009, observational studies of hand hygiene compliance demonstrated rates between 5% and 89% with an overall average compliance of 38.7%.

FIGURE 8: HAND HYGIENE COMPLIANCE – MEDICLINIC SOUTHERN AFRICA (2012)
Sample size: 5 401



* *The category "nursing staff" includes registered nurses, enrolled nurses and enrolled nursing auxiliaries.*
** *The category "complementary services" includes care workers, physiotherapists, phlebotomists and general assistants.*

FIGURE 9: ANTIMICROBIAL UTILISATION INDICATORS – MEDICLINIC SOUTHERN AFRICA (2010 – 2012)



Antimicrobial stewardship

The third initiative involves the promotion of the rational use of antimicrobials through a comprehensive antimicrobial stewardship programme. A uniquely developed methodology focuses on measuring and reporting antimicrobial utilisation at hospital level. Additional antimicrobials were included in the indicators in 2012 in order to improve reporting accuracy, which had a significant influence on the results. Therefore the indicators for the previous years had to be recalculated retrospectively for comparative purposes.

Figure 9 reflects the most prominent antimicrobial utilisation indicators. No internal or external benchmarks are available yet.

There was a significant improvement in the usage of undesired surgical prophylaxis. This can be attributed to the availability of more specific international as well as internal surgical prophylaxis guidelines. More than half of Mediclinic Southern Africa hospitals (56%) now have an antimicrobial stewardship team focusing on inappropriate antimicrobial usage, and it is anticipated that inappropriate antimicrobial usage will be reduced further in the near future.

FIGURE 10: ADVERSE EVENTS – MEDICLINIC SOUTHERN AFRICA (2010 – 2012)

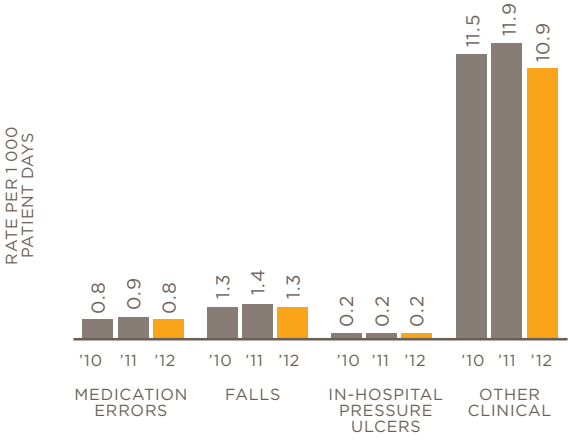
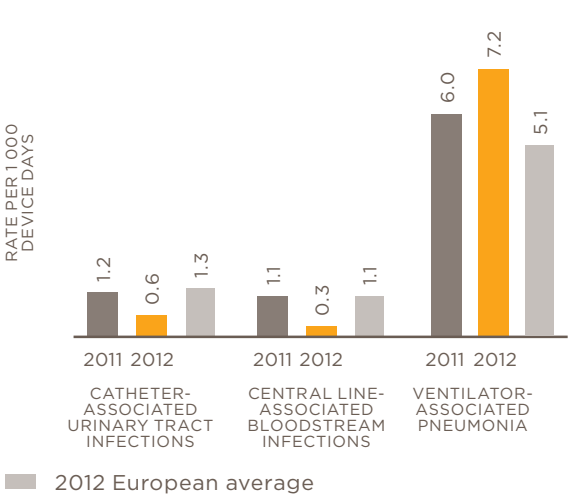


FIGURE 11: DEVICE-ASSOCIATED INFECTIONS – HIRSLANDEN (2011 – 2012)



ADVERSE EVENTS

The adverse events in **Figure 10** are reported per 1 000 patient days to be in line with international reporting standards.

Mediclinic Southern Africa has an in-house reporting system for capturing near misses and adverse events. The aim of reporting these events is to learn from them and to prevent their recurrence by implementing preventative strategies. There were no significant changes in the incidence of medication errors, falls and pressure ulcers (all grades are included and reported on), but there was a reduction in the overall numbers of all other clinical adverse events.

CLINICAL AUDITS

Regular clinical audits form an important part of Mediclinic Southern Africa's continuous quality improvement programme. These audits are performed by the regional clinical teams during regular visits to each hospital. The findings of these audits are used to formulate proactive responses to clinical system failures.

HIRSLANDEN

HEALTHCARE-ASSOCIATED INFECTIONS

Hirslanden has been assisted in infection prevention and control by the Beratungszentrum für Hygiene (BZH) in Freiburg, Germany, since 1998. All Hirslanden hospitals use the standardised Hospital Infection Surveillance System of the BZH to record HAIs. This system is based on the criteria of the US Centres for Disease Control and Prevention. Each hospital has an infection control committee that oversees infection prevention and control. Hospitals are also represented on the group infection control committee, where hospital results and standardisation policies are discussed. During 2011 a national initiative on infection control was started in which all Hirslanden hospitals participate. The first results are expected during 2013.

Figure 11 shows the device-associated infection rates in Hirslanden critical care units (CCUs). Hirslanden figures as well as the European benchmarks have been recalculated and will therefore differ from those reported in the previous report. Annual rates compare favourably with the European benchmarks (75% percentile). Infection prevention and control is a key performance indicator and hospitals are strongly focused on this aspect of their operations.

FIGURE 12: POST-OPERATIVE WOUND INFECTIONS FOR SPECIFIC TYPES OF PROCEDURES– HIRSLANDEN (2012)

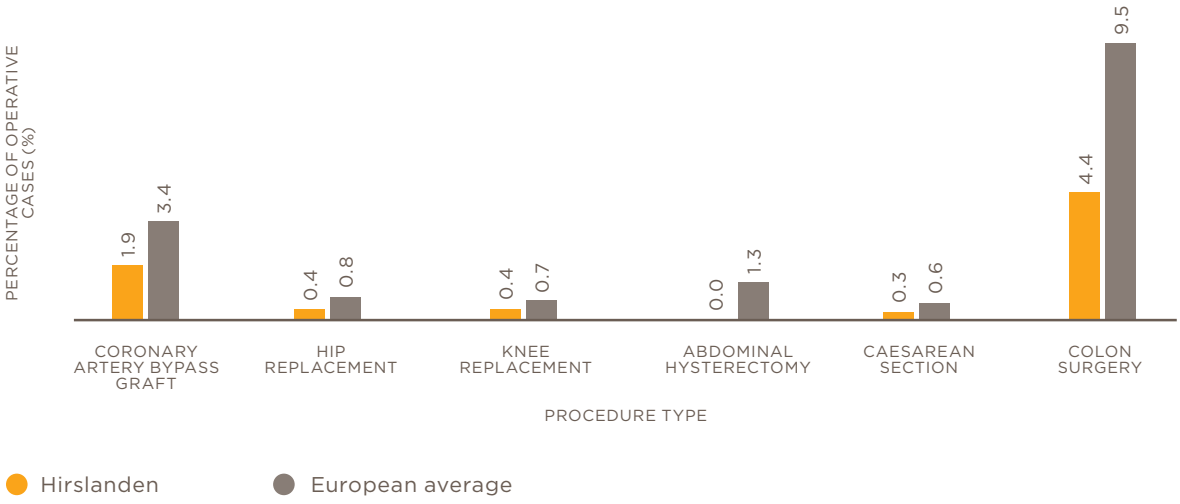


Figure 12 reflects the post-operative wound infection rates of selected procedures. Hirslanden hospitals compare very favourably with the European benchmarks.

Methicillin-resistant Staphylococcus Aureus (MRSA) is a bacterium which is well known for developing resistance against multiple antimicrobials. Patients with impaired defence mechanisms against infections are particularly at risk. Patients who are hosts of this bacterium should therefore be isolated. Early detection and isolation of possible hosts by screening methods and consequent hand hygiene is important to prevent infection of other patients. All patients who are transferred from foreign countries, outside CCUs and nursing homes are thoroughly screened. In 2012 MRSA infections were detected in 148 cases.

ADVERSE EVENTS

An important aspect of improving the quality and safety of patient care is the prevention of adverse events which could cause harm to patients. However, the very low occurrence of some events prevents a systematic analysis of underlying factors. In this case the gathering of information on near misses is a very effective method to improve the processes of care. A total of 1 382 cases were reported in 2012.

Hirslanden also participates in the International Quality Indicator Project® (IQIP) for documented falls. Its weighted average figures are reflected in **Figure 13**. The figure shows that Hirslanden compares favourably with other participating European hospitals.

FIGURE 13: IQIP WEIGHTED AVERAGE FALL RATE – HIRSLANDEN (2010 – 2012)

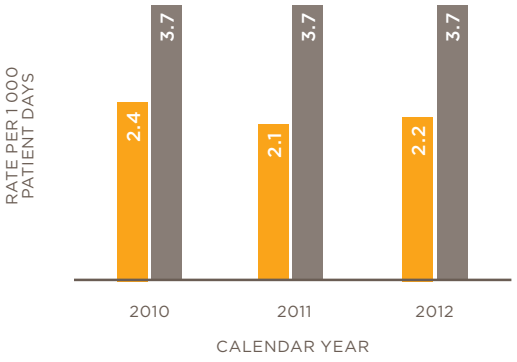


FIGURE 14: IQIP WEIGHTED AVERAGE IN-HOSPITAL PRESSURE ULCER RATE – HIRSLANDEN (2010 – 2012)

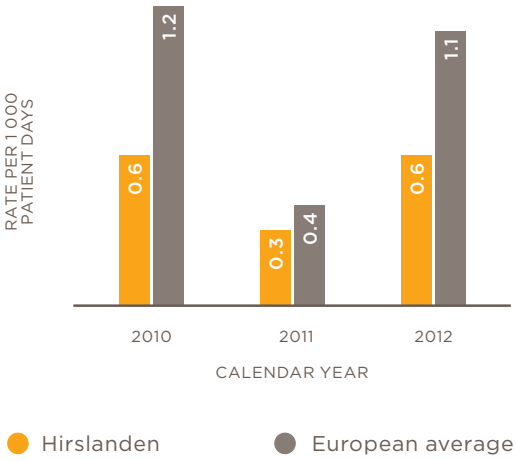
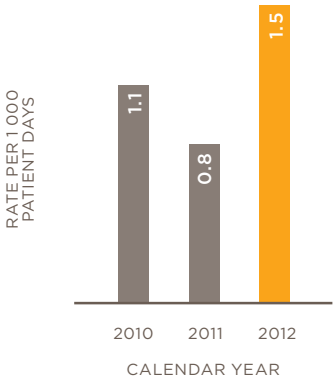


FIGURE 15: HEALTHCARE-ASSOCIATED INFECTIONS – MEDICLINIC MIDDLE EAST (2010 – 2012)



Another IQIP indicator that Hirslanden participates in is pressure ulcers in acute care. Its weighted average figures are reflected in **Figure 14**. This once again compares favourably with other participating European hospitals.

CLINICAL AUDITS

Clinical audits were done to verify the successful introduction of the safe surgery checklist concept, which was launched in 2010. All hospitals complied.

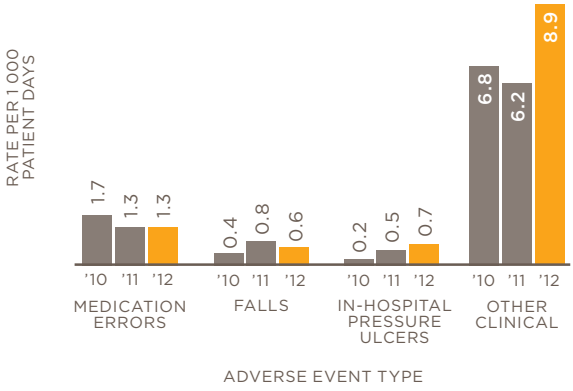
MEDICLINIC MIDDLE EAST

HEALTHCARE-ASSOCIATED INFECTIONS

The Mediclinic Middle East infection prevention and control programme is comprehensive and consists of hospital-based infection control specialists, multidisciplinary infection control committees and a detailed reporting system. Apart from monitoring general infection rates, the hospitals rigorously track surgical site infections, ventilator-associated pneumonia, catheter-associated urinary tract infections, MRSA and other resistant organisms. Nursing staff play a key role in this regard to ensure compliance with international standards. **Figure 15** reflects the overall HAI rate for Mediclinic Middle East. The HAI rate increased from 0.8 to 1.5 per 1 000 patient days due to the increase in the incidence of ventilator-associated pneumonias as indicated in **Figure 16**. Although there was an increase in the HAI rate per 1 000 patient days from 2011 to 2012, it is still very low.

FIGURE 16: DEVICE-ASSOCIATED AND SURGICAL SITE INFECTIONS – MEDICLINIC MIDDLE EAST (2011 – 2012)

FIGURE 17: ADVERSE EVENTS – MEDICLINIC MIDDLE EAST (2010 – 2012)



Mediclinic Middle East focuses on the prevention of surgical site infections and three types of device-associated infections, as well as antimicrobial stewardship. Hospitals which actively implemented evidence-based interventions have shown a reduction in these types of HAIs.

Figure 16 shows a significant decrease in central line-associated bloodstream and surgical site infection rates in 2012 when compared to 2011. This was mainly due to the implementation of reliable evidence-based practices such as strict antimicrobial guidelines and the implementation of central line bundles in the CCU. The actual number of ventilator-associated pneumonia increased due to a substantial increase in the number of ventilator days for both hospitals in 2012 as well as a higher acuity level of the patients admitted in the CCU and neonatal CCU.

ADVERSE EVENTS

Figure 17 reflects the most pertinent adverse events. The medication errors, falls and skin-related rates remained constant. Mediclinic Middle East included more adverse events in the "Other clinical" category causing a significant increase from 6.2% in 2011 to 8.9% in 2012. Mediclinic Middle East engaged in various hospital event management training programmes and adjusted processes that led to improved reporting of adverse events.

CLINICAL AUDITS

Mediclinic Middle East makes extensive use of audits to promote patients' safety and quality of care. Medical record, anaesthetic, epidural, prescription and surgical audits are performed regularly.

CHECKLISTS

Surgical safety checklists were implemented in 2009 at both hospitals, with excellent compliance. This initiative, which contributes significantly to patient safety, is also aligned with one of the six patient safety goals of the JCI.

CLINICAL PERFORMANCE MEASUREMENT

Clinical indicators and outcome measures are the "vital signs" of clinical care and provide an idea of the performance and integrity of this very important core element of operating hospitals. Organisations can either develop these indicators and outcome measures internally, or participate in external initiatives. Mediclinic has been following both these approaches to measure clinical performance.

With internal developments it is usually the availability of accurate and reliable clinical information that dictates which indicators and outcome measures are selected. Internally developed indicators can usually not be compared with published benchmarks or figures from other organisations, because of differences in data structures, definitions and criteria, but are valuable for internal benchmarking and trend analyses. Examples include the mortality rates, re-admissions and adverse events indicators reported by all three operating platforms, and the extended stay indicator reported by Mediclinic Southern Africa.

When participating in external initiatives, organisations have to purposefully collect data according to strict agreed-upon criteria. The data from the different organisations are then combined, external benchmarks calculated and comparisons made. Examples include the Vermont Oxford Network (VON) in neonatal critical care, of which hospitals of both Mediclinic Southern Africa and Mediclinic Middle East are members, and the IQIP indicators that all Hirslanden hospitals participate in.

MEDICLINIC SOUTHERN AFRICA

COMORBIDITIES

Comorbidities are chronic underlying medical conditions that might be present in a patient on admission to a hospital, but do not constitute the reason for admission. It is important to measure comorbidities, since they have the potential to impact the level of care and/or length of stay of a patient during hospitalisation.

The proportion of patients who were admitted to hospital with comorbidities in 2012 was 30% compared to 29% in the previous year. Hypertension, obesity and diabetes mellitus were the most common underlying chronic conditions.

Although obesity is not regarded as a chronic underlying medical condition unless it is quite severe, it can have a significant impact on morbidity while in hospital. In 2012 about 67% of adult patients admitted were overweight or obese.

CLINICAL INDICATORS

This section deals with some of the most prominent indicators that are frequently used internationally, namely mortality, extended stay and re-admission rates. Analysing these indicators as well as the underlying reasons for their occurrence is very important in the management of quality care.

Mortality

Mortality is one of the most important indicators for determining quality care. Mediclinic Southern Africa uses a statistical methodology to adjust hospital mortality rates for a number of risk factors (e.g. age, gender, comorbidities) in order to make justifiable comparisons between hospitals and reporting periods. The expected mortality is a statistical calculation that takes the above-mentioned patient risk factors into consideration. The mortality index is the actual mortality in relation to the calculated expected mortality.

FIGURE 18: INPATIENT MORTALITY – MEDICLINIC SOUTHERN AFRICA (2010 – 2012)

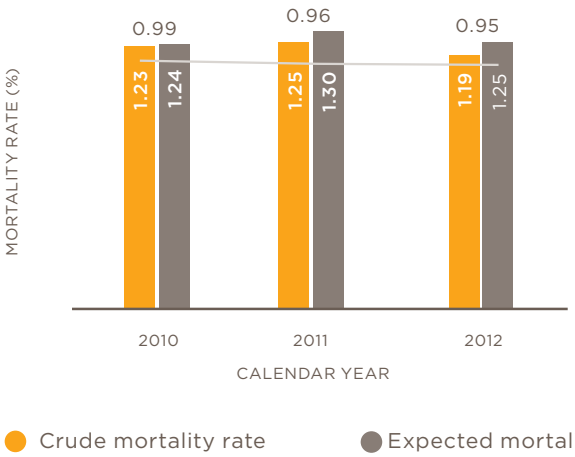
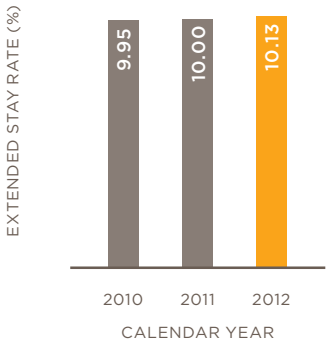


FIGURE 19: OVERALL EXTENDED STAY RATE – MEDICLINIC SOUTHERN AFRICA (2010 – 2012)



Crude mortality rate Expected mortality rate Mortality index

Figure 18 reflects the inpatient mortality rates.

The mortality index improved slightly from 4% better than expected in 2011 to 5% better than expected in 2012. It is noticeable that the index for the last three years was below one. Hospitals are continuously focusing on their indices, supported by detailed monthly reports and audits.

Extended stay

The extended stay indicator measures the percentage of cases with hospital stays that exceeded a calculated extended stay point, and is regarded as a proxy measure for quality of care. The extended stay point was calculated as the 90th percentile of hospital stays for each admission type over the past three calendar years. As this calculation is performed on a three-year rolling period, the nominal figures may differ from reports of previous years. Note that the percentages provided are unadjusted, and may reflect patient demographics, comorbidity profiles and complications. This indicator was developed internally, and comparable external benchmarks are therefore not available.

Figure 19 reflects the overall extended stay rate for Mediclinic Southern Africa, which increased slightly in 2012. This is mainly because of an increased comorbidity profile of patients in 2012.

Re-admission

The re-admission indicator calculation is based on the number of patients re-admitted to hospital within 30 days of discharge. This includes scheduled (planned) as well as unscheduled (unplanned) re-admissions, but it is the latter that are important as they represent late complications of initial admissions. Because of the nature of available Mediclinic Southern Africa information, it is impossible to distinguish accurately between planned and unplanned admissions. The methodology used in calculating this indicator does, however, exclude certain admission types with a high percentage of predictable planned re-admissions, for example, cataract surgery (one eye followed by the next), haematology, chemotherapy, ante-partum admissions and sleep studies. Although still an incomplete science, re-admission is generally accepted as one of the proxy measures for quality of care if used as a trend indicator.

FIGURE 20: RE-ADMISSION RATES – MEDICLINIC SOUTHERN AFRICA (2010 – 2012)

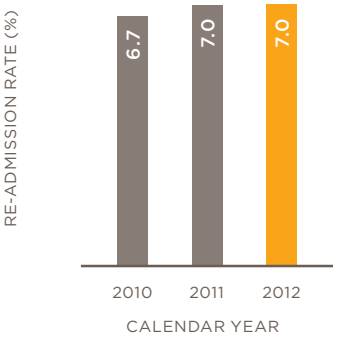


Figure 20 reflects the 30-day re-admission rate for all hospital admissions. The overall re-admission rate remained unchanged during the period under review. The indicator was developed internally and comparable external benchmarks are not available.

CLINICAL OUTCOMES

Vermont Oxford Network

The Vermont Oxford Network (VON) is an initiative aimed at measuring and improving the quality of care in neonatal CCUs. The initiative is based in Vermont, USA, with participating units all around the world. Mediclinic Southern Africa has been participating in the VON quality initiative since 2001. Currently 21 Mediclinic Southern Africa hospitals are participating in the initiative.

Although all babies admitted to the neonatal CCUs are included in the programme, VON specifically focuses on the very low birth weight (< 1 501g) infants because of the significant complexities involved in treating them.

Table 1 reports the general statistics of this subset of the neonatal critical care population. Mediclinic Southern Africa's statistics for 2011 and 2012 are compared with the official VON annual report figures for 2011, as the VON annual reports only become available six months after year end and the 2012 report was therefore not available in time to be included in this report.

TABLE 1: VON QUALITY OUTCOMES AS A PERCENTAGE OF CASES ON THE DATABASE – MEDICLINIC SOUTHERN AFRICA (2010 – 2012)

Very low birth weight infants (< 1 501g)	Mediclinic Southern Africa 2010	2011	2012	VON 2011
Respiratory support				
Respiratory distress syndrome	83%	83%	**80%**	73%
Pneumothorax	3%	2%	**1%**	4%
Early continuous positive airway pressure (CPAP)	37%	37%	**43%**	45%
Ventilation	43%	46%	**42%**	63%
Chronic lung disease (CLD) 36 weeks (gestational age < 33 weeks)	15%	16%	**14%**	25%
HAIs	17%	17%	**15%**	14%
Other outcomes				
Patent ductus arteriosus	25%	21%	**18%**	32%
Necrotising enterocolitis	6%	6%	**7%**	6%
Periventricular-intraventricular haemorrhage	21%	20%	**18%**	25%
Retinopathy of prematurity	16%	9%	**10%**	31%
Mortality	17%	18%	**17%**	15%

Mediclinic Southern Africa admitted 589 very low birth weight infants in 2012, with an average weight of 1 117g at birth. The average gestational age was 29 weeks compared to the 28 weeks of VON. The average discharge weight was 1 878g compared to the VON average of 2 255g, and the length of stay of 42 days was significantly shorter than the 54 days of VON.

Table 1 reflects the VON quality outcomes for the participating hospitals.

Respiratory support parameters compare favourably with the VON averages. The occurrence of respiratory distress syndrome remained higher than the benchmark, but decreased slightly from 2011. The early continuous positive airway pressure rate increase is encouraging, and it is now in line with the VON benchmark. Also encouraging is the ventilation rates that remained lower than the VON benchmark. The resultant incidence of chronic lung disease also remained lower than the VON benchmark. The HAI rate decreased in 2012 and is now in line with the VON benchmark.

TABLE 2: GENERAL INDICATORS, RISK FACTORS AND OUTCOMES AS A PERCENTAGE OF CASES ON THE DATABASE – MEDICLINIC SOUTHERN AFRICA (2010 – 2012)

	2010	2011	2012
Post-operative outcomes			
Infections	2.0%	2.6%	**2.7%**
Re-operation	4.9%	5.4%	**3.1%**
Mortality			
Expected mortality (EuroSCORE)	7.2%	7.7%	**11.8%**
Actual mortality	4.7%	5.4%	**4.4%**
Mortality index	0.66	0.70	**0.37**
Re-admission (within 30 days)	7.8%	11.6%	**9.5%**

TABLE 3: APACHE® III-j MORTALITY INDEX – MEDICLINIC SOUTHERN AFRICA (2010 – 2012)

	2010	2011	2012
Cases	37 741	40 095	**43 141**
Average age	57.3	59.8	**58.3**
Average length of stay (total hospital stay)	7.9	7.8	**7.7**
Average days in unit	3.5	3.5	**3.5**
Mortality index	0.72	0.70	**0.66**

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Within this group of very low birth weight infants, chronic lung disease, periventricular-intraventricular haemorrhage and retinopathy of prematurity greatly determine survival and eventual quality of life. In all of these critical parameters Mediclinic Southern Africa continued to perform better than average compared with the VON. These results can mainly be attributed to the continued professionalism, commitment and enthusiasm of the staff and doctors working in the units.

Adult Cardio-thoracic Database

The Adult Cardio-thoracic Database (ACTD) is modelled on the database of the Society of Thoracic Surgeons in the United Sates. The primary aim of this initiative is to measure and improve the clinical outcomes of cardio-thoracic surgery. It has been used in Mediclinic Southern Africa hospitals with cardio-thoracic units since 2005.

Table 2 reflects the ACTD clinical outcomes. Comparable international figures are not freely available, hence the year-on-year comparisons.

The mortality index (actual/expected) decreased significantly from 0.70 to 0.37. The expected mortality rate increased from 7.7% in 2011 to 11.8% in 2012 mainly because of an increase in the number of patients older than 60 years as well as an increase in the number of patients receiving valve surgery, and actual mortality decreased to 4.4%. The re-admission and re-operation rates decreased significantly, and infection rates reflected minimal change. The database remains a very valuable tool in support of quality improvement.

APACHE® III-j

APACHE® III-j is a hospital mortality prediction methodology for patients in the adult critical care setting and is a useful tool in evaluating quality of care in this complex setting. Patients are evaluated and scored on a number of clinical parameters within the first 24 hours of admission to critical care. An expected mortality calculation is therefore based on the clinical condition of each patient.

During 2009 the APACHE® III-j scoring system was implemented in the adult CCUs of all qualifying Mediclinic Southern Africa hospitals. More than 43 100 cases were scored in 63 units at 41 participating hospitals in 2012. Mediclinic Southern Africa is currently in the process of migrating from APACHE® III-j to the more advanced APACHE® IV in order to stay in line with world mortality analysis trends.

Table 3 reflects some important statistics, the most important being the mortality index, which is the relationship between the actual and predicted mortalities. The mortality index of 0.66 implies that the overall mortality of the scored cases was 34% better than expected. It is also noticeable that the index is lower compared to the previous year.

The implementation of the APACHE® scoring system in all Mediclinic Southern Africa adult CCUs is an important step towards a more measurable approach to quality care in this complex setting.

FIGURE 21: IQIP WEIGHTED AVERAGE MORTALITY RATE – HIRSLANDEN (2010 – 2012)

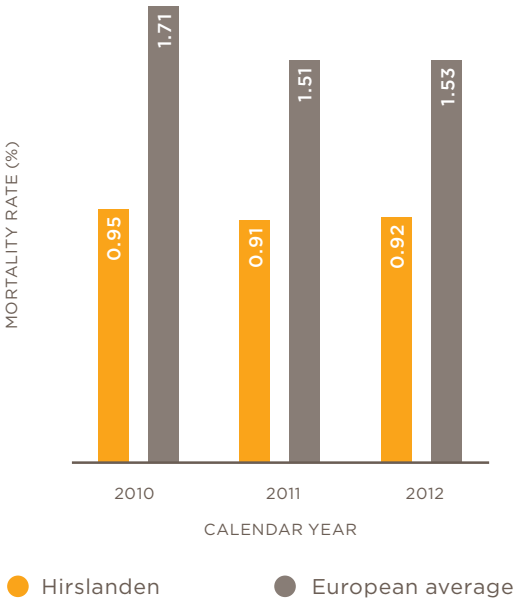
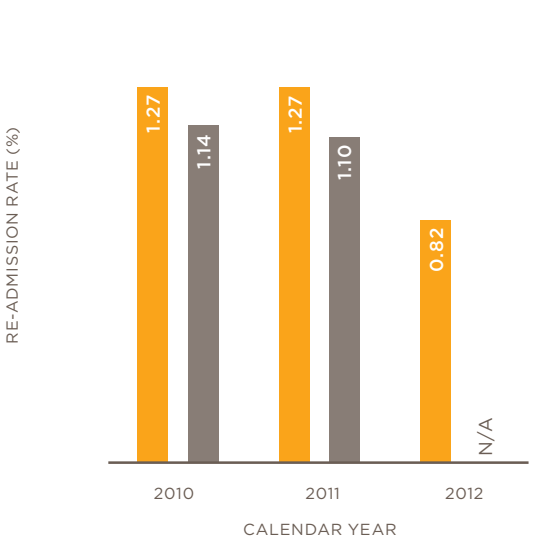


FIGURE 22: IQIP WEIGHTED AVERAGE RE-ADMISSIONS WITHIN 15 DAYS – HIRSLANDEN (2010 – 2012)



HIRSLANDEN

CLINICAL INDICATORS

Hirslanden has been participating in the IQIP since 2006. The initiative was developed over 16 years ago in the United States and currently more than 400 organisations in 18 countries participate in the initiative. The IQIP develops performance indicators that facilitate participants' efforts to understand and improve performance. IQIP participants receive quarterly data reports, which allow for longitudinal trending and comparison with regional, national and international aggregate rates. Thirteen Hirslanden hospitals have been participating in a set of five IQIP indicators as directed by the Hirslanden clinical governance committee since 2008.

Mortality

Figure 21 reflects the IQIP weighted average mortality rates for the last three calendar years. Hirslanden continues to experience a significantly lower mortality rate compared to other participating hospitals in Europe.

Re-admission

Figure 22 reflects the new indicator introduced by Hirslanden in 2011, namely re-admissions within 15 days. This indicator is more applicable to the requirements of the Swiss Diagnosis Related Groupings (SwissDRG) system which was implemented in January 2012 as a hospital reimbursement system for all Swiss hospitals. The re-admission rate decreased from 1.27% in 2011 to 0.82% in 2012 mainly due to changes in the SwissDRG patient management processes. IQIP did not release a 2012 benchmark for 15-day re-admissions because of an international decrease in participating hospitals for this indicator.

Unscheduled returns to the operating theatre

The IQIP weighted average rates for unscheduled returns to the operating theatre for the last three calendar years are reflected in **Figure 23**. Unscheduled returns to the operating theatre are not planned and are believed to be the result of early complications. Hirslanden figures compare favourably with participating European hospitals.

FIGURE 23: IQIP WEIGHTED AVERAGE UNSCHEDULED RETURN TO OPERATING THEATRE RATE – HIRSLANDEN (2010 – 2012)

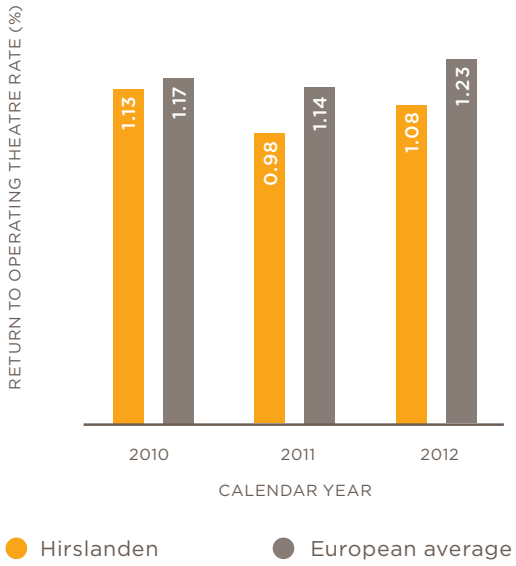


TABLE 4: SAPS II MORTALITY INDEX – HIRSLANDEN (2011 – 2012)

	Hirslanden		SAPS II Bench-mark
	2011	2012	2012
Cases	5 427	**5 976**	
Expected	10.5%	**12.0%**	10.0%
Actual	4.2%	**4.4%**	4.0%
Mortality Index	0.40	**0.36**	0.40
Average age of patients	67.9	**67.4**	63.0
Average length of stay in CCU (days)	2.29	**2.1**	2.4
Percentage of ventilated patients	37.9%	**41.2%**	33.0%

CLINICAL OUTCOMES

Simplified Acute Physiology Score (SAPS) II

SAPS II is a hospital mortality prediction methodology for patients in the adult critical care setting and is a useful tool in evaluating quality of care in this complex environment. Patients are evaluated and scored on a number of clinical parameters within the first 24 hours of admission to critical care. An expected mortality calculation is therefore based on the clinical condition of each patient.

The SAPS II scoring methodology is used in the CCUs of all Hirslanden hospitals.

Table 4 reflects some important statistics, the most important being the mortality index, which is the relationship between the actual and predicted mortalities. The mortality index of 0.36 in 2012 implies that the overall mortality of the scored cases was 64% better than expected. Because of a change in definition of ventilated patients, the related indicator differs from previous reports.

FIGURE 24: INPATIENT MORTALITY – MEDICLINIC MIDDLE EAST (2010 – 2012)

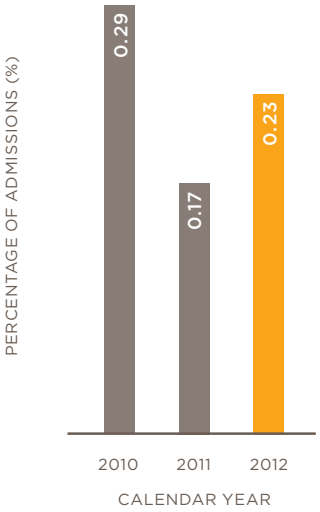
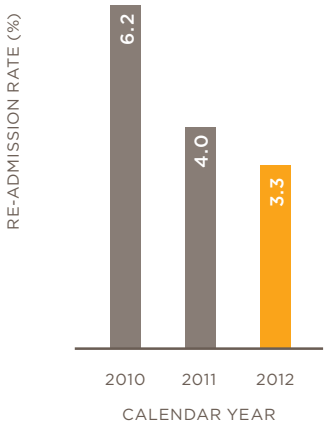


FIGURE 25: RE-ADMISSION RATES – MEDICLINIC MIDDLE EAST (2010 – 2012)



MEDICLINIC MIDDLE EAST

CLINICAL INDICATORS

Mortality

Figure 24 reflects the actual combined mortality rates for both Mediclinic Middle East hospitals. It is important to note that these figures are not yet adjusted for severity of disease, types of surgery or other patient factors. For the same reasons expected mortality figures cannot be calculated.

Actual mortality increased from 0.17% to 0.23% in 2012, but remained significantly lower than the actual mortality for both Mediclinic Southern Africa and Hirslanden. This is due to the fact that Dubai has a very young population (average age of 32 years), and the types of surgery performed are in general not as invasive and complex as in the other two operating platforms.

Re-admission

Figure 25 reflects the 30-day re-admission rate for both hospitals. All admission types, except oncology, are included in the calculation. Comparable external benchmarks are unfortunately not available and an internal benchmark is used to compare this indicator. The re-admission rate has decreased significantly since 2010.

CLINICAL OUTCOMES

Vermont Oxford Network

The VON database was implemented at both Mediclinic Middle East hospitals during 2009. Though the case volumes for these two centres are small, their outcomes compare very favourably with the VON network averages.

Although all babies admitted to the neonatal CCUs are included in the programme, the VON specifically focuses on the very low birth weight (< 1 501g) infants because of the significant complexities involved in treating them.

Mediclinic Middle East figures for 2012 are compared with the official VON annual report for 2011, as the VON annual reports only become available six months after year end and the 2012 report was therefore not available in time to be included in this report.

Mediclinic Middle East admitted 42 very low birth weight infants, with an average weight of 1 106g at birth in 2012. Average gestational age was 29 weeks compared to the 28 weeks of VON. The average discharge weight was 1 949g compared to the VON average of 2 255g, and length of stay of 45 days was significantly shorter than the 54 days of VON.

TABLE 5: VON QUALITY OUTCOMES AS A PERCENTAGE OF CASES ON THE DATABASE – MEDICLINIC MIDDLE EAST (2010 – 2012)

Very low birth weight infants (< 1 501g)	Mediclinic Middle East 2010	2011	2012	VON 2011
Respiratory support				
Respiratory distress syndrome	75%	87%	**86%**	73%
Pneumothorax	0%	5%	**0%**	4%
Early continuous positive airway pressure (CPAP)	23%	30%	**45%**	45%
Ventilation	56%	57%	**45%**	63%
CLD 36 weeks (gestational age < 33 weeks)	0%	6%	**3%**	25%
HAIs	15%	13%	**5%**	14%
Other outcomes				
Patent ductus arteriosus	10%	27%	**21%**	32%
Necrotising enterocolitis	0%	0%	**2%**	6%
Periventricular-intraventricular haemorrhage	23%	31%	**24%**	25%
Retinopathy of prematurity	44%	38%	**69%**	31%
Mortality	8%	15%	**7%**	15%

TABLE 6: GENERAL INDICATORS, RISK FACTORS AND OUTCOMES AS A PERCENTAGE OF CASES ON THE DATABASE – MEDICLINIC MIDDLE EAST (2010 – 2012)

	2010	2011	2012
Post-operative outcomes			
Infections	0.0%	0.0%	**1.8%**
Re-operation	2.6%	1.4%	**12.7%**
Mortality			
Expected mortality (EuroSCORE)	9.1%	5.7%	**3.5%**
Actual mortality	2.6%	2.7%	**1.8%**
Mortality index	0.28	0.48	**0.52**
Re-admission (within 30 days)	2.6%	4.1%	**0.0%**

TABLE 7: APACHE® III-j MORTALITY INDEX – MEDICLINIC MIDDLE EAST (2010 – 2012)

	2010	2011	2012
Cases	195	902	**1 390**
Average age	52.7	51.9	**50.9**
Average length of stay (total hospital stay)	5.4	5.6	**4.6**
Average days in unit	3.2	1.9	**2.4**
Mortality index	0.6	0.2	**0.3**

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Table 5 reflects the quality outcomes for both Mediclinic Middle East hospitals.

Chronic lung disease at 36 weeks remained low. The HAI and mortality rates decreased significantly in 2012 and are well below the VON 2011 average. The reasons for the significant retinopathy of prematurity rate increase in 2012 are being investigated. In most of the other clinical outcomes Mediclinic Middle East hospitals performed satisfactorily when compared with the VON average, and the results can once again be attributed to the professionalism, commitment and enthusiasm of the staff and doctors.

Adult Cardio-thoracic Database

Although the cardio-thoracic surgery team has been collecting clinical outcomes data as part of their own initiative since 2002, they implemented the ACTD database at the Mediclinic City Hospital in 2009. Although the primary aim of the ACTD initiative is to measure and improve the clinical outcomes of cardio-thoracic surgery, it also enables the comparison of results between the Group's operating platforms.

Table 6 reflects general indicators, patient risk factors and clinical outcomes. Comparable international benchmarks are not freely available, hence the year-on-year comparisons.

Both expected and actual mortality rates decreased during the last year. The mortality index increased slightly, but is still significantly lower than one. The number of re-operations increased significantly in 2012, mainly as a result of post-operative bleeding experienced by some patients.

APACHE® III-j

Mediclinic Middle East implemented the APACHE® III-j database at both hospitals during 2009. A total of 1 390 cases were scored in the CCUs of the two hospitals in 2012.

Table 7 reflects some important statistics, the most important being the mortality index, which is the relationship between the actual and predicted mortalities. The mortality index increased and the length of stay decreased in 2012. Mediclinic Middle East is also in the process of migrating from APACHE® III-j to APACHE® IV in order to stay abreast of the international trend.

CLINICAL INFORMATION MANAGEMENT

Hospital clinical information systems (CIS) play a significant role in improving quality and safety of patient care, improving efficiencies, and optimising revenue. These systems support the flow, storage and utilisation of clinical information by way of comprehensive electronic medical records, and provide functionalities like electronic scripting and decision support. Hirslanden successfully implemented a comprehensive CIS as a pilot project at Klinik Aarau three years ago, made numerous improvements over time, and is planning to roll this installation out to all other Hirslanden hospitals. Mediclinic Middle East standardised its CIS across all its hospitals and multidisciplinary outpatient clinics. The functionalities currently in use are not as comprehensive as those of the Hirslanden installation, and planning is under way to enhance this. Mediclinic Southern Africa maintains a number of clinical datasets (APACHE® III-j, VON, cardiac surgery, ICNet infection data, and hospital events) and has digitised radiology in 25 hospitals, but does not have a comprehensive CIS, which is being addressed.

Clinical coding is the translation of relevant clinical information into clinical codes. Clinical codes are elements of hierarchical coding systems that represent clinical information in organised and standardised formats. Accurate clinical coding is important for managing reimbursement systems and analysis. An increasing number of hospital reimbursement arrangements at Mediclinic rely on accurate clinical coding, the most prominent of which is Diagnosis Related Groupings (DRGs). Mediclinic also uses clinical codes to aggregate, analyse and interpret clinical activities in a meaningful way, and it forms the basis of most clinical performance indicators. Clinical coding should therefore always provide a true reflection of patients' pathways through hospitals. Operating platforms use the diagnosis and procedural coding systems specific to their industry standards. Clinical coding is done at hospital level at Mediclinic Southern Africa and Mediclinic Middle East, and centrally at Hirslanden. All three operating platforms have a strong focus on training, internal audits, and coding support systems.

Another well-developed aspect of clinical information management at Mediclinic is the use of administrative data to measure clinical performance. Mediclinic Southern Africa has over many years refined its techniques in groupings, algorithms, data leveraging and analytics in a mature data warehouse environment. These capabilities are now being extended to Hirslanden and Mediclinic Middle East, and used to create an international data warehouse that combines all three operating platforms' information to reflect the activities of the entire Group.

CLINICAL SERVICES DEVELOPMENT

The concept of coordinated care (competence) centres is an important part of Hirslanden's strategy, and more than 100 centres have been established over time. An evaluation model, based on the criteria of different sources such as EFQM, JCI and ISO 9001, has been developed to grade and refine the functions of these centres. The model will be adapted for use throughout the Mediclinic Group.

The most prominent coordinated care centre within Mediclinic Southern Africa is located in the Wits Donald Gordon Medical Centre (WDGMC). The WDGMC is a private academic hospital for the training of specialists and sub-specialists, and is a public private partnership between Wits University and Mediclinic Southern Africa. This unique facility, which was established in 2002, increased the training capacity within the Wits Faculty of Health Sciences and combines traditional public sector training with exposure to private sector facilities and expertise. The WDGMC model of care is based on provision of high-quality, evidence-based care through multidisciplinary, peer reviewed teams.

The centre currently funds 18 Sub-specialist Programmes and five Specialist Programmes for two- and four-year training periods respectively. Since inception, 24 specialists and sub-specialists have completed their training, with a further 12 graduates expected in 2013. A further 60 government-funded registrars (specialists in training) have rotated through the centre to gain exposure to disciplines not available in the public sector.

MEDICLINIC STRIVES TO PROVIDE INTERNATIONALLY COMPARABLE QUALITY CARE IN A SAFE ENVIRONMENT AT ALL TIMES

The WDGMC operates South Africa's largest solid organ transplant unit, established in 2004, and performs liver, kidney, simultaneous kidney-pancreas, and pancreas after kidney transplants. The surgical team is known as the Wits Transplant Team and provides a service to both public and private sector patients. Kidney transplants are performed by the same team at the WDGMC and the Charlotte Maxeke Johannesburg Academic Hospital, whereas liver transplants are only performed at the WDGMC on both public and private patients. The unit performed a total of 103 transplants in 2012. All cases are peer reviewed pre- and post-operatively by the multidisciplinary team. All morbidity and mortality outcomes are measured and benchmarked against international standards, to which they compare very favourably. The unit has recently recruited an internationally acclaimed expert in the field of paediatric liver transplantation to develop split liver and living donor paediatric liver transplantation at the centre, which is not currently available in South Africa.

The WDGMC is also academically known for its colorectal, hepatobiliary and multidisciplinary CCUs, and its geriatric unit has a public private partnership with Helen Joseph Hospital. The WDGMC plans to further expand in the future to maximise the benefit of private sector funding and expertise for the benefit of patients in all sectors of the healthcare landscape.

THE WAY FORWARD

Based on the available information, the clinical performance of the Group was once again satisfactory, and patients admitted to Mediclinic hospitals can have peace of mind regarding their expected clinical outcomes. This discipline, however, requires continued focus and relentless attention to detail.

An integrated care framework for the Group has been developed and is in the process of being implemented. The objective is to ensure that clinical planning and execution at all levels of the organisation are undertaken in a multidisciplinary and integrated way. Group-wide clinical governance standards will be reviewed and enhanced during the upcoming year. Operating platforms are working on aligned patient safety and quality improvement initiatives, and clinical performance indicators are being consolidated for comparative purposes. Coding and clinical information management abilities are being improved across the operating platforms. Hirslanden is preparing to roll out its clinical information system, and Mediclinic Middle East is preparing to enhance its existing electronic patient record functionality in the inpatient setting.

We believe that the effort involved and the money spent on developing clinical services are sound investments in assisting the Group to build a secure future.

A COMPREHENSIVE SYSTEM OF INTERNAL CONTROLS IS IN PLACE T0 MITIGATE RISK

RISK MANAGEMENT REPORT

The Board is ultimately accountable for the Group's risk management process and system of internal control. In terms of a mandate by the Board, the Audit and Risk Committee monitors the risk management process and systems of internal control of the Group. The Board oversees the activities of the Audit and Risk Committee, the Group's internal and external auditors and the Group's risk management function as delegated to the Company's Audit and Risk Committee.

RISK MANAGEMENT

The Enterprise-wide Risk Management ("ERM") policy is benchmarked against the international COSO (Committee of Sponsoring Organisations of the Treadway Commission) framework and incorporates the recommendations of the King III Report, defines the risk management objectives, methodology, risk appetite, process and the responsibilities of the various risk management role players in the Group. The ERM policy is subject to annual review and any amendments are submitted to the Audit and Risk Committee for approval.

The objective of risk management in the Group is to establish an integrated and effective risk management framework where important risks are identified, quantified and managed.

The Group's risk management process is supported by an ERM software application which is implemented across the Group to support the risk management process in all three operating platforms. The Group's priority risk items, together with key measures taken to mitigate these risks, are listed in **Table 1**.

TABLE 1: PRIORITY RISK ITEMS

	Risk[1]	Description of risk	Mitigation of risk
Compliance risks	**Legal and regulatory compliance**	Failure to comply with laws and regulations may result in fines, prosecution or damage to reputation.	• Company secretarial and/or legal departments in the different operating platforms support operational management and monitor regulatory developments and, where necessary, obtain expert legal advice for the effective implementation of compliance initiatives. • Compliance risks are identified and assessed as part of departmental risk registers. • The Social and Ethics Committee monitors compliance in the Group.
	Confidentiality	Unauthorised access and sharing of confidential Company information.	• Policies and procedures are in place.
Human resources risks	**Availability, recruitment and retention of skilled resources**	There is a shortage of skilled labour, particularly a shortage of qualified and experienced nursing staff in Southern Africa.	• The employment, recruitment and retention strategies are explained in the detailed Sustainable Development Report. • Extensive training and skills development programme, which is further explained in the detailed Sustainable Development Report. • Foreign recruitment programme which is further explained in the detailed Sustainable Development Report.
	Availability and support of medical practitioners	The availability and support of admitting doctors, whether independent or employed, are critical to the services the Group provides.	• Doctors' retention and recruitment strategies. • Monitoring of doctor satisfaction, movement and doctors' profiles. • Further details on the relationship with doctors are provided in the detailed Sustainable Development Report.
Credit and market risks	**Regulatory risk**	The risk of a change in laws and regulations applicable to the Group. The South African government is developing a plan to implement major health sector reform and has proposed the introduction of a National Health Insurance. In January 2012 Switzerland implemented healthcare reform, when the revised Federal Health Insurance Act became effective. Certain aspects of the new regulations are still uncertain. Tariff reform expected in UAE during next financial year.	• Mediclinic Southern Africa, Mediclinic Middle East and Hirslanden have implemented proactive engagement strategies with stakeholders. • Health policy units were created in Mediclinic Southern Africa and in Hirslanden to conduct research and to provide strategic input into engagement with the reform processes. • Active industry participation in both Mediclinic Southern Africa and in Hirslanden. • Mediclinic Middle East has set up a Funder Relations Department to prepare for tariff reform.
	Availability of capital and financing and liquidity risk	The cost, terms and availability of capital to finance strategic expansion opportunities and/or the re-financing or re-structuring of existing debt which has been affected by prevailing capital market conditions.	• Long-term planning of capital requirements and cash-flow forecasting. • Monitoring of cash-generating capacity within the Group. • Proactive and long-term agreements with banks and other funders on funding facilities. • Monitoring of compliance to the requirements of debt covenants. • Further details on capital risk management and the Group's borrowings are contained in the financial statements.
	Economic and business environment	The downturn in the general economic and business environment, including all those factors that affect a company's operations, customers, competitors, stakeholders, suppliers and industry trends. The downturn in Europe involved mainly the surrounding countries of Switzerland, while the Swiss economy remained relatively strong.	• All three operating platforms have implemented systems to monitor developments in the economic and business environment of trends and early warning indicators.
	Competition	The risk relating to the uncertainty created by the existence of competitors or the emergence of new competitors with their own strategies.	• Proactive monitoring.
	Credit risk	Credit risk is the risk of loss because of a funder's inability to pay the outstanding balance owing or the inability to recover outstanding amounts due from the patient	• Regulated minimum solvency requirements. • Billing and recovery policies and processes. • Monitoring of funders.

	Risk[1]	Description of risk	Mitigation of risk
Physical and operational risks	**Hospital-acquired infections** 	The risk of an infection outbreak in the hospital or clinic.	• Extensive infection prevention and control procedures. • Continuous monitoring. • Utilisation of infection prevention and control specialists. • For more information refer to Clinical Services Report.
	Clinical risks 	All clinical risks associated with the provision of clinical care resulting in undesired provision of clinical care or clinical outcomes.	• Refer to Clinical Services Report for a detailed analysis of the strategies to manage and monitor clinical risks.
	Medical malpractice 	Incidents caused by professional negligence due to an act or omission by a healthcare provider in which the care provided deviates from accepted standards of practice and causes harm to the patient.	• Extensive clinical governance processes (refer to the Clinical Services Report) and quality control and maintenance processes implemented throughout the Group. • Limitation of liability because of independence of doctors model applied in Mediclinic Southern Africa and in Hirslanden. • Policies and processes are in place to ensure compliance with applicable healthcare legislation.
Technology risks	**Information systems security and availability risk** 	Information systems security risk relates to the failure of data integrity and confidentiality, and availability risk relates to the instances where systems are not available for use by their intended users.	• Comprehensive IT logical access, change and physical access controls. • System design and architecture. • Disaster recovery planning.
	Medical technology risk 	The risk of not maintaining a competitive edge in the utilisation and availability of new medical technology, or not ensuring that new medical technology is cost-effective, proven and safe, or investing in new medical technology which is subsequently not utilised effectively.	• Ongoing monitoring and evaluation of new technology. • Defined approval process for the acquisition of new technology.
Business continuity risks	**Fire and allied perils** 	Fire and allied perils causing damage or business interruption.	• All three operating platforms have plans to deal with disasters and employ extensive fire-fighting and detection systems, and have comprehensive maintenance processes to reduce the risk. • Comprehensive insurance to deal with financial impact of potential disasters is in place.
	Regional instability 	The potential for operational disruption caused by instability or war in the region.	• These are external risk factors which are not within the control of management; however, management closely monitor and assess developments in order to take appropriate action when required.
	Pandemics and disease outbreaks 	A pandemic is an epidemic of infectious disease that is spreading through human populations across a large region. Disease outbreak includes highly infectious diseases with a high mortality rate.	• Comprehensive processes for infection and prevention control are in place. • Detailed plans to deal with these types of events. • Clinical governance processes further explained in the Clinical Services Report.

[1] The flags indicate the operating platform where the risk is included as a priority risk in the operating platform's central risk register.

Key:  = Mediclinic Southern Africa  = Hirslanden  = Mediclinic Middle East

INTERNAL CONTROL

The Group has in place a comprehensive system of internal controls which is designed to ensure that risks are mitigated and that the Group's objectives are attained. The system includes monitoring mechanisms and ensures that appropriate actions are taken to correct deficiencies when they are identified.

During the year each operating platform updated their combined assurance plans for the next financial year. These plans detail the various assurance processes, including internal and external audit processes which are in place to evaluate the effectiveness of key controls designed to mitigate the significant risks identified in each operating platform. The Group makes use of an outsourced internal audit function which complies with the principles of the King III Report. Internal audit's scope includes the operations of Mediclinic Southern Africa, Mediclinic Middle East and a review of the assurance processes in Hirslanden.

At Mediclinic Southern Africa the effectiveness of the system of internal financial control is independently evaluated through an extensive internal audit programme as well as by the external auditors, PricewaterhouseCoopers, for those processes on which they rely for external audit purposes. In addition to these audits, the effectiveness of operational procedures is examined internally through an on-site hospital peer review process conducted by regional management and through an extensive controls self-assessment process conducted by the hospital management teams. The results of these assurance processes are monitored by the Group's risk management function and reported to Mediclinic Southern Africa's executive management.

Mediclinic Southern Africa has further implemented a comprehensive independent accreditation process with two independent organisations:

- COHSASA (Council for Health Services Accreditation of Southern Africa), which is accredited by ISQua (the International Society for Quality in Health Care), which enables Mediclinic Southern Africa's participating hospitals to be measured against internationally accredited quality standards; and

- ISO 14001:2004 certification by NQA (National Quality Assurance Limited) / UKAS (United Kingdom Accreditation Service).

At Hirslanden the effectiveness of the system of internal control is independently evaluated by the external auditors, PricewaterhouseCoopers. In compliance with Swiss legislation the external auditors also review the system of internal financial control. Hirslanden has implemented a comprehensive quality management process and in 2012 achieved a level where all hospitals and its Head Office were certified in terms of ISO 9001:2008. Hirslanden's commitment to and achievements under the total quality management approach according to the European Foundation for Quality Management is further elaborated on in the Sustainable Development Report. During the year the Group internal audit function performed a review of the work performed by the Swiss Association for Quality and Management Systems (SQS) which enables it to rely on the quality of the audit work performed by the SQS auditors and integrate these together with the work performed by PricewaterhouseCoopers into its internal audit review of the effectiveness of the controls which are designed to mitigate significant risks identified by the ERM process which is in place in Hirslanden. The results of these and other operational assurance processes are monitored by Hirslanden's executive management.

THE GROUP'S RISK MANAGEMENT IS AIMED AT ESTABLISHING AN EFFECTIVE RISK MANAGEMENT FRAMEWORK TO IDENTIFY, QUANTIFY AND MANAGE IMPORTANT RISKS

At Mediclinic Middle East the effectiveness of the system of internal financial control is independently evaluated through an internal audit programme as well as by the external auditors, KPMG, for those processes on which they rely for the external audit purposes. Both the Mediclinic Welcare Hospital and the Mediclinic City Hospital's facilities are accredited by the JCI (Joint Commission International), an international quality measurement accreditation organisation, aimed at improving quality of care. The group's eight clinics in Dubai are preparing for accreditation during the current financial year. On top of this the two hospitals are preparing for reaccreditation. In addition to the above, Mediclinic City Hospital has been accredited by the Centre for Healthcare Planning and Quality (CPQ). Both the JCI and the CPQ accreditation is based on international consensus standards and sets uniform, achievable expectations for structures, processes and outcomes for hospitals. All the laboratories within the group have undergone ISO accreditation and, in addition to this, the Mediclinic City Hospital Laboratory has been accredited by the College of American Pathologists (CAP).

The company secretaries at Group level and at operating platform level are responsible for providing guidance in respect of compliance with applicable laws and regulations.

EFFECTIVENESS OF RISK MANAGEMENT PROCESS AND SYSTEM OF INTERNAL CONTROL

The Board, through the Audit and Risk Committee, regularly receives reports on and considers the activities of the Mediclinic Southern Africa, Hirslanden and Mediclinic Middle East's internal and external auditors and the Group's risk management function. The Board, through the Audit and Risk Committee, is satisfied that there is an effective risk management process in place and that there is an adequate and effective system of internal control to mitigate the significant risks faced by the Group to an appropriate level for the Group.

MEDICLINIC REMAINS COMMITTED TO MAINTAINING STRICT PRINCIPLES OF GOOD CORPORATE GOVERNANCE

CORPORATE GOVERNANCE REPORT

GOVERNANCE FRAMEWORK

Mediclinic remains committed to maintaining strict principles of good corporate governance to ensure that its business is managed responsibly and with integrity, fairness, transparency and accountability. The board of directors of the Company ("the Board") supports the governance principles and guidelines contained in the Companies Act, 71 of 2008, as amended ("the Companies Act"), the JSE Listings Requirements, the King Code of Governance for South Africa 2009 and King Report on Governance for South Africa 2009 (jointly referred to as "King III") and is satisfied that effective controls are implemented and complied with throughout the Group.

The Board is satisfied that the Company has met the requirements of the Companies Act, the Listings Requirements of the JSE Limited ("the JSE") and the majority of the principles contained in King III throughout the period under review. The JSE Listings Requirements require all JSE-listed companies to report on the application of the King III principles in accordance with the "apply or explain" approach of King III. While the vast majority of King III principles are applied by the Company, those principles which have not been applied are explained in this integrated annual report, also stating for what part of the year any non-compliance had occurred.

An index on the Company's application of each King III principle is published on the Company's website at www.mediclinic.com.

A Group Corporate Governance Manual dealing with board practices and group policies provides guidance to the Company Secretary and the Board of the Company, as well as the company secretaries, boards and management of the Company's three operating platforms in Southern Africa, Switzerland and the United Arab Emirates to ensure that similar corporate governance practices are followed throughout the Group. The Company Secretary provides continuous guidance on corporate governance-related matters to the operating platforms.

Compliance with all relevant laws, regulations, accepted standards or codes is integral to the Group's risk management process and is monitored. As in previous years, there has been no major non-compliance by, nor fines or prosecutions against the Group during the period under review.

During the year, the Group continued with its efforts commenced during the previous year, to ensure that the Company and its subsidiaries and associated companies comply with the requirements of the Companies Act, such as updating the board charter, mandates and Group policies; and the replacement of the Memoranda and Articles of Association of the Group's companies registered in South Africa with the newly required Memoranda of Incorporation. The Company's new Memorandum of Incorporation was approved by the shareholders at the annual general meeting held on 26 July 2012.

BOARD RESPONSIBILITIES

A formal code of conduct ("the Board Charter") sets out the responsibilities of the Board, Chairman, Chief Executive Officer, Lead Independent Director, individual directors and the Company Secretary. The Board's key responsibilities in terms of the Board Charter include:

- the creation of sustainable shareholder value;
- directing, assessing and authorising the Group's strategies;
- ensuring that the Group's strategic and operational objectives are achieved;
- the enforcement of adequate risk management practices;
- the handling of all aspects that are of a material or strategic nature or that may impact on the Group's reputation;
- the monitoring of compliance with laws, regulations and the Group's Code of Business Conduct and Ethics;

- ensuring an appropriate business culture, management style and retention of management expertise and competence;
- identifying and managing potential conflicts of interest;
- ensuring that relevant and accurate information is timeously communicated to stakeholders;
- ensuring that remuneration of directors and senior management occurs in terms of the Group remuneration policy;
- empowering management to execute their tasks along delegated authorities;
- ensuring that the Board's composition incorporates the necessary skills and experience;
- the appointment of new directors;
- compliance with the Group's values; and
- ensuring the Group's financial performance and maintenance of its status as a going concern.

All Group policies, including the Board Charter, are reviewed annually. During the year only minor amendments were made to the Board Charter, mainly to incorporate the role of the Social and Ethics Committee and including the annual evaluation of the Company Secretary, as required in terms of the JSE Listings Requirements.

The Board has full and effective control of the Company and all material resolutions have to be approved by the Board. The Board meets at least six times per annum and on an *ad hoc* basis and, if required, measures exist to accommodate any resolutions that may have to be approved between meetings. Members of the Board and sub-committees receive an agenda containing comprehensive and accurate information well ahead of time. This enables them to meet their commitments and to determine whether or not prescribed functions have been executed according to set standards, within the margins of cautious and predetermined risk levels and according to international best practices.

Every director has free access to senior management and the Company Secretary.

COMPOSITION

As at the date of approval of the integrated annual report on 21 May 2013, the Board consisted of a non-executive Chairman, five executive directors and nine non-executive directors, of whom six are regarded as independent, as illustrated in **Figure 1**. The attendance of Board meetings is set out in **Figure 2**. The composition of the Board reflects an appropriate balance between executive and non-executive directors to ensure that there is a clear division of responsibilities so that no one individual has unfettered decision-making powers. Due to changes in the Board's composition during the year, the composition now meets the King III recommendation to have the majority of directors as non-executives, and the majority of the non-executives as independent.

The Group maintains an appropriate balance between entrepreneurial growth and compliance with corporate governance requirements. Board members possess a variety of skills and experience, and are involved in all material business decisions, enabling them to contribute to the strategic and general guidance of management and the business.

The roles and responsibilities of the Chairman and the Chief Executive Officer are segregated. Every year, at the first Board meeting after the annual general meeting, both the Chairman and the Chief Executive Officer are formally elected by the Board for a term of one year by way of a closed ballot.

The Board acknowledges the principle in King III recommending that an independent non-executive director be appointed as Chairman. Given the current chairman, Dr Edwin Hertzog's involvement in a chief executive capacity from the incorporation of the Company until his appointment as Chairman in 1992 and his resultant in-depth industry knowledge and experience, it is considered to undoubtedly be in the Company's and the Group's best interest to have him as Chairman. As a result, Mr Desmond Smith fulfils the role of Lead Independent Director ("LID"), as recommended in King III and as required in terms of the JSE Listings Requirements. The main functions of the LID are, *inter alia*, to provide leadership to the Board when the Chairman has a conflict of interest and

FIGURE 1: BOARD AND SUB-COMMITTEE COMPOSITION

Board
Executive directors:
Danie Meintjes (Chief Executive Officer)
Craig Tingle (Chief Financial Officer)
Ronnie van der Merwe (Chief Clinical Officer)
Koert Pretorius (CEO: Mediclinic Southern Africa)
Ole Wiesinger (CEO: Hirslanden)
Non-executive directors:
Edwin Hertzog (Chairman)*
Jannie Durand**
Kabs Makaba**
Pieter Uys**
Independent non-executive directors:
Alan Grieve
Robert Leu
Nandi Mandela
Trevor Petersen
Anton Raath
Desmond Smith

Audit and Risk Committee
Desmond Smith (Chairman)
Alan Grieve
Trevor Petersen
Anton Raath

Remuneration and Nominations Committee
Trevor Petersen (Chairman)
Jannie Durand
Robert Leu
Anton Raath

Social and Ethics Committee
Nandi Mandela (Chairperson)
Danie Meintjes
Pieter Uys
Ronnie van der Merwe

Investment Sub-committee
Edwin Hertzog (Chairman)
Jannie Durand
Alan Grieve
Danie Meintjes
Anton Raath
Craig Tingle

* *Dr Edwin Hertzog is not regarded as independent as he was employed in an executive capacity prior to his retirement on 31 August 2012. In terms of King III and the JSE Listings Requirements, a director shall not be regarded as independent if he has been employed by the company or the group in any executive capacity during the preceding three financial years.*

** *These directors are listed as non-executive directors and not regarded as independent because of their indirect interest in the Company. Messrs Jannie Durand and Pieter Uys are employees of Remgro, which held 43.4% at year end through Industrial Partnership Investments (Pty) Ltd. Dr Kabs Makaba is also a director of one of the Company's strategic black partners, Phodiso Holdings, which held 4.76% at year end through Mpilo Investment Holdings 2 (RF) (Pty) Ltd, a special purpose vehicle established in 2005 for purposes of the Company's black ownership initiative.*

perform the evaluations of the Chairman and the independence of the independent non-executive directors.

Mr Danie Meintjes, who has served on the Board since 1996 and as Chief Executive Officer from 1 April 2010, is responsible for the day-to-day management of the Group and the implementation of the strategies and policies adopted by the Board.

In terms of the Company's Memorandum of Incorporation, one third of the non-executive directors must retire each year on a rotational basis, but may make themselves available for re-election for a further term. The directors to retire shall be those who have been longest in office since their last election. A director who has already held his office for a period of three years since his last election shall retire at such meeting. There is a clear policy detailing procedures for appointments to the Board, which are formal and transparent. The appointment of directors is a function of the entire Board, based on recommendations made by the Remuneration and Nominations Committee.

BOARD, COMMITTEE AND DIRECTOR EVALUATIONS

The Board annually conducts an objective evaluation in respect of the Board's performance regarding its role and functioning. The evaluation process also includes formal evaluations of Board committees, individual directors and the

independence of the independent non-executive directors, with a specific focus on those directors who have served longer than nine years on the Board. Due to composition changes, no self-evaluation of the Social and Ethics Committee and the Remuneration and Nominations Committee was conducted. The Board, however, reviews the functioning of all the Board committees as part of the Board evaluation process.

During the evaluation process conducted during the previous reporting period and the most recent evaluations conducted in March 2013, the Board identified no major areas for improvement. The results of the evaluations are documented and areas raised which require further attention duly minuted, which are available to the external auditors. The only areas which were raised requiring further attention are:

- review of the remuneration of the members of the Audit and Risk Committee, which was subsequently done by the Remuneration and Nominations Committee as part of the annual review of the remuneration payable to Board and committee members;
- review of the remuneration of the executive directors to align compensation with the long-term interests of the Company, which is already receiving the attention of the Remuneration and Nominations Committee, as reported in the Remuneration Report;
- feedback on succession planning, which is dealt with by the Remuneration and Nominations Committee, will in future be more fully communicated to the Board.

Following the evaluation of the independent directors, the Board was satisfied that they are independent in character and judgement, also with regard to Mr Anton Raath, who has served on the Board since 1996. The Board confirmed that it is satisfied that there are no relationships or circumstances which affect or appear to affect his judgement and that his independence is not in any way affected by his length of service.

INDUCTION OF NEW DIRECTORS

Newly appointed directors follow an extensive induction programme coordinated by the Chairman and supported by the Company Secretary upon their appointment. The induction programme includes information sessions with management, as well as visits to the Company's hospitals, ensuring that new directors obtain a good understanding of the Company's core business and their fiduciary duties. They further receive extensive information on the JSE Listings Requirements and the obligations therein imposed upon directors, and they are continuously informed of any amended and new relevant legislation, as well as any changes in business risks that may have an impact on the Group. The Group's Corporate Governance Manual is also used during the induction process. During the period under review Messrs Jannie Durand, Alan Grieve, Trevor Petersen and Pieter Uys and Ms Nandi Mandela were appointed to the Board and received formal induction.

Directors are entitled, after consultation with the Chairman, to obtain independent professional advice about any aspect of the business at the expense of the Company.

COMPANY SECRETARY

Mr Gert Hattingh is the Company Secretary and also the Executive: Group Services of the Company and stands central to the corporate governance of the Group. The Company Secretary is responsible for providing guidance to the Board collectively and to the directors individually with regard to their duties, responsibilities and powers; making them aware of legislation and regulations relevant to the Company; and ensuring the proper administration of the proceedings and matters relating to the Board, the Company and the shareholders of the Company in accordance with applicable legislation and procedures.

The Board has unlimited access to the Company Secretary, who advises the Board and the sub-committees on relevant matters, including compliance with the Group's policies and procedures, the JSE Listings Requirements, relevant legislation, statutory regulations and King III.

During the reporting period the Board has expanded its annual evaluation process of the Board, committees and directors, by also including an annual evaluation in respect of the Company Secretary. The Board has considered and is satisfied that the Company Secretary is competent and has the requisite qualifications and experience to effectively execute his duties. A brief CV of the Company Secretary is included on page 11 of this integrated annual report.

The Board confirms that the Company Secretary maintains an arm's length relationship with the Board and the directors, taking into account that the Company Secretary is not a director of the Company and is not related to any of the directors.

EXECUTIVE MANAGEMENT

The Company's executive management committee meets on a monthly basis, or more regularly if required, to consider, *inter alia*, investment opportunities, operational matters and other aspects of strategic importance to the Group. They are continuously in contact with the Group's management teams of Southern Africa, Switzerland and the United Arab Emirates to ensure effective communication, decision-making and execution of strategies. The terms of reference of executive management are codified setting out their role and responsibilities, specifically with regard to their authority levels, which are reviewed annually by management and communicated to the Board.

The Chief Executive Officers of the Group's operating platforms in Southern Africa and Switzerland also serve on the Board, although these are not held *ex officio*. Because of the relative size of the Group's operations in the United Arab Emirates, the Chief Executive Officer of Mediclinic Middle East, Mr David Hadley, is not a member of the Board. He is, however, a member of the Company's executive management committee.

BOARD COMMITTEES

Specific responsibilities are delegated to the Board's sub-committees, which have defined tasks in terms of approved mandates. Reports on the committees' activities are also submitted to the Board. The main sub-committees are described below.

AUDIT AND RISK COMMITTEE

The responsibilities of the Audit and Risk Committee are codified in a mandate from the Board, which is reviewed at least annually by the Board. The main objectives of the committee are to:

- perform the statutory functions of an audit committee in terms of the Companies Act and other functions delegated to it by the Board;
- assess the policy of the Group with regard to internal control, accounting systems and policies, audit and public reporting of the Company and its subsidiaries, in order to make appropriate recommendations to the Board;
- assist in the evaluation of risk and control procedures, and to ensure that all the risks applicable to the Group are understood and appropriately managed by ensuring an effective control environment within the Group and by approving the overall risk management processes within the Group in order to make appropriate recommendations to the Board; and
- assist the Board to ensure that reporting to shareholders is comprehensive, accurate and timely.

The composition of and attendance at committee meetings are set out in **Figure 3**.

The committee's report, describing how it has discharged its statutory duties in terms of the Companies Act and its additional duties assigned to it by the Board in respect of the financial year ended 31 March 2013, is included in the annual financial statements published on the Company's website at www.mediclinic.com.

REMUNERATION AND NOMINATIONS COMMITTEE

The Remuneration and Nominations Committee meets periodically to discuss matters such as the Group's remuneration policy and philosophy, Board structure and composition, executive management and staff remuneration, directors' remuneration and management incentive schemes. The committee also aims to ensure that adequate succession planning measures are in place. The committee's

responsibilities are codified in a mandate from the Board, which is reviewed at least annually by the Board.

The composition of and attendance at committee meetings are set out in **Figure 4**. The Group's Chief Executive Officer and Mediclinic Southern Africa's General Manager: Remuneration also attend meetings.

The Group's remuneration policy, approach and compensation structure are set out in the Remuneration Report included in this integrated annual report. As recommended in King III, the Group's remuneration policy was approved by the shareholders of the Company at the last annual general meeting held on 26 July 2012 by way of a non-binding advisory vote, with 97.66% of the shareholders present or represented and entitled to vote, voting in favour of the resolution. The policy will be put forward for such non-binding advisory vote at each annual general meeting of the Company.

INVESTMENT SUB-COMMITTEE

The Investment Sub-committee is responsible for reviewing and making recommendations to the Board regarding proposed investments and capital expenditures of the Group that exceed set authority levels and meets on an *ad hoc* basis. The composition of and attendance at committee meetings are set out in **Figure 5**.

ATTENDANCE OF MEETINGS

FIGURE 2: ATTENDANCE OF BOARD MEETINGS

		May 2012	Jun 2012	Jul 2012	Aug 2012	Sep 2012	Nov 2012	Feb 2013	Mar 2013
Executive	Edwin Hertzog (Chairman)*	✓	✓	✓	✓	n/a*	n/a*	n/a*	n/a*
	Danie Meintjes	✓	✓	✓	✓	✓	✓	✓	✓
	Koert Pretorius	✓	✓	✓	✓	✓	✓	✓	✓
	Craig Tingle	✓	✓	✓	✓	✓	✓	✓	✓
	Ronnie van der Merwe	✓	✓	✓	✓	✓	✓	✓	✓
	Ole Wiesinger	✓	✓	✓	✓	✓	✓	✓	✓
Non-executive	Edwin Hertzog (Chairman)*	n/a*	n/a*	n/a*	n/a*	✓	✓	✓	✓
	Joseph Cohen (resigned 26 Jul 2012)	✓	✓	✓	n/a	n/a	n/a	n/a	n/a
	Jannie Durand (appointed 7 Jun 2012)	n/a	✓	✓	✓	✓	✓	✓	✓
	Kabs Makaba	✓	✓	✓	✓	✓	✓	✓	✓
	Mamphela Ramphele (resigned 26 Jul 2012)	x	✓	✓	n/a	n/a	n/a	n/a	n/a
	Pieter Uys (appointed 1 Apr 2013)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
	Chris van den Heever (resigned 1 Feb 2013)	✓	✓	✓	✓	✓	✓	n/a	n/a
Independent non-executive	Alan Grieve (appointed 13 Sep 2012)	n/a	n/a	n/a	n/a	✓	✓	✓	✓
	Robert Leu	✓	✓	✓	✓	✓	✓	✓	✓
	Zodwa Manase (resigned 26 Jul 2012)	✓	✓	✓	n/a	n/a	n/a	n/a	n/a
	Nandi Mandela (appointed 13 Sep 2012)	n/a	n/a	n/a	n/a	✓	✓	✓	✓
	Trevor Petersen (appointed 13 Sep 2012)	n/a	n/a	n/a	n/a	✓	✓	✓	✓
	Anton Raath	✓	✓	✓	✓	✓	✓	✓	✓
	Desmond Smith	✓	x	✓	✓	✓	✓	✓	✓
	Wynand van der Merwe (resigned 26 Jul 2012)	✓	✓	✓	n/a	n/a	n/a	n/a	n/a

* *Dr Edwin Hertzog retired with effect from 31 August 2012 from his executive role, but remains on the Board as a non-executive Chairman. A part of his attendance is therefore recorded as an executive director. With effect from 1 September 2012 his attendance is recorded as a non-executive director.*

FIGURE 3: ATTENDANCE OF AUDIT AND RISK COMMITTEE MEETINGS

Committee member (all independent non-executive)	May 2012	Nov 2012	Mar 2013
Desmond Smith (Chairman)	✓	✓	✓
Alan Grieve (appointed as committee member 13 September 2012)	n/a	✓	✓
Robert Leu (resigned as committee member 13 September 2012)	✓	n/a	n/a
Zodwa Manase (resigned as board and committee member 26 July 2012)	✓	n/a	n/a
Trevor Petersen (appointed as committee member 1 January 2013)	n/a	n/a	✓
Anton Raath	✓	✓	✓

FIGURE 4: ATTENDANCE OF REMUNERATION AND NOMINATIONS COMMITTEE MEETINGS

Committee member	Apr 2012	May 2012	Oct 2012	Mar 2013
Wynand van der Merwe (Chairman) (Independent non-executive) (resigned as board and committee member 26 July 2012)	✓	✓	n/a	n/a
Trevor Petersen (Chairman) (Independent non-executive) (appointed as committee member and chairman 13 September 2012)	n/a	n/a	✓	✓
Jannie Durand (Non-executive) (appointed as committee member 26 July 2012)	n/a	n/a	✓	✓
Edwin Hertzog (Executive) (resigned as committee member 13 September 2012)	✓	✓	n/a	n/a
Robert Leu (Independent non-executive) (appointed as committee member 26 July 2012)	n/a	n/a	✓	✓
Anton Raath (Independent non-executive)	✓	✓	✓	✓
Thys Visser (Non-executive) (passed away 26 April 2012)	✓	n/a	n/a	n/a

FIGURE 5: ATTENDANCE OF INVESTMENT SUB-COMMITTEE MEETINGS

Committee member	Jul 2012	Dec 2012
Edwin Hertzog (Chairman) (Executive) (Non-executive since 1 September 2012)	x	x
Joe Cohen (Non-executive) (resigned as Board and committee member 26 July 2012)	✓	n/a
Jannie Durand (Non-executive) (appointed as committee member 26 July 2012)	n/a	✓
Alan Grieve (Independent non-executive) (appointed as committee member 13 September 2012)	n/a	✓
Anton Raath (Independent non-executive)	✓	✓
Danie Meintjes (Executive)	✓	✓
Koert Pretorius (Executive) (resigned as committee member 26 July 2012)	✓	n/a
Craig Tingle (Executive)	✓	✓
Ronnie van der Merwe (Executive) (resigned as committee member 26 July 2012)	x	n/a
Ole Wiesinger (Executive) (resigned as committee member 26 July 2012)	x	n/a

FIGURE 6: ATTENDANCE OF SOCIAL AND ETHICS COMMITTEE MEETINGS

Committee member	May 2012	Nov 2012
Chris van den Heever (Chairman) (Non-executive) (resigned as Board and committee member 1 February 2013)	✓	✓
Nandi Mandela (Chairperson) (Independent non-executive) (appointed as committee member 13 September 2012 and committee chairperson 27 February 2013)	n/a	✓
Danie Meintjes (Executive)	✓	✓
Pieter Uys (Non-executive) (appointed as committee member 1 April 2013)	n/a	n/a
Ronnie van der Merwe (Executive)	✓	✓

SOCIAL AND ETHICS COMMITTEE

The Board established the Company's Social and Ethics Committee and appointed its first members in February 2012. The responsibilities of the committee are codified in a mandate from the Board, which is reviewed at least annually by the Board. The main objectives of the committee are to:

- assist the Board in ensuring that the Group is and remains a good and responsible corporate citizen by monitoring the sustainable development performance of the Group; and
- perform the statutory functions of a social and ethics committee in terms of the Companies Act and other functions delegated to it by the Board.

The composition of and attendance at committee meetings are set out in **Figure 6**.

The committee's report, describing how it has discharged its statutory duties in terms of the Companies Act and its additional duties assigned to it by the Board in respect of the financial year ended 31 March 2013, is included on page 94 of this integrated annual report.

DEALINGS IN SECURITIES

Procedures are in place to prevent directors and senior management of the Group from trading in the Company's shares during price-sensitive or closed periods, which are more restrictive than those required in terms of the JSE Listings Requirements. In terms of the Group's policy, closed periods commence two months prior to the expected publication date of the year-end or interim financial results of the Company up to the publication date, alternatively from the last day of the financial year or the first six-month period of the financial year up to the publication date of the annual or interim financial results of the Company, whichever is the longest. Directors and senior management throughout the Group are informed of the closed periods by the Company Secretary. Furthermore, the directors and company secretaries of the Company and its major subsidiaries, as well as selected senior management are not allowed to trade in the Company's shares, unless the prior written approval of the Chairman, or in his absence the Chief Executive Officer, has been obtained.

CONFLICT OF INTERESTS

All employees within the Group are obliged to disclose any potential conflict of interests as well as any gift or invitation by a supplier or a third party. In addition, Board members and the company secretaries of the Company and its major subsidiaries are required to disclose their shareholding in the Company, other directorships and any potential conflict of interests, which are monitored by the Company Secretary. Where a potential conflict of interests exists, directors are expected to excuse themselves from relevant discussions and decisions.

ICT GOVERNANCE

Information and Communications Technology (ICT) is a pervasive technology and cuts across all aspects of the business. It is a critical enabler of the transactional processes of our business as well as the information analytical functions of management. The increase in business systems integration, information security challenges and interconnectivity can result in significant costs and risks. ICT offers exceptional opportunities for growth and renewal, as well as for enabling and transforming the business. The Mediclinic Board and executive management are well informed about the role of ICT and its impact on the business. The Board recognises that ICT is fundamental to the support, sustainability and growth of the organisation. The Board is satisfied that ICT is properly managed and that it is aligned with the objectives of our business.

The Group's ICT Executive together with an ICT management committee, with representation from all three operating platforms, are responsible for the development and implementation of the Group's ICT strategy in support of the Group's business strategy, as well as for ensuring that ICT synergies across the platforms are maximised. The ICT management committee is responsible for monitoring the platforms' adherence to the Group's ICT Governance Policy, and ICT risk management is fully integrated in the Group's risk management process as elucidated in the Risk Management Report.

RISK MANAGEMENT AND INTERNAL CONTROL

The Group's reporting on its risk management process and system of internal control is included in the Risk Management Report.

EXTERNAL AUDIT

The Audit and Risk Committee is responsible for nominating the Company's external auditor and determining its terms of engagement. PricewaterhouseCoopers Inc., as the re-appointed external auditor of the Company during the period under review, whose report is included in the annual financial statements, is responsible for providing an independent opinion on the financial statements. The external audit function offers reasonable, but not absolute, assurance on the fair presentation of the financial disclosures.

The external auditors of the Company and its major subsidiaries operating in Southern Africa and Switzerland meet the external auditor registration requirements in terms of the JSE Listings Requirements.

The Audit and Risk Committee meets at least three times per year with the external and internal auditors and executive management to ensure that their efforts pertaining to risk management and internal control are properly coordinated.

INVESTOR RELATIONS AND SHAREHOLDER COMMUNICATION

The Board is committed to keeping shareholders and the investor community informed of developments in the Group's business. Our engagement with our shareholders and the investment community is dealt with in the detailed Sustainable Development Report published on the Company's website.

THE SOCIAL AND ETHICS COMMITTEE ASSISTS THE BOARD IN ENSURING THAT THE GROUP REMAINS A GOOD AND RESPONSIBLE CORPORATE CITIZEN

The Social and Ethics Committee ("the Committee") assists the Board in ensuring that the Mediclinic Group is and remains a good and responsible corporate citizen, and to perform the statutory functions required of a social and ethics committee in terms of the Companies Act, 71 of 2008, as amended ("the Companies Act"). This report is presented by the Committee to describe how it has discharged its statutory duties in terms of the Companies Act as well as its additional duties assigned to it by the Board in respect of the financial year ended 31 March 2013.

COMPOSITION AND MEETINGS

The Committee consists of an independent non-executive chairperson, one non-executive director and two executive directors (as set out in **Figure 1**), who are suitably skilled and experienced. The two executive members are Mr Danie Meintjes, the Group's Chief Executive Officer, and Dr Ronnie van der Merwe, the Group's Chief Clinical Officer. The Chief Executive Officers of the Group's operating platforms, the Executive: Group Services and Group Risk Manager are invited to attend all Committee meetings. Attendance at the Committee meetings during the period under review was as follows:

Figure 1: COMPOSITION AND ATTENDANCE OF COMMITTEE MEETINGS

	May 2012	Nov 2012
Chris van den Heever (Chairman) (Non-executive) (resigned as Board and committee member 1 February 2013)	✓	✓
Nandi Mandela (Chairperson) (Independent non-executive) (appointed as committee member 13 September 2012 and committee chairperson 27 February 2013)	n/a	✓
Danie Meintjes (Executive)	✓	✓
Pieter Uys (Non-executive) (appointed as committee member 1 April 2013)	n/a	n/a
Ronnie van der Merwe (Executive)	✓	✓

ROLE AND FUNCTION OF THE COMMITTEE

The responsibilities and functioning of the Committee are governed by a formal mandate approved by the Board, which is subject to regular review by the Board, but at least annually. The main objectives of the Committee are to assist the Board in ensuring that the Group is and remains a good and responsible corporate citizen by monitoring the sustainable development performance of the Group, which includes the following main responsibilities outlined below.

POLICY REVIEW

The Committee is responsible for developing and reviewing the Group's policies with regard to the commitment, governance and reporting of the Group's sustainable development performance and for making recommendations to management and/or the Board in this regard. During the year, the Committee reviewed the Group's Code of Business Conduct and Ethics, Group Sustainable Development Policy, Group Environmental Policy and the Group Social Affairs Policy. Minor amendments to the Group's Code of Business Conduct and Ethics were approved by the Board upon recommendation of the Committee. These policies are published on the Company's website at www.mediclinic.com.

MONITORING SUSTAINABLE DEVELOPMENT PERFORMANCE

The Committee performs a monitoring role in respect of the sustainable development performance of the Group, specifically relating to:

- stakeholder engagement;
- health and public safety, which includes occupational health and safety as well as the clinical quality of the Group's services;
- broad-based black economic empowerment;
- labour relations and working conditions;
- training and skills development of our employees;
- management of the Group's environmental impacts;
- ethics and compliance; and
- corporate social investment.

The Committee's monitoring role also includes the monitoring of relevant legislation, other legal requirements or prevailing codes of best practice, specifically with regard to matters relating to social and economic development, good corporate citizenship, the environment, health and public safety, consumer relationships, as well as labour and employment. During the period under review

feedback on the Group's compliance management process – which is monitored through the Group's risk management process, with a particular focus on relevant legislation, requirements and codes applicable in South Africa – was reviewed by the Committee. The Committee further reviewed and approved the report on the application of the King III principles as published on the Company's website.

The Committee is satisfied with the Company's performance in each of the areas listed above, as further reported on in the detailed Sustainable Development Report published on the Company's website. An abridged version of the Sustainable Development Report is included in the integrated annual report, which focuses mainly on the Group's performance against the key sustainability priorities.

The Committee further monitors the results of the participation in external surveys in respect of any sustainability aspect pertaining to the Group. In this regard, the Committee noted the external recognition and achievements by the Group, as reported in **Figure 1** of the abridged Sustainable Development Report. Particular focus was placed on the results of the 2012 JSE SRI Index, and those indicators which the Company has not met in an attempt to identify areas for improved sustainability policy, management and reporting.

KEY SUSTAINABILITY PRIORITIES

The Committee is responsible for annually revising or determining, in conjunction with senior management, the Group's key sustainability priorities. The key priorities reported on in **Figure 2** of the abridged Sustainable Development Report were confirmed by the Committee, as recommended by management.

PUBLIC REPORTING AND ASSURANCE

The Committee is responsible for reviewing and approving the annual sustainability content included in the integrated annual report and/or published on the Company's website, and determining and making recommendations on the need for external assurance of the Group's public reporting in sustainable development performance.

The Committee reviewed the Clinical Services Report and the abridged Sustainable Development Report included in the integrated annual report, as well as the detailed Sustainable Development Report published on the Company's website. These reports were also approved by the Board, upon the recommendation of the Committee. The Committee is satisfied that the current level of combined assurance provides the necessary independent assurance over the quality and reliability of the information presented. The Committee will continue to monitor whether additional forms of assurance are required in future.

The Committee is also required to report through one of its members to the Company's shareholders on the matters within its mandate at the Company's annual general meeting. Shareholders will be referred to this report by the Committee, read with the detailed Sustainable Development Report, at the Company's annual general meeting on 25 July 2013. Any specific questions to the Committee may be sent to the Company Secretary prior to the meeting.

ASSESSMENT OF COMMITTEE'S PERFORMANCE

Due to composition changes, no self-evaluation of the Committee was conducted. The Board, however, assesses the functioning of the Committee and the level of feedback received from the Committee annually, as further detailed in the Corporate Governance Report. During the first assessment of the Committee conducted in March 2013 (approximately one year after the establishment of the Committee), the Board confirmed that the Committee functions effectively.

N Mandela
Chairperson: Social and Ethics Committee

Stellenbosch
21 May 2013

AS A GROUP, MEDICLINIC IS FIRMLY COMMITTED TO MANAGING OUR BUSINESS IN A SUSTAINABLE WAY AND UPHOLDING THE HIGHEST STANDARDS OF ETHICS AND CORPORATE GOVERNANCE

ABRIDGED SUSTAINABLE DEVELOPMENT REPORT

This report is an abridged version of the detailed Sustainable Development Report published in respect of the financial year ended 31 March 2013, which report is available on the Company's website at www.mediclinic.com. The detailed report is also available for inspection at the Company's registered office at Mediclinic Offices, Strand Road, Stellenbosch, during normal business hours. A printed copy may be requested from the Company (see contact details on page 132).

As a Group, Mediclinic is firmly committed to managing our business in a sustainable way and upholding the highest standards of ethics and corporate governance practices. The benefits of delivering on these commitments are many – through our sustainability efforts we maintain our business integrity, we maintain and improve the confidence, trust and respect of our stakeholders, we offer improved access to capital by providing a responsible investment proposition, and we increase our ability to attract and retain staff.

Mediclinic's track record on delivering growth and creating long-term value in all its business operations in Southern Africa, Switzerland and the UAE is testament to our strategy of being a long-term player and delivering a sustainable business. While growth, profitability and creating shareholder value are certainly major strategic drivers, with a compounded annual growth rate for the past seven years of 28.9% in Group revenue and 29.3% in normalised EBITDA, this cannot be achieved unless we have the best possible clinical quality standards for our patients; value our employees by following fair labour practices and offering competitive remuneration, training and development opportunities; respect the communities within which we operate and contribute to the well-being of society; and carefully manage our impacts on the environment by focusing on our carbon footprint, use of energy, and water resource and waste management.

It is evident from the Group's risk profile that regulatory reforms are changing healthcare, where private healthcare providers are often the key focus group. We manage these risks effectively, as reported in our Risk Management Report and the Operational Reviews. Despite the many challenges facing private healthcare today, we are confident that Mediclinic is a growing and sustainable business delivering value to all our stakeholders in the short, medium and long term.

SCOPE AND BOUNDARY OF REPORT

This report is Mediclinic's 11th Sustainable Development Report in respect of the financial year ended 31 March 2013.

With this report, we aim to provide our stakeholders with information on the non-financial aspects of the corporate practice of the Group and all its business divisions in Southern Africa, Switzerland and the United Arab Emirates ("UAE") that, in turn, create economic, social and environmental value. The scope of this report includes the Group's operations in Southern Africa, Switzerland and the UAE, but as a JSE-listed company with the majority of our operations based in South Africa and with largely South African investors, particular emphasis is placed on our Southern African operating platform. Although we are a private hospital group with materially the same principles applying in each of our operating platforms, each of our operating platforms is managed separately and they have some cultural and economic differences – we therefore provide information about each platform under separate headings to give our stakeholders a better understanding of the variances within each of our three operating platforms.

REPORTING PRINCIPLES

The principles and recommendations on integrated sustainability reporting contained in the King Report on Governance for South Africa 2009 ("King III") as well as the G3.1 Sustainability Reporting Guidelines developed by the Global Reporting Initiative ("GRI G3.1") form the basis of this report. The report was prepared in accordance with application level C of the GRI G3.1. The GRI G3.1 disclosure index, which identifies the location of the standard disclosures required by the Global Reporting Initiative's sustainability reporting guidelines, is published as an annexure to the detailed Sustainable Development Report published on the Company's website at www.mediclinic.com.

As referred to in the report profile on the inside front cover, we have also noted and applied several of the recommendations contained in the local and international discussion papers and consultation drafts on integrated reporting issued by the Integrated Reporting Committee of South Africa and the International Integrated Reporting Committee. As a constituent of all the JSE SRI (socially responsible investment) indexes conducted to date, which index showcases those listed companies meeting a set of criteria that measure economic, social and environmental commitment and performance, due regard is also given to the JSE SRI index criteria.

ORGANISATIONAL STRUCTURE

Mediclinic is an international private hospital group with three operating platforms in Southern Africa (South Africa and Namibia), Switzerland and the UAE, with its Head Office situated in Stellenbosch, South Africa. The Group's management and operational structure is also divided into three operating platforms, as illustrated in the organisational chart on page 6. The three operating platforms operate separately from one another, each with its own management team. Mediclinic International, as the holding company of the Mediclinic Group, sets the strategic objectives and governance framework for the Group. The management teams of the operating platforms report to the Executive Committee of Mediclinic on a regular basis. Because of the Group's structure, reporting on each element included in this report is done per platform, unless Group standards apply.

EXTERNAL RECOGNITION AND ACHIEVEMENTS

We are proud of the external recognition and achievements during the reporting period highlighted in **Figure 1**.

FIGURE 1: EXTERNAL RECOGNITION AND ACHIEVEMENTS

Group	Included in the 2012 JSE SRI Index for the ninth consecutive year, an initiative of the JSE which showcases those JSE-listed companies meeting a set of criteria that measure economic, social and environmental commitment and performance. Report prepared in accordance with GRI G3.1 sustainable development reporting guidelines with a self-declared application level C. Finalist in the Internal Marketing Programmes category for "Mediclinic Group Conference", with media partner Jupiter Drawing Room, at the prestigious Loerie Awards.
Southern Africa	Thirty-three hospitals accredited by the Council for Health Services Accreditation of Southern Africa (COHSASA), an agency accredited by the International Society for Quality in Healthcare to accredit hospitals. Thirty-nine of the group's 52 hospitals ISO 14001:2004 (environmental management) certified. Ranked joint 4th position in the Carbon Disclosure Project 2012. Externally assessed BBBEE scorecard at Level 4 contributor. Mediclinic Southern Africa, with communication consultants Stone, won awards in the Social Media for the Public Relations and Digital Media Relations categories at the Public Relations Institute of South Africa's PRISM Awards 2013. *Mediclinic Family* magazine received a highly commended award in the Education, Health, Conservation, Safety & Security category at the 2012 PICA Awards, in which the Magazine Publishers' Association of South Africa recognises excellence in magazine publishing industry standards. Selected by Superbrands, an independent arbiter of branding, as one of the leading brands in South Africa. One of the group's Nurse Educators was awarded the Young Nurse Leaders Award at the 2012 Leadership Awards of the Forum for Professional Nurse Leaders, which award honours outstanding young nurse leaders (35 years and younger) for distinguishing achievements.
Switzerland	All 14 hospitals and head office ISO 9001:2008 (quality management) certified. Klinik Hirslanden, Klinik Im Park and since 2013 also Klinik Stephanshorn recognised as CO_2-reduced businesses by the Swiss Energy Agency for the Economy on behalf of the Swiss Federal Office of Energy. This achievement recognises the contracted commitment to reduce CO_2 emissions within operations. All 14 hospitals and head office underwent self-assessment under the EFQM (the European Foundation for Quality Management) Excellence Model. Klinik Hirslanden recognised for four stars and AndreasKlinik Cham Zug recognised for three stars against the EFQM Excellence Model. The six-storey extension to Klinik Hirslanden in Zurich which opened in May 2013 adheres to the MINERGIE® standards for buildings. The MINERGIE standards are voluntary building standards on sustainable use of energy and a broad use of renewable energy sources resulting in a reduced environmental impact.
UAE	Both hospitals are Joint Commission International (JCI) accredited. JCI is an international accreditation organisation for healthcare organisations focused on improving the safety of patient care through accreditation. Both hospitals will go through the re-accreditation process in July 2013, along with the first accreditation of the group's eight clinics. The accreditation of the clinics will result in the group's clinics being the second network of clinics to receive the JCI network accreditation in the UAE. The pathology laboratories of both hospitals are ISO 15189: 2009 certified. All five clinics with in-house laboratories also achieved this accreditation during the year. Mediclinic City Hospital's pathology laboratory is accredited by the College of American Pathologists (CAP) and will undergo re-accreditation in August 2013. Mediclinic Welcare Hospital was accredited as a Center of Excellence in Minimally Invasive Gynaecology by the Surgical Review Corporation, endorsed by the American Board of Surgeons. As part of the accreditation, four doctors from Mediclinic Welcare Hospital were named Center of Excellence designees. Mediclinic Welcare Hospital achieved Gold Standard in its re-accreditation by the American Heart Association.

KEY PRIORITIES: PERFORMANCE AGAINST OBJECTIVES

A few highlights of the Group's performance against its key sustainability priorities for the period under review are summarised in **Figure 2**. All of these focus areas are dealt with in greater detail throughout this integrated annual report or the detailed Sustainable Development Report published on the Company's website at www.mediclinic.com.

FIGURE 2: KEY PRIORITIES: PERFORMANCE AGAINST OBJECTIVES
(refer also to **Figure 1:** External recognition and achievements)

OBJECTIVES	INDICATORS OF OUR PERFORMANCE	For more information refer to
PRIORITY 1:	**QUALITY AND SAFETY OF PATIENT CARE**	
Continued focus on clinical quality	Comprehensive clinical governance programme consisting of focus areas in leadership and accountability, healthcare workforce, infrastructure and environment, clinical care management and clinical information management. Clinical Hospital Committees with various sub-committees established throughout the Group. Focused clinical audits used at most hospitals throughout the Group. Clinical outcomes are benchmarked throughout the Group through participation in external initiatives such as the Vermont Oxford Network, aimed at measuring and improving the quality of care in neonatal intensive care units; the Adult Cardio-thoracic Database, aimed at measuring and improving the clinical outcomes of cardio-thoracic surgery; APACHE III-j, a hospital mortality prediction methodology for adult intensive care patients used to evaluate the quality of care in this complex setting; and the IQIP clinical indicators. Important clinical indicators such as mortality, extended stay and re-admissions are measured and compared within the Group. Thirty-three hospitals accredited by the Council for Health Services Accreditation of Southern Africa (COHSASA), an agency accredited by the International Society for Quality in Healthcare to accredit hospitals, which is currently led by a Mediclinic patient safety expert. All Mediclinic Southern Africa hospitals are participating in the "Best Care… Always" patient safety initiative, a collaborative quality industry initiative to promote patient safety between the public and private sector. Participation shows marked reductions in healthcare-associated infections (HAIs) and continued implementation of changes to address HAIs. A new cardiac electrophysiology laboratory established at Mediclinic Panorama – the second cardiac electrophysiology laboratory in Mediclinic Southern Africa. Piloting the application of an internal model for accrediting Hirslanden competence centres at different levels. Successful introduction of the concept of patient-centred care at Hirslanden group. EFQM model implemented throughout Hirslanden, with all 14 hospitals and head office completing an EFQM self-assessment during the year. All 14 Hirslanden hospitals and head office ISO 9001:2008 (quality management) certified. Development of clinical key performance indicators (KPIs) that will be included in the annual doctors' performance review process at Mediclinic Middle East. Both Mediclinic Middle East hospitals JCI accredited, with re-accreditation due to take place in July 2013 along with the first accreditation of the group's eight clinics. The pathology laboratory of both Mediclinic Middle East hospitals ISO 15189:2009 certified, with all clinics with in-house laboratories achieving accreditation during the year. College of American Pathologists (CAP) accreditation of the laboratory of Mediclinic City Hospital. Re-accreditation will take place in August 2013. A Hospital Information System ("HIS") implemented at Mediclinic Welcare Hospital and One EMR, a centralised electronic medical record software application, implemented across all units to maximise efficiency and ensure all patient records can be accessed from any facility.	Clinical Services Report

FIGURE 2: KEY PRIORITIES: PERFORMANCE AGAINST OBJECTIVES (CONTINUED)
(refer also to **Figure 1:** External recognition and achievements)

OBJECTIVES	INDICATORS OF OUR PERFORMANCE	For more information refer to
PRIORITY 1:	**QUALITY AND SAFETY OF PATIENT CARE** continued	
Provide and maintain high-quality hospital infrastructure	Expenditure on capital projects and new equipment to expand and refurbish facilities, as well as repairs and maintenance of facilities during period under review: • R968m (2012: R797m) in Southern Africa • R1 556m (CHF172m) (2012: R1 161m (CHF138m)) in Switzerland • R150m (AED65m) (2012: R86m (AED42m)) in UAE Comprehensive maintenance and asset management systems applied throughout the Group.	Operational Reviews Detailed Sustainable Development Report: Quality and care of facilities
Ensure adequate supply and optimal utilisation of skilled and experienced employees	Continuous training and development of our employees (see "employee training and development" below) to ensure retention of staff where skills shortage is most critical. Various initiatives between Mediclinic Southern Africa and local and national government authorities to collaborate on training needs. Foreign recruitment drives for nurses from India to alleviate critical nurse shortage in Southern Africa. Hirslanden also recruits from other European countries to address local skills shortages in Switzerland. The majority of Mediclinic Middle East's staff is recruited from abroad.	Operational Reviews Detailed Sustainable Development Report: – Priority 2: Nursing and general skills shortage in this **Figure 2** below – Our People: Employee recruitment, retention and remuneration – Training and skills development
Excellent patient and doctor satisfaction levels	Patient satisfaction surveys conducted throughout the Group's hospitals, with the average patient satisfaction levels at 76% for Mediclinic Southern Africa (with target at 77%), 87% for Hirslanden (with target at 88%) and 93% for Mediclinic Middle East (with target at 90%). **Patient satisfaction levels** 2009/10 / 2010/11 / 2011/12 / **2012/13** Mediclinic Southern Africa: 73% / 75% / 76% / **76%** Hirslanden*: 86% / 85% / 93% / **87%** Mediclinic Middle East: 90% / 89% / 89% / **93%** * *The patient satisfaction results for the period under review are based on the Picker patient satisfaction survey that was conducted in 2012. It is not comparable to the 2011/12 results which were based on the ANQ (the Swiss National Association for Quality Development) satisfaction survey. The results shown above, prior to the 2011/12 results, are also based on the Picker review.* Patient Journey programme initiated at Mediclinic Southern Africa to improve patients' experience in our hospitals; and discussions under way as to how it can be implemented at Mediclinic Middle East. Patient satisfaction survey of Mediclinic Southern Africa expanded to include 14 questions on clinical outcomes. Regular doctor satisfaction surveys conducted throughout the Group. Hirslanden commenced with the implementation of a Customer Relationship Management System in 2011, which includes a complaint management system and the integration of the existing Hirslanden Healthline database and the database of all affiliated doctors. After evaluation of the pilot project at Klinik Hirslanden, the roll-out to the rest of the group commenced in April 2012 and is progressing well.	Chief Executive Officer's Report Clinical Services Report Detailed Sustainable Development Report: – Engagement with stakeholders (specifically sections dealing with engagement with patients and doctors) – Quality of care and facilities: Clinical quality; and Patient satisfaction

FIGURE 2: KEY PRIORITIES: PERFORMANCE AGAINST OBJECTIVES (CONTINUED)
(refer also to **Figure 1:** External recognition and achievements)

OBJECTIVES	INDICATORS OF OUR PERFORMANCE	For more information refer to
PRIORITY 2:	**NURSING AND GENERAL SKILLS SHORTAGE**	
Development and training of staff to maintain and improve quality service delivery	The average spending on training expressed as a percentage of payroll was 4% (2012: 4%) by Mediclinic Southern Africa, 4.2% by Hirslanden and 0.3% (2012: 0.3%) by Mediclinic Middle East. Performance reviews to develop staff and identify training needs conducted with all Hirslanden and Mediclinic Middle East employees and with 95.4% of Mediclinic Southern Africa employees. At Mediclinic Southern Africa 36 274 structured learning interventions were recorded, with 6 187 at Mediclinic Middle East. At Hirslanden, 700 apprentice employees received formal training (federal certificate, higher college, college or graduate students) across 27 professions, of which 599 students were healthcare professionals and 28 junior doctors. In-house leadership and management courses were attended by 232 management employees. Furthermore, approximately 1 000 in-house training sessions were conducted by the group's 14 hospitals. The first results of a KPI system to measure Mediclinic Southern Africa's training performance was developed during the previous year, used as a tool for implementing initiatives to address areas where training results can be improved. Strong focus on continuous professional development of medical staff at all three platforms.	Operational Reviews Detailed Sustainable Development Report: – Our people: performance reviews – Training and skills development
Retention of staff	The Group offers market-related salaries and benefits to our employees, based on the principles of internal equity, external equity and fairness in accordance with the Group's Remuneration Policy. Periodic employee satisfaction surveys conducted. Other key performance indicators measured on a continuous basis include turnover rate and absenteeism. Recruitment approach consistent with promoting the Group as an employer of choice. Sound performance management procedures in place to identify areas for improvement and training needs, recognising good performance and promoting opportunities for career development and contributing to a contented workforce. Mediclinic Middle East has reduced working hours for all units from 50 hours to 45 hours per week, an initiative which has gained very positive feedback from employees.	Remuneration Report Detailed Sustainable Development Report: – Our People: Labour relations and working conditions; Performance management; and Employee recruitment, retention and remuneration – Training and skills development
Alleviate shortage of nurses and general skills shortage through in-service training and support of external training institutions	Refer also to the performance indicators under "development and training of staff to maintain and improve quality service delivery" in this **Figure 2**. All six of Mediclinic Southern Africa's learning centres offer the Diploma in General Nursing and the Diploma in Operating Room Practice registered by the Department of Higher Education and Training. Financial support of more than R4.4m provided to academic institutions in Southern Africa. Public forums to address skills shortages attended on regular basis and good relations maintained with relevant legislative bodies. Joint collaboration with Western Cape Department of Health to train Operating Room Practitioners for Groote Schuur Hospital and Tygerberg Hospital. During the 2012 academic year 520 students completed basic nursing courses; 70 students completed post-basic nursing courses; 978 learners completed other Mediclinic Southern Africa courses in various disciplines.	Operational Reviews Detailed Sustainable Development Report: – Our People: Performance management; and Employee recruitment, retention and remuneration – Training and skills development

FIGURE 2: KEY PRIORITIES: PERFORMANCE AGAINST OBJECTIVES (CONTINUED)
(refer also to **Figure 1:** External recognition and achievements)

OBJECTIVES	INDICATORS OF OUR PERFORMANCE	For more information refer to
PRIORITY 3:	**BBBEE (SOUTH AFRICA ONLY)**	
Sustainable transformation in all elements of BBBEE scorecard	Level 4 contributor on generic BBBEE scorecard, as externally verified. Number of black employees increased year-on-year from 62.7% to 64.1% of total employees. Black management representation increased from 11% in 2006 to 22% at year end. Diversity workshops held at all the facilities throughout the group. Further follow-up workshops were held with management teams during the course of the year.	Detailed Sustainable Development Report: – Broad-based black economic empowerment
PRIORITY 4:	**CSI/COMMUNITY INVOLVEMENT**	
Improving the health and well-being of communities in which we operate	Approximately R5.8m (2012: R5.0m) spent on CSI in Southern Africa, of which R2.8m (2012: R2.5m) was donated to 52 accredited community organisations. Various health awareness campaigns throughout the Group. Mediclinic Southern Africa partnered with various Departments of Health making our facilities and staff available at no cost: – 87 surgical procedures to reduce waiting lists at the Red Cross Children's Hospital in the Western Cape Province; – 120 female patients screened for breast cancer at three public hospitals in KwaZulu-Natal; – 52 accredited organisations received monetary support in the amount of R2.75m. Hirslanden spent CHF1.7m on CSI projects during the period under review through donations. Mediclinic Middle East contributed approximately AED400 000 (2012: AED400 000) to corporate social responsibility projects during the reporting period. Initiatives included free health screenings, health talks, awareness campaigns on particular health topics and blood donation campaigns. For the year ahead AED500 000 has been budgeted for corporate social responsibility projects and the key focus areas will be health, education, sport and welfare of individuals affected by war and natural disasters in the region.	Operational Reviews Detailed Sustainable Development Report: – Our community involvement
PRIORITY 5:	**MANAGING OUR ENVIRONMENTAL IMPACT**	
Effective environmental management systems to monitor and minimise impacts	ISO 14001 environmental management standards implemented at all 52 Mediclinic Southern Africa hospitals. Ranked joint 4th position in the Carbon Disclosure Project 2012. Mediclinic Southern Africa's total CO_2e emissions decreased from 113 to 111 tonnes CO_2e per bed day. Klinik Hirslanden, Klinik Im Park and since 2013 also Klinik Stephanshorn recognised as CO_2-reduced businesses by the Swiss Energy Agency for the Economy on behalf of the Swiss Federal Office of Energy. This achievement recognises the contracted commitment to reduce CO_2 emissions within operations. The six-storey extension to Klinik Hirslanden in Zurich which opened in May 2013 adheres to the MINERGIE® standards for buildings. The MINERGIE standards are voluntary building standards on sustainable use of energy and a broad use of renewable energy sources resulting in a reduced environmental impact. At Mediclinic City Hospital electricity consumption increased by only 2%, even though there was a 20% increase in bed days.	Operational Reviews Detailed Sustainable Development Report: – External recognition and achievements – Environmental performance

PROUDLY SELECTED BY SUPERBRANDS, AN INDEPENDENT ARBITER OF BRANDING, AS ONE OF THE LEADING BRANDS IN SOUTH AFRICA

FIGURE 3: COMBINED ASSURANCE

ASSURANCE OUTPUT	BUSINESS PROCESSES ASSURED	PROVIDER
Independent external auditor's report	Financial reporting	PricewaterhouseCoopers Inc.
Internal auditor's report (also expanded to Mediclinic Middle East during the year)	Risk-based selection of audit areas	Remgro Internal Audit
Internal risk management	All key business risk areas	Internal management surveys
External calculation of carbon footprint based on carbon emissions data of Mediclinic Southern Africa	Carbon footprint calculation	Carbon Calculated
ISO 14001:2004 certification of 39 of Mediclinic Southern Africa's 52 hospitals	Environmental management system	NQA (National Quality Assurance Limited)/UKAS (United Kingdom Accreditation Service)
COHSASA accreditation of 33 of Mediclinic Southern Africa's 52 hospitals	Quality standards of healthcare facilities	COHSASA (Council for Health Services Accreditation of Southern Africa), which is accredited by ISQua (the International Society for Quality in Health Care)
BBBEE Level 4 contributor verification	Broad-based black economic empowerment	AQRate
ISO 9001:2008 certification of all 14 Hirslanden hospitals and Hirslanden Head Office	Quality management	Swiss Association for Quality and Management Systems (SQS)
Self-assessment against EFQM Excellence Model by all 14 Hirslanden hospitals and Hirslanden Head Office	Assessment against the EFQM Excellence Model, a framework for organisational management systems aimed at promoting sustainable excellence within organisations.	EFQM Excellence Model
JCI accreditation of both Mediclinic Middle East hospitals (accreditation of clinics planned for June 2013)	Quality and safety of patient care	Joint Commission International (JCI)
ISO 15189: 2009 certification of the pathology laboratories of both Mediclinic Middle East hospitals	Pathology laboratories of both Mediclinic Middle East hospitals	International Organisation for Standards
College of American Pathologists (CAP) accreditation of the laboratory of Mediclinic City Hospital	Laboratory of Mediclinic City Hospital	College of American Pathologists

ASSURANCE

The independent assurance of sustainability reporting and disclosure is recommended in King III, the integrated reporting guidelines and GRI G3.1. There is an increasing trend in South Africa to have limited external assurance on selected non-financial information. We accept our accountability to our stakeholders to present information that is relevant, accurate and reliable. We follow a combined assurance model, with assurance between management, internal audit and external assurance, as illustrated in **Figure 3**. We believe that these assurance methods provide the necessary independent assurance over the quality and reliability of those processes and the information presented. The different options and levels of external assurance available are continuously being considered to determine the way forward on external assurance.

MANAGEMENT APPROACH

The Group Sustainable Development Policy, Group Environmental Policy, Group Social Affairs Policy and Code of Business Conduct and Ethics codify our long-standing commitment to conducting business responsibly. The policies are reviewed annually by management, with recommendations to the Board as part of the annual policy review. A review was performed in 2013 with no material amendments approved.

The most senior executive manager responsible for coordinating sustainable development throughout the Group is the Company Secretary and Executive: Group Services, Mr Gert Hattingh.

The management approach to the sustainability indicators reported on is dealt with in this report in the relevant sections pertaining to them.

ETHICS AND COMPLIANCE

Please visit the governance section on our website at www.mediclinic.com for a copy of our Code of Business Conduct and Ethics and the contact details of the relevant Ethics Contact Persons within the Group.

Conducting business in an honest, fair and legal manner is a fundamental guiding principle in the Mediclinic Group, which is actively endorsed by the Board and management. Ethical behaviour has always been a fundamental guiding principle and management continually focuses on establishing a culture of responsibility, fairness, honesty, accountability and transparency in the Group. This commitment is firmly entrenched in the Group and supports its vision to be regarded as the most respected and trusted provider of hospital services by our patients, doctors and funders of healthcare. The Group's commitment to ethical standards is set out in the Group's values, and is supported by the Group Code of Business Conduct and Ethics ("the Code"). The Code provides a framework for employees of the standards of business conduct and ethics that are required of all business divisions, directors and employees within the Group in order to promote and enforce ethical business practices and standards throughout the Group. The code is available to all staff and also communicated to all new employees as part of the on-boarding process.

Any employee or external stakeholder throughout the Group is able to report any wrongdoing on a confidential and anonymous basis to the Ethics Lines of Mediclinic, Mediclinic Southern Africa, Hirslanden and Mediclinic Middle East.

During the year, there were no incidents of material non-compliance with any laws, regulations, accepted standards or codes applicable to the Group, with no significant fines being imposed, including concerning specifically:

- health and safety impacts of the group's services;
- marketing communications, including advertising, promotion and sponsorships;
- the provision or use of the group's services; and
- the environment.

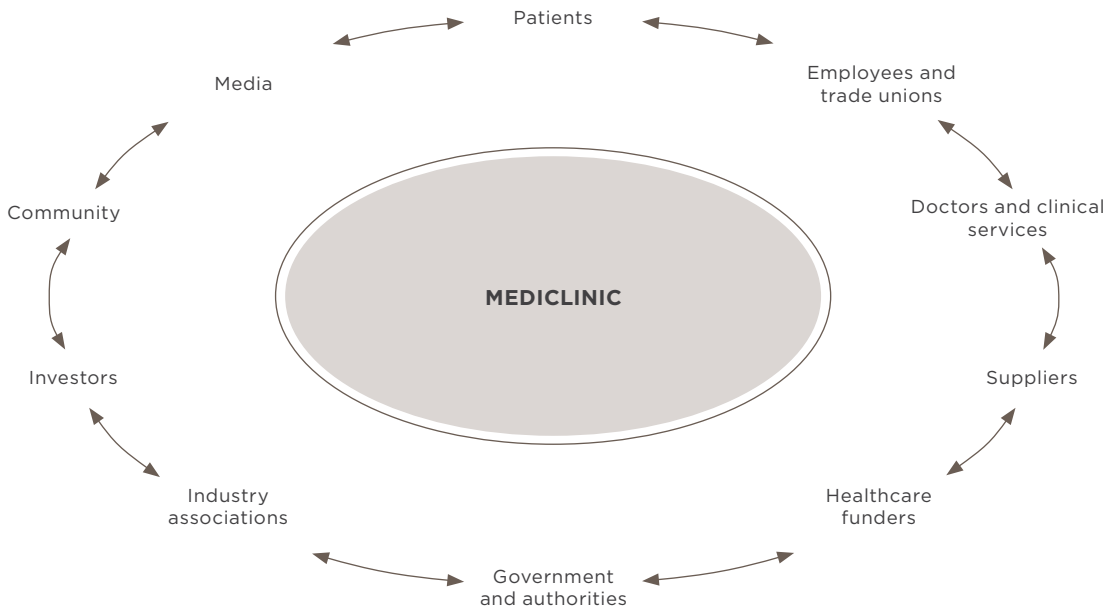
Further details on the Group's policies and practices towards the highest ethical standards can be found in the detailed Sustainable Development Report published on the company's website at www.mediclinic.com.

ENGAGEMENT WITH OUR STAKEHOLDERS

Our commitment to our stakeholders to conduct our business in a responsible and sustainable way, and to respond to their needs, is entrenched in our values and supported by the Group Code of Business Conduct and Ethics. The nature of our business implies close engagement with our stakeholders, as indicated in the stakeholder map (**Figure 4**). Effective communication with our stakeholders is fundamental in maintaining our corporate reputation as a trusted and respected provider of healthcare and in positioning ourselves as a leading international private hospital group through our brand philosophy "Science of Care". A wide variety of communication vehicles are used to engage with stakeholders, which serves as an impact assessment to assess stakeholders' needs and to effectively respond thereto. Stakeholders' legitimate expectations have been taken into account in setting our key sustainability priorities (see **Figure 2**), as reported on throughout this report.

The Company and the three operating platforms regularly publish information relevant to their stakeholders on their respective websites: www.mediclinic.com for Mediclinic International; www.mediclinic.co.za for the Southern African

FIGURE 4: MEDICLINIC'S STAKEHOLDER MAP



operations; www.hirslanden.com for the Swiss operations; and www.mediclinic.ae for the UAE operations and also makes use of various social media communication methods. During the year, Mediclinic Middle East's website was completely redesigned in line with the Mediclinic brand.

Further details on the Group's stakeholder engagement can be found in the detailed Sustainable Development Report published on the Company's website at www.mediclinic.com.

QUALITY OF CARE AND FACILITIES

Mediclinic is committed to quality care and aspires to be regarded as the most respected and trusted provider of hospital services by patients, doctors and funders of healthcare. Its focus on quality healthcare extends from the skills of supporting doctors to the care of patients, from the empathy of its nursing staff to the high standards of its facilities, from the meticulous maintenance of world-class technology to upholding the fairest possible tariff. By focusing on a patient-centred team approach to improve quality and safety of care, the Group has established a culture of quality that permeates every aspect of the business and encourages the Group's employees and associated doctors to continuously strive to improve patient care and patient safety. The Group's dedication to excellence in healthcare is evidenced by the quality of its facilities.

Our business is about the health of our patients and improving their quality of life. The health and safety of our patients therefore form the core of our business. Various regulations, voluntary initiatives and internal procedures exist that govern the standards of our services and facilities to ensure the health and safety of our patients. During the reporting period there were no material incidents of non-compliance with such regulations, initiatives and procedures.

CLINICAL QUALITY

The Group approaches clinical quality by focusing on structures, processes and outcomes of care. Superior clinical outcomes (or end results) can only be achieved through infrastructure of the highest standard and care processes that are sophisticated, reliable and free of errors. For details on the Group's clinical quality initiatives please refer to the Clinical Services Report included in the integrated annual report.

QUALITY OF FACILITIES AND EQUIPMENT

The Group strives to provide the best healthcare facilities and technology affordable and available in the different countries in which it operates. Our maintenance systems are risk orientated, aimed at patient safety and ensure the provision of service excellence that is respected and relied upon. The planned maintenance systems and related

procedures are constantly being evaluated to ensure that patient safety is paramount.

The Group's buildings, plant and equipment have to be maximised through reliable technical support in order to ensure a safe and user-friendly environment for staff and clients. With this in mind, and as further dealt with in the Operational Reviews of the three operating platforms included in this integrated annual report, the Group continuously invest in capital projects and new equipment to expand and refurbish its facilities and on the replacement of existing equipment, as well as on the repair and maintenance of property and equipment.

Further details on the maintenance and quality initiatives of the Group's operating platforms can be found in the detailed Sustainable Development Report published on the Company's website at www.mediclinic.com.

PATIENT SATISFACTION

The well-being of our patients forms the cornerstone of the Group's business, hence our commitment to deliver excellent patient care focusing on the needs and satisfaction levels of our patients. The Group continuously measures patient satisfaction through ongoing satisfaction surveys at each of its hospitals and clinics to identify potential focus areas for improvement in order to ensure the continuous delivery of a quality service. The results are reviewed daily, reported on monthly and serve as a tool to improve service delivery. The overall patient satisfaction levels of the Group's operating platforms are included in **Figure 2**.

The operating platforms have developed internal key performance indicator systems measuring not only the financial performance of their hospitals, but also including, *inter alia*, patient satisfaction as an indicator.

Mediclinic Southern Africa has expanded the scope of its patient survey to include 14 new questions covering clinical care and outcomes. As reported earlier in this report, the group's Patient Journey programme is gaining momentum with the first projects aimed at improving the patient experience at our hospitals under way.

The roll-out of Hirslanden's Customer Relationship Management (CRM) system commenced in April 2012 and is ongoing. The system is used to manage all customer feedback, customer needs and other guest relations relevant information, and the data of all employed doctors. The CRM system supports the network marketing project referred to earlier under our engagement with doctors, the Hirslanden Privé project and delivers some customer relations relevant parameters for the clinic management function. The system is continuously being improved and the addition of event and campaign management and iPad integration is planned for the year ahead.

BROAD-BASED BLACK ECONOMIC EMPOWERMENT*

* *As BBBEE is unique to South Africa, this section focuses only on the Group's BBBEE initiatives in South Africa.*

The Board views the Group's South African business as an integral part of the political, social and economic community in South Africa and is committed to sustainable transformation as part of its business strategy. Enhancing the group's current broad-based black economic empowerment ("BBBEE") initiatives is a priority for Mediclinic Southern Africa and the group regularly reviews its BBBEE strategy with the aim of effecting improvements across all seven pillars of the BBBEE scorecard. Mediclinic Southern Africa's Transformation Committee meets regularly to monitor the group's performance, with feedback to Mediclinic Southern Africa's Executive Committee, ensuring appropriate focus is placed on the group's commitment to the development and implementation of sustainable BBBEE initiatives.

Mediclinic Southern Africa is assessed annually by an accredited verification agency against the generic scorecard criteria set by the Department of Trade and Industry ("DTI"), the results of which are included in the detailed Sustainable Development Report. This assessment (which is based on the information as at the time of the assessment) indicates that the group's score has decreased to 71.97 (2012: 75.27). Mediclinic Southern Africa is therefore a Level 4 contributor (a Level 1 contributor has a total of 100+ points and a Level 8 contributor has less than 40 points). The reduction in the score achieved during the year is mainly

FIGURE 5: MEDICLINIC SOUTHERN AFRICA'S SUMMARISED EMPLOYMENT EQUITY REPORT

	Male			Female			Foreign Nationals		Total
	African Coloured Indian		White	African Coloured Indian		White			
Occupational levels	***Target***	**Actual**		***Target***	**Actual**		**Male**	**Female**	
Top management	*2*	2	12	*0*	0	0	0	0	**14**
Senior management	*2*	2	19	*0*	0	2	0	0	**23**
Professionally qualified and experienced specialists and mid-management	*52*	46	170	*72*	71	246	1	3	**537**
Skilled technical and academically qualified workers, junior management, supervisors, foremen and superintendents	*265*	263	179	*1 786*	1 875	2 596	58	93	**5 064**
Semi-skilled and discretionary decision-making	*874*	886	130	*4 376*	4 462	1 438	1	15	**6 932**
Unskilled and defined decision-making	*216*	198	19	*437*	407	13	0	0	**637**
TOTAL PERMANENT		**1 397**	**529**		**6 815**	**4 295**	**60**	**111**	**13 207**
Temporary employees		11	8		9	30	6	20	84
GRAND TOTAL		**1 408**	**537**		**6 824**	**4 325**	**66**	**131**	**13 291**

Exceeded target Met target Did not achieve target

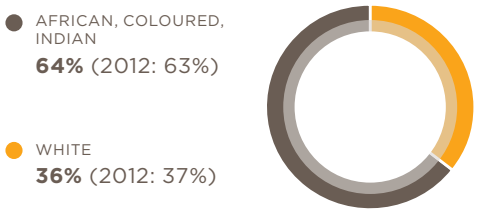
attributed to the stricter procurement targets set and new initiatives are to be identified to regain and exceed the previous levels going forward. Our scorecard still reflects our commitment to promoting BBBEE with regard to procurement, ownership, socio-economic development and enterprise development. A copy of the scorecard is published on the website of Mediclinic Southern Africa (www.mediclinic.co.za).

Mediclinic Southern Africa's focus on employment equity is in line with the group's overall transformation objectives. Various policies governing diversity and equal opportunities are in place and we have a specific employment equity policy to manage the requirements of the relevant labour laws.

The new targets set by the DTI with effect from 2012 relating to employment equity have increased the group's challenges in this regard. Mediclinic Southern Africa has set new employment equity goals up to 2017, with the 2012 calendar year's targets included in **Figure 5**, which has been approved by the Department of Labour. The updated goals form part of a new five-year Employment Equity Plan that has been approved by the group's Employment Equity Committee. The Employment Equity Committees at regional and hospital level are in the process of reviewing their goals in order to align them with the group's goals.

The summarised employment equity report (EEA2) (**Figure 5**), as submitted to the Department of Labour in October 2012, is published here as required in terms of section 22 of the Employment Equity Act. The current workforce profile shows a steady improvement in the amount of equity candidates appointed to the skilled technical and academically qualified workers, junior management, supervisors, foremen and superintendents category. Black representation at management level has increased year on year from 11% in 2006 to 22% at year end. This level, however, still presents a challenge to the group, with low staff turnover remaining a limiting factor. Of all senior appointments (level C5 and above) made during the period under review, 45.4% (2012: 47.7%) were from the designated groups, against the set target

FIGURE 6: MEDICLINIC SOUTHERN AFRICA: RACE DISTRIBUTION



of 40% for the year. The overall racial distribution of Mediclinic Southern Africa's full-time employees is set out in **Figure 6**.

Further details on the Group's BBBEE initiatives can be found in the detailed Sustainable Development Report published on the Company's website at www.mediclinic.com

ECONOMIC IMPACTS

Mediclinic, like other organisations, has many economic impacts on our stakeholders through, amongst other things, the generation and distribution of value, the creation of employment opportunities, remunerating our employees fairly and competitively, and our corporate social investment. We continuously manage these and engage with our stakeholders on matters relevant to them, as reported elsewhere in this report. Further details on access to and affordability of healthcare; efficiency and cost-effectiveness; healthcare reform; and public private initiatives are included in the Operational Reviews included in this integrated annual report and the detailed Sustainable Development Report published on the Company's website at www.mediclinic.com.

OUR PEOPLE

The success of Mediclinic is dependent on the commitment of our more than 23 400 employees to deliver quality healthcare. The composition of our employees by employment type, gender and age per each of our operating platforms is reported in the detailed Sustainable Development Report published on the Company's website at www.mediclinic.com. The number of employees per operating platform is included in the organisational chart on page 6 of this integrated annual report.

LABOUR RELATIONS AND WORKING CONDITIONS

The Group believes in creating and maintaining sound labour relations, which support its goal of being the employer of choice in the healthcare industry. This is measured by regular employee satisfaction surveys and continuous assessment of the Group's employment conditions. The Group's policies and procedures are evaluated regularly to ensure that our employees are treated fairly and that they work in a safe environment. The Group continuously strives to ensure that all its employees are informed of their benefits, and this information is communicated to staff via the intranet, staff newsletters and other communication media referred to in the section in the detailed Sustainable Development Report dealing with our engagement with employees.

Mediclinic Southern Africa's trade union membership declined from 15.7% in 2011 to 12.4% at year-end of employees covered by collective bargaining agreements, with no trade union membership by the Hirslanden or Mediclinic Middle East employees. Mediclinic Southern Africa maintains good working relationships with trade unions with which it has recognition agreements. No wage disputes were declared in 2012 and all unions settled on the proposed salary increases, based on the Mediclinic remuneration principles.

The employee relations policies of the operating platforms – which deals with matters relating to misconduct, incapacity of employees and the disciplinary and grievance procedures – are communicated to new employees as part of their on-boarding process and are also available to all staff to ensure that employees are aware of the avenues to put grievances forward, should they have the need to. Mediclinic Southern Africa communicates its Employee Relations Policy with regular training workshops and monthly online-based facilitation sessions.

PERFORMANCE MANAGEMENT

Employee performance reviews are conducted throughout the Group. They provide an opportunity for both employee and employer to identify areas for improvement and training needs, recognising good performance and promoting opportunities for career development, and contributing to a contented workforce. It is a process which facilitates the alignment of company goals and objectives to individual outputs and provides all employees with an opportunity to identify their training and development needs. In Hirslanden and Mediclinic Middle East 100% of employees received formal performance reviews during the year, with 95.4% of Mediclinic Southern Africa employees receiving formal performance reviews.

EMPLOYEE RECRUITMENT, RETENTION AND REMUNERATION

Together with the Group's retention and training strategies, the recruitment of the right calibre of personnel is vital to deliver on our commitment to quality. The Group acknowledges that the ability to recruit and retain skilled staff is a critical factor in ensuring the sustainable performance of the Group in the intensely competitive and dynamic business environment in which it operates. Some examples of our initiatives to retain staff include:

- maintaining a pleasant working environment, with leadership that acts with honesty and integrity;
- providing training and development opportunities for both clinical and non-clinical staff;
- following fair management practices;
- remunerating employees competitively, offering family-friendly benefits and incentivising performance through bonus schemes; and
- communicating with staff and involving them in the day-to-day business decisions.

DIVERSITY AND EQUAL OPPORTUNITIES

Mediclinic is committed to non-discriminatory treatment in all our employment practices. Our employment policies, including hiring, training, working conditions, compensation and benefits, promotion, termination and retirement, are based on individual qualifications, performance, skills and experience. We treat our employees equally, irrespective of gender, age, sexual orientation, disability or other status unrelated to performing the job. The nature of the healthcare industry leans towards a female-orientated environment, which results in a disproportionate representation in relation to gender. No differentiation is made in the basic salary offered to men compared to that offered to women throughout the Group.

During the year no material incidents of discrimination were observed or reported throughout the Group.

HEALTH AND SAFETY AT WORK

Special attention is given to health and safety aspects in the workplace to ensure a safe environment for the Group's employees, patients and their visitors. The health of the Group's employees is important and ensures the sustainability of the quality care to its patients. Programmes and procedures implemented by the various business units to mitigate health and safety risks include:

- health and safety committees;
- monitoring of injuries and absenteeism;
- health assessments, training and programmes; and
- HIV/AIDS programme in Mediclinic Southern Africa.

Further details on the Group's labour relations and working conditions; employee performance management; employee recruitment, retention and remuneration; diversity and equal opportunities; and health and safety at work can be found in the detailed Sustainable Development Report published on the Company's website at www.mediclinic.com.

TRAINING AND SKILLS DEVELOPMENT

The Group's training programmes are focused on improving its human capital, improving core business processes, maintaining and promoting quality service delivery in all aspects of the business, and alleviating the shortage of skills, especially in nursing.

The Group continues to invest significantly in training and skills development, with Mediclinic Southern Africa investing approximately 4% of payroll, Hirslanden approximately 4.2% and Mediclinic Middle East 0.34%. Mediclinic's stated commitment to quality care continues to drive skills development as a priority at all levels, which is reflected in the number of learning initiatives undertaken each year.

Further details on the Group's training and skills development of its employees, as well as the continuous professional development of doctors and the Group's financial and other support to academic institutions can be found in the detailed Sustainable Development Report published on the Company's website at www.mediclinic.com.

INVESTING IN THE COMMUNITY

Mediclinic's contribution towards sustaining a healthy community starts within our own facilities, where we strive to provide clinical excellence and quality care. We contribute to the well-being of the communities within which we operate by investing in ongoing initiatives that address socio-economic problems or risks and have established ourselves as an integral member of these communities, extending our quality service offering beyond the walls of our hospitals and enriching the lives of many communities throughout South Africa, Switzerland and the UAE. We structure our corporate social investment ("CSI") activities around the improvement of healthcare through training and education, sponsorships, donations, staff volunteerism, public private initiatives and joint ventures.

During the year, Mediclinic Southern Africa contributed R5.8m on CSI initiatives, with Hirslanden contributing CHF1.7m and Mediclinic Middle East contributing approximately AED400 000.

Further details on the Group's corporate social investment and community involvement initiatives can be found in the detailed Sustainable Development Report published on the Company's website at www.mediclinic.com.

ENVIRONMENTAL PERFORMANCE

The Group is committed to protecting the environment, conserving natural resources and utilising resources in an effective and responsible way, ensuring the health and safety of its employees and clients by adopting sound health, safety and environmental practices in all its business activities.

The Group Environmental Policy, aimed at minimising Mediclinic's environmental impacts, requires each operating platform of the Group to:

- identify and comply with relevant environmental legislation and regulations;
- identify and manage all risks relating to the Group's impact on the environment with regard to water use and recycling, energy use and conservation, emissions and climate change, and waste management and recycling;
- define environmental management programmes in accordance with international standards to achieve continual improvement of the Group's environmental management systems;
- create environmental awareness among all employees;
- set objectives and targets to prevent pollution and minimise the impact of the Group's activities on the environment;
- encourage reduction, re-use and re-cycling of general waste;
- manage hazardous waste, including healthcare risk waste;

- influence the Group's suppliers and service providers to adopt similar programmes, in order to limit its overall impact on the environment;
- nurse the use of resources; and
- engage with the Group's stakeholders on its environmental performance in an open and transparent manner.

Further details on the Group's environmental management can be found in the detailed Sustainable Development Report published on the Company's website at www.mediclinic.com.

MEDICLINIC WELCOMES YOUR FEEDBACK

The Group is committed to being a good corporate citizen and values the opinions and suggestions of all our stakeholders. You are invited to give us your feedback on this report or on any matter relating to the Group's sustainable development practices. A sustainable development survey is also published on our website and we invite you to take a few minutes of your time to complete this survey. For any enquiries relating to the group's sustainability issues, please contact:

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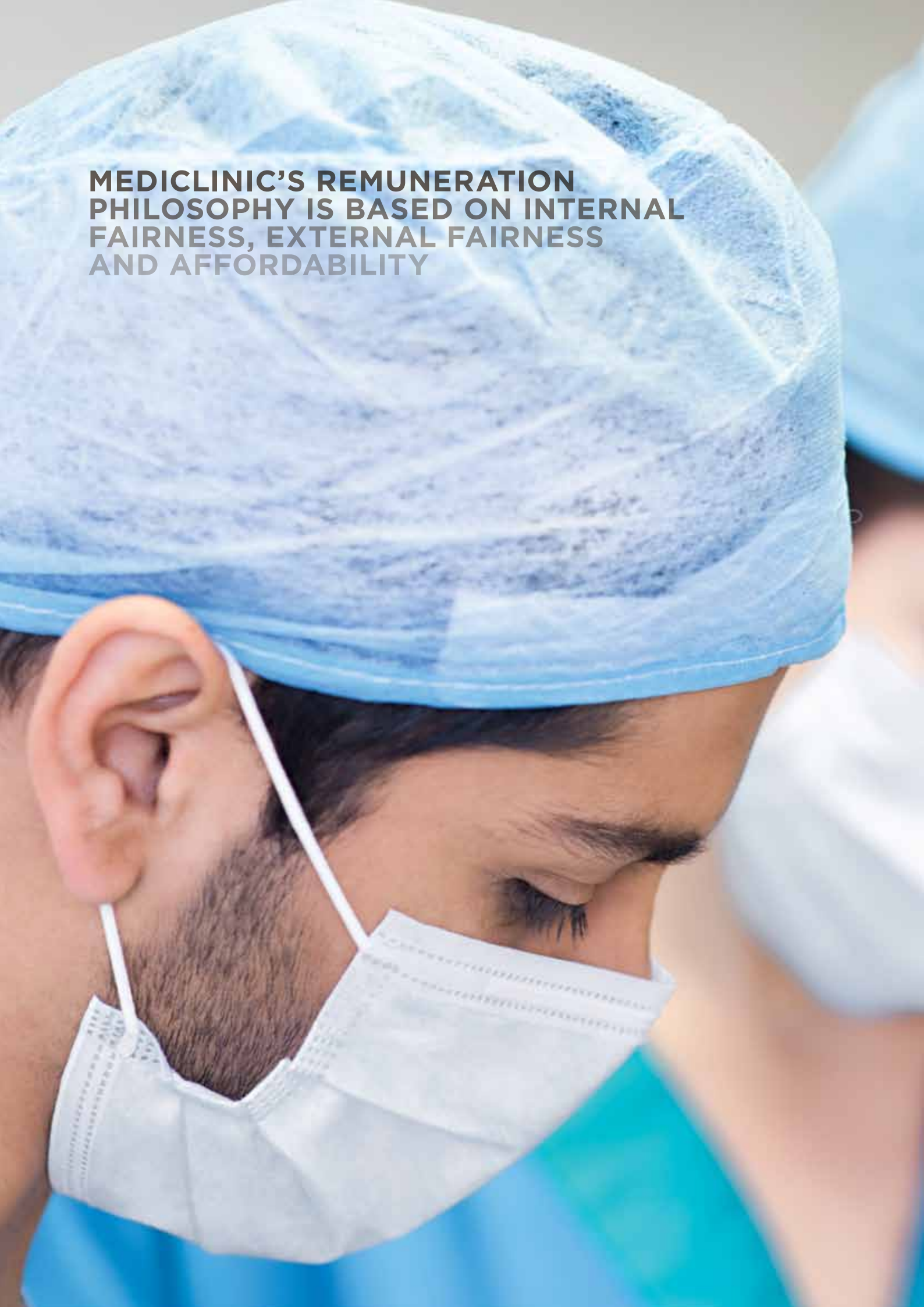


MEDICLINIC'S REMUNERATION PHILOSOPHY IS BASED ON INTERNAL FAIRNESS, EXTERNAL FAIRNESS AND AFFORDABILITY

REMUNERATION REPORT

INTRODUCTION

This report provides a summary of the Mediclinic Group's remuneration approach in respect of executive and non-executive directors of Mediclinic, as well as senior managers across the Group. The role of the Company's Remuneration and Nominations Committee with regard to the Company's remuneration approach is also highlighted.

REMUNERATION AND NOMINATIONS COMMITTEE AND KEY ACTIVITIES

Mediclinic's Remuneration and Nominations Committee is responsible for, *inter alia*, determining the governance of remuneration matters, the Group remuneration policy and the remuneration of executive directors and senior managers, as well as the compensation of non-executive directors, which is ultimately approved by the shareholders.

Details on the mandate, composition of and attendance at meetings held by the Remuneration and Nominations Committee are set out in the Corporate Governance Report, included in this integrated annual report.

Key activities during the year under review include the following:

- review of developments in local and global remuneration best practices;
- approval of increases and adjustments for executive directors and senior management;
- approval of the general increase principles, guidelines and percentages for all other employees;
- recommendation to the Board of the performance criteria for short-term incentives for the year under review;
- review of and recommendation to the Board of short-term incentive values for executive directors and eligible members of management, as per the rules of the short-term incentive scheme; and
- recommendation of the fees payable to non-executive directors for final approval by the shareholders at the 2013 annual general meeting of the Company.

REMUNERATION POLICY

The Group's remuneration policy aims to ensure that the Group remunerates directors and senior management in a manner that supports the achievement of the vision and strategic objectives of the Group, while attracting and retaining scarce skills and rewarding high levels of performance. In general, the remuneration offered by the Group needs to be competitive in order to attract and retain high-calibre staff in the markets where we operate.

Our remuneration philosophy is based on the following principles:

- internal fairness;
- external fairness; and
- affordability.

The remuneration approach that guides the level of salaries of all directors and senior management is furthermore aimed at:

- achieving the strategic objectives of the Group;
- ensuring that no discrimination occurs;
- recognising exceptional and value-adding performance;
- encouraging effective team performance; and
- promoting cost-effectiveness.

In order to balance external equity with affordability and to ensure that market-related salaries are offered to staff, the Group participates in several salary surveys and uses that information for benchmarking purposes.

The Group's management remuneration structures consist of fixed and variable components:

- fixed: guaranteed base salary and benefits; and
- variable: short-term and long-term incentive schemes.

Fixed salary – Market data is used to benchmark salary levels for directors, senior managers and general staff. This information, combined with the individual's performance assessment, is the key consideration for the annual salary reviews.

Retirement benefits – The Group offers membership to a defined contribution fund for Mediclinic Southern Africa employees and to defined benefit funds for Hirslanden employees. Retirement benefits are provided to employees of Mediclinic Middle East according to the local labour laws of the United Arab Emirates.

Other benefits – These include benefits such as medical insurance, death and disability insurance, leave and long-service awards, as applicable in the different operating platforms of the Group.

Short-term incentives – Executive directors and senior managers of the Group participate in cash management incentive schemes per operating platform. Payments in terms of short-term incentives to management are dependent upon achievement against the annual business performance targets and remain subject to the final discretionary approval of the Board.

Long-term incentives – Up to the year under review, a defined percentage of the short-term bonus value, based on the job level of the participant, had to be invested in Mediclinic shares. A refund, based on the share value, was payable should a participant resign from the Group within a period of three years after the bonus pay-out. The section under long-term incentives lower down describes the change that has been made.

All Mediclinic Southern Africa employees up to, and including, first line management level participate in an employee ownership scheme through the Mpilo trusts, which is set out in more detail in the detailed Sustainable Development Report, available on the Company's website at www.mediclinic.com. Mediclinic Southern Africa's nursing and pharmacy staff participate in a retention bonus scheme, which has contributed favourably towards the reduction of nursing and pharmacy staff turnover.

SHORT-TERM INCENTIVES

The key business performance criterion for the financial year in respect of the management incentive schemes was operating income before interest, taxation, depreciation and amortisation ("EBITDA") with a minimum weighting of 60%, together with additional subset indicators per operating platform as set out in **Figure 1**:

FIGURE 1: BUSINESS PERFORMANCE CRITERIA

	WEIGHTING
Mediclinic Southern Africa	
EBITDA	70%
Hospital EBITDA margin	5%
EBITDA converted into cash	10%
Patient satisfaction	5%
Employment equity	5%
Salary cost as % of turnover	5%
Hirslanden	
EBITDA	90%
EBITDA converted into cash	3%
Patient satisfaction	7%
Mediclinic Middle East	
EBITDA	60%
Increase in turnover	15%
Outstanding debtors days	15%
Salaries as % of turnover	10%

The weighting per business performance criteria differs per operating platform to allow flexibility to the local platform management to drive certain behaviours which they believe are important for success.

In respect of the financial year the following bonuses, expressed as a percentage of the maximum bonus, were achieved:

- Mediclinic Southern Africa 40% (2012: 90%)
- Hirslanden 66% (2012: 50%)
- Mediclinic Middle East 85% (2012: 100%)

Only 40% of the maximum bonus was paid to Mediclinic Southern Africa employees due to the fact that its EBITDA target, which carries a 70% weighting for purposes of the bonus, was not achieved. The targeted EBITDA was optimistic and also not achieved due to unforeseen delays at the building project at Mediclinic Pietermaritzburg.

The bonuses of management of Mediclinic International were *pro rated* to the relative contributions of the operating platforms to the Group, which resulted in a bonus payable as 53.4% (2012: 71%) of the maximum bonus.

The maximum bonus payable to any executive director, in terms of the cash management incentive scheme, is 80% of annual base salary.

LONG-TERM INCENTIVES

During the year under review the Mediclinic Management Incentive Scheme, as previously approved by the shareholders, which consisted of a cash bonus component, as well as a compulsory investment portion of the after-tax value of the bonus in Mediclinic shares, was amended to a pure short-term cash incentive scheme, with no compulsory investment in Mediclinic shares. This is in line with the market and on advice received from expert remuneration consultants.

Expert remuneration consultants were furthermore appointed to propose a properly structured market-related, long-term incentive scheme for senior executives.

PAYMENTS TO EXECUTIVE DIRECTORS AND PRESCRIBED OFFICERS

Remuneration of executive directors is compared to the 60th percentile of the market for comparable roles in companies of similar size.

The remuneration of executive directors and prescribed officers for the period under review is set out in **Figure 2**.

Executive directors have standard service contracts with a notice period of a maximum of three months.

PAYMENTS TO NON-EXECUTIVE DIRECTORS

Non-executive directors do not receive any benefits or share options from the Company apart from directors' fees, which fees are pre-approved annually by the Company's shareholders at the annual general meeting. The directors receive a fee per meeting, with only 50% of the respective fee per meeting payable in the case of non-attendance of a meeting. The fees payable to Mr JA Grieve and Prof RE Leu are annual fees, prorated according to number of meetings attended.

The remuneration of non-executive directors for the period under review is set out in **Figure 3**.

No non-executive director is elected for a period longer than three years. In terms of the Company's Memorandum of Incorporation, one third of the non-executive directors retire from office at each annual general meeting and are eligible for re-election at such meeting. The directors to retire shall be those who have been longest in office since their last election. A director who has already held his office for a period of three years since his last election shall retire at such meeting.

SHAREHOLDING BY DIRECTORS

The number of shares held by each director and prescribed officer of the Company is set out on page 129 of this integrated annual report.

FIGURE 2: REMUNERATION OF EXECUTIVE DIRECTORS AND PRESCRIBED OFFICERS

R'000	Guaranteed salary[1]	Retirement funding	Other benefits	Annual incentives	Total 2013	Total 2012
Executive directors						
E de la H Hertzog[2]	1 427	121	69	865	**2 481**	5 945
DP Meintjes	4 980	412	205	1 976	**7 573**	6 825
KHS Pretorius	3 288	273	26	722	**4 309**	4 814
CA van der Merwe[3]	2 706	227	26	808	**3 767**	4 061
CI Tingle	4 080	336	25	1 605	**6 046**	5 715
TO Wiesinger[4]	6 428	842	341	2 327	**9 938**	9 215
Total	22 909	2 211	692	8 302	**34 114**	36 575
Prescribed officers						
GC Hattingh	2 358	195	26	695	**3 274**	2 846
DJ Hadley[5]	3 530	281	15	1 457	**5 283**	4 490
Total	5 888	476	41	2 152	**8 557**	7 336

1 *Guaranteed salary includes 13th cheque.*
2 *Retired as executive director on 31 August 2012.*
3 *An amount of R661 000 relating to share options exercised is included in the previous year's remuneration.*
4 *Remuneration in local currency: CHF1 097 746 (2012: CHF1 090 568).*
5 *Remuneration in local currency: AED2 278 583 (2012: AED2 109 297).*

FIGURE 3: REMUNERATION OF NON-EXECUTIVE DIRECTORS

R'000	Board fees	Lead independent director fees	Audit and Risk Committee	Remuneration and Nominations Committee	Social and Ethics Committee	Investment Sub-committee	Total 2013	Total 2012
E de la H Hertzog[1]	171	–	–	–	–	17	**188**	–
JC Cohen[2]*	–	–	–	–	–	–	**–**	261
JJ Durand[3]*	208	–	–	35	–	23	**266**	–
JA Grieve [4, 5, 6]*	544	–	–	–	–	–	**544**	–
RE Leu [5, 7]	1 011	–	–	–	–	–	**1 011**	925
MK Makaba	237	–	–	–	–	–	**237**	194
ZP Manase[2]	89	–	23	–	–	–	**112**	246
N Mandela[4]	119	–	–	–	18	–	**137**	–
TD Petersen[4]	119	–	23	52	–	–	**194**	–
AA Raath**	237	–	70	70	–	47	**424**	363
MA Ramphele[2]	74	–	–	–	–	–	**74**	138
DK Smith	222	23	103	–	–	–	**348**	312
CM van den Heever[8]*	178	–	–	–	52	–	**230**	205
WL van der Merwe[2]	89	–	–	52	–	–	**141**	278
MH Visser[9]*	–	–	–	18	–	–	**18**	327
Total	3 298	23	219	227	70	87	**3 924**	3 249

1 *Became non-executive chairman on 1 September 2012.*
2 *Retired as a director on 26 July 2012.*
3 *Appointed as a director on 7 June 2012.*
4 *Appointed as a director on 13 September 2012.*
5 *Actual annual fee pro rated according to number of meetings attended.*
6 *Remuneration in local currency: CHF 60 058 (2012: CHF Nil).*
7 *Remuneration in local currency: CHF111 640 (2012: CHF109 450).*
8 *Resigned as a director on 31 January 2013.*
9 *Passed away on 26 April 2012.*
* *Fees paid to employer companies.*
** *Component of fees paid to employer company.*

ABRIDGED FINANCIAL STATEMENTS
for the year ended 31 March 2013

INDEPENDENT AUDITOR'S REPORT
TO THE SHAREHOLDERS OF MEDICLINIC INTERNATIONAL LIMITED

The abridged consolidated financial statements, which comprise the abridged consolidated statement of financial position as at 31 March 2013, the abridged consolidated income statement and the abridged consolidated statements of comprehensive income, changes in equity and cash flows for the year then ended, and related notes, as set out on pages 121 to 127, are derived from the audited consolidated financial statements of Mediclinic International Limited for the year ended 31 March 2013. We expressed an unmodified audit opinion on those consolidated financial statements in our report dated 21 May 2013. Our auditor's report on the audited consolidated financial statements contained an Other Matter paragraph (refer below).

The abridged consolidated financial statements do not contain all the disclosures required by International Financial Reporting Standards and the requirements of the Companies Act of South Africa as applicable to annual financial statements. Reading the abridged consolidated financial statements, therefore, is not a substitute for reading the audited consolidated financial statements of Mediclinic International Limited.

DIRECTORS' RESPONSIBILITY FOR THE ABRIDGED CONSOLIDATED FINANCIAL STATEMENTS
The Company's directors are responsible for the preparation of an abridged version of the audited consolidated financial statements in accordance with the requirements of the JSE Limited Listings Requirements for abridged reports, set out in note 1 to the abridged consolidated financial statements, and the requirements of the Companies Act of South Africa as applicable to summary financial statements.

AUDITOR'S RESPONSIBILITY
Our responsibility is to express an opinion on the abridged consolidated financial statements based on our procedures, which were conducted in accordance with International Standard on Auditing (ISA) 810, "Engagements to Report on Summary Financial Statements".

OPINION
In our opinion, the abridged consolidated financial statements derived from the audited consolidated financial statements of Mediclinic International Limited for the year ended 31 March 2013 are consistent, in all material respects, with those consolidated financial statements, in accordance with the requirements of the JSE Limited Listings Requirements for abridged reports, set out in note 1 to the abridged consolidated financial statements, and the requirements of the Companies Act of South Africa as applicable to summary financial statements.

The Other Matter paragraph in our audit report dated 21 May 2013 states that as part of our audit of the consolidated financial statements for the year ended 31 March 2013, we have read the Directors' Report, the Audit Committee's Report and the Company Secretary's Certificate for the purpose of identifying whether there are material inconsistencies between these reports and the audited consolidated financial statements. These reports are the responsibility of the respective preparers. The Other Matter paragraph states that, based on reading these reports, we have not identified material inconsistencies between these reports and the audited consolidated financial statements. The paragraph furthermore states that we have not audited these reports and accordingly do not express an opinion on these reports. The Other Matter paragraph does not have an effect on the abridged consolidated financial statements or our opinion thereon.

PRICEWATERHOUSECOOPERS INC.
Director: NH Döman
Registered Auditor

Stellenbosch
21 May 2013

STATEMENT OF FINANCIAL POSITION
AS AT 31 MARCH 2013

	2013 R'm	2012 R'm
ASSETS		
Non-current assets	**47 875**	42 033
Property, equipment and vehicles	**40 233**	34 808
Intangible assets	**7 279**	6 350
Investments in associates	**2**	1
Other investments and loans	**17**	662
Derivative financial instruments	**100**	–
Deferred income tax assets	**244**	212
Current assets	**8 899**	8 162
Inventories	**684**	582
Trade and other receivables	**5 466**	4 815
Current income tax assets	**44**	4
Derivative financial instruments	**–**	24
Other investments and loans	**–**	128
Investment in money market funds	**–**	510
Cash and cash equivalents	**2 705**	2 099
Total assets	**56 774**	50 195
EQUITY		
Capital and reserves		
Stated and issued capital	**11 027**	65
Share premium	**–**	6 066
Treasury shares	**(256)**	(269)
Share capital	**10 771**	5 862
Retained earnings	**1 655**	4 171
Other reserves	**4 953**	83
Attributable to equity holders of the Company	**17 379**	10 116
Non-controlling interests	**796**	1 288
Total equity	**18 175**	11 404
LIABILITIES		
Non-current liabilities	**32 537**	32 969
Borrowings	**25 359**	22 864
Deferred income tax liabilities	**6 227**	5 303
Retirement benefit obligations	**501**	823
Provisions	**365**	240
Derivative financial instruments	**85**	3 739
Current liabilities	**6 062**	5 822
Trade and other payables	**4 135**	3 460
Borrowings	**1 011**	1 930
Provisions	**322**	121
Derivative financial instruments	**65**	–
Current income tax liabilities	**529**	311
Total liabilities	**38 599**	38 791
Total equity and liabilities	**56 774**	50 195

INCOME STATEMENT
AS AT 31 MARCH 2013

	Notes	2013 R'm	2012 R'm
Revenue	4	**24 562**	21 986
Cost of sales		**(13 845)**	(12 314)
Administration and other operating expenses		**(5 454)**	(5 003)
Operating profit before depreciation (EBITDA)	5	**5 263**	4 669
Depreciation and amortisation		**(999)**	(910)
Operating profit		**4 264**	3 759
Other gains and losses	6	**531**	(26)
Income from associates		**2**	1
Finance income		**68**	85
Finance cost	7	**(5 166)**	(1 642)
(Loss)/profit before tax		**(301)**	2 177
Income tax expense		**(442)**	(693)
(Loss)/profit for the year		**(743)**	1 484
Attributable to:			
Equity holders of the Company		**(1 002)**	1 221
Non-controlling interests		**259**	263
		(743)	1 484
(Loss)/earnings per ordinary share attributable to the equity holders of the Company – cents			
Basic	2	**(135.0)**	179.8
Diluted	2	**(131.3)**	173.5

STATEMENT OF COMPREHENSIVE INCOME
FOR THE YEAR ENDED 31 MARCH 2013

	2013 R'm	2012 R'm
(Loss)/profit for the year	**(743)**	1 484
Other comprehensive income		
Items that may be reclassified to the income statement		
Currency translation differences	**1 705**	1 405
Fair value adjustment – cash flow hedges	**3 203**	(1 126)
	4 908	279
Items that may not be reclassified to the income statement		
Actuarial gains and losses	**201**	(403)
Other comprehensive income/(loss), net of tax	**5 109**	(124)
Total comprehensive income for the year	**4 366**	1 360
Attributable to:		
Equity holders of the Company	**4 064**	1 035
Non-controlling interests	**302**	325
	4 366	1 360

CONSOLIDATED STATEMENT OF CHANGES IN EQUITY
FOR THE YEAR ENDED 31 MARCH 2013

	2013 R'm	2012 R'm
Opening balance	**11 404**	10 560
Shares issued	**5 000**	–
Share issue costs	**(104)**	–
Movement in shares held in treasury	**13**	19
Movement in share-based payment reserve	**5**	6
Capital contributed by non-controlling interests	**–**	3
Non-controlling interests acquired by the Group	**(588)**	–
Total comprehensive income for the year	**4 366**	1 360
Transactions with non-controlling shareholders	**(1 268)**	3
Gain on sale of nil-paid letters of allocation	**41**	–
Distributed to shareholders	**(488)**	(436)
Distributed to non-controlling interests	**(206)**	(111)
Closing balance	**18 175**	11 404
Comprising		
Share capital	**11 027**	65
Share premium*	**–**	6 066
Treasury shares	**(256)**	(269)
Share-based payment reserve	**140**	135
Foreign currency translation reserve	**4 833**	3 171
Hedge reserve	**(20)**	(3 223)
Retained earnings	**1 655**	4 171
Shareholders' equity	**17 379**	10 116
Non-controlling interests	**796**	1 288
Total equity	**18 175**	11 404

* *During the year the par value ordinary shares were converted into no par value ordinary shares and consequently the share premium balance was transferred to the ordinary share account as stated capital.*

SEGMENTAL REPORT
FOR THE YEAR ENDED 31 MARCH 2013

	2013 R'm	2012 R'm
Revenue		
Southern Africa	**10 185**	9 423
Middle East	**2 485**	1 831
Switzerland	**11 892**	10 732
	24 562	21 986
EBITDA		
Southern Africa	**2 169**	1 957
Middle East	**495**	348
Switzerland	**2 599**	2 364
	5 263	4 669
Operating profit		
Southern Africa	**1 887**	1 701
Middle East	**382**	250
Switzerland	**1 995**	1 808
	4 264	3 759

The consolidation of the governance functions within the Group has resulted in a change in the composition of the reportable segments. The prior year has been restated accordingly.

ABRIDGED CONSOLIDATED STATEMENT OF CASH FLOWS
FOR THE YEAR ENDED 31 MARCH 2013

	2013 R'm Inflow/ (outflow)	2012 R'm Inflow/ (outflow)
CASH FLOW FROM OPERATING ACTIVITIES		
Cash received from customers	**24 706**	21 704
Cash paid to suppliers and employees	**(19 129)**	(17 438)
Cash generated from operations	**5 577**	4 266
Interest received	**62**	51
Interest paid	**(1 571)**	(1 576)
Tax paid	**(514)**	(525)
Net cash generated from operating activities	**3 554**	2 216
CASH FLOW FROM INVESTMENT ACTIVITIES	**(537)**	(1 055)
Investment to maintain operations	**(792)**	(731)
Investment to expand operations	**(1 249)**	(742)
Proceeds on disposal of property, equipment and vehicles	**52**	23
Insurance proceeds	**–**	27
Proceeds from other investments and loans	**4**	5
Proceeds from derivative financial instrument	**25**	24
Proceeds from FVTPL financial assets	**868**	134
Purchases of FVTPL financial assets	**–**	(144)
Proceeds from money market funds	**1 200**	823
Purchases of money market funds	**(657)**	(507)
Interest received	**12**	33
Net cash generated/(utilised) before financing activities	**3 017**	1 161
CASH FLOW FROM FINANCING ACTIVITIES	**(2 839)**	(735)
Proceeds of shares issued	**5 000**	–
Share issue costs	**(104)**	–
Distributions to non-controlling interests	**(206)**	(111)
Distributions to shareholders	**(488)**	(436)
Proceeds from borrowings	**21 996**	–
Repayment of borrowings	**(24 941)**	(214)
Settlement of interest rate swap	**(1 633)**	–
Refinancing transaction costs	**(615)**	–
Contributions by non-controlling interests	**–**	7
Acquisition of non-controlling interest	**(1 971)**	–
Treasury shares purchased	**(16)**	(9)
Proceeds from disposal of treasury shares	**27**	28
Proceeds on disposal of nil-paid letters of allocation	**41**	–
Proceeds on disposal of non-controlling interest	**71**	–
Net increase in cash, cash equivalents and bank overdrafts	**178**	426
Opening balance of cash, cash equivalents and bank overdrafts	**1 981**	1 447
Exchange rate fluctuations on foreign cash	**541**	108
Closing balance of cash, cash equivalents and bank overdrafts	**2 700**	1 981

	2013 R'm	Change %	2012 R'm
1. BASIS OF PREPARATION			
The accounting policies applied in the preparation of these abridged consolidated financial statements, which are based on reasonable judgements and estimates, are in accordance with International Financial Reporting Standards (IFRS) and are consistent with those applied in the prior year with the exception of the change in segmental reporting. The segmental report was changed after the composition of the Group's reportable segments was reconsidered. The abridged consolidated financial statements have been prepared in terms of IAS 34 Interim Financial Reporting as well as in compliance with the Companies Act 71 of 2008, as amended, and the Listings Requirements of the JSE Limited. The preparation of the consolidated financial statements was supervised by the Chief Financial Officer, Mr CI Tingle CA(SA).			
The abridged consolidated financial statements do not contain all the information and disclosures required in the consolidated financial statements. The consolidated financial statements have been extracted from the audited consolidated financial statements upon which PricewaterhouseCoopers Inc. has issued an unqualified report. The audited consolidated financial statements and the unqualified audit report are available for inspection at the registered office of the Company.			
2. EARNINGS PER ORDINARY SHARE			
Earnings reconciliation			
(Loss)/profit attributable to shareholders	**(1 002)**		1 221
Re-measurements for headline earnings	**(6)**		1
Profit on sale of property, equipment and vehicles	**(6)**		(1)
Impairment of property and equipment	**–**		2
Income tax effects	**1**		–
Headline (loss)/earnings	**(1 007)**	**(182)**	1 222
Re-measurements for normalised headline earnings	**3 331**		(14)
Group one-off refinancing charges	**3 215**		–
Pre-acquisition tariff provision	**151**		–
Past-service cost	**(35)**		(14)
	(297)		3
Normalised headline earnings	**2 027**	**67**	1 211
	'000		'000
Weighted average number of shares			
Before rights offer	**714 856**		627 280
Adjustment for rights offer (IAS 33 para 26)	**27 002**		51 872
Weighted average number of ordinary shares in issue	**741 858**		679 152
Diluted weighted average number of shares			
Before rights offer	**735 860**		651 779
Adjustment for rights offer (IAS 33 para 26)	**27 002**		51 872
Diluted weighted average number of ordinary shares in issue	**762 862**		703 651
	Cents		Cents
Earnings per ordinary share			
– Basic (loss)/earnings basis	**(135.0)**	**(175)**	179.8
– Diluted(loss)/earnings basis	**(131.3)**		173.5
– Basic headline (loss)/earnings basis	**(135.6)**	**(175)**	179.9
– Diluted headline (loss)/earnings basis	**(131.9)**		173.7
– Basic normalised headline earnings basis	**273.2**	**53**	178.3
– Normalised diluted headline earnings basis	**265.7**		172.1

	2013 R'm	Change %	2012 R'm
3. DIVIDENDS PER ORDINARY SHARE	**Cents**		Cents
Dividends declared during the year:			
interim dividend – number 31 (2012: number 29)	**25.3**		23.0
final dividend – number 32 (2012: number 30)	**60.5**		55.0
	85.8		78.0
The dividends paid in 2013 (dividend number 30 & 31) were 80.3 cents per share (2012: 73.0 cents, dividend number 28 & 29). A final dividend (dividend number 32) in respect of the year ended 31 March 2013 of 60.5 cents per share was declared at a directors' meeting on 21 May 2013. These financial statements do not reflect this dividend payable.			
4. REVENUE RECONCILIATION			
Revenue	**24 562**		21 986
Adjusted for:			
Pre-acquisition tariff provision	**151**		–
Normalised revenue	**24 713**	12	21 986
5. EBITDA RECONCILIATION			
Operating profit before depreciation (EBITDA)	**5 263**		4 669
Adjusted for:			
Past-service cost	**(35)**		(14)
Impairment of property and equipment	**–**		4
Pre-acquisition tariff provision	**151**		–
Normalised EBITDA	**5 379**	15	4 659
6. OTHER GAINS AND LOSSES			
Realised gains on forward contracts	**574**		24
Stamp duty	**(41)**		–
Other	**(2)**		(50)
	531		(26)
7. FINANCE COST			
Interest	**1 301**	(18)	1 579
Amortisation of capitalised financing fees	**89**		81
Loan breakage charges	**54**		–
Preference share dividend	**59**		–
Accelerated recognition of capitalised financing fees	**163**		–
Derecognition of Swiss interest rate swap	**3 531**		–
Less: amounts included in the cost of qualifying assets	**(31)**		(18)
	5 166		1 642

	2013 R'm	Change %	2012 R'm
8. COMMITMENTS			
Capital commitments	**2 766**		2 161
Southern Africa	**2 050**		1 427
Middle East	**27**		31
Switzerland	**689**		703
	R		R
9. EXCHANGE RATES			
Average Swiss franc (ZAR/CHF)	**9.05**		8.45
Closing Swiss franc (ZAR/CHF)	**9.69**		8.50
Average UAE dirham (ZAR/AED)	**2.32**		2.03
Closing UAE dirham (ZAR/AED)	**2.51**		2.09
	'000		'000
10. NUMBER OF SHARES ISSUED			
Number of ordinary shares in issue	**826 957**		652 315
Number of ordinary shares held in treasury	**(19 078)**		(23 758)
Number of ordinary shares in issue net of treasury shares	**807 879**		628 557

11. EVENTS AFTER THE REPORTING DATE

The directors are not aware of any matter or circumstance arising since the end of the financial year that would significantly affect the operations of the Group or the results of its operations.

ANALYSIS OF SHAREHOLDERS
AS AT 28 MARCH 2013

DISTRIBUTION OF ORDINARY SHAREHOLDERS

	Number of shareholders	Number of shares	%
Public shareholders	11 870	384 880 076	46.54%
Non-public shareholders	36	442 077 249	53.46%
– Directors and their associates	9	5 915 745	0.72%
– Directors of major subsidiaries and senior management* and their associates	21	667 758	0.08%
– Own holdings (held by Medipark Clinic (Pty) Ltd as treasury shares)	1	7 993	0.00%
– Industrial Partnership Investments (Pty) Ltd (Remgro)	1	358 869 121	43.40%
– Black economic empowerment shareholders	4	76 616 632	9.26%
	11 906	826 957 325	100.00%

* *The directors and employees listed here are those who are obliged to comply with the Group's Procedure on Dealings In Mediclinic Shares prohibiting such directors and employees to trade in Mediclinic shares during the Company's closed periods and unless they have obtained prior clearance to deal by the Chairman.*

	Number of shares	%
Distribution of local and foreign beneficial shareholding:	826 957 325	100.00%
– South African	759 388 990	91.83%
– Foreign	67 568 335	8.17%

MAJOR SHAREHOLDERS

In terms of the principles of disclosure in accordance with section 56(7)(b) of the Companies Act, 71 of 2008, as amended, the following shareholders held a beneficial interest of 5% or more in the Company on 28 March 2013:

	Number of shares	%
Industrial Partnership Investments (Pty) Ltd (Remgro)	358 869 121	43.40%
Government Employees Pension Fund	83 151 101	10.06%
Black economic empowerment shareholders	76 616 632	9.26%
– Mpilo Investment Holdings 2 (RF) (Pty) Ltd (Phodiso Holdings)	39 332 736	4.76%
– Mpilo Investment Holdings 1 (RF) (Pty) Ltd (Circle Capital)	23 377 488	2.83%
– The Mpilo Trust & The Mpilo Trust (Namibia)	13 906 408	1.68%

SHAREHOLDING SPREAD

	Number of shareholders	%	Number of shares	%
1 – 1 000 shares	4 807	40.37%	2 186 928	0.26%
1 001 – 10 000 shares	5 696	47.84%	18 030 624	2.18%
10 001 – 100 000 shares	1 046	8.79%	31 156 330	3.77%
100 001 – 1 000 000 shares	292	2.45%	93 034 995	11.25%
Over 1 000 000 shares	65	0.55%	682 548 448	82.54%
	11 906	100.00%	826 957 325	100.00%

DIRECTORS' AND PRESCRIBED OFFICERS' INTERESTS*

	2013				2012			
	Direct beneficial	**Indirect beneficial**	**Held by associates**	**% of issued shares**	Direct beneficial	Indirect beneficial	Held by associates	% of issued shares
Directors:								
E de la H Hertzog	**71 424**	**4 766 718**	**487 825**	**0.64%**	34 845	3 760 053	384 803	0.64%
JC Cohen (resigned 26 July 2012)	**–**	**–**	**–**	**–**	–	–	–	–
JJ Durand	**–**	**–**	**–**	**–**	–	–	–	–
JA Grieve	**–**	**–**	**–**	**–**	–	–	–	–
RE Leu	**–**	**–**	**–**	**–**	–	–	–	–
MK Makaba**	**–**	**–**	**–**	**–**	–	–	–	–
ZP Manase (resigned 26 July 2012)	**–**	**–**	**–**	**–**	–	–	–	–
N Mandela	**–**	**–**	**–**	**–**	–	–	–	–
DP Meintjes	**237 801**	**–**	**–**	**0.03%**	168 910	–	–	0.03%
TD Petersen	**–**	**–**	**–**	**–**	–	–	–	–
KHS Pretorius	**140 000**	**–**	**–**	**0.02%**	129 518	–	–	0.02%
AA Raath	**–**	**–**	**–**	**–**	–	–	–	–
MA Ramphele (resigned 26 July 2012)	**–**	**–**	**–**	**–**	–	–	–	–
DK Smith	**–**	**–**	**–**	**–**	–	–	–	–
CI Tingle	**173 185**	**–**	**–**	**0.02%**	120 988	–	–	0.02%
PJ Uys	**–**	**–**	**–**	**–**	–	–	–	–
CM van den Heever (resigned 1 February 2013)	**–**	**–**	**–**	**–**	–	–	–	–
CA van der Merwe	**37 835**	**–**	**–**	**0.00%**	22 377	–	–	0.00%
WL van der Merwe (resigned 26 July 2012)	**957**	**–**	**–**	**0.00%**	957	–	–	0.00%
late MH Visser	**–**	**–**	**–**	**–**	–	–	–	–
TO Wiesinger	**–**	**–**	**–**	**–**	–	–	–	–
	661 202	**4 766 718**	**487 825**	**0.71%**	477 595	3 760 053	384 803	0.71%
Prescribed officers:								
DJ Hadley	**37 313**	**–**	**–**	**0.00%**	21 167	–	–	0.00%
GC Hattingh	**–**	**150 000**	**–**	**0.02%**	–	114 146	–	0.02%
	37 313	**150 000**	**–**	**0.02%**	21 167	114 146	–	0.02%

* *There have been no changes in the directors' and prescribed officers' interests between 28 March 2013 and the approval of the annual financial statements on 21 May 2013.*

** *Dr MK Makaba holds a 5.08% interest in Phodiso Holdings Limited, which company is the holder of all the issued ordinary shares in Mpilo Investment Holdings 2 (RF) (Pty) Ltd, which holds a 4.76% interest in Mediclinic.*

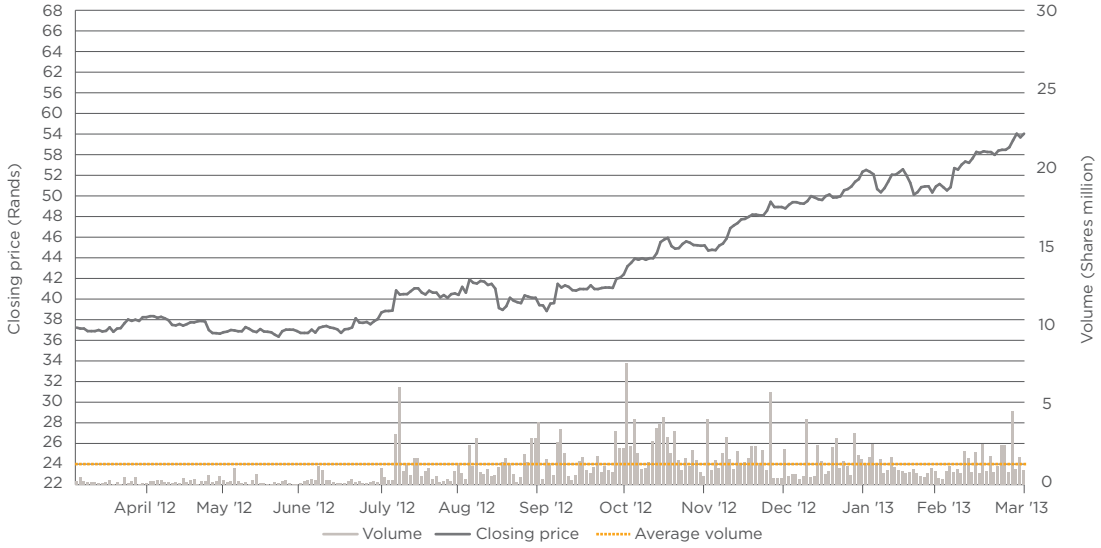
JSE SHARE PERFORMANCE

	2013	2012
Market capitalisation as at 31 March (R'000)	**53 090 660**	24 461 825
Price (cents per share)		
Last trading day in March	**6 420**	3 750
Highest	**6 548**	4 199
Lowest	**3 601**	2 810
Number of shares traded (000's)	**125 013**	118 734

ANALYSIS OF SHAREHOLDERS
AS AT 28 MARCH 2013 continued

SHARE CLOSING PRICE FROM 2000 – 2013

TRADING STATISTICS (SHARE CLOSING PRICE AND VOLUME)



SHARE PERFORMANCE COMPARED TO JSE ALL SHARE INDEX (REBASED TO 100)

SHAREHOLDERS' DIARY

ANNUAL GENERAL MEETING	Thursday, 25 July 2013
PUBLICATION OF FINANCIAL REPORTS	
Announcement of interim results	November
Interim report	November
Announcement of annual results	May
Integrated annual report	June
PAYMENTS TO SHAREHOLDERS	
Interim payment: dividend number 31	
Gross dividend (cents per share)	25.3
Dividend net of dividend withholding tax (cents per share)	21.505
Declaration date	Tuesday, 6 November 2012
Last date to trade cum dividend	Friday, 30 November 2012
First date of trading ex dividend	Monday, 3 December 2012
Record date	Friday, 7 December 2012
Payment date	Monday, 10 December 2012
Final payment: dividend number 32	
Gross dividend (cents per share)	60.5
Dividend net of dividend withholding tax (cents per share)	51.425
Declaration date	Tuesday, 21 May 2013
Last date to trade cum dividend	Thursday, 13 June 2013
First date of trading ex dividend	Friday, 14 June 2013
Record date	Friday, 21 June 2013
Payment date	Monday, 24 June 2013

ADMINISTRATION

COMPANY NAME AND REGISTRATION NUMBER
Mediclinic International Limited
1983/010725/06

HEAD OFFICE ADDRESS AND REGISTERED OFFICE
Mediclinic Offices, Strand Road, Stellenbosch, 7600
Postal address: PO Box 456, Stellenbosch, 7599
Tel: +27 21 809 6500 Fax: +27 21 886 4037
Ethics Line: 0800 005 316 or ethics@mediclinic.com

E-MAIL AND WEBSITE
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COMPANY SECRETARY
Gert Hattingh

INVESTOR RELATIONS CONTACTS
Chief Financial Officer: Craig Tingle – craig.tingle@mediclinic.com
Corné Heyns – corne.heyns@mediclinic.com

TRANSFER SECRETARIES
Computershare Investor Services Proprietary Limited
70 Marshall Street, Johannesburg, 2001
Postal address: PO Box 61051, Marshalltown, 2107
Tel: +27 11 370 7700 Fax: +27 11 688 7716

AUDITOR
PricewaterhouseCoopers Inc.
Stellenbosch

SPONSOR
Rand Merchant Bank (a division of FirstRand Bank Limited)

LISTING
JSE Limited
Sector: Non Cyclical Consumer Goods – Health
Share code: MDC
ISIN code: ZAE000074142

GLOSSARY

TERM	MEANING
ACTD	Adult Cardio-thoracic Database
base rates*	the price for treatment of a DRG case with a case weight of 1.0
Board	the board of directors of Mediclinic International
CAGR (%)	compounded annual growth rate
cash conversion (%)	cash generated from operations divided by normalised EBITDA
CCU	critical care unit
CDLI	Carbon Disclosure Leadership Index
CDP	Carbon Disclosure Project
COHSASA	Council for Health Services Accreditation in South Africa
Companies Act	the South African Companies Act, 71 of 2008, as amended
Company	Mediclinic International Limited (previously named Medi-Clinic Corporation Limited)
CSI	corporate social investment
DHA	Dubai Health Authority
DHCC	Dubai Healthcare City
DoH	Department of Health
DRG	Diagnosis Related Grouping
EFQM	European Foundation of Quality Management
Emirates Healthcare	Emirates Healthcare Holdings Limited BVI, the intermediary holding company of the Group's operations in the United Arab Emirates, which is referred to as Mediclinic Middle East throughout the report
GDP	gross domestic product
GRI G3.1	the G3.1 Sustainability Reporting Guidelines developed by the Global Reporting Initiative
Group	Mediclinic International and its three operating platforms in Southern Africa, Switzerland and the United Arab Emirates ("group" refers to one of the Group's operating platforms, as the context may indicate, as defined below)
group	one of the operating platforms of the Group, as the context may indicate (please note that "group" is as defined in this definition and "Group" refers to the entire Mediclinic Group as defined above)
HAI	healthcare-associated infection
HASA	Hospital Association of South Africa
headline earnings	earnings attributable to ordinary shareholders excluding capital profits and losses as defined in Circular 3/2009 issued by the South African Institute of Chartered Accountants
headline earnings per share (HEPS) (cents)	headline earnings divided by the weighted average number of ordinary shares in issue
highly specialised medicine (HSM)*	based on an inter-cantonal agreement, highly specialised fields of medicine, e.g. neurosurgery, are to be concentrated in only a few medical centres across Switzerland
Hirslanden	the brand name under which the Group's operations in Switzerland conducts business, with Klinik Hirslanden AG as the operating platform's operating company
HISS	Hospital Infection Surveillance System
hospital lists*	cantonal (federal system) list of all hospitals with public service mandates for inpatient treatments, listing which hospitals are eligible to treat patients with basic health insurance and receive reimbursement (now based on the DRG system) through the public health insurance scheme; and receive public funding for investments in addition to the DRG-based reimbursement

** These terms relate specifically to the Group's operations in Switzerland.*

TERM	MEANING
HPCSA	Health Professions Council of South Africa
IQIP	International Quality Indicators Project®
JCI	Joint Commission International, an international quality measurement accreditation organisation, aimed at improving quality of care
JSE	JSE Limited, the stock exchange of South Africa based in Johannesburg
JSE SRI Index	Socially Responsible Investment Index of the JSE
King III	King Code of Governance for South Africa 2009 and King Report on Governance for South Africa 2009
market capitalisation	closing share price on the JSE multiplied by the number of ordinary shares in issue before deducting treasury shares
Mediclinic Middle East	the Group's operations in the United Arab Emirates, trading under the Mediclinic brand, with Emirates Healthcare Holdings Limited BVI as the intermediary holding company of the Group's operations in the United Arab Emirates
Mediclinic Southern Africa	the Group's operations in South Africa and Namibia, trading under the Mediclinic brand, with Mediclinic Southern Africa (Pty) Ltd as the intermediary holding company of the Group's operations in South Africa and Namibia
Mediclinic Switzerland	the Group's operations in Switzerland, trading under the Hirslanden brand, with Mediclinic Switzerland AG as the intermediary holding company of the Group's operations in Switzerland
MRSA	Methicillin-resistant Staphylococcus Aureus
net asset value per ordinary share (cents)	net asset value divided by the number of ordinary shares in issue at year end
next financial year	the financial year which commenced on 1 April 2013 and ending on 31 March 2014
NHI	National Health Insurance of South Africa
normalised EBITDA	operating profit before depreciation and amortisation excluding one-off items
normalised headline earnings	earnings attributable to ordinary shareholders excluding capital profits and losses as defined in Circular 3/2009 issued by the South African Institute of Chartered Accountants excluding one-off items
normalised headline earnings per share (HEPS) (cents)	normalised headline earnings divided by the weighted average number of ordinary shares in issue
normalised price-earnings ratio	closing share price on the JSE divided by the basic headline earnings per share excluding one-off items
operating platform/s	Mediclinic Southern Africa, Hirslanden (Switzerland) and Mediclinic Middle East and their subsidiaries and associated entities, or any one of them as the context may indicate
period under review	the financial year which commenced on 1 April 2012 and ended on 31 March 2013
price-earnings ratio	closing share price on the JSE divided by the basic headline earnings per share
SAPS II	Simplified Acute Physiology Score II, a hospital mortality prediction methodology for patients in the adult critical care
UAE	United Arab Emirates
VON	Vermont Oxford Network, an initiative aimed at measuring and improving the quality of care in neonatal critical care units

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