MEDICLINIC
INTERNATIONAL

EXPERTISE YOU CAN TRUST.

INTEGRATED ANNUAL REPORT
for the financial year ended 31 March 2012

CONTENTS

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 2012, and covers all our operations in Southern Africa and Switzerland, which are wholly owned, as well as our operations in the United Arab Emirates, in which we have a 50.4% equity interest. 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. Although the Group's operations in Switzerland are relatively small compared to Southern Africa, the Swiss operations contributed 49% to the Group's revenue and are therefore considered to have a material impact on the Group's ability to create and sustain value.

The report will be posted to our shareholders and stakeholders who have requested to be added to our mailing list no later than 27 June 2012.

REPORTING PRINCIPLES

The contents included in the 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 International to create and sustain value for our stakeholders.

This integrated annual report was prepared in accordance with 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"). 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. The Company has also considered and applied many of the recommendations contained in the Discussion Papers on integrated reporting issued by the Integrated Reporting Committee of South Africa and the International Integrated Reporting Committee in 2011. We have prepared a more succinct integrated annual report by only including an abridged version of the Group's Sustainable Development Report. The detailed report is available on the Company's website at www.mediclinic.com.

SIGNIFICANT EVENTS DURING REPORTING PERIOD

No significant events occurred during the reporting period or after the end of the reporting period, which may have an impact on the Group's operations.

EXTERNAL AUDIT AND ASSURANCE

The Company's annual financial statements and the Group's 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 is included on page 113.

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 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 the inside of the back cover or the more detailed contact details on our website at www.mediclinic.com.

MEDICLINIC
INTERNATIONAL

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 has been listed on the JSE, the South African securities exchange, since 1986. The Group's head office is based in Stellenbosch, South Africa.

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WWW.MEDICLINIC.COM

PERFORMANCE HIGHLIGHTS

SALIENT FEATURES

- STRONG PERFORMANCE IN SOUTHERN AFRICA AND AN EXCELLENT PERFORMANCE IN THE UAE
- SOLID PERFORMANCE BY MOST OF THE SWISS HOSPITALS OFFSET BY CHALLENGES IN THE BERNE HOSPITALS
- NORMALISED HEADLINE EARNINGS INCREASED BY 12%
- NORMALISED HEADLINE EARNINGS PER SHARE INCREASED BY 7%
- STRONG CASH GENERATION
- FINAL DIVIDEND PER ORDINARY SHARE INCREASED TO 55.0 CENTS (2011: 50.0 CENTS)

REVENUE
R21 986 MILLION

NORMALISED HEADLINE EARNINGS
R1 211 MILLION

NORMALISED EBITDA
R4 659 MILLION

CASH GENERATED FROM OPERATIONS
R4 266 MILLION

FINANCIAL		2012	2011	% change
Revenue	R'm	**21 986**	18 625	18%
Normalised EBITDA	R'm	**4 659**	4 103	14%
Cash generated from operations	R'm	**4 266**	4 179	2%
Normalised headline earnings	R'm	**1 211**	1 082	12%
Total assets	R'm	**50 195**	43 537	15%
Shareholders' equity	R'm	**10 116**	9 489	7%
Return on shareholders' equity	%	**12.0%**	11.4%	5%
Normalised headline earnings per ordinary share – basic	cents	**193.0**	179.6	7%
Normalised headline earnings per ordinary share – diluted	cents	**185.7**	171.9	8%
Total distribution per ordinary shares	cents	**78.0**	73.0	7%
Net asset value per ordinary share	cents	**1 609.4**	1 516.7	6%
Adjusted net asset value per ordinary share*	cents	**2 238.9**	1 903.1	18%
Share performance				
– Closing price at year end	cents	**3 750**	2 900	29%
– Market capitalisation	R'bn	**24.5**	18.9	30%
Capital expenditure on projects, new equipment and replacement of equipment	R'm	**1 443**	1 127	28%
– Southern Africa	R'm	**523**	446	17%
– Switzerland	R'm	**869**	635	37%
– United Arab Emirates	R'm	**51**	46	11%

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

PERFORMANCE HIGHLIGHTS continued

OPERATIONAL		2012	2011
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		**9 191**	8 896
– Southern Africa		**7 378**	7 103
– Switzerland		**1 479**	1 457
– United Arab Emirates		**334**	336
Number of licensed/registered theatres		**340**	339
– Southern Africa		**254**	253
– Switzerland		**76**	76
– United Arab Emirates		**10**	10

SOCIAL		2012	2011
Number of employees*		**21 981**	21 183
– Southern Africa		**13 846**	13 588
– Switzerland		**6 321**	5 919
– United Arab Emirates		**1 814**	1 676
Staff turnover rate			
– Southern Africa	%	**10.6%**	10.3%
– Switzerland	%	**16.0%**	14.5%
– United Arab Emirates	%	**11.1%**	10.7%
Training spent** as approximate % of payroll			
– Southern Africa	%	**4%**	4%
– United Arab Emirates	%	**0.3%**	0.3%
Spent on corporate social investment			
– Southern Africa***	R'm	**5.0**	4.0
– Switzerland	CHF'm	**1.6**	1.6
– United Arab Emirates	AED'm	**0.4**	0.4
BBBEE (South Africa only)			
– BBBEE scorecard contributor level		**3**	3
– % black employees	%	**62.7%**	60.2%
– % black management employees	%	**22.3%**	20.0%

* *See organisational structure on page 4.*

** *The Group aims to provide comparable data in respect of Hirslanden in future.*

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

ENVIRONMENTAL		2012	2011
Ranking in Carbon Disclosure Project*		**43rd**	2nd
Total carbon emissions (CO_2e)**	Tons		
– Southern Africa (as per CDP 2010 and 2011)		**186 437**	179 948
– Switzerland (per 2010 and 2011 calendar years)		**9 100**	9 310
Total energy usage	Gigajoules	**874 178**	849 702
– Southern Africa		**626 149**	603 170
– Switzerland (per 2010 and 2011 calendar years)		**195 000**	194 653
– United Arab Emirates (hospitals only)		**53 029**	51 879

* *See explanation for the decline in ranking in the Sustainable Development Report published on the Company's website.*

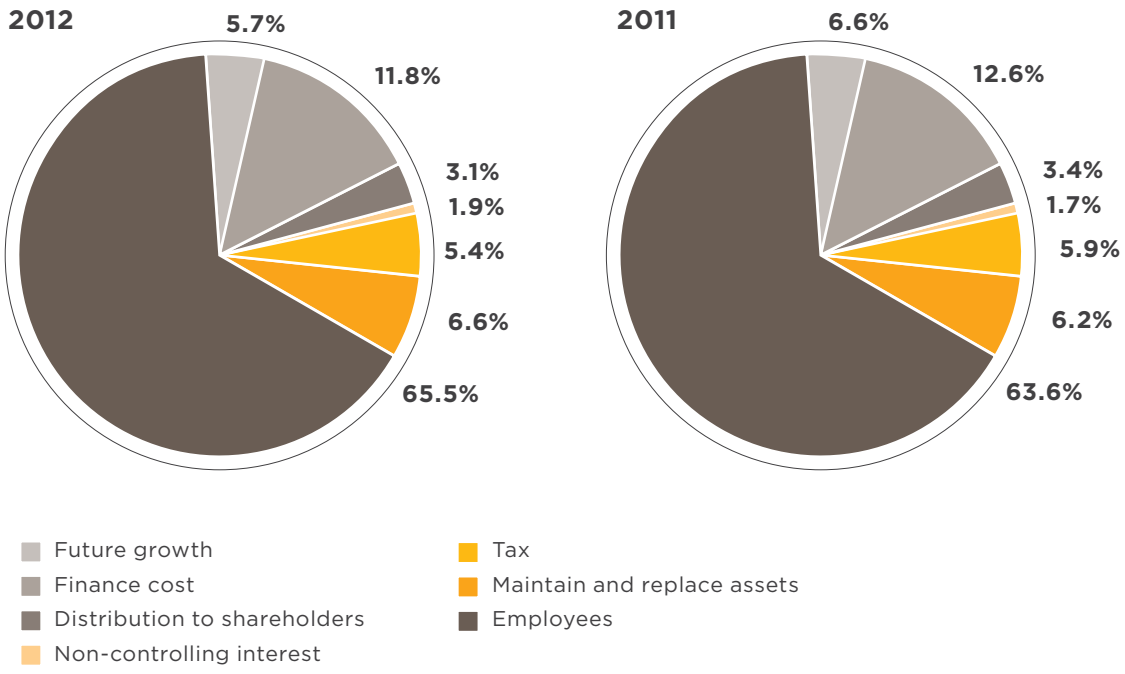
** *The carbon emissions by Mediclinic Southern Africa and Hirslanden are not directly comparable as they follow different management measures.*

OTHER	2012	2011
Inclusion in JSE SRI Index	**Yes**	Yes

VALUE ADDED STATEMENT

	2012 R'm	%	2011 R'm	%
VALUE CREATED				
Revenue	**21 986**		18 625	
Cost of materials and services	**(8 195)**		(6 849)	
Finance income	**85**		61	
	13 876	**100.0**	11 837	100.0
DISTRIBUTION OF VALUE				
To employees as remuneration and other benefits	**9 091**	**65.5**	7 525	63.6
Tax and other state and local authority levies (excluding VAT)	**749**	**5.4**	702	5.9
To suppliers of capital:				
Non-controlling interests	**263**	**1.9**	204	1.7
Finance cost on borrowed funds	**1 642**	**11.8**	1 491	12.6
Distributions to shareholders	**436**	**3.1**	398	3.4
	12 181	**87.7**	10 320	87.2
VALUE RETAINED				
To maintain and replace assets	**910**	**6.6**	738	6.2
Income retained for future growth	**785**	**5.7**	779	6.6
	1 695	**12.3**	1 517	12.8

DISTRIBUTION OF VALUE



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

ORGANISATIONAL STRUCTURE

COUNTRY OF OPERATION		
South Africa and Namibia	Switzerland	United Arab Emirates
BRAND OR TRADING NAME		
MEDICLINIC	hirslanden	EHL Management Services
HOSPITALS AND CLINICS IN OPERATION		
Operates 49 private hospitals throughout South Africa and three in Namibia, with 7 378 beds in total.	Operates 14 private hospitals with 1 479 beds in Switzerland.	Operates two hospitals with 334 beds and eight clinics in Dubai in the United Arab Emirates.
NUMBER OF EMPLOYEES		
13 846 (16 367 full-time equivalents, which include agency staff)	6 321 (which include full-time and part-time permanent employees)	1 814
NATURE OF OWNERSHIP		
100% owned through wholly owned subsidiary (with some group companies partly owned).	100% owned through wholly owned subsidiaries.	50.4% owned through wholly owned subsidiaries.

WHO WE ARE

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WHAT WE DO

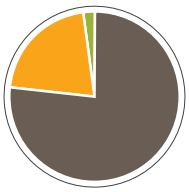
We are a private hospital group focused on providing acute care, specialist-orientated, multi-disciplinary hospital services and related service offerings. We place science at the heart of our care process by providing evidence-based care of the highest standard. Our patients receive controlled and customised treatment, orchestrated by a team of world-class specialists devoted to delivering the best possible clinical outcomes in multi-disciplinary 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.

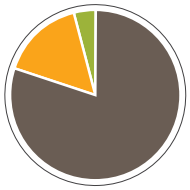
DISTRIBUTION OF THE GROUP'S 68 HOSPITALS

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



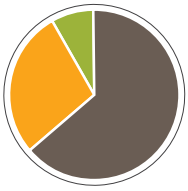
DISTRIBUTION OF THE GROUP'S 9 191 BEDS

- **SOUTHERN AFRICA** 7 378 (80%)
- **SWITZERLAND** 1 479 (16%)
- **UAE** 334 (4%)



DISTRIBUTION OF THE GROUP'S 21 981 EMPLOYEES

- **SOUTHERN AFRICA** 13 846 (63%)
- **SWITZERLAND** 6 321 (29%)
- **UAE** 1 814 (8%)



OUR BUSINESS MODEL

We offer multi-disciplinary, 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 Governance 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, while in Dubai most of the supporting doctors are employed.

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

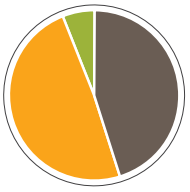
Our business model has resulted in consistent earnings growth, quality service delivery, manageable risks, and generally a business that sustains growth and value to all our stakeholders.

CONTRIBUTION TO GROUP REVENUE R21 986M

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

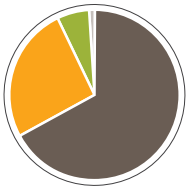
CONTRIBUTION TO GROUP NORMALISED EBITDA OF R4 659M

- **SOUTHERN AFRICA** R1 957m (42%)
- **SWITZERLAND** R2 350m (50%)
- **UAE** R352m (8%)



CONTRIBUTION TO GROUP NORMALISED HEADLINE EARNINGS OF R1 211M

- **SOUTHERN AFRICA** R787m (65%)
- **SWITZERLAND** R296m (25%)
- **UAE** R114m (6%)
- **CORPORATE** R14m (1%)



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 Governance 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 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).

NUMBER OF EMPLOYEES
21 981

NUMBER OF HOSPITALS
68

NUMBER OF BEDS
9 191

OUR BOARD AND MANAGEMENT ARE COMMITTED TO DELIVERING SHAREHOLDER VALUE

EXECUTIVE DIRECTORS

1. E de la H (Edwin) Hertzog (62)
Chairman
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. Other directorships include Distell, Remgro and Total (SA).

2. 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.

3. CI (Craig) Tingle (53)
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.

4. CA (Ronnie) van der Merwe (49)
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 July 2010.

5. KHS (Koert) Pretorius (49)
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.

6. TO (Ole) Wiesinger (49)
Chief Executive Officer: Mediclinic Switzerland (Hirslanden)
Ph.D., Postgraduate Studies in Health Economics
Joined the Hirslanden group in 2004. Appointed as the Chief Executive Officer of Mediclinic Switzerland and a director of the Company in 2008.

INDEPENDENT NON-EXECUTIVE DIRECTORS

7. 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.

8. RE (Robert) Leu (65)
Master in Economics, Ph.D., Professor in Economics
Executive director of the Department of Economics at the University of Berne in Switzerland. Also serves on the board of Mediclinic Switzerland. Appointed as an independent non-executive director of the Company in July 2010.

9. ZP (Zodwa) Manase (51)
B.Compt. (Hons), H.Dip. (Tax), CA(SA)
Chief Executive Officer of the audit firm, Manase & Associates. Appointed as a director of the Company in 2008. Other directorships include Total (SA), State Information Technology Agency and MTN Zakhele.

10. AA (Anton) Raath (56)
B.Comm., CA(SA)
Chief Executive Officer of Glacier, a subsidiary of Sanlam. Appointed as a director of the Company in 1996.

11. WL (Wynand) van der Merwe (60)
M.B.Ch.B., M.Med., F.F.A. (SA), MD
Dean of the Faculty Health Sciences of Stellenbosch University. Appointed as a director of the Company in 2001.

NON-EXECUTIVE DIRECTORS**

12. JC (Joe) Cohen (45)
B.Sc. in Economics
A managing partner of Trilantic Capital Partners. Appointed as a director of the Company in 2008.

13. JJ (Jannie) Durand (45)
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.

14. 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.

15. MA (Mamphela) Ramphele (64)
M.B.Ch.B., Diploma in Tropical Health and Hygiene, B.Comm., Diploma in Public Health, Ph.D.
Chairperson of Gold Fields. Appointed as a director of the Company in 2005. Other directorships include Remgro and Anglo American.

16. CM (Chris) van den Heever (47)
B.Eng. (Chem), MBA
An investment manager at Remgro (and previously at VenFin). Appointed as a director of the Company in 2010. Other directorships include One Digital Media, Tracker, Tsb Sugar and Wispeco.

* *Please refer to the explanation in respect of the classification of Dr Hertzog as executive chairman on page 76 of this annual report.*
** *Please refer to the explanation why these directors are not regarded as independent on page 77 of the Corporate Governance Report.*

1. EDWIN HERTZOG

2. DANIE MEINTJES

3. CRAIG TINGLE

4. RONNIE VAN DER MERWE

5. KOERT PRETORIUS

6. OLE WIESINGER

7. DESMOND SMITH

8. ROBERT LEU

9. ZODWA MANASE

10. ANTON RAATH

11. WYNAND VAN DER MERWE

12. JOE COHEN

13. JANNIE DURAND

14. KABS MAKABA

15. MAMPHELA RAMPHELE

16. CHRIS VAN DEN HEEVER

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.

www.mediclinic.com

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

STRATEGIC OBJECTIVES

WE ARE FOCUSED ON BUILDING STRONG POSITIONS IN ATTRACTIVE GEOGRAPHIC MARKETS

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 (focusing on high return, low-risk projects) based on sound investment principles and to demonstrate efficiency and diligence in the planning and execution of such opportunities.

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.

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.

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 regards 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.

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.

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.

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 PLAYER

- Mediclinic is a long-term investor in and manager of acute care, specialist-orientated, multi-disciplinary 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 high-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 maintained or expanded 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 manage 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 Middle East).
- 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*	**2012 IFRS R'm**	2011 IFRS R'm	2010 IFRS R'm	2009 IFRS R'm	2008 IFRS R'm	2007 IFRS R'm	2006 IFRS R'm
INCOME STATEMENTS								
REVENUE	29.2%	**21 986**	18 625	17 141	16 351	9 579	5 364	4 723
Normalised EBITDA	29.5%	**4 659**	4 103	3 736	3 431	2 062	1 152	988
Past service cost		**14**	33	97	–	–	–	–
Impairment charges (2011: includes related insurance proceeds)		**(4)**	50	–	–	–	–	–
BEE share-based payment		**–**	–	–	–	–	–	(85)
EBITDA		**4 669**	4 186	3 833	3 431	2 062	1 152	903
Depreciation		**(890)**	(726)	(705)	(672)	(336)	(146)	(124)
Amortisation/impairment of goodwill		**(20)**	(12)	(13)	(12)	(5)	–	–
Operating profit	30.0%	**3 759**	3 448	3 115	2 747	1 721	1 006	779
Other gains and losses		**(26)**	13	28	–	–	–	–
Income from associates		**1**	4	7	2	–	1	13
Exceptional items		**–**	–	–	–	–	–	43
Finance income		**85**	61	41	67	49	44	70
Finance cost		**(1 642)**	(1 491)	(1 524)	(1 602)	(685)	(88)	(45)
Profit before tax		**2 177**	2 035	1 667	1 214	1 085	963	860
Income tax expense		**(693)**	(654)	(481)	(502)	(364)	(270)	(428)
Profit for the year		**1 484**	1 381	1 186	712	721	693	432
Attributable to:								
Equity holders of the Company	23.9%	**1 221**	1 177	1 058	636	610	582	338
Non-controlling interests		**263**	204	128	76	111	111	94
		1 484	1 381	1 186	712	721	693	432
Headline earnings	26.4%	**1 222**	1 110	1 028	624	608	581	300
Normalised headline earnings	14.0%	**1 211**	1 082	852	624	608	581	553
STATEMENTS OF FINANCIAL POSITION								
ASSETS								
Property, equipment and vehicles		**34 808**	30 409	28 046	32 479	30 972	3 124	2 327
Intangible assets		**6 350**	5 565	5 243	6 293	6 101	419	48
Other investments and loans		**663**	712	26	32	34	46	119
Deferred income tax assets		**212**	210	220	178	123	120	123
Derivative financial instruments		**–**	33	–	–	43	–	–
Current assets		**8 162**	6 608	4 829	4 892	4 326	1 780	980
Total assets		**50 195**	43 537	38 364	43 874	41 599	5 489	3 597
EQUITY								
Equity attributable to owners of parent		**10 116**	9 489	6 650	7 091	8 560	2 068	1 641
Non-controlling interests		**1 288**	1 071	966	898	807	752	290
LIABILITIES								
Long-term interest-bearing borrowings		**22 864**	20 414	20 667	24 349	23 266	996	848
Deferred income tax liability		**5 303**	4 773	4 399	5 162	5 088	5	5
Retirement benefit obligations		**823**	383	346	997	639	129	102
Derivative financial instruments		**3 739**	2 170	2 331	2 512	595	–	–
Provisions		**361**	271	185	229	190	–	–
Current liabilities		**5 701**	4 966	2 820	2 636	2 454	1 539	711
Total equity and liabilities		**50 195**	43 537	38 364	43 874	41 599	5 489	3 597
STATEMENTS OF CASH FLOWS								
Cash generated from operating activities	27.5%	**4 266**	4 179	3 800	3 346	1 517	1 187	994
Net finance income/(cost)		**(1 525)**	(1 368)	(1 396)	(1 438)	(419)	(44)	25
Tax paid		**(525)**	(495)	(444)	(522)	(360)	(306)	(448)
Cash flow from operating activities		**2 216**	2 316	1 960	1 386	738	837	571
Cash flow from investment activities		**(1 055)**	(2 563)	(1 271)	(1 380)	(16 898)	(672)	(388)
Cash flow from financing activities		**(735)**	688	(542)	125	16 461	43	(830)
Cash distributions to minorities		**(111)**	(59)	(55)	(54)	(41)	(40)	(39)
Distributions to shareholders		**(436)**	(398)	(374)	(339)	(189)	(178)	(166)
Special dividend to shareholders		**–**	–	–	–	–	–	(1 327)
Proceeds from issuance of ordinary shares		**–**	1 331	–	–	4 472	–	–
Movement in borrowings		**(214)**	(208)	(155)	547	12 219	248	689
Other		**26**	22	42	(29)	–	13	13
Net movement in cash and bank overdrafts		**426**	441	147	131	301	208	(647)
Opening balance of cash and bank overdrafts		**1 447**	967	941	787	357	149	796
Exchange rate fluctuations on foreign cash		**108**	39	(121)	23	129	–	–
Closing balance of cash and bank overdrafts		**1 981**	1 447	967	941	787	357	149

Compounded Annual Growth Rate

STATISTICS AND PERFORMANCE PER PLATFORM

	CAGR#	**2012**	2011	2010	2009	2008	2007	2006
Mediclinic Southern Africa								
Number of hospitals		**52**	52	52	51	51	50	47
Licensed beds		**7 378**	7 103	7 035	6 855	6 776	6 845	6 613
Licensed theatres		**254**	253	252	248	248	243	234
Revenue (R'm)	12.2%	**9 423**	8 632	7 680	6 792	6 056	5 364	4 723
Normalised EBITDA (R'm)	12.1%	**1 957**	1 837	1 651	1 458	1 302	1 152	988
Normalised EBIT (R'm)	13.9%	**1 701**	1 608	1 445	1 281	1 143	1 006	779
Normalised EBITDA margin (%)		**20.8%**	21.3%	21.5%	21.5%	21.5%	21.5%	20.9%
Hirslanden								
Number of hospitals		**14**	14	13	13	13		
Licensed beds		**1 479**	1 457	1 365	1 334	1 301		
Licensed theatres		**76**	76	71	71	64		
Revenue (R'm)	14.8%	**10 732**	8 659	8 335	8 737	6 185*		
Normalised EBITDA (R'm)	14.4%	**2 350**	2 026	1 953	1 961	1 373*		
Normalised EBIT (R'm)	14.4%	**1 794**	1 593	1 516	1 507	1 046*		
Normalised EBITDA (CHF'm)	5.8%	**278**	285	266	245	222		
Normalised EBIT (CHF'm)	5.8%	**212**	224	206	188	169		
Normalised EBITDA margin (%)		**21.9%**	23.4%	23.4%	22.5%	22.2%*		
Emirates Healthcare								
Number of hospitals		**2**	2	2	2	1		
Licensed beds		**334**	336	336	321	120		
Licensed theatres		**10**	10	10	10	4		
Revenue (R'm)	39.6%	**1 831**	1 334	1 126	822	482		
Normalised EBITDA (R'm)	62.9%	**352**	240	132	(7)	50		
Normalised EBIT (R'm)	84.3%	**254**	164	57	(60)	22		
Normalised EBITDA (AED'm)	60.8%	**174**	122	62	(3)	26		
Normalised EBIT (AED'm)	83.6%	**125**	84	27	(25)	11		
Normalised EBITDA margin (%)		**19.2%**	18.0%	11.8%	(0.9%)	10.3%		
Share ratios								
Headline earnings per ordinary share (cents)								
Basic	14.5%	**194.9**	184.2	180.8	111.5	144.5	162.2	86.3
Diluted	16.2%	**187.5**	176.3	171.7	105.6	133.6	147.2	76.3
Normalised headline earnings per ordinary share (cents)								
Basic	3.3%	**193.0**	179.6	149.9	111.5	144.5	162.2	159.3
Diluted	4.7%	**185.7**	171.9	142.4	105.6	133.6	147.2	140.9
Distribution per ordinary share (cents)	5.4%	**78.0**	73.0	73.0	68.6	61.2	54.1	53.1
Net asset value per ordinary share (cents)	23.2%	**1 609.4**	1 516.7	1 181.4	1 265.5	1 527.5	575.5	460.7
Adjusted net asset value per ordinary share (cents)**	30.1%	**2 238.9**	1 903.1	1 639.4	1 752.2	1 657.6	575.5	460.7
JSE								
Market capitalisation (R'bn)		**24.5**	18.9	16.0	12.7	11.7	9.9	8.1
Price (cents per share)								
31 March		**3 750**	2 900	2 700	2 150	1 970	2 510	2 065
Highest		**4 199**	3 150	2 765	2 575	2 695	2 860	2 230
Lowest		**2 810**	2 325	1 865	1 535	1 811	1 740	1 420
Number of shares traded (000)		**118 734**	98 979	101 801	116 798	131 057	78 700	112 967
Price-earnings ratio		**19.2**	15.7	14.7	19.3	13.6	15.5	23.9
Normalised price-earnings ratio		**19.4**	16.1	17.8	19.3	13.6	15.5	13.0
Number of shares								
Ordinary shares issued (000)		**652 315**	652 315	593 014	593 014	394 338	394 338	350 066
Weighted average for basic earning per share (000)		**627 280**	602 467	568 721	559 336	421 437	357 606	347 140
Weighted average for diluted earnings per share (000)		**651 779**	629 488	598 656	590 999	455 748	394 107	392 417
Exchange rates								
Average rate (Swiss franc)	R/CHF	**8.45**	7.11	7.35	8.01	6.18*		
Closing rate (Swiss franc)	R/CHF	**8.50**	7.42	6.93	8.32	8.14		
Average rate (UAE dirham)	R/AED	**2.03**	1.96	2.13	2.41	1.94		
Closing rate (UAE dirham)	R/AED	**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.*

THE SUCCESSFUL AND CONSISTENT GROWTH OF MEDICLINIC CONTINUED DURING THE YEAR UNDER REVIEW

Edwin Hertzog *Chairman*

It is a privilege to report on the progress of Mediclinic during the last financial year. Mediclinic is a company that was listed on the JSE in 1986 with a market capitalisation of R170m which has currently grown to around R24bn. During the year under review growth continued: in Dubai it was remarkable, in Southern Africa it was solid and in the Eastern Region of Switzerland it was satisfactory. The Berne hospitals in the Western Region of Switzerland are, however, not operating at an optimal level due to the reasons as explained in the Operational Review of Mediclinic Switzerland.

The successful and consistent growth of Mediclinic over many years could only be achieved through a business model based on solid pillars which continues to be executed efficiently.

The operational highlights and challenges of the past year are included in the Group's CEO Report and the Operational Reviews of the three operating platforms. The Group's CFO Report provides detailed information regarding the year's financial performance. It is not my intention to duplicate or summarise any of the information provided in these five reports. I shall rather try to provide our shareholders with some of the reasons – in terms of the business model and its execution – why I believe they can have faith in the longer-term outlook of the Group.

THE BUSINESS MODEL

To fulfil its vision of being respected internationally and preferred locally, the Group continues to focus on:

- Providing cost-effective, quality healthcare by operating acute care, specialist-orientated, multi-disciplinary hospitals.

  Although hospital services form the backbone of the Group's activities, it is also not averse to venture into profitable related services, such as the eight outpatient clinics it currently operates across Dubai or the Medical Human Resources agency and ER24 emergency vehicle service operated in South Africa.

- Being regarded by doctors, patients and healthcare funders as the most trusted and respected healthcare services provider.

  The increase in bed days sold across all three operating platforms during the last year is an indication of continued success in this regard.

- Ensuring that the quality of life of our patients is improved.

  The Group's Clinical Governance programme monitors many aspects of the clinical services delivered. Although this is a huge task and still work in progress across the globe, the Group regards itself as a leader in the field.

- Being an ethical and responsible corporate citizen.

  The Group's track record speaks for itself.

- Building strong positions in attractive geographical markets.

  To have started the Group in the complex Southern African market, where affordability is a major issue, provided many advantages. The Group managed to grow in a relatively short period to one of the three leading private hospital operators in this region. From there it moved on to Dubai, where in a period of about five years it became the biggest provider of private healthcare services in this vibrant Middle East market. With its expansion to Switzerland in 2007 the Group established itself as the biggest private hospital group in this mature and financially stable country.

- Taking a long-term outlook, which is shared by the Group's founding and majority shareholder, Remgro.

  For this reason the Group also owns virtually almost all of its hospital properties and continues to invest substantial amounts in their proper upkeep.

FOCUSED ON PROVIDING THE BEST POSSIBLE FACILITIES, WITH TECHNOLOGY OF AN INTERNATIONAL STANDARD

EXECUTION OF THE MODEL

Healthcare services are basically provided by the people, infrastructure and technology involved (along with the necessary pharmaceutical supplies). To ensure a sound future, the Group continues to:

- Attract, retain and support the right number of doctors providing the right quality of services at its facilities.

  The model by which they provide their services vary: in South Africa virtually all the doctors are in independent practices. In Dubai virtually all the doctors are employed by the Group and in Switzerland some of the doctors are employed but most are not.

- Attract, retain and train the right management, nurses and other hospital staff.

  The Group has had remarkable stability amongst its senior management members over nearly three decades. The turnover of nursing staff in South Africa, and especially Dubai, has also dropped remarkably over the last number of years to a level which no longer causes concern.

- Maintain and upgrade its buildings according to a scheduled programme, spending funds according to internationally recommended norms.

- Invest in maintaining and upgrading the technology available at its facilities according to formulae, which have proved itself within the Group over many years.

- Expand its activities and investment in the field of clinical governance. In the healthcare world of today, patients need to satisfy themselves that their clinical outcomes are what they can reasonably expect. For this reason, many different indicators of the patient's hospital experience and clinical outcome have to be measured and followed up, where necessary. More details in this regard are provided in the Clinical Governance Report.

- Investigate ways of implementing further cost-effective centralisation of services and best practices on regional, operating platform and Group level.

PROSPECTS

Healthcare is fortunately not a fashion item or a commodity where demand or price can suddenly surge or decline. However, affordability remains a big issue all over the world and shortages of skilled human resources, negative regulatory or political environments as well as vigorous competition often create great challenges.

On the other hand, universal positive factors for the industry such as ageing populations, new technologies, better clinical outcomes, greater affluence and better informed members of the public all assist the Group.

For the Group its three major operational challenges in the year ahead will in all likelihood remain the new health services payment system with all its implications in Switzerland, the regulatory environment in South Africa and potential new competition in Dubai. The refinancing of the Group's debt structure will also continue to receive focused attention in the year ahead. The improvement of operational efficiencies across the Group remains ongoing, but will receive special attention in the Berne hospitals.

Overall, we believe that the Group's successful track record and proven abilities will stand it in good stead to not only face the year ahead with optimism, but also the longer term.

DIRECTORATE MATTERS*

There were no changes to the Board of Mediclinic during the period under review.

Mr Thys Visser, who served as a non-executive director since 2005 representing Remgro Limited, tragically passed away on 26 April 2012. Mr Visser was an exceptional leader and businessman. He will be long remembered, both for his significant contribution to the Group and as a person.

Ms Zodwa Manase and Prof. Wynand van der Merwe (both independent non-executive directors), as well as Dr Mamphela Ramphele (non-executive director), will retire on 26 July 2012. We are thankful to them for the significant contribution they have made over a long period to the Group.

The filling of these vacancies is receiving the attention of the Board.

I will retire as an executive director in August 2012, but will remain on the Board as a non-executive chairman. A further announcement will be made in due course confirming the exact date.

APPRECIATION

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

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

Edwin Hertzog
Chairman

** Subsequent to the Board's approval of this report, Mr Joe Cohen also confirmed that he will retire as a non-executive director on 26 July 2012; and Mr Jannie Durand was appointed by the Board as a non-executive director on 7 June 2012.*

DESPITE CHALLENGES AND UNCERTAINTIES, THE GROUP ACHIEVED GOOD REVENUE GROWTH

Danie Meintjes *Chief Executive Officer*

The period under review was a challenging year, especially with the various regulatory changes in Switzerland. Despite the challenges and uncertainties, the Group achieved good revenue growth in Southern Africa and Switzerland and exceptional growth in Dubai. Switzerland had satisfactory growth despite operating in a very competitive and a low-inflation environment.

STRATEGIC PRIORITIES

Mediclinic International's continued growth and success have been achieved through our long-standing commitment to delivering a sustainable business model that will continue to improve the quality of life and care of our patients and to create shareholder value for generations to come. For information about the Group's sustainability initiatives and performance, please refer to the abridged Sustainable Development Report included in this integrated annual report, and the detailed report published on our website at www.mediclinic.com.

During the period under review the Group focused on the following strategic priorities:

- ensuring it constantly meets the needs of patients;
- driving volume growth and managing costs without ever compromising on patient safety;
- constantly monitoring and evaluating changes to the economic and regulatory environments to ensure the Group is well positioned; and
- unlocking synergies between the Group's three operating platforms, with an overall aim of becoming a successful international hospital group rather than a group of associated hospitals.

The Group made good progress in respect of each of these priorities during the period under review.

PERFORMANCE AGAINST OBJECTIVES

MEETING PATIENTS' NEEDS

Patient satisfaction is one of the Group's highest priorities, and we are committed to accumulate accurate and reliable data on patient satisfaction levels. Independent consultants continuously measure patients' views in Southern Africa and Switzerland, and the Group follows a similar in-house process in Dubai.

The Group targets different inpatient satisfaction levels in the three operating platforms based on historical performance. Irrespective of the targets, the aim is to continuously improve on performance and we are pleased to report that all three platforms increased their performance in this regard. Southern Africa achieved a 76% (2011: 75%), Dubai 89% (2011: 89%) and Switzerland 91% (2011: 85%) satisfaction levels for inpatients. The patient satisfaction results for Switzerland are based on the ANQ (the Swiss National Association for Quality Development) satisfaction survey. Previously the results were based on the Picker review. At the time of preparing this report, the Picker results were not available and the results are therefore not comparable to those of the previous year.

To further improve on the reliability of these measurements, we established a task group to investigate the possibility of contracting a single independent consulting group to standardise the methodology and the actual measurement for all platforms in order to establish better global benchmarking.

Mediclinic Southern Africa embarked on a project to improve the overall patient experience in the hospitals. The project will involve a multi-disciplinary task team, who will conduct an in-depth investigation to evaluate all processes and touch points of the patient journey during any hospital visit, with the aim to improve the overall service experience.

DRIVING VOLUME AND MANAGING COSTS

The Group achieved satisfactory growth compared to the previous year. Revenue increased by 18% to R21 986m (2011: R18 625m). At constant exchange rates, revenue was 9% higher.

It is particularly pleasing to report that the Group experienced satisfactory growth in bed days sold: Mediclinic Southern Africa increasing by 3.3%, Mediclinic Switzerland by 1.7% and Emirates Healthcare by 24.3%.

The Group's normalised EBITDA margin remains a constant focus, as it shows the effectiveness of its cost management. Normalised EBITDA was 14% higher at R4 659m (2011: R4 103m), equating to a margin of 21.2%, compared to 22.0% in 2011. The Berne hospitals in Switzerland faced a number of challenges which impacted the margin, details of which are covered in the Switzerland operational report.

Normalised headline earnings per ordinary share increased by 7% to 193.0 cents (2011: 179.6 cents).

MONITORING AND EVALUATING THE REGULATORY AND ECONOMIC ENVIRONMENT

Rising healthcare costs and the impact of this on the affordability of healthcare are a global concern. Cost drivers include ageing populations, new technology, consumerism and specific diseases such as HIV/AIDS. Each country has its own regulations and proposals for reform, which potentially influence the market for healthcare services. During the period under review the Group continued its participation in numerous research, discussions and lobbying activities in all three operating platforms.

SOUTHERN AFRICA

Members of South African medical schemes are still the key target market for Mediclinic Southern Africa, and it is comforting to note that membership continues to grow, albeit at a moderate rate. According to the Council of Medical Schemes' quarterly report, the total medical aid membership was 8.47 million by the end of September 2011 with a CAGR of 4.1% between 2005 and 2010.

The Department of Health (DoH) published a Green Paper on the National Health Insurance (NHI) scheme in August 2011. Mediclinic is of the opinion that an NHI, and specifically the initial activities to institute an NHI, will not have any significant effect on the medical schemes market or the private sector industry in the immediate future. Reinstating good access to quality care in the public sector requires addressing major systemic issues in the public sector and a significant increase in human resource capacity. These can only be properly addressed in the longer term. The Minister of Health acknowledges these constraints and has identified them as critical challenges that have to be addressed as a priority in order for the NHI to achieve its aims. Initiatives such as reopening nursing colleges, increasing the capacity of medical schools and better management of hospitals are planned by the Department of Health.

We remain confident about the business environment in Southern Africa. This is confirmed by the significant CAPEX investments we made during the year and which we plan for the new financial year.

SWITZERLAND

The long-awaited and much debated healthcare regulatory changes for Switzerland were implemented with effect 1 January 2012. Although there are still uncertainties on some issues, the key changes involved the implementation of:

i. a revision of the hospital planning for the country that led to new lists of hospitals which specify those that are eligible to treat patients with mandatory insurance;
ii. a new hospital financing system which redefines the funding proportions of the cantons versus the health insurance companies; and
iii. the introduction of fixed fees for inpatient services based on Diagnosis Related Grouping (DRG).

The implementation of the new regulatory changes necessitated significant administrative and information system changes. This was hampered by the lack of timeous information, and local management did well to ensure a rather smooth transition under these circumstances.

Further information on the regulatory changes is reported in the Operational Review: Switzerland.

UNITED ARAB EMIRATES (UAE)

No major regulatory changes were implemented during the year under review. We are of the opinion that Dubai and some of the other Emirates might introduce compulsory healthcare insurance for expatriates in line with the system that was introduced by Abu Dhabi around five years ago. Management is monitoring the developments and specifically the DRG process in Abu Dhabi.

The recent political unrest in some of the Middle Eastern countries had no negative impact on business or on the political stability of the UAE. On the contrary, the UAE is actually seen as a safe haven where the impact on our business was rather positive.

UNLOCKING SYNERGIES

Mediclinic International contracted the services of a professional consulting firm to assist with the formal evaluation of our existing international operating model. The key objective of the project is to increase collaboration across the organisation so that synergies can be leveraged, best practices be shared, and to drive international alignment through clearly defined management structures and levels of responsibility.

We plan to complete the project towards the middle of the new financial year.

GROUP PERFORMANCE

With the exception of some hospitals in Hirslanden's Western Region, the Group is pleased with its financial performance during the period under review.

SOUTHERN AFRICA

Mediclinic Southern Africa contributed 43% of the Group's revenue and 42% of its normalised EBITDA (2011: 46% and 45% respectively).

Availability of specialists, especially for some outlying hospitals is an ongoing challenge. Mediclinic Southern Africa has a well-established doctor recruitment programme to assist with the early identification of practice opportunities at the different hospitals, as well as a web-based doctor recruitment facility to identify newly qualified doctors.

WE REMAIN FOCUSED ON MEETING THE NEEDS OF OUR PATIENTS

The continued shortage of skilled nurses in South Africa remains a challenge and Mediclinic Southern Africa is focused on the retention and recruitment of skilled nurses. It is pleasing to report that the recruitment programme of specialist nurses from India proved to be very successful. An additional group of Indian nurses will join towards the end of 2012, with a further number in the recruitment pipeline. The longer-term and more sustainable solution is to train more South Africans to bridge the shortage. For this reason Mediclinic Southern Africa is making meaningful investments in nurse training.

Mediclinic Southern Africa retained its BBBEE Level 3 contributor status during the period under review, and it is particularly pleasing to note the progress that was made in terms of transformation at management levels.

For more information regarding our initiatives to address the shortage of skilled nurses and BBBEE refer to the abridged Sustainable Development Report.

SWITZERLAND

Hirslanden contributed 49% of the Group's revenue and 50% of its normalised EBITDA (2011: 47% and 49% respectively). As discussed in the Chief Financial Officer's Report, the fluctuation of the rand against the Swiss franc influenced the reported figures. Excluding some hospitals in the Western Region, all the other Hirslanden hospitals performed satisfactorily despite the uncertainties related to the regulatory changes.

The construction of the new southern wing at the flagship Klinik Hirslanden in Zurich is progressing according to plan, and the facilities are planned to open towards the end of the year.

Klinik Stephanshorn in the Canton of St. Gallen, which was acquired during the previous financial year, outperformed its budget for the year. Further investments will be made in the construction of new doctor consulting rooms to attract and accommodate more doctors at the hospital.

UNITED ARAB EMIRATES

Emirates Healthcare contributed 8% of the Group's revenue and 8% of its normalised EBITDA (2011: 7% and 6% respectively).

Performance in Dubai was again very strong. The City Hospital opened a further 30 beds of the available 70 beds that were previously used as office space, and managed to utilise the new capacity well.

The three clinics that were acquired from Emirates Healthcare during January 2011 are now fully integrated and well positioned to further improve their performance.

OUTLOOK

The affordability of healthcare continues to be a global challenge. However, the Group has a three-decade track record of successfully managing private hospitals and has proved its resilience, despite past regulatory changes and severe economic declines.

The regulatory changes in Switzerland are still in flux, and it is difficult to predict the exact final impact of the changes going forward, but we do not foresee major upheavals.

We are optimistic about the growth potential of the Dubai operations, as The City Hospital is planning to commission the remaining unutilised capacity (outpatient as well as inpatient) during the course of the year ahead.

We will stay focused on meeting the needs of our patients in the most cost-effective way and will also continue to explore innovative ways to add value to our broader stakeholder community.

Our continuous investment in creating new capacity along with the upgrading of our infrastructure in all three platforms, confirm our belief in the future of our industry and the Group.

I would like to thank all our supporting doctors, management and staff for their contributions towards the success we achieved during the year.

Danie Meintjes
Chief Executive Officer

THE GROUP DELIVERED SOLID FINANCIAL RESULTS AND GROWTH

Craig Tingle *Chief Financial Officer*

INTRODUCTION

The Group delivered solid financial results and growth for 2012, despite continuing challenging global economic conditions.

GROUP OVERVIEW

GROUP FINANCIAL PERFORMANCE

The Group uses normalised EBITDA, normalised headline earnings and normalised headline earnings per share as non-IFRS 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 headline earnings per share in terms of accounting standards, excluding one-off items. The term 'normalised' used herein has replaced the term 'core' used in previous reports.

RESULTS OVERVIEW

Group revenue increased by 18% to R21 986m (2011: R18 625m) for the year under review. Normalised operating income before interest, tax, depreciation and amortisation ("normalised EBITDA") was 14% higher at R4 659m (2011: R4 103m). Normalised headline earnings rose by 12% to R1 211m (2011: R1 082m).

FIGURE 1: EBITDA RECONCILIATION

R'm	2012	2011
EBITDA	**4 669**	4 186
Adjusted for:		
Past service cost	**(14)**	(33)
Impairment of property and equipment	**4**	34
Insurance proceeds	**–**	(84)
Normalised EBITDA	**4 659**	4 103

Normalised basic headline earnings per ordinary share increased by 7% to 193.0 cents (2011: 179.6 cents), reflecting the increase in shares in issue after the rights offer in August 2010.

At constant exchange rates, normalised EBITDA increased by 4%, normalised headline earnings increased by 7%, and normalised headline earnings per share increased by 3%.

The calculations of normalised EBITDA (see **Figure 1**), normalised headline earnings and normalised basic headline earnings per share are before the effects of an impairment charge of R4m and R2m after share of minorities taken into account together with a one-off past service cost credit of R14m (CHF1.7m) and R11m (CHF1.3m) after provisioning for tax relating to the integration of Klinik St. Anna pension fund.

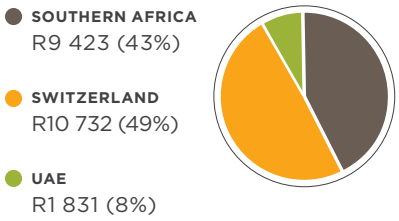
Before taking these adjustments into account, reported EBITDA increased by 12% to R4 669m (2011: R4 186m).

Excluding current and prior year re-measurements relating to normalised headline earnings, headline earnings rose by 10% to R1 222m (2011: R1 110m) and basic headline earnings per ordinary share increased by 6% to 194.9 cents (2011: 184.2 cents).

As indicated in previous annual reports, the Group is moving towards a targeted dividend cover of three times, based on Group headline earnings. The total dividend per share for the period under review is 78.0 cents (2011: 73.0 cents).

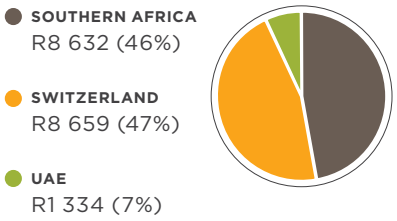
FIGURE 2: REVENUE (R'M)

2012



TOTAL R22.0 BILLION

2011



TOTAL R18.6 BILLION

REVENUE

The geographical composition of the Group's revenue for 2012 and 2011 is shown in **Figure 2**.

As shown in **Figure 3**, revenue increased by 18% to R21 986m (2011: R18 625m).

NORMALISED EBITDA

The Group's normalised EBITDA margin decreased from 22.0% in 2011 to 21.2% in 2012. The EBITDA margins of the Group's platforms were 20.8% for Southern Africa, 21.9% for Switzerland and 19.2% for the United Arab Emirates.

The geographical composition of the Group's Normalised EBITDA for 2012 and 2011 is shown in **Figure 4**.

As shown in **Figure 5**, normalised EBITDA increased 14% to R4 659m (2011: R4 103m).

FINANCE COST

The Group's finance cost was R1 642m, compared with R1 491m in 2011. Included in the finance cost is R81m (2011: R78m) of amortisation charges in respect of raising fees paid on the Group's debt. These fees are amortised over the terms of the corresponding loans in line with future cash payments, as prescribed by IAS 39 Financial Instruments.

The geographical composition of the Group's finance cost for 2012 is shown in **Figure 6**.

FIGURE 3: REVENUE GROWTH (R'M)

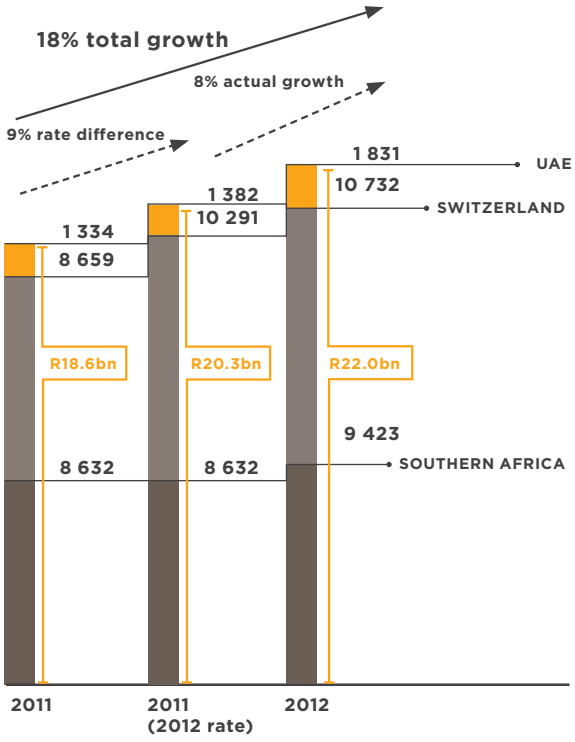
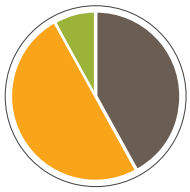


FIGURE 4: NORMALISED EBITDA (R'M)

2012

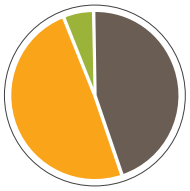
- **SOUTHERN AFRICA** R1 957 (42%)
- **SWITZERLAND** R2 350 (50%)
- **UAE** R352 (8%)



TOTAL R4.7 BILLION

2011

- **SOUTHERN AFRICA** R1 837 (45%)
- **SWITZERLAND** R2 026 (49%)
- **UAE** R240 (6%)



TOTAL R4.1 BILLION

FIGURE 5: NORMALISED EBITDA GROWTH (R'M)

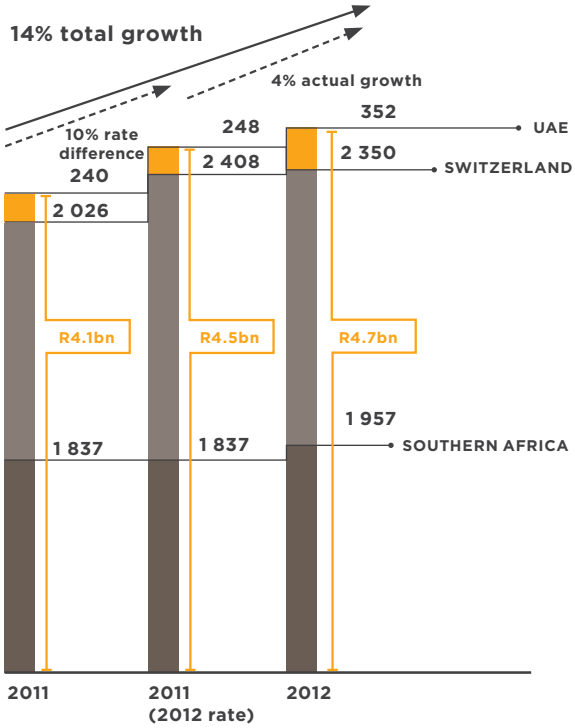
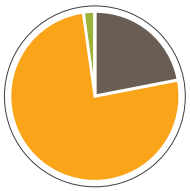


FIGURE 6: FINANCE COST (R'M)

2012

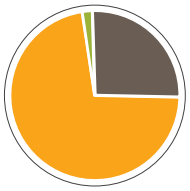
- **SOUTHERN AFRICA** R369 (22%)
- **SWITZERLAND** R1 244 (76%)
- **UAE** R29 (2%)



TOTAL R1.6 BILLION

2011

- **SOUTHERN AFRICA** R384 (26%)
- **SWITZERLAND** R1 068 (72%)
- **UAE** R39 (2%)



TOTAL R1.5 BILLION

FIGURE 7: NORMALISED HEADLINE EARNINGS (R'M)

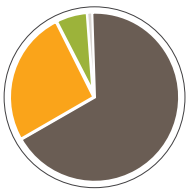
2012

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

TOTAL R1.2 BILLION

2011

- SOUTHERN AFRICA R727 (67%)
- SWITZERLAND R286 (26%)
- UAE R62 (6%)
- CORPORATE R7 (1%)



TOTAL R1.1 BILLION

CONTRIBUTION TO GROUP NORMALISED HEADLINE EARNINGS

The geographical composition of the Group normalised headline earnings for 2012 and 2011 is shown in **Figure 7**.

CASH FLOW

Cash flow continued to be strong. The Group converted 92% (2011: 102%) of Normalised EBITDA into cash generated from operations, compared with a target of 100%. The cash conversions of the individual platforms are discussed below.

Cash and cash equivalents increased to R2 099m at year end, compared with R1 567m at 31 March 2011.

INTEREST-BEARING BORROWINGS

Interest-bearing borrowings ("debt") increased from R22 248m at 31 March 2011 to R24 794m at year end, mainly as a result of the change in the closing rand/CHF exchange rate. The CHF closing exchange rate moved from R7.42 at 31 March 2011 to R8.50 at year-end.

The geographical composition of the Group's debt at 31 March 2012 is shown in **Figure 8**.

The foreign debt of the Group's Swiss and Middle Eastern operations, amounting to R21 162m, is matched with assets in the same currencies. This 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.

ASSETS

Property, equipment and vehicles increased from R30 409m at 31 March 2011 to R34 808m at 31 March 2012 and intangible assets increased from R5 565m at 31 March 2011 to R6 350m at 31 March 2012. These increases are mainly as a result of the change in the closing rand/CHF exchange rate, as mentioned above.

TREASURY SHARES

During the year the Group utilised 1 110 422 treasury shares for the executive share option scheme and the management incentive scheme. Furthermore, 300 000 shares 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 AED3.675.

The CHF spot rate moved from R7.42 at 31 March 2011 to R8.50 at 31 March 2012, and averaged R8.45 for the year (2011: R7.11).

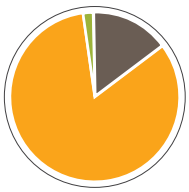
The AED spot rate moved from R1.85 at 31 March 2011 to R2.09 at 31 March 2012, and averaged R2.03 (2011: R1.96) for the year.

Accounting convention requires the Group to convert its offshore statement of financial position at the year-end spot rate, while its offshore income statements are converted at the average rate for

FIGURE 8: DEBT (R'M)

2012

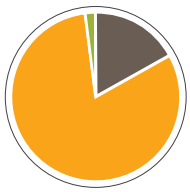
- **SOUTHERN AFRICA** R3 631 (14%)
- **SWITZERLAND** R20 723 (84%)
- **UAE** R440 (2%)



TOTAL R24.8 BILLION

2011

- **SOUTHERN AFRICA** R3 757 (17%)
- **SWITZERLAND** R18 083 (81%)
- **UAE** R408 (2%)



TOTAL R22.2 BILLION

the year. The difference between the spot rates and the average rates results in distortions, when ratios between the balance sheet 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 405m (2011: R488m) and was credited to the statement of comprehensive income.

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 R471m (CHF55.4m) (2011: R71m (CHF9.5m)), 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 105% (2011: 106%) funded at 31 March 2012. 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 2012.

The higher pension liability resulted in an amount of R413m (CHF49m) being charged (2011: R86m (CHF11.6m)) to the consolidated statement of comprehensive income for the year. An amount of R114m (CHF13.5m) (2011: R102m (CHF14.3m)), 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 R14m (CHF1.7m) was made relating to the integration of Klinik St. Anna pension fund.

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. The overall decline of interest rates led to the increase of the fair value liability of the Group's interest rate swaps from R2 214m at 31 March 2011 to R3 739m at year end and an amount of R1 126m (2011: credited R246) was charged to the consolidated statement of comprehensive income.

FIGURE 9: MEDICLINIC SOUTHERN AFRICA REVENUE (ZAR'BN)

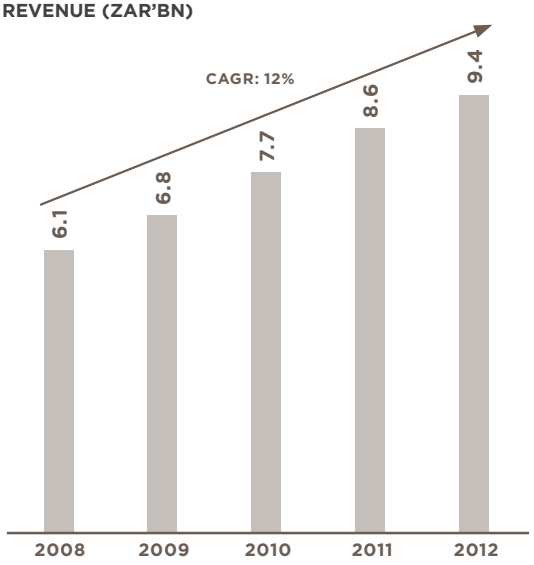
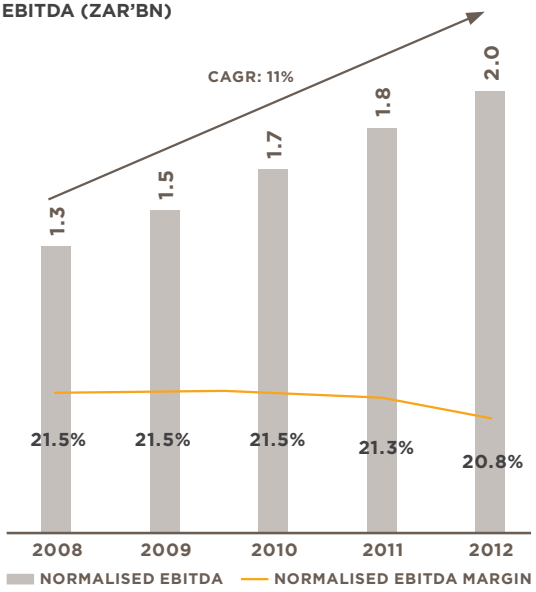


FIGURE 10: MEDICLINIC SOUTHERN NORMALISED EBITDA (ZAR'BN)



OPERATIONS IN SOUTHERN AFRICA

MEDICLINIC SOUTHERN AFRICA

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

The Southern African group revenue increased by 9% to R9 423m (2011: R8 632m) for the year under review (**Figure 9**). Normalised EBITDA was 7% higher at R1 957m (2011: R1 837m).

After incurring depreciation charges of R256m (2011: R229m), net finance charges of R328m (2011: R348m), taxation of R434m (2011: R388m) and deducting the interest of minority shareholders in the attributable income of the Southern African group amounting to R152m (2011: R141m), the Southern African operations contributed R787m (2011: R731m) to the normalised attributable income of the Group.

The Southern African operations' EBITDA margin decreased slightly from 21.3% to 20.8%. The margin was negatively affected by 0.2% because of the straight-lining of a major lease renewal; furthermore the margin was negatively affected by a non-recurring 0.3% which resulted from the launch of the new Mediclinic brand.

The Southern African operations' cash flow continued to be strong despite some major medical schemes payments being received a few days after the financial year end since 31 March 2012 was not a business day (Saturday). The Southern African operations converted 97% (2011: 111%) of EBITDA into cash generated from operations.

Cash and cash equivalents increased from R755m at 31 March 2011 to R821m at year end.

Interest-bearing borrowings decreased from R3 757m at 31 March 2011 to R3 631m at year end.

OPERATIONS IN SWITZERLAND

HIRSLANDEN

Hirslanden's reported results for 2012 were affected by exchange rate movements. The average rand/CHF exchange rate for the year fell from R7.11 in 2011 to R8.45 in 2012.

Hirslanden's revenue increased by 24% (4% at constant foreign exchange rates) to R10 732m (CHF1 270m) (2011: R8 659m (CHF1 218m)) for the year under review. Normalised EBITDA was 16% higher (2% lower at constant foreign exchange rates) at R2 350m (CHF278m) (2011: R2 026m (CHF285m)).

FIGURE 11: HIRSLANDEN REVENUE (CHF MILLION)

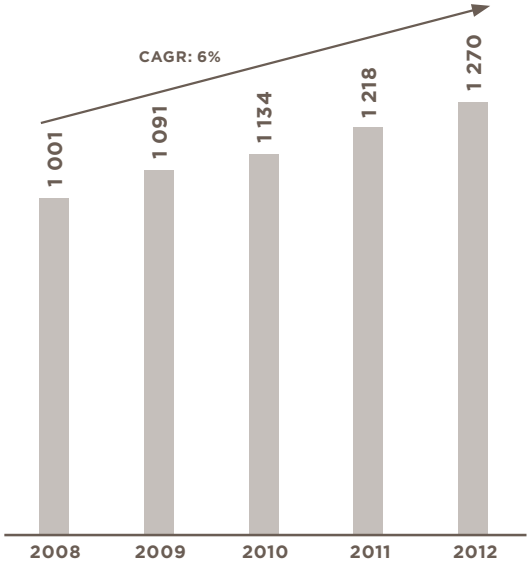
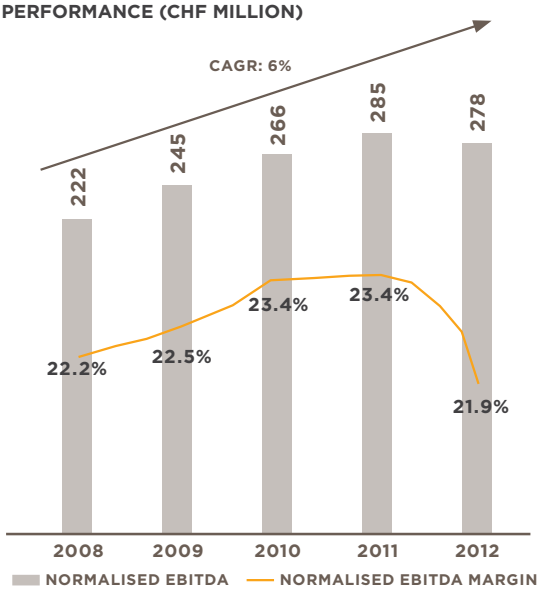


FIGURE 12: HIRSLANDEN EBITDA GROWTH AND PERFORMANCE (CHF MILLION)



After incurring depreciation charges of R556m (CHF66m) (2011: R433m (CHF61m)), net finance charges of R1 239m (CHF147m) (2011: R1 060m (CHF149m)) and tax of R260m (CHF31m) (2011: R251m (CHF35m)) and income from associates of R1m (CHF0.1m) (2011: R4m (CHF1m), Hirslanden contributed R296m (CHF34m) (2011: R286m (CHF41m)) to the attributable income of the Group.

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

The normalised EBITDA margin of the group decreased from 23.4% to 21.9%.

The margin was affected by the following factors:

- The implementation of a revised labour law during the year and the additional staff required in the fields of medical coding and controlling as a result of the introduction of the new Swiss Diagnosis Related Grouping (DRG) added R46m (CHF5.5m) to personnel expenses. Management is focusing on overall personnel costs to mitigate the impact of these developments.
- The trend of a gradually increasing percentage of generally insured patients is continuing. The fact that private and semi-private insurance premiums have not increased in 2012 is a positive development to counter this trend.
- The Berne hospitals faced a number of challenges:
  - Administrative challenges in first implementing the All Patient DRG (APDRG) system in 2010 and then the Swiss DRG system in 2012 were substantial. This led to increases in staff costs and trade debtors.
  - Cost structures were furthermore increased as a result of the capacity creation at Klinik Beau Site without achieving the budgeted initial revenue increases.
  - Moderate tariff declines have been experienced since the implementation of APDRGs in 2010 and Swiss DRGs in 2012.
  - Berne is a competitive market where the numerous uncertainties regarding the hospital list status created general recruitment and retention challenges with doctors.

Hirslanden converted 84% (2011: 94%) of normalised EBITDA into cash generated from operations. An expected temporary increase in trade debtors as the result of the implementation of the new DRG system had a negative effect on the cash conversion. Furthermore, an IAS 19 pension fund adjustment of R114m (CHF13.5m) (2011: R102m (CHF14.3m)), being the employer contributions exceeding the current service cost, was credited to the consolidated income statement. If the IAS 19 non-cash flow pension fund credit is excluded, the Hirslanden group would have converted 88% EBITDA into cash from operations.

FIGURE 13: EMIRATES HEALTHCARE REVENUE (AED MILLION)

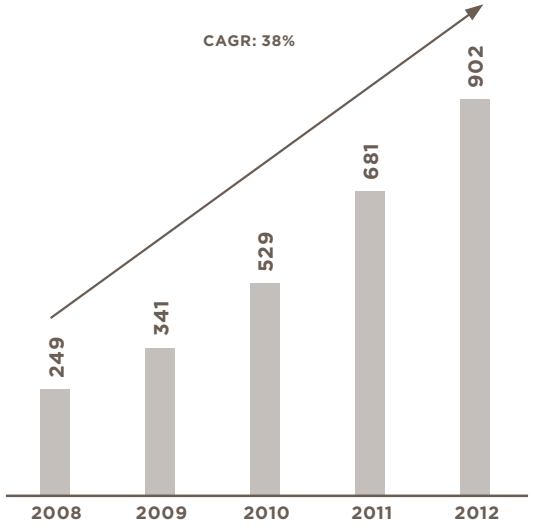
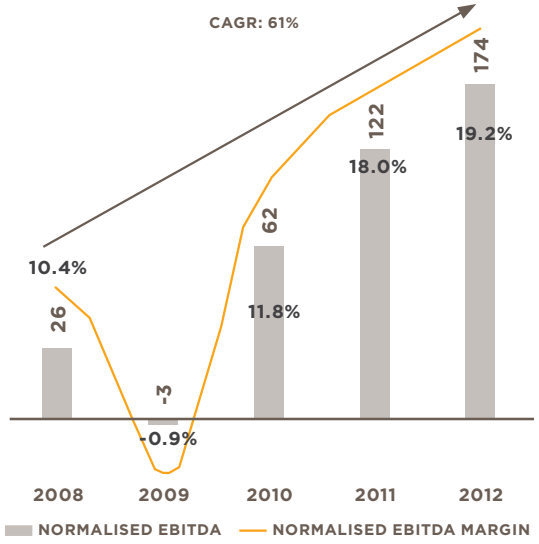


FIGURE 14: EMIRATES HEALTHCARE CORE EBITDA GROWTH AND MARGIN (AED MILLION)



Cash and cash equivalents decreased from R699m (CHF94m) at 31 March 2011 to R588m (CHF69m) at year end.

Interest-bearing borrowings increased from R18 083m (CHF2 437m) at 31 March 2011 to R20 723m (CHF2 438m) at year end, mainly because of the increase in the spot rate of the rand/CHF exchange rate.

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

OPERATIONS IN UNITED ARAB EMIRATES

EMIRATES HEALTHCARE

Emirates Healthcare's reported results for 2012 were affected by exchange rate movements. The average rand/AED exchange rate for the year fell from R1.96 in 2010 to R2.03 in 2012.

Revenue increased by 37% (32% at constant foreign exchange rates) to R1 831m (AED902m) (2011: R1 334m (AED681m)) for the year under review. Emirates Healthcare's historical revenue performance is set out in **Figure 13**.

Normalised EBITDA increased by 47% (43% at constant exchange rates) to R352m (AED174m) (2011: R240m (AED122m)) and the EBITDA margin increased from 18.0% to 19.2%.

After incurring depreciation charges of R98m (AED48m) (2011: R76m (AED38m)), net finance charges of R27m (AED14m) (2011: R38m (AED19m)) and the sharing of minority shareholders in the attributable income of Emirates Healthcare amounting to R113m (AED56m) (2011: R63m (AED32m)), Emirates Healthcare contributed R114m (AED56m) (2011: R63m (AED33m)) to the attributable income of the Group.

Emirates Healthcare converted 119% (2011: 100%) of EBITDA into cash generated from operations. Cash and cash equivalents increased from R114m (AED61m) at 31 March 2011 to R325m (AED155m) at year end.

Interest-bearing borrowings increased from R408m (AED221m) at 31 March 2011 to R440m (AED210m) at year end mainly as a result of the change in the closing rand/AED exchange rate.

Emirates Healthcare's historical EBITDA performance is set out in **Figure 14**.

GROUP DIVIDEND POLICY

Although the Group's ability to pay dividends is dictated by the Southern African operations' cash flow, the Group is targeting a dividend cover of three times, based on Group normalised headline earnings, which is in line with levels prior to the Hirslanden acquisition. This does not imply a reduction in dividend per share, only an indicative target which the Board will seek to achieve over time.

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, the Sustainable Development Report and notes 3.1 and 3.3 to the annual financial statements on pages 128 to 130.

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 International Financial Reporting Standards (IFRS) and are consistent with those applied in the prior year.

Craig Tingle
Chief Financial Officer

WE HAVE CONTINUED TO PERFORM WELL IN OUR SOUTHERN AFRICAN MARKETS

KOERT PRETORIUS
CHIEF EXECUTIVE OFFICER: MEDICLINIC SOUTHERN AFRICA

BUSINESS ENVIRONMENT

Notwithstanding the worldwide economic pressures on the group's South African business community, the country's healthcare sector continues to show gradual but positive long-term growth. The medical schemes market, which accounts for approximately 90% of the group's South African revenue, grew by 3.1% to 8 315 718 members in 2010. The quarterly report of the Council for Medical Schemes (CMS) for the period ending 30 September 2011 indicates that overall medical scheme membership has increased further and now stands at 8 469 784 members. Most of this growth can be attributed to the growth in membership of the Government Employees Medical Scheme (GEMS), where further membership growth is anticipated by the scheme's management.

The medical scheme industry is financially sound. As reported by the CMS annual report 2010 to 2011, total industry reserves increased by 10.8% from R29.4bn to R32.6bn over the course of the last financial year. It is important to note that the medical scheme industry is undergoing a period of strong consolidation. The number of schemes reduced from 144 in 2000 to 97 in September 2011. However, only 29 of these 97 schemes have a membership base in excess of 30 000 members. The two dominant medical schemes (Discovery Health and GEMS) account for over 40% of total medical scheme members.

In addition, the membership mix shows very interesting trends from a hospital perspective, as we see a growth in membership in the age bands of 45 to 49 and over 85, as well as a year-on-year increase in the absolute number of dependants who are registered for chronic medication benefits. This contributes to the sustained increase in the volume (3.3% during the period under review) of bed days sold by the group.

Within this context, the Department of Health has committed to achieving universal coverage through the proposed National Health Insurance scheme (NHI), as published in a Green Paper. Mediclinic has continued to engage with the government and various stakeholders on the most appropriate

mechanisms for achieving universal coverage and promoting access to affordable high-quality healthcare. The Minister of Health, however, has continued to implement some of the pillars that would be needed for the implementation of the NHI, such as introducing a bill to establish the Office of Health Standards Compliance to parliament, and announcing the first 10 NHI pilot sites for the Primary Healthcare project. The Minister of Health has recognised that there is a severe shortage of all professional categories of staff, a lack of sufficient management capacity in hospitals and a lack of capacity to train much-needed human resources.

Mediclinic is of the opinion that the NHI and indeed these initial activities to institute the NHI will not have any significant effect on the medical schemes market or the private sector industry in the foreseeable future. Reinstating good access to quality care in the public sector to achieve universal healthcare through the NHI requires addressing the major systemic issues in the public sector and a significant increase in human resources capacity. These can only be properly addressed over the longer term. The Minister of Health acknowledges

NUMBER OF EMPLOYEES
13 846

NUMBER OF HOSPITALS
52

NUMBER OF BEDS
7 378

NUMBER OF THEATRES
254

INCREASE IN INPATIENT ADMISSIONS
+2.4%

INCREASE IN AVERAGE INCOME PER BED DAY
+5.1%

INCREASE IN REVENUE
+9%

PATIENT SATISFACTION LEVEL
76%

these constraints and has identified them as critical challenges that have to be addressed as a priority in order for the NHI to achieve universal coverage. Initiatives which we can only encourage, such as reopening nursing colleges, increasing the capacity of medical schools and better management of hospitals, are planned by the Department of Health.

In addition, the Minister of Finance recently changed the tax subsidy system to a tax credit system, which will make private healthcare more affordable for the lower-income bracket members. This creates a more enabling environment for an increase in the number of medical scheme members going forward.

BUSINESS PERFORMANCE

Mediclinic Southern Africa achieved revenue growth of 9% in 2012. This was the result of:

- a 3.3% increase in bed days sold – the increase in utilisation was more evident in medical than surgical cases;
- a 5.1% increase in the average income per bed day; and
- a 0.6% increase in other revenue.

The number of patients admitted increased by 2.4%, while the average length of stay increased by 0.9%.

The EBITDA margin of Mediclinic Southern Africa decreased slightly to 20.8%.

During the period under review Mediclinic Southern Africa invested the following amounts:

- R293m (2011: R222m) in capital projects and new equipment to enhance its business;
- R230m (2011: R224m) to replace existing equipment;
- a further R78m was spent during 2011 on the fire damage at Mediclinic Constantiaberg; and
- R274m (2011: R236m) to repair and maintain property and equipment, which was charged through the income statement.

For the next financial year Mediclinic Southern Africa's budget is:

- R727m for capital projects and new equipment;
- R250m for replacing existing equipment; and
- R281m for repairs and maintenance.

The incremental EBITDA resulting from capital projects in progress or approved is budgeted at R64m and R65m for 2013 and 2014 respectively.

The number of licensed hospital beds increased from 7 103 to 7 378 during the period under review, while patient satisfaction levels improved from 75% to 76%, meeting the target.

BUILDING PROJECTS

During the period under review Mediclinic Southern Africa completed building projects at:

- Mediclinic Stellenbosch (10 additional beds);
- Mediclinic Paarl (2 additional beds and 1 theatre);
- Mediclinic Cape Town (new doctors consulting block);
- Mediclinic Kimberley (12 additional beds);
- Mediclinic Kloof (32 additional beds);
- Mediclinic Welkom (36 additional beds and upgrade);
- Mediclinic Potchefstroom (13 additional beds;
- Mediclinic Highveld (27 additional beds);
- Mediclinic George (7 additional beds);
- Mediclinic Bloemfontein (6 additional beds);
- Wits Donald Gordon Medical Centre (7 additional beds);
- Mediclinic Nelspruit (78 additional beds) (partially completed); and
- Mediclinic Limpopo (45 additional beds) (partially completed).

The following building projects are ongoing:

- Mediclinic Nelspruit (2 theatres and upgrade, due for completion in July 2012);
- Mediclinic Limpopo (15 additional beds and upgrade, due for completion in March 2013);
- Mediclinic Cottage (upgrade and 14 additional beds, due for completion in December 2012);
- Mediclinic Louis Leipoldt (major upgrade, due for completion during 2013);
- Mediclinic Hoogland (4 additional beds, new doctors consulting block and upgrade, due for completion in December 2012);
- Mediclinic Otjiwarongo (2 additional beds, due for completion in June 2012);
- Mediclinic Muelmed (30 additional beds, due for completion in May 2012);
- Mediclinic Pietermaritzburg (80 additional beds, new cardiac unit, two theatres and a cathlab and upgrade, due for completion in June 2013);
- Mediclinic Windhoek (27 beds, consulting rooms and parking, due for completion in February 2014);
- Mediclinic Stellenbosch (upgrade, due for completion in September 2013);
- Mediclinic Milnerton (10 additional beds, due for completion in November 2012);
- Mediclinic Legae (new emergency centre, due for completion in July 2012); and
- Wits Donald Gordon Medical Centre (upgrade, due for completion during 2013).

THERE ARE ATTRACTIVE GROWTH OPPORTUNITIES IN SOUTHERN AFRICA

The following projects will begin during the next financial year:

- New hospital in Centurion (174 beds);
- Mediclinic Howick (22 additional beds and upgrade);
- Mediclinic Kloof (additional consulting rooms);
- Mediclinic Marapong (relocating hospital);
- Mediclinic Newcastle (10 additional beds); and
- Mediclinic Victoria (14 additional beds and consulting rooms).

The number of licensed beds is expected to increase from 7 378 to 7 483 during the next financial year.

SUSTAINABILITY

PEOPLE

Recruiting and retaining high-quality medical professionals is fundamental to Mediclinic Southern Africa's sustainability. There is 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 in order to promote the training of skilled healthcare personnel and thus sustain quality outcomes in providing healthcare. The provisional registration of the institution has been converted to full registration; it is registered to present a Diploma in General Nursing Science and a Diploma in Operating Room Practice. Mediclinic Southern Africa also has provisional registration, until December 2015, to present Enrolled Nursing programmes.

A total of 641 learners completed undergraduate programmes and 83 learners completed postgraduate programmes during the 2011 academic year. A further 911 learners completed in-house structured Mediclinic programmes.

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

Following the results of the employee relationship assessment, a further study was conducted with members of management to address matters relating to engagement. Focused improvement actions are under way at operational level.

SOCIETY

The Mediclinic Corporate Social Investment Programme (CSI) 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 a need. During the past financial year our activities included the following:
  - Partnered with the Gauteng Department of Health, where 60 tonsillectomy operations were performed at Mediclinic Medforum in Pretoria. The patients were from Steve Biko Academic Hospital. This project was worth R360 000.
  - In the Western Cape Province we partnered with the Red Cross War Memorial Children's Hospital via The Children's Hospital Trust to the value of R135 000, where 56 children benefited. The project was aimed at reducing the waiting list for surgical procedures at the hospital.
  - Mediclinic Southern Africa also donated 28 cardiac ICU beds to Tygerberg Hospital to the value of R500 000.

- Tier 2
  This tier is focused 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 66 accredited community organisations with monetary support of R2.5m. In kind donations (of linen, beds and the like) were also made from hospital level to the value of R200 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 playing a positive role in making a difference in the lives of local communities.

ENVIRONMENT

Mediclinic Southern Africa is at the forefront of the Group's drive to minimise its environmental impact and is committed to ensuring 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-eight of Mediclinic Southern Africa's 52 hospitals are now ISO 14001-certified, an increase of four during the period under review. The aim is for a further one hospital to be certified in the coming year. The number of ISO 14001-trained hospitals, which includes the 38 certified hospitals, increased from 43 to 51. These hospitals follow the same environmental management practices and are also subject to annual internal audits. All 52 hospitals should be trained during the year ahead.

OUTLOOK

There are further 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, but this is a normal part of the healthcare operating environment and we monitor the regulatory position so that we can play an appropriate role in decision-making.

WE CONTINUE TO INCREASE OUR MARKET SHARE THROUGH ORGANIC GROWTH AND ACQUISITIONS

DR OLE WIESINGER
CHIEF EXECUTIVE OFFICER: MEDICLINIC SWITZERLAND

BUSINESS ENVIRONMENT

Hirslanden is the largest private hospital group in Switzerland and in recent years it has increased its market share through organic growth and acquisitions. Its primary competitor is the public hospital sector.

Although the Swiss economy grew at a slower rate than in the previous year (1.9% and 2.6% respectively), it still appears strong when compared with its European neighbours. Both the rate of inflation and the level of unemployment remain at low levels. Switzerland thus remains attractive to foreign workers and professionals. In 2011 the level of immigration rose by 15%.

As of 1 January 2012 the following major elements of the revised Swiss Health Insurance Act (KVG) were implemented: (i) the introduction of fixed fees for inpatient services based on the new Swiss Diagnosis Related Grouping (DRG); (ii) a new hospital financing system which redefines the funding ratios of the cantons versus the health insurance companies; and (iii) the revision of the hospital planning that led to new hospital lists, defining those hospitals that are eligible to treat generally insured patients.

The introduction of this new planning and financing system was certainly the major challenge in this financial year and probably one of the biggest in Hirslanden's history. From a strategic point of view, this change was critical to the company as it also meant significant operational changes. These changes go along with increased regulatory constraints that will affect future business development to a certain extent.

Hirslanden's strategy is to obtain listing status for all its hospitals in Switzerland, since management believes that this can ensure the required number of patients in the long term. The general outcome looks promising, but there are still a number of areas of concern. All the hospitals, with the exception of Klinik Im Park in Zurich (subject to a legal appeal) and the Lausanne hospitals (only limited service mandates with fixed number of generally insured cases), are on the hospital lists.

In some hospitals there are certain exceptions regarding the service mandates (e.g. limitation on highly specialised treatments) that are currently being debated and also legally challenged.

With the introduction of DRGs new insurance contracts had to be negotiated, the whole invoicing process remodelled, and new documentation and coding processes installed. Ongoing discussions with insurance companies and cantons had to be undertaken and, based on these, short notice system adjustments made. Hirslanden hospitals were the first in Switzerland to invoice under the Swiss DRGs. Nevertheless, there was still an invoicing backlog as at financial year end. On the revenue side the change meant that the revenue allocation and in-house calculation had to be adjusted and, for example, new revenue splits between the hospital and the doctors were implemented. In addition, the hospitals had to fulfil the requirements of the cantons as an important new debtor in the financing system.

The current price level (base rate in the DRG system) is as expected in most cantons, but these prices are provisional and can therefore be subject

NUMBER OF EMPLOYEES
6 321

NUMBER OF HOSPITALS
14

NUMBER OF BEDS
1 479

NUMBER OF THEATRES
76

INCREASE IN INPATIENT ADMISSIONS

+4%

INCREASE IN AVERAGE INCOME PER BED DAY

+2%

INCREASE IN REVENUE

+4%

PATIENT SATISFACTION LEVEL

91%

to review. Taking into account all these significant and complex changes in the last couple of months, the current situation is in line with expectations, except for Berne as described herein.

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 on the business;
- highly specialised medicine (HSM) developments can have an impact on the future patient profile of some hospitals; and
- cantons subsidising public hospitals.

In 2008 the cantons approved an agreement that aims to coordinate highly specialised medicine (HSM) throughout Switzerland. The process of allocating medical services has been biased, however, with no private hospital representation on the advisory body or in the decision-making

body. As a consequence, public hospitals agreed on the structure of HSM and where it should be based. Thus there is a real danger that the health directors, who are also the operators of hospitals in many cantons, can expand certain medical services to the point of being monopolistic. This is demonstrated by the decision on specialised interventional neurology, where Hirslanden was overlooked despite its having the concentration of specialists in the country. Hirslanden expects the decisions on HSM to be made exclusively according to the criteria of quality, economics and number of cases, and not according to politically motivated considerations.

BUSINESS PERFORMANCE

Hirslanden achieved revenue growth of 4% during the period under review. This was the result of:

- a 4% increase in inpatient admissions;
- a slight decrease in the average length of stay; and
- a 2% increase in the average income per bed day.

Hirslanden's EBITDA margin declined to 21.9% (2011: 23.4%). The margin decline is mainly attributable to a general under-performance in the Western Region. In two hospitals, Klinik Beau-Site and Clinique Bois-Cerf, costs related to expansion projects led to a margin decrease. The revised labour law meant an increase in personnel expenses as a consequence of the requirement for higher staff numbers at all hospitals. Furthermore, additional experts in medical coding and controlling had to be hired as a result of the introduction of the Swiss DRG.

In the year under review the Eastern Region showed a strong performance well ahead of the previous year and in line with expectations. The recently acquired Klinik Stephanshorn integrated well into the Group and its financial results were exceptionally strong. On the other hand, the Western Region struggled and financial results ended below previous years' numbers in the Berne and the Lausanne hospitals.

The main deviations, however, stem from the Berne hospitals where several factors influenced the disappointing financial outcome. The hospitals experienced a steady decline in the revenues per case, attributed to tariff system changes, insurance mix deterioration and shorter hospital stays. The change from a fee-for-service-based approach to a flat-rate-per-case system, the All Patient DRG (APDRG), for all generally insured patients was introduced in 2010. This new system also led to process changes such as more focus on the length of stay of generally insured patients. With the adoption of the Swiss DRG in 2012 yet another new tariff regime had to be implemented in Berne which, again, was significantly different from the APDRG system. All these tariff regime and resulting process changes (service capturing, coding, invoicing, attention to length of stay, etc.) had a challenging impact on the hospitals' performance. In addition, the hospital planning process has been problematic and the corresponding uncertainties led to problems in terms of patient referrals as well as new doctor recruitment. The very competitive market environment in Berne furthermore contributes to general retention and recruitment difficulties.

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

- R456m (CHF54m) (2011: R312m (CHF44m)) on capital projects and new equipment to enhance its business;
- R413m (CHF49m) (2011: R323m (CHF45m)) on replacing existing equipment; and
- R292m (CHF35m) (2011: R232m (CHF33m)) on repairing and maintaining property and equipment, which was charged through the income statement.

For the year ahead, CHF73m is budgeted for capital projects and new equipment, CHF52m for the replacement of 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 CHF12m in 2013 and 2014 respectively.

PUBLIC PRIVATE PARTNERSHIP PROJECTS ARE IMPLICIT IN HIRSLANDEN'S STRATEGY

The number of fully operational inpatient beds increased from 1 457 to 1 479 during the period under review. The increase is a result of 19 additional beds in the recently opened physician and bed wing at Klinik Beau-Site and another three beds from a room restructuring at Klinik St. Anna.

NEW MANAGEMENT STRUCTURE

As of December 2011 the Group has been organised into two regions (Eastern and Western Region). With 14 hospitals located in 10 cantons, the Group has reached critical mass; it therefore makes sense to employ two full-time chief operating officers to address the strategic demands. Both regions encompass seven hospitals on joint locations now working more closely together.

BUILDING PROJECTS

Building projects completed during the period under review were:

- Klinik St. Anna opened a medical facility at the city's main train station on 1 April 2011. Besides treating users and employees of the rail system, the centre offers a wide range of health services.
- A trauma centre was opened at Hirslanden Klinik Aarau on 1 July 2011 to cope with the increasing number of patients presenting with accident-related injuries.
- Upgrades at Klinik Beau-Site in Berne included the construction of a doctors' centre with 19 additional inpatient beds (European autumn 2011), the expansion of the critical care unit from eight to 12 beds (December 2011) and a general refurbishment of the hospital, due for completion in the European autumn 2012.

The major ongoing expansion projects are:

- The construction of the new wing (Enzenbühl Trakt) at Klinik Hirslanden in Zurich is running according to schedule. The underground car park opened in September 2011, and the framework of the building was completed in December 2011. It is expected that the commissioning of the new wing (with an additional 72 inpatient beds and eight ICU beds) will take place in 2013 during the European Spring.
- Work on a health centre at Klinik Stephanshorn in St. Gallen will commence in March 2012 and its opening is planned for September 2012.

TECHNOLOGICAL INVESTMENT

Clinique Bois-Cerf in Lausanne commissioned its new Institute for Radiology on 17 January 2012. The expanded range of medical treatment will strengthen the hospital's orthopaedic and sports medicine offering. The new Centre for Radiotherapy is due to be opened at the same location at the end of 2012.

In March 2012 Clinique Cecil in Lausanne installed a state-of-the-art computer tomography. It offers a substantially lower level of radiation and an expanded range of screenings, including those for cardiac disease.

SUSTAINABILITY

QUALITY

Hirslanden continued developing its quality management during 2011. The significance of the Swiss Association of Quality Assurance (ANQ) in hospitals and care installations grew at national level. All Hirslanden hospitals participate in the ANQ measuring programme. In addition, Hirslanden also published its first public quality report. Very few private hospitals publish such data at this level of transparency. There were significant improvements, particularly in device-associated infections in the hospitals' critical care units.

PEOPLE

Hirslanden is working towards promoting synergies between hospitals at national level. The HR and finance departments at Klinik Hirslanden, Klinik Im Park and Head Office were amalgamated, which will enhance the HR disciplines such as recruitment, administration and payroll/financing. The aim is to position Hirslanden as the employer of choice, and improve personnel and management development.

Hirslanden continues to make considerable investments in training. During the year under

review, 703 learners and students were upskilled at 27 educational institutions; 599 of these were in medical disciplines. In addition, there are numerous trainee positions.

ENVIRONMENT

Hirslanden's greatest contributor to the carbon footprint is on energy consumption; therefore lowering emissions and following energy-efficient building standards, such as MINERGIE, are a priority, where economically justifiable. Klinik Hirslanden's Enzenbühl Trakt is being built to these standards.

The Swiss Energy Agency of the Economy (EnAW), on behalf of the Swiss Federal Office of Energy (BFE), awarded Klinik Hirslanden and Klinik Im Park the "CO_2 reduced" title. This recognises their contracted commitment to reduce CO_2 emissions within their operations.

The engineering services team (TES) of each hospital is responsible for managing environmental impact. They plan and execute building projects and control the outcome. Many of the building projects include energy- and resource-efficiency aspects. The heads of the engineering teams meet on a regular basis. They exchange knowledge on projects; e.g. the Ecojet project was launched as a pilot at Hirslanden Klinik Aarau in 2010 and was expanded at Klinik Am Rosenberg in Heiden in 2011. The overall activities of the TES are guided by the head of investment, real estate and movables (Head Office).

A new position will be created in the investment, real estate and movables team in 2012 to manage energy projects, coordinate the TES and introduce a reporting process.

OUTLOOK

Public private partnership projects are implicit in Hirslanden's strategy. In actively seeking such opportunities, which are mutually beneficial to both parties, Hirslanden laid the foundations for such a partnership with a regional hospital on Lake Zurich in March 2012. The two parties are planning a radiotherapy centre at the public hospital in Männedorf. The centre is due to be opened at the start of 2014. This will create a comprehensive interdisciplinary range of medical treatments, including radiation treatment, which will include a linear accelerator that will allow tumours to be treated during outpatient treatment sessions.

In order to address the demanding situation in Berne, two task forces were initiated: one focusing on the strategic and positioning level led by the CEO, and the other addressing the administrative view led by the CFO. Several measures have already been defined by both work streams and initial results are expected within the next three to six months. However, the repositioning and strengthening of the hospitals can only be achieved within the next 12 months. The ongoing uncertainty regarding hospital planning is potentially hindering an immediate reaction and might lead to further re-balancing measures, depending on the outcome.

Hirslanden sees significant growth potential in its existing hospitals and is following a consistent and sustainable strategy, investing an average of 10% of its revenue in maintenance, replacement, extension projects and acquisitions:

- Klinik St. Anna is expected to finalise its new Wing A between 2013 and 2016, with capacity for operation theatres, a recovery room, a critical care station, high care, emergency, radiology, a day clinic, central sterilisation unit, cardiac catheterisation laboratory and a hospital unit.
- The Institute for Radiology and Nuclear Medicine at Klinik Hirslanden will, as from May 2012, offer PET/CT (position emission tomography/computer tomography) along with the existing SPECT (single photon emission computed tomography) test.
- Klinik Beau-Site is planning a centrally located health centre inside Berne's main railway station. The centre will boast a comprehensive medical and physiotherapeutic range of services. This type of health centre with horizontal and vertical integration of outpatient healthcare services is an innovation in the canton of Berne. The centre's doors are expected to open on 1 March 2013.

EMIRATES HEALTHCARE HAS ESTABLISHED ITSELF AS ONE OF THE MOST TRUSTED PROVIDERS OF HEALTHCARE IN DUBAI

DAVID HADLEY
CHIEF EXECUTIVE OFFICER: EMIRATES HEALTHCARE

BUSINESS ENVIRONMENT

The UAE is showing signs that it has recovered from the economic turmoil which began in 2008. Real Gross Domestic Product is estimated to have risen by 3.3% in 2011 (UAE Economy Minister), more than double the pace of 2010, a direct result of higher oil prices, increased oil production and the effects of the Arab Spring. Abu Dhabi accounted for 60% of the GDP and Dubai 29%. Although the Arab Spring has brought conflict to large swathes of the region, speculation that the unrest might move into the UAE has proved unfounded and the UAE remains a stable and peaceful business environment. In fact, the country is viewed as a 'safe haven' by tourists and investors, and it has benefited from an influx of individuals from around the region who are now choosing to spend holidays, make investments or even set up home in the UAE rather than in more volatile countries such as Egypt or Morocco. This obviously has significant implications for the healthcare sector in the UAE and has contributed to some of the outstanding results Emirates Healthcare has seen this year.

Of course, the Iran crisis remains a threat and Emirates Healthcare is monitoring the situation closely. However, we agree with the general consensus in the UAE that a major war is unlikely. The hope is that the crisis should be resolved by economic sanctions and political pressure on an Iranian government which does not appear to have the support of its people.

The UAE continues to have the second highest rate of diabetes in the world, with estimates suggesting that between 19% and 25% of the adult population suffer from the disease, compared to a global average of just 6%. Diseases caused by a sedentary and unhealthy lifestyle such as diabetes, heart disease and cancer remain significant threats to which the local healthcare sector must respond. Maternity and paediatric services also account for a larger proportion of the healthcare market than in other parts of the world because of the comparatively young population in the UAE. Likewise, geriatric care makes up a much smaller segment of the market.

Emirates Healthcare has established itself as one of the most trusted providers of healthcare in Dubai. During the period under review it introduced new services such as CVac therapy for ovarian cancer and therapeutic apheresis, set up orthotics and prosthetics services and, excitingly, introduced nuclear medicine and neuroscience programmes: in some cases these are not just new to Dubai but to the UAE as a whole or even the entire Middle East. This means that patients who would normally have travelled abroad for treatment now feel confident that they will receive the same, if not better, treatment at an Emirates Healthcare facility in Dubai.

Overall, the UAE's healthcare infrastructure is still insufficient to cope with the demands of an ever-increasing population and Emirates Healthcare has identified areas for expansion.

NUMBER OF EMPLOYEES
1 814

NUMBER OF HOSPITALS
2

NUMBER OF BEDS
334

NUMBER OF THEATRES
10

NUMBER OF CLINICS
8

INCREASE IN INPATIENT ADMISSIONS
+22.7%

INCREASE IN CLINIC OUTPATIENT CONSULTATIONS
+65.4%

INCREASE IN REVENUE
+32%

PATIENT SATISFACTION LEVEL
89%

BUSINESS PERFORMANCE

Emirates Healthcare achieved revenue growth of 32% during the period under review. If the three additional Emaar clinics acquired towards the end of the previous financial year are excluded from the figures, the revenue grew at 22.9%. This was the result of:

- a 22.7% increase in inpatient admissions, in addition to a 23% increase last year;
- a 13.4% increase in hospital outpatient and accident and emergency admissions, compared to a 10% increase last year; and
- a 65.4% increase in clinic outpatient consultations (a result of the acquisition of the Emaar clinics).

The group's EBITDA increased by 40.4%, a direct result of revenue growth across the Group. It is important to note that the acquisition of the Emaar clinics, particularly Arabian Ranches Clinic, had a negative impact on our EBITDA for the year. If the

three Emaar clinics are excluded, EBITDA would have grown by 41% and our EBITDA margin would have been 21%. These clinics started to perform in the second half of the financial year, once the facilities were adequately staffed, and it is expected that their contribution in the next financial year will be more positive. The straight lining of the rent also had a material (2 – 3%) impact on this year's EBITDA as a result of the fact that four of Emirates Healthcare's clinics have relatively new lease agreements.

Other achievements during the period under review include the establishment of a Funder Relations department, the development of an additional Outpatient Department at The City Hospital, the launch of centres of competence such as a breast medicine unit and the successful implementation of a social media strategy.

During the reporting period Emirates Healthcare invested R26m (AED13m) (2011: R26m (AED13m)) on capital projects and new equipment to enhance its business as well as R25m (AED12m) (2011: R20m (AED10m)) on the replacement of existing equipment. In addition, R35m (AED17m) (2011: R31m (AED16m)) was spent on the repair and maintenance of property and equipment, charged through the income statement. For the current financial year, AED14m is budgeted for capital projects and new equipment to enhance its business, AED33m for the replacement of existing equipment and AED18m for repairs and maintenance.

The number of licensed hospital beds remained constant at 334 during the period. The City Hospital has the capacity to add another 40 beds (including 10 beds used for dialysis) under its existing licence and this is anticipated to occur in September 2012.

Patient satisfaction remained at 89% against a target of 90% during the period under review.

BUILDING PROJECTS

During the period under review Welcare Hospital upgraded its radiology facility, accident and emergency department, first-floor corridors and landscaping. The City Hospital closed the swimming pool, completed a new seminar room on the 9th floor, constructed a second-floor outpatient department to expand the services to 25 more consultation rooms, six treatment rooms and six discipline-specific treatment rooms for urology, ophthalmology, breast imaging, neurosciences and general surgery, created a new Medical Records department, which has been completed to cope with the growth of The City Hospital, as well as new prayer rooms and ablution facilities.

The next financial year will see the relocation of the Emirates Diagnostic Clinic to new premises, the relocation of the group's corporate staff to new offices to free up space for the implementation of a new centralised laboratory at EHL Dubai Mall Medical Centre, the expansion of the Neonatal ICU and the introduction of the UAE's first maternity high-dependency unit at The City Hospital and the building of a new structure at The City Hospital to accommodate the expansion of the accident and emergency department as well as the operating theatres.

SUSTAINABILITY

PATIENT TRUST

Winning patient trust is paramount to the success of Emirates Healthcare's business and the marked increase in inpatient/outpatient admissions and consultations is a clear indication that Emirates Healthcare is achieving this. The company 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, the positioning of Emirates Healthcare doctors as

EMIRATES HEALTHCARE IS COMMITTED TO WORKING WITH THE COMMUNITY IN WHICH IT OPERATES

figures of authority through media appearances and, most importantly in this financial year, social media. Social media was identified as a key opportunity for communication with the patient audience; a social media strategy was developed, a social media agency retained, a digital media team appointed and Facebook pages launched for each individual facility. To date, engagement on the Facebook pages has risen almost 200% for the hospitals and there is a high level of positive interaction between the facilities and participants on the pages.

PEOPLE

Emirates Healthcare has undergone rapid expansion in terms of employee numbers, with a 7% 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 newly introduced life insurance and permanent disability benefit, comprehensive training, open communication, sound management practices and staff recognition in the form of social events.

Emirates Healthcare organises Continued Medical Education (CME) sessions both at an individual facility level and a corporate level for Emirates Healthcare and community-based doctors. It also held two nursing conferences, each attended by approximately 250 nurses from the group and beyond.

In the next financial year Emirates Healthcare will be introducing a succession management programme with particular focus on specific managerial positions.

COMMUNITY

Emirates Healthcare 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 where it is able. Corporate social investment initiatives run by the company have included free health screenings, health talks, awareness campaigns on particular health topics and blood donation campaigns.

Emirates Healthcare 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 EHL 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 and as First Aid provider at events such as the Dubai Terry Fox Run (6 000 participants), South African Weekend (2 000 attendees), Dubai Cycling Challenge (2 000 participants) and the 5 km Women's Run (2 000 participants).

Emirates Healthcare has budgeted AED500 000 for community initiatives in the year ahead, compared to the AED400 000 spent during the period under review.

ENVIRONMENT

Emirates Healthcare 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 City Hospital has restarted its 'Go Green' committee after several months of inactivity; it is responsible for spreading the message of environmental awareness to all staff. The group has installed movement sensors and electronic lights in its outpatient consulting rooms and all bathrooms, and doubled the amount of recycled waste.

Welcare Hospital has also introduced measures to control the consumption of water in areas such as the toilets and kitchens, proper servicing of air-conditioning systems and eliminating unnecessary usage of air-conditioning.

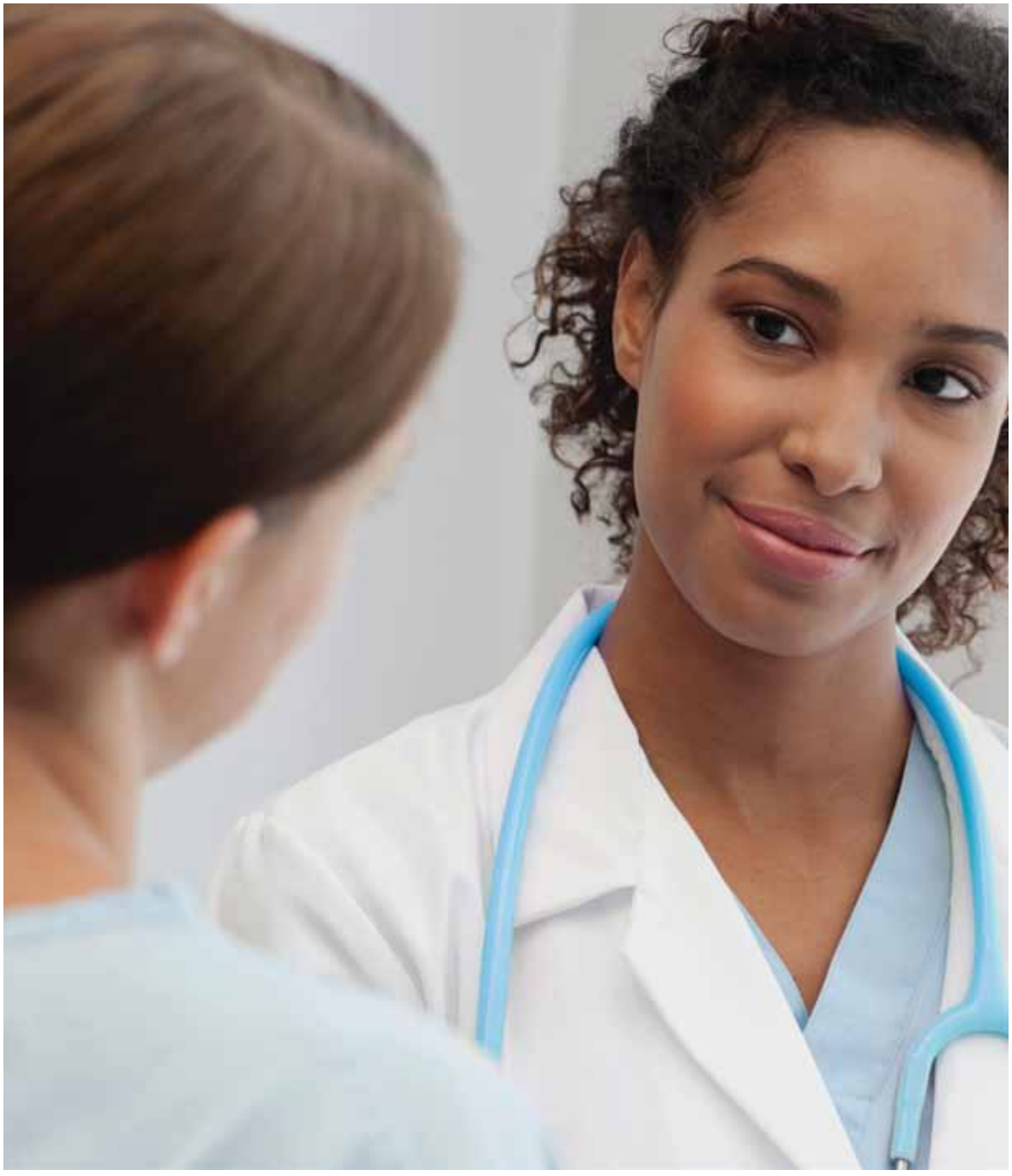
Overall energy usage increased slightly as a result of increased patient volumes, but water usage declined despite the uplift in patient numbers.

OUTLOOK

Emirates Healthcare remains positive about the outlook for the year ahead, despite the challenges it will face from increased competition and tariff reform. The current economic climate in the UAE, combined with the strong reputation for quality healthcare that the group's hospitals and clinics have built up, a focus on engaging with community doctors to increase referrals and the expansion of social media activity into new channels should all assist the business to grow at a significant rate. The group is actively seeking new opportunities for the expansion of its facilities.

In terms of the healthcare sector as a whole, Emirates Healthcare is proud to be working with the Dubai health authorities on a number of initiatives such as setting standards for electronic claims communication, coding and billing. These should all help to ensure that, going forward, the healthcare sector in Dubai becomes more transparent, ethical and in line with international best practice – something which is long overdue.

LEADERSHIP IS INDISPENSABLE IN THE PROMOTION OF QUALITY AND SAFETY OF PATIENT CARE



INTRODUCTION

Mediclinic strives to provide internationally comparable quality care in a safe environment at all times. Quality of care and patient safety are therefore key focus areas throughout the Group.

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 information management. Mediclinic Southern Africa, Hirslanden and Emirates Healthcare are following a unified approach to clinical governance. Certain important principles are adhered to, 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.

ACHIEVEMENTS

- Antibiotic stewardship programme established at Mediclinic Southern Africa
- Clinical services committee established at Emirates Healthcare to formulate clinical strategy and define scope of future services
- Development of an internal model for accrediting Hirslanden competence centres at different levels
- Improved software supported patient feedback process implemented at Hirslanden
- Significant improvement in clinical coding at Hirslanden by establishing a regional coding centre

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 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 multi-disciplinary 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. Each hospital has a multi-disciplinary clinical hospital committee that drives quality and safety at hospital level and promotes cooperation between doctors, nursing staff and management. Each hospital also has an infection control specialist supported by an infection control sub-committee.

HIRSLANDEN

Every Hirslanden hospital has a quality manager, an infection control specialist, a critical incident manager as well as several sub-committees 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.

EMIRATES HEALTHCARE

Both Emirates Healthcare hospitals have a full-time medical director coordinating the activities of all the doctors in the facility, as well as an active

WE HAVE A WELL-TRAINED, SKILLED AND EXPERIENCED HEALTHCARE WORKFORCE

and functioning clinical hospital committee. These committees are multi-disciplinary, and there is excellent cooperation between doctors, nurses and management. Each committee has six sub-committees covering infection control, clinical risk management, credentialling, research, patient safety and pharmaceutical use.

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 all practising doctors must be in possession of full registration in their specific fields of speciality with the Health Professions Council of South Africa. 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 training in nursing to continuous professional development of healthcare professionals by providing training courses in basic life support (BLS) and advanced life support (ALS), sponsoring international conference attendance as well as hosting training workshops.

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 assessments take place, and employees are managed in terms of objectives. Healthcare education is highly regulated in Switzerland, and Hirslanden participates by offering more than 200 healthcare apprenticeships and more than 145 positions for further training. The continuous training of nurses is coordinated by training managers in every hospital, and resuscitation (BLS, ALS) training takes place on an ongoing basis.

EMIRATES HEALTHCARE

Emirates Healthcare 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 the 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, Emirates Healthcare 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 sub-committees.

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 Emirates Healthcare group. These courses include training in BLS and ALS.

A formal relationship between Welcare Hospital and the Ian Donald School of Ultrasound at the University of Dubrovnik, Croatia, has been established. Welcare Hospital is now officially recognised and accredited by the University

as a centre for postgraduate training, and qualifications are also recognised in full throughout the European Union.

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 32 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. Thirteen hospitals are currently certified and Klinik Stephanshorn will follow during 2012.

EMIRATES HEALTHCARE

Joint Commission International (JCI) accreditation is a requirement of the Dubai Healthcare City as well as the DHA, and both Emirates Healthcare hospitals were successfully accredited during 2010. In addition to JCI accreditation, the laboratory of The City Hospital also achieved the very prestigious College of American Pathologists accreditation at the end of 2009 and successfully re-accredited in 2011 and also obtained ISO 15189:2009 certification in 2010.

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 exposed to error. Hospitals face many clinical risks, the most prominent of which are healthcare-associated infections (HAIs) and hospital adverse events. These and other clinical risks are managed through different control measures and continuous process re-engineering.

HAIs, previously known as hospital-acquired infections, 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 antibiotic resistance. All operating platforms are therefore strongly focused on infection 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

TABLE 1: HAI RATE PER 1 000 PATIENT DAYS (CALENDAR YEAR)

	2009	2010	2011
HAI rate	3.4	4.7	**4.3**

TABLE 2: DEVICE-ASSOCIATED AND SURGICAL SITE INFECTIONS PER 1 000 DEVICE DAYS (CALENDAR YEAR)

	2011
Catheter-associated urinary tract infections	**5.1**
Central line-associated infections	**4.0**
Ventilator-associated pneumonia	**13.8**
Surgical site infections (per 1 000 theatre cases)	**3.7**

hospital event management systems in which all events are reported and analysed, and corrective action taken to prevent recurrence.

It is important to note that all indicators are reported per calendar year. Figures may therefore not be directly comparable with those of past reports. This was done to ensure completeness and consistency, as a significant time lag needs to be provided for in the collecting of clinical data.

MEDICLINIC SOUTHERN AFRICA

HEALTHCARE-ASSOCIATED INFECTIONS

Mediclinic Southern Africa operates a robust and comprehensive infection surveillance programme using the US Centre for Disease Control as a reference point. This is supported by a national electronic database of all HAIs into which laboratory results are electronically imported. The system monitors organism-resistant patterns and infection outbreaks, sends out alerts and generates reports three times a day. The services of independent microbiologists and infection control specialists are regularly utilised in order to ensure continuous improvements in the infection prevention and control programme. **Table 1** reports HAIs per 1 000 patient days, in line with international reporting trends. There was a slight decrease in the HAI rate during the 2011 calendar year.

Mediclinic Southern Africa participates in the "Best Care...Always!" campaign, which was launched in South Africa in August 2009 as a national collaboration between the major private hospital groups. Mediclinic Southern Africa, as one of the founding campaign hospital groups, has committed all of its 52 hospitals to the campaign's initiatives. The campaign entails the implementation of evidence-based interventions shown to reduce device-associated and surgical site infections, to promote the rational use of antimicrobials and

TABLE 3: AGGREGATED DATA FOR MEASURES OF ANTIMICROBIAL USAGE PER 1 000 BED DAYS

Period	2010	2011
Days multi-cover (≥ 4 antimicrobials)	0.6	**0.7**
Prolonged treatment per 1 000 exposures	8.7	**9.6**

TABLE 4: ADVERSE EVENTS PER 1 000 PATIENT DAYS (CALENDAR YEAR

	2010	2011
Medication errors	0.8	**0.9**
Falls	1.3	**1.4**
Hospital skin-related events	0.2	**0.2**
Other clinical	11.5	**11.9**

to measure results. **Table 2** reports the "Best Care... Always!" indicators for the first calendar year after the launch of the initiative. Although there are still some reporting issues, these figures give a baseline indication of activities. No internal or external benchmarks are available yet.

The promotion of the rational use of antimicrobials through a comprehensive antimicrobial stewardship programme is gaining momentum. A central antimicrobial committee works closely with microbiologists in coordinating the programme. A unique methodology to measure and report antimicrobial utilisation at hospital level was developed and these reports empower clinical hospital committees to purposefully manage antimicrobial utilisation.

Table 3 reports the most prominent antimicrobial utilisation indicators for the 2011 calendar year. No internal or external benchmarks are available yet.

ADVERSE EVENTS

The adverse events in **Table 4** are now reported per 1 000 patient days to be more in line with international reporting trends.

Medication errors occur at various points in the medication pathway, such as incorrect ordering by clinicians and during the administration of medication; they showed a slight increase during the 2011 calendar year.

Falls and injuries sustained by patients while in hospital remain an enormous challenge, and there was a slight increase in the rate of falls during the 2011 calendar year. Hospitals rely on the events management system to systematically record and analyse falls in order to implement preventative measures. During the 2011 calendar year 67%

TABLE 5: DEVICE-ASSOCIATED INFECTIONS IN CRITICAL CARE UNITS PER 1 000 DEVICE DAYS (CALENDAR YEAR)

	Catheter-associated urinary tract infections		Central line-associated infections		Ventilator-associated pneumonia	
	2010	2011	2010	2011	2010	2011
Hirslanden	2.37	**1.26**	2.12	**1.00**	6.19	**5.33**
European 75th percentile (surgical CCUs)	2.94	**2.94**	2.26	**2.26**	12.62	**12.62**
European 75th percentile (interdisciplinary CCUs)	1.25	**1.23**	1.32	**1.32**	10.88	**10.88**
European average (surgical CCUs)	2.52	**2.52**	1.56	**1.56**	8.92	**8.92**
European average (interdisciplinary CCUs)	1.05	**1.05**	1.01	**1.01**	6.46	**6.46**

* *European benchmarks have been recalculated and therefore differ from those of the previous report.*

TABLE 6: POST-OPERATIVE WOUND INFECTIONS AS A PERCENTAGE OF THESE TYPES OF ADMISSIONS (CALENDAR YEAR)

	Coronary artery bypass graft	Hip replace-ment	Knee replace-ment	Abdominal hyste-rectomy	Caesarean section	Colon-surgery
Number of hospitals participating	4	11	11	2	3	2
Hirslanden	1.74	0.67	0.49	0.86	0.00	2.43
European 75th percentile	4.01	1.32	1.00	1.87	0.99	12.56
European average	3.32	0.81	0.75	1.42	0.74	9.55

of all reported falls occurred in patients' rooms. Approximately 32% of all reported falls resulted in injuries. Most falls occurred among stroke, knee replacement and heart failure patients as well as among patients older than 80 years of age.

Pressure ulcers remained unchanged for the 2011 calendar year. These events can occur quite frequently in the treatment of seriously ill patients in the acute care setting and can lead to substantial morbidity. Diligent prevention is therefore essential, as the treatment of skin lesions can be very challenging. Each patient's risk of developing a skin lesion on admission is assessed. Seriously ill patients are reassessed regularly while in hospital, and all skin lesions are reported and analysed on the hospital event management system.

CLINICAL AUDITS

Regular clinical audits form part of Mediclinic Southern Africa's continuous quality improvement programme; they are performed by the regional clinical teams during regular visits to each hospital. The findings of these audits are used to enhance a proactive response 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. Some Hirslanden hospitals have been using the standardised Hospital Infection Surveillance System (HISS) of BZH to record HAIs since 2000. This system is based on the criteria of the US Centres for Disease Control and Prevention. Since 2008 all hospitals have been using the HISS to record HAIs. Each hospital has an infection control committee that oversees infection prevention and control. Hospitals are also represented at 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 are participating. The first results are expected in 2013.

Table 5 shows the device-associated infection rates in Hirslanden critical care units (CCUs). As most patients treated in CCUs at Hirslanden hospitals are surgical in nature, the more appropriate Surgical CCUs benchmark was added to the table for comparative purposes. Annual rates of all three compare favourably with the European benchmarks (75% percentile). Infection prevention and control became a key performance indicator during the 2011 calendar year, and hospitals focused strongly on this aspect of their operations.

Table 6 reports 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

TABLE 7: IQIP WEIGHTED AVERAGE FALL RATE PER 1 000 BED DAYS (CALENDAR YEAR)

	2007	2008	2009	2010	2011
Hirslanden	1.60	1.90	2.20	2.40	**2.11**
Europe	2.01	2.25	2.83	3.70	**3.68**

TABLE 8: IQIP WEIGHTED AVERAGE SKIN-RELATED EVENTS PER 1 000 BED DAYS (CALENDAR YEAR)

	2007	2008	2009	2010	2011
Hirslanden	0.48	0.31	0.54	0.57	**0.30**
Europe	1.18	1.22	1.02	1.18	**0.44**

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. During 2011 MRSA infections were detected in 144 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. Previously every hospital used its own unique reporting system, but a standardised reporting system was introduced in 2008. During 2011 a total of 1 222 cases were reported.

Hirslanden also participates in the International Quality Indicator Project® (IQIP) indicator for documented falls. Its weighted average figures for the 2011 calendar year are reported in **Table 7**. The table shows that Hirslanden compares favourably with other participating European hospitals.

Pressure ulcers in acute care are another IQIP indicator that Hirslanden participates in. Its weighted average figures for the 2011 calendar year are reported in **Table 8**. This once again compares favourably with other participating European hospitals.

CLINICAL AUDITS

To check the accuracy of the data, collection audits were performed at every hospital in 2011.

TABLE 9: HAI RATE PER 1 000 PATIENT DAYS (CALENDAR YEAR

	2010	2011
HAI rate	1.1	**0.8**

TABLE 10: ADVERSE EVENTS RATE PER 1 000 PATIENT DAYS (CALENDAR YEAR)

	2010	2011
Medication errors	1.7	**1.3**
Falls	0.4	**0.8**
Hospital skin-related events	0.2	**0.5**
Other clinical	6.8	**6.2**

EMIRATES HEALTHCARE

HEALTHCARE-ASSOCIATED INFECTIONS

The Emirates Healthcare infection prevention and control programme is comprehensive and consists of hospital-based infection control specialists, multi-disciplinary infection control committees and a detailed reporting system. Apart from monitoring general infection rates, the hospitals rigorously track surgical site infections, ventilator-associated infections, catheter-related infections, MRSA and other resistant organisms. Nursing staff play a key role in this regard to ensure compliance with international standards. **Table 9** refers.

ADVERSE EVENTS

The reporting definitions have changed to report adverse events as a rate per 1 000 patient days. **Table 10** reports on the most prominent adverse events.

CLINICAL AUDITS

Emirates Healthcare makes extensive use of audits to promote patients' safety and quality of care. Medical record, anaesthetic, epidural, prescription and surgical audits are performed frequently.

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 INFORMATION

Clinical indicators and outcome measures are the "vital signs" of clinical care and give 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.

TABLE 11: MORTALITY AS A PERCENTAGE OF HOSPITAL ADMISSIONS (CALENDAR YEAR)

	2007	2008	2009	2010	2011
Actual	1.15%	1.16%	1.20%	1.23%	**1.25%**
Expected	1.15%	1.19%	1.22%	1.24%	**1.30%**
Index	1.00	0.97	0.98	0.99	**0.96**

With internal developments it is usually the availability of accurate and reliable clinical information that dictates which indicators and outcome measures are chosen. 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 Mediclinic Southern Africa, Hirslanden and Emirates Healthcare, 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 Emirates Healthcare 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 on 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 for the 2011 calendar year was 29% compared to 22% for the previous calendar year. Hypertension, diabetes mellitus and obesity are the most common underlying chronic conditions.

Although obesity is not regarded as a chronic underlying medical condition unless it is quite severe, it can impact significantly on morbidity while in hospital. During the 2011 calendar year about 67% (69% in 2010) 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. It needs to be interpreted with caution, because of the influence of patient demographics, comorbidity profiles, reasons for admission and the types of surgeries performed. Mediclinic Southern Africa uses a statistical methodology to adjust hospital mortality rates for these factors 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.

Table 11 reports the mortality rates for the 2011 calendar year.

The mortality index for 2011 has improved from 1% better than expected in 2010 to 4% better than expected in 2011. It is noticeable that the index for the last five years has been below one. Hospitals are continuously focusing on their indexes, 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 for the 2011 calendar year, and is regarded as a proxy measure for quality of care. The extended stay point was calculated as the 90th percentile of hospital stays over the past three calendar years for each admission type. As this 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

TABLE 12: OVERALL EXTENDED STAY RATE AS A PERCENTAGE OF HOSPITAL ADMISSIONS (CALENDAR YEAR)

	2009	2010	2011
Extended stay rate (overall)	10.04%	10.13%	**10.10%**

TABLE 13: RE-ADMISSION RATE AS A PERCENTAGE OF HOSPITAL ADMISSIONS (CALENDAR YEAR)

	2008	2009	2010	2011
Re-admissions	7.0%	6.6%	6.7%	**7.0%**

TABLE 14: VON GENERAL STATISTICS (CALENDAR YEAR)

Very low birth weight infants (< 1 501g)	Mediclinic Southern Africa 2010	Mediclinic Southern Africa 2011	VON 2010
Number of cases	543	**563**	53 862
Average birth weight in grams	1 105	**1 109**	1 053
Average gestational age in weeks	29	**29**	28
Average discharge weight in grams	1 913	**1 904**	2 245
Length of stay in days	43	**43**	62

TABLE 15: VON QUALITY OUTCOMES AS A PERCENTAGE OF CASES ON THE DATABASE (CALENDAR YEAR)

Very low birth weight infants (< 1 501g)	Mediclinic Southern Africa 2010	Mediclinic Southern Africa 2011	VON 2010
Respiratory support			
Respiratory distress syndrome	83%	**83%**	73%
Pneumothorax	3%	**2%**	4%
Early continuous positive airway pressure (CPAP)	37%	**37%**	40%
Ventilation	43%	**46%**	41%
Chronic lung disease (CLD) 36 weeks (gestational age < 33 weeks)	15%	**16%**	26%
HAIs	17%	**17%**	15%
Other outcomes			
Patent ductus arteriosus	25%	**21%**	37%
Necrotising enterocolitis	6%	**6%**	6%
Periventricular-intraventricular haemorrhage	21%	**20%**	26%
Retinopathy of prematurity	16%	**9%**	33%
Mortality	17%	**18%**	13%

and complications. This indicator was developed internally; comparable external benchmarks are not available.

Table 12 reports the overall extended stay rate for Mediclinic Southern Africa, which decreased slightly during the 2011 calendar year.

Re-admission

The re-admission indicator is calculated based on the number of patients re-admitted to hospital within 30 days after 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. However, the methodology used in calculating this indicator has now been adapted to 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. This was done in order to reduce the percentage of planned admissions in the indicator. 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.

Table 13 reports the 30-day re-admission rate for all hospital admissions. The overall re-admission rate increased as a result of an increased change in the complexity of cases. The indicator was developed internally and comparable external benchmarks are not available.

CLINICAL OUTCOMES

Vermont Oxford Network

Neonatal CCUs deal with complex and very high-risk patients and require experienced teams that follow a sophisticated and rigorous approach to patient care. This is an enormous challenge for which the VON is an excellent support vehicle.

The VON is an initiative aimed at measuring and improving the quality of care in a neonatal CCU. The project is based in Vermont in the United States, 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, the VON specifically focuses on the very low birth weight (< 1 501g) infants, because of the significant complexities involved in treating them.

Table 14 deals with the general statistics of this subset of the neonatal critical care population. Mediclinic Southern Africa's statistics for the 2010 and 2011 calendar years are compared with the official VON annual report for the 2010

TABLE 16: ACTD VOLUME STATISTICS (CALENDAR YEAR)

	2010	2011
Total number of cases	653	**534**
Procedures		
Coronary artery bypass graft (CABG)	516	**433**
Valve surgery	181	**138**
Other cardiac procedure	32	**21**

calendar year, as the VON annual reports only become available six months after year end and the 2011 report was therefore not available in time to be included in this report. A small number of previously unreported cases for 2010 have been included.

Table 15 reports the 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 a lower rate of chronic lung disease than the VON benchmark was experienced during 2011. The HAI rate remained the same for 2011, and is comparable with the VON average of 15%. The mortality rate at 18% remained higher than the VON average. This can be attributed to the dissimilar outcome profiles of new, smaller and more rural-based Mediclinic Southern Africa units enrolled in the VON database over the last four years.

Within this group of very low birth weight infants, chronic lung disease, periventricular-intraventricular haemorrhage and retinopathy of prematurity (which decreased significantly as a result of an increase in eye exams being performed) greatly determine survival and eventual quality of life. In all of these critical parameters Mediclinic Southern Africa performed better than average compared with the VON. These results can mainly be attributed to the 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 at Mediclinic Panorama since August 2005, at Mediclinic Bloemfontein and Mediclinic Vergelegen since 2009, and was implemented at Mediclinic Heart Hospital in 2011.

TABLE 17: GENERAL INDICATORS, RISK FACTORS AND OUTCOMES AS A PERCENTAGE OF CASES ON THE DATABASE (CALENDAR YEAR)

	2010	2011
Risk factors		
Overweight/obese (BMI > 25)	76%	**80%**
Hypertension	70%	**66%**
Dyslipidemia	62%	**66%**
Smoker	50%	**47%**
Diabetes	27%	**28%**
Other post-operative outcomes		
Infections	2.0%	**2.6%**
Re-operation	4.9%	**5.4%**
Mortality		
Expected mortality (EuroSCORE)	7.2%	**7.7%**
Actual mortality	4.7%	**5.4%**
Mortality index	0.66	**0.70**
Re-admission (within 30 days)	7.8%	**11.6%**

Table 16 reports some general volume statistics. It is important to note that some of the procedures reported in Table 16 were performed simultaneously during the same operation but are reported separately.

Table 17 reports on general indicators, patient risk factors and clinical outcomes. Comparable international figures are not freely available, hence the year-on-year comparisons.

During the 2011 calendar year about 81% of ACTD patients had coronary artery bypass graft procedures compared to 79% the previous year, and 26% had valve surgery compared to 28% last year. The number of female patients admitted decreased from 26% in 2010 to 24% in 2011, while the number of male admissions increased by 2% to 76% in 2011.

Patient risk factors remained essentially unchanged. The mortality index (actual/expected) decreased from 0.66 to 0.35, and remains significantly lower than the benchmark index of 1. The re-admission rate increased, with 11.6% of all patients in the ACTD database being re-admitted to hospital within 30 days of the original procedure during the 2011 calendar year. In summary, the database is a very valuable tool in support of quality improvement and has been embraced by the cardio-thoracic teams at the participating Mediclinic Southern Africa hospitals.

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

TABLE 18: APACHE® III-J MORTALITY INDEX (CALENDAR YEAR)

	2009	2010	2011
Cases	27 881	37 741	**40 095**
Average age	56.1	57.3	**59.8**
Average length of stay (total hospital stay)	8.1	7.9	**7.8**
Average CCU days	1.8	1.7	**1.7**
Average high care days	1.8	1.8	**1.8**
Mortality index	0.79	0.72	**0.70**

* *APACHE is a registered trademark of Cerner Corporation, Kansas City, Missouri, USA.*

TABLE 19: IQIP WEIGHTED AVERAGE MORTALITY RATES AS A PERCENTAGE OF HOSPITAL DISCHARGES (CALENDAR YEAR)

	2007	2008	2009	2010	2011
Hirslanden	1.11	0.96	0.88	0.95	**0.91**
Europe	2.38	2.22	2.11	1.71	**1.51**

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. During 2011 a total of 40 095 cases were scored in 62 CCUs at 41 participating hospitals.

Table 18 reports on some important statistics, the most important being the mortality index, which is the relationship between the actual and predicted mortalities. The mortality index of 0.70 implies that the overall mortality of the scored cases was 30% better than expected. It is also noticeable that the index is 2% lower compared to the previous year.

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

HIRSLANDEN

CLINICAL INDICATORS

Hirslanden has been participating in the IQIP since 2006. The initiative was developed over 15 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

TABLE 20: IQIP WEIGHTED AVERAGE RE-ADMISSION RATES WITHIN 31 DAYS AS A PERCENTAGE OF HOSPITAL DISCHARGES (CALENDAR YEAR)

	2009	2010	2011
Hirslanden	1.49	1.41	**2.23**
Europe	1.27	1.44	**2.05**

TABLE 21: IQIP WEIGHTED AVERAGE RE-ADMISSION RATES WITHIN 15 DAYS AS A PERCENTAGE OF HOSPITAL DISCHARGES (CALENDAR YEAR)

	2009	2010	2011
Hirslanden	1.31	1.27	**1.27**
Europe	0.91	1.14	**1.1**

TABLE 22: IQIP WEIGHTED AVERAGE UNSCHEDULED RETURNS TO THE OPERATING THEATRE AS A PERCENTAGE OF OPERATIONS PERFORMED (CALENDAR YEAR)

	2007	2008	2009	2010	2011
Hirslanden	1.32	1.19	1.07	1.13	**0.98**
Europe	1.44	1.52	1.47	1.17	**1.14**

Hirslanden hospitals have been participating in a set of five IQIP indicators as directed by the Hirslanden clinical governance committee since 2008. It is important to note that all the IQIP results are reported per calendar year.

Mortality

Table 19 reports the IQIP weighted average mortality rates for the last five calendar years. Although Hirslanden experienced a significantly lower mortality rate compared to other participating hospitals in Europe, the 2011 annual rate decreased slightly compared to the previous year.

Re-admission

The IQIP weighted average rates for unscheduled re-admissions during the last three calendar years are reported in **Table 20**. Unscheduled re-admissions in this IQIP indicator are defined as unplanned and assumed to be the result of late complications. These figures are therefore not comparable with those of Mediclinic Southern Africa reported earlier. The ratio (re-admission within 31 days) in 2011 is higher than other participating hospitals in Europe. This result was further investigated. Audits of the data collection processes in some hospitals showed that they are not in line with the requirements provided by IQIP and these hospitals have started to adjust their data collection process accordingly.

In 2011 Hirslanden introduced a new indicator, namely re-admissions within 15 days (**Table 21**). This indicator is more applicable to the requirements of the Swiss Diagnosis Related Grouping (DRG) system which

TABLE 23: SAPS II MORTALITY INDEX (CALENDAR YEAR)

	2010		2011	
	Hirslanden	SAPS II Benchmark	Hirslanden	SAPS II Benchmark
Cases	5 737		**5 427**	
Expected	10.2%	9.0%	**10.5%**	**10.0%**
Actual	4.3%	4.0%	**4.2%**	**4.0%**
Mortality Index	0.42	0.44	**0.40**	**0.40**
Average age of patients	66.4	64.0	**67.9**	**62.0**
Average length of stay in CCU (days)	2.38	3.60	**2.29**	**2.5**
Percentage of ventilated patients	40.8%	32.0%	**37.9%**	**32.0%**

TABLE 24: MORTALITY AS A PERCENTAGE OF HOSPITAL ADMISSIONS (CALENDAR YEAR)

	2007	2008	2009	2010	2011
Actual	0.24%	0.30%	0.33%	0.29%	**0.17%**

was implemented in January 2012 as a hospital reimbursement system for all Swiss hospitals. The Swiss DRG system covers re-admissions occurring within 18 days after discharge.

Unscheduled returns to the operating theatre

The IQIP weighted average rates for unscheduled returns to the operating theatre for the last five calendar years are reported in **Table 22**. 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.

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 23 reports on some important statistics, the most important being the mortality index, which is the relationship between the actual and predicted mortalities. The mortality index of 0.40 in 2011 implies that the overall mortality of the scored cases was 60% better than expected. Because of a change in definition of ventilated patients, the related indicator differs from previous reports.

TABLE 25: RE-ADMISSIONS AS A PERCENTAGE OF HOSPITAL ADMISSIONS (CALENDAR YEAR)

	2009	2010	2011
Re-admissions	5.5%	6.2%	**4.0%**

EMIRATES HEALTHCARE

CLINICAL INDICATORS

Mortality

Table 24 reports the actual combined mortality rates for both Emirates Healthcare 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 decreased from 0.29% to 0.17% in 2011, and remains 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

Table 25 reports 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 manage this indicator. The re-admission rate decreased significantly during the 2011 calendar year.

CLINICAL OUTCOMES

Vermont Oxford Network

The VON database was implemented at both Emirates Healthcare hospitals during 2009. Though the case volumes for these two centres were small, their outcomes compare very favourably against the VON network averages.

TABLE 26: VON GENERAL STATISTICS (CALENDAR YEAR)

Very low birth weight infants (< 1 501g)	Emirates Healthcare 2010	Emirates Healthcare 2011	VON 2010
General			
Number of cases	48	**60**	53 862
Average birth weight in grams	1 165	**1 140**	1 053
Average gestational age in weeks	29	**29**	28
Average discharge weight in grams	1 768	**1 787**	2 245
Length of stay in days	34	**38**	62

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.

Table 26 deals with the general statistics of this subset of the neonatal critical care population. Emirates Healthcare figures for the 2011 calendar year are compared with the official VON annual report for the 2010 calendar year, as the VON annual reports only become available six months after year end and the 2011 report was therefore not available in time to be included in this report.

Table 27 reports the quality outcomes for both Emirates Healthcare hospitals.

The HAI rate decreased slightly. The mortality rate increased, but is still comparable to the VON 2010 average of 13%. In most of the other clinical outcomes Emirates Healthcare hospitals performed satisfactorily when compared with the VON average, and the results can 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 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 28 reports some general volume statistics. It is important to note that some of the procedures reported in Table 28 were performed simultaneously during the same operation but are reported separately.

TABLE 27: VON QUALITY OUTCOMES AS A PERCENTAGE OF CASES ON THE DATABASE (CALENDAR YEAR)

Very low birth weight infants (< 1 501g)	Emirates Healthcare 2010	Emirates Healthcare 2009	VON 2010
Respiratory support			
Respiratory distress syndrome	75%	**87%**	73%
Pneumothorax	0%	**5%**	4%
Early continuous positive airway pressure (CPAP)	23%	**30%**	40%
Ventilation	56%	**57%**	41%
CLD 36 weeks (gestational age < 33 weeks)	0%	**6%**	26%
HAIs	15%	**13%**	15%
Other outcomes			
Patent ductus arteriosus	10%	**27%**	37%
Necrotising enterocolitis	0%	**0%**	6%
Periventricular-intraventricular haemorrhage	23%	**31%**	26%
Retinopathy of prematurity	44%	**38%**	33%
Mortality	8%	**15%**	13%

Table 29 reports on general indicators, patient risk factors and clinical outcomes. Comparable international benchmarks are not freely available, hence the year-on-year comparisons.

The number of female patients admitted in 2011 increased by 2% from 9% in 2010, while the number of male admissions decreased by 2% from 91% in 2010 to 89% in 2011. Seventy-nine per cent of patients had coronary artery bypass graft procedures during the 2011 calendar year. The patients were younger than their Mediclinic Southern Africa counterparts and with a different risk profile. There were three re-admissions and two mortalities in 2011, which compares favourably with international benchmarks.

APACHE® III-J

Emirates Healthcare implemented the APACHE®III-J database at both hospitals during 2009. A total of 902 cases were scored in the CCUs of the two hospitals during 2011.

Table 30 reports some important statistics, the most important being the mortality index, which is the relationship between the actual and predicted mortalities. The mortality index as well as CCU length of stay decreased significantly, which can be attributed to the lower risk profile of patients treated in 2011.

TABLE 28: ACTD VOLUME STATISTICS (CALENDAR YEAR)

	2010	2011
Total number of cases	76	**73**
Procedures		
Coronary artery bypass graft (CABG)	63	**58**
Valve surgery	14	**11**
Other cardiac procedure	2	**4**

CLINICAL INFORMATION MANAGEMENT

Clinical coding is one of the cornerstones of clinical information management and is a focus area at all operating platforms. The establishment of a regional coding centre at Hirslanden has brought about a significant improvement in clinical coding. Mediclinic Southern Africa is in the process of evaluating an encoding software programme which will support quicker and more accurate coding.

Hirslanden established a medical controlling function, and DRG analysis and reporting has commenced. This initiative will enhance the ability to deal with the new Swiss-DRG reimbursement system. Hirslanden implemented an improved software-supported patient feedback process that enables more accurate feedback and better response times.

All high-risk units at Emirates Healthcare are now submitting detailed annual reports on their quality and safety activities. This enhanced inter-departmental communication and the sharing of best practices.

CLINICAL BUSINESS DEVELOPMENT

Hirslanden developed an internal model for accrediting current and future competence centres at different levels of maturity. The concept of competence centres is an important part of Hirslanden's strategy, and more than a 100 centres have been established over time. This evaluation model is a further development in refining the functioning of these centres.

Emirates Healthcare established a clinical services committee in order to formulate clinical strategy and define the scope of future services.

THE WAY FORWARD

The clinical performance of the Group was once again satisfactory. This means that 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.

TABLE 29: GENERAL INDICATORS, RISK FACTORS AND OUTCOMES AS A PERCENTAGE OF CASES ON THE DATABASE (CALENDAR YEAR)

	2010	2011
Risk factors		
Overweight/obese (BMI > 25)	57%	**73%**
Hypertension	71%	**73%**
Dyslipidemia	62%	**68%**
Smoker	58%	**64%**
Diabetes	41%	**37%**
Other post-operative outcomes		
Infections	0.0%	**0.0%**
Re-operation	2.6%	**1.4%**
Mortality		
Expected mortality (EuroSCORE)	9.1%	**5.7%**
Actual mortality	2.6%	**2.7%**
Mortality index	0.28	**0.48**
Re-admit (30 days)	2.6%	**4.1%**

TABLE 30: APACHE* III-J MORTALITY INDEX (CALENDAR YEAR)

	2009	2010	2011
Cases	82	195	**902**
Average age	51.6	52.7	**51.9**
Average length of stay (total hospital stay)	5.6	5.4	**5.6**
Average CCU days	4.0	3.2	**1.9**
Average high care days	0.0	0.0	**0.5**
Mortality index	0.2	0.6	**0.2**

* *APACHE is a registered trademark of Cerner Corporation, Kansas City, Missouri, USA.*

Clinical patient care is about patient-centred teamwork and time will be spent during the year ahead to develop an integrated care framework for the Group. The objective is to ensure that clinical planning and execution at all levels of the organisation are undertaken in a multi-disciplinary and integrated way. Another focus area will be to create a better alignment between operating platforms with regard to patient safety and quality improvement initiatives. Clinical information management abilities will be improved across the operating platforms and further planning will be done on the possible introduction of clinical information systems and electronic records at each operating platform.

We believe that the effort involved and the money spent on enhancing this discipline are sound investments in assisting the Group to build a secure future.

A COMPREHENSIVE SYSTEM OF INTERNAL CONTROLS IS IN PLACE TO MITIGATE RISKS

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 Committees of Mediclinic Southern Africa, Hirslanden and Emirates Healthcare, 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 tolerance and 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 within which important risks are identified, quantified and managed in order to achieve an optimal risk/reward profile. An integrated approach ensures that risk management is incorporated into the day-to-day operational management processes and therefore allows management to focus on core activities.

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. • During the year a Social and Ethics Committee was established which has been mandated to monitor 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 Sustainable Development Report. • The extensive training and skills development programme is explained in the Sustainable Development Report. • Foreign recruitment programme.
	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.	• Strategies for retention and recruitment of doctors. • Monitoring of doctor satisfaction, movement and doctors' profiles. • Further details on the relationship with doctors are provided in the 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.	• Both Mediclinic Southern Africa 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. • Emirates Healthcare has set up a Funder Relations Department to prepare for tariff reform. • Further details on the regulatory risks impacting on Mediclinic Southern Africa and on Hirslanden are provided in their respective Operational Reviews.
	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 with the requirements of debt covenants. • Further details on capital risk management and the Group's borrowings are provided on page 130 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 the development of trends in the economic and business environment 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 Governance 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 Governance 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 Governance 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 Governance 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  = Emirates Healthcare

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 its combined assurance plans for the next financial year. These plans detail the various assurance processes, including internal and external audit processes that 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 and a review of the assurance processes in Hirslanden. During the year no internal audits were performed at Emirates Healthcare.

At Mediclinic Southern Africa the effectiveness of the system of internal control is independently evaluated by the external auditors, PricewaterhouseCoopers, as well as through an extensive internal audit programme. 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, Ernst & Young. 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 2011 achieved a level where 13 of its hospitals and its Head Office were certified in terms of ISO 9000:2008. 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 Clinical Governance Report and the Sustainable Development Report. During the year the Group internal audit function carried out 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 done by the SQS auditors and integrate these together with the work performed by Ernst & Young into its internal audit review of the effectiveness of the controls which are designed to mitigate significant risks identified by the ERM process in place in Hirslanden. The results of these and other operational assurance processes are monitored by Hirslanden's executive management.

At Emirates Healthcare the effectiveness of the system of internal control is independently evaluated by the external auditors, KPMG. Both the Welcare Hospital and The City Hospital's facilities are accredited by the JCI (Joint Commission International), an international quality measurement accreditation organisation, aimed at improving the quality of care. The eight clinics are preparing for accreditation during the next financial year. The accreditation is based on international consensus standards and sets uniform, achievable expectations for structures, processes and outcomes for hospitals.

The company secretaries at Group level and at operating platform level are responsible for providing guidance in respect of compliance with the 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, Mediclinic Southern Africa's, Hirslanden's and Emirates Healthcare's Audit and Risk Committees, internal and external auditors, Mediclinic Southern Africa's Risk Management Committee and the Group's risk management function. The Board, via 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

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 ("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. We believe that the King III principles and the increased governance requirements of the Companies Act can only be beneficial to the reputation of South African businesses as leaders in corporate governance.

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.

A Group Corporate Governance Manual dealing with board practices and group policies provides guidance to the company secretaries and the boards of directors of the Company and 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.

A major focus during the year was to ensure compliance with the new requirements of the Companies Act, such as the establishment of the Company's Social and Ethics Committee and the replacement of the Memoranda and Articles of Associations of the Group's companies registered in South Africa with the newly required Memoranda of Incorporation, as is required in terms of the Companies Act to be completed by 30 April 2013. The Company's Memorandum of Incorporation will be presented to the shareholders at the annual general meeting 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 personnel 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.

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 year end the Board consisted of an executive Chairman, five executive directors and ten non-executive directors, of whom five 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. Although the majority of directors are non-executive, the majority of the non-executives are not independent, as recommended in King III. The Board regards the current composition as being in the best interest of the Company.

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.

Although the Chairman of the Board, Dr Edwin Hertzog, is classified as an executive director, the Board considers him to be "semi-executive" as he holds various other directorships, including his role as Deputy Chairman of Remgro and board member of two other Remgro associated companies, of which one is listed on the JSE. The Board acknowledges the principle in King III recommending the appointment of an independent non-executive director as Chairman, but given Dr 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 undoubtedly considered to 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 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 (which may occur in cases where the Chairman is executive) and perform the evaluations of the Chairman and the independence of the independent non-executive directors.

FIGURE 1: BOARD AND SUB-COMMITTEE COMPOSITION

Board
Executive directors:
Edwin Hertzog (Chairman)
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: Mediclinic Switzerland/Hirslanden)
*Non-executive directors:**
Joe Cohen
Kabs Makaba
Mamphela Ramphele
Chris van den Heever
Thys Visser**
Independent non-executive directors:
Robert Leu
Zodwa Manase
Anton Raath
Desmond Smith
Wynand van der Merwe

Audit and Risk Committee
Desmond Smith (Chairman)
Robert Leu
Zodwa Manase
Anton Raath

Remuneration and Nominations Committee
Wynand van der Merwe (Chairman)
Edwin Hertzog
Anton Raath
Thys Visser**

Social and Ethics Committee
Chris van den Heever (Chairman)
Danie Meintjes
Ronnie van der Merwe

Investment Sub-committee
Edwin Hertzog (Chairman)
Joe Cohen
Anton Raath
Thys Visser**
All other executive Board members

* *These directors are listed as non-executive directors and not regarded as independent because of their indirect interest in the Company. Mr Joe Cohen represents Trilantic Capital Partners, which held 6.01% of the issued shares in the Company at year end; Dr Kabs Makaba and Dr Mamphela Ramphele represent our strategic black partners, Phodiso Holdings and Circle Capital Partners, which indirectly held 6.03% and 3.58% respectively at year end; and Mr Chris van den Heever and the late Mr Thys Visser represent Remgro, which indirectly held 43.4% at year end.*

** *Subsequent to year end, the late Mr Thys Visser tragically passed away following a car accident on 26 April 2012. Refer to the Chairman's Report for a brief tribute to the late Mr Visser for his significant contribution to the Company. Mr Jannie Durand, the newly appointed Chief Executive Officer of Remgro, whose brief CV appears on page 8, was appointed by the Board as a director on 7 June 2012.*

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 Memorandum of Incorporation (currently still named the Articles of Association) of the Company, one third of the directors must retire each year on a rotational basis, but may make themselves available for re-election for a further term. 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 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. The first evaluation of the Social and Ethics Committee will be conducted during the next evaluation process in 2013, as this committee was only established by the Board in February 2012 and had its first meeting on 27 March 2012.

During the evaluation process conducted during the previous reporting period and the most recent evaluations conducted in March 2012, the Board identified no major areas for improvement. A few Board members did express uncertainty about the succession planning of the Chairman, Chief Executive Officer, executive directors and senior management. In terms of the mandate of the Remuneration and Nominations Committee, the committee assumes responsibility for succession planning with feedback to the Board. Subsequent to this matter being raised, a detailed presentation in this regard has been scheduled for the new financial year for further discussion by 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 and Prof. Wynand van der Merwe, who have served on the Board since 1996 and 2001 respectively. The Board confirmed that it is satisfied that there are no relationships or circumstances which affect or appear to affect their judgement and that their independence is not in any way affected by their 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 no new Board appointments were made.

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 SECRETARIAT

The Board has unlimited access to the Company Secretary, Mr Gert Hattingh, 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.

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 all 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 qualifications and address of the Company Secretary appear on the inside of the back cover of this integrated annual report.

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.

Because of the relative size of the Group's operations in the United Arab Emirates, the Chief Executive Officer of the Emirates Healthcare, 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 Audit and Risk Committees of the Group's three operating platform companies report to the Group's Audit and Risk Committee at each meeting.

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 2012 is included in the annual financial statements on pages 111 to 112 of this integrated annual report. The composition of and attendance at committee meetings are also included in the committee's report.

SOCIAL AND ETHICS COMMITTEE

The Board established the Company's Social and Ethics Committee and appointed its first members on 29 February 2012. The responsibilities of the committee are codified in a mandate from the Board, which will be 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 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 2012 is included on pages 84 to 85 of this integrated annual report. The composition of and attendance at committee meetings are also included in the committee's report.

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 3**. The committee is chaired by Prof. Wynand van der Merwe, an independent non-executive director. The Group's Chief Executive Officer and Mediclinic Southern Africa's Human Resources Executive 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 27 July 2011 by way of a non-binding advisory vote, with 98.92% 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.

ATTENDANCE OF MEETINGS

FIGURE 2: ATTENDANCE OF BOARD MEETINGS

	Apr 2011	May 2011	Jul 2011	Sep 2011	Nov 2011	Feb 2012	Mar 2012
Edwin Hertzog* (Chairman)	✓	✓	✓	✓	✓	✓	✓
Danie Meintjes	✓	✓	✓	✓	✓	✓	✓
Koert Pretorius	✓	✓	✓	✓	✓	✓	✓
Craig Tingle	✓	✓	✓	✓	✓	✓	✓
Ronnie van der Merwe	✓	✓	✓	✓	✓	✓	✓
Ole Wiesinger	✓	✓	✓	✓	✓	✓	✓
Joe Cohen	✓	✓	✓	✓	✓	✓	✓
Kabs Makaba	✓	✓	✓	✓	✓	✓	✓
Mamphela Ramphele	x	✓	x	✓	x	✓	x
Chris van den Heever	x	✓	✓	✓	✓	✓	✓
Thys Visser**	✓	✓	✓	✓	✓	✓	✓
Robert Leu	✓	✓	✓	✓	✓	✓	✓
Zodwa Manase	✓	✓	✓	x	✓	✓	✓
Anton Raath	✓	✓	✓	x	✓	✓	✓
Desmond Smith	✓	✓	✓	✓	✓	✓	✓
Wynand van der Merwe	✓	✓	✓	✓	x	✓	✓

* *Please refer to the explanation in respect of the classification of Dr Edwin Hertzog as executive Chairman on page 76 of the report.*

** *Please refer to the footnote below **Figure 1**.*

FIGURE 3: ATTENDANCE OF REMUNERATION AND NOMINATIONS COMMITTEE MEETINGS

	Apr 2011	May 2011	Jul 2011	Oct 2011
Wynand van der Merwe (Chairman) (Independent non-executive)	✓	✓	✓	✓
Edwin Hertzog (Executive)	✓	✓	✓	✓
Anton Raath (Independent non-executive)	✓	x	x	✓
Thys Visser* (Non-executive)	✓	✓	✓	✓

FIGURE 4: ATTENDANCE OF INVESTMENT SUB-COMMITTEE MEETINGS

	Mar 2011	Sep 2011	Feb 2012
Edwin Hertzog (Chairman) (Executive)	✓	x	✓
Joe Cohen (Non-executive)	✓	✓	✓
Anton Raath (Independent non-executive)	✓	✓	✓
Thys Visser* (Non-executive)	✓	✓	✓
Danie Meintjes (Executive)	✓	✓	✓
Koert Pretorius (Executive)	✓	✓	✓
Craig Tingle (Executive)	✓	✓	✓
Ronnie van der Merwe (Executive)	✓	✓	✓
Ole Wiesinger (Executive)	✓	✓	✓

* *Please refer to the footnote below **Figure 1**.*

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. At year end the committee consisted of all the executive directors as well as Messrs Joe Cohen, Anton Raath and the late Thys Visser. The composition of and attendance at committee meetings are set out in **Figure 4**.

The attendance of the Audit and Risk Committee and the Social and Ethics Committee meetings are set out in the reports by the committees, respectively on pages 111 and 84 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. 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

Although Information and Communications Technology (ICT) governance has always been an important component of our governance processes, our integrated annual reports have not previously included detailed information on this subject. Because of the integral part of ICT and the significant value added to the business, we have included a summary here.

ICT is a pervasive technology and cuts across all aspects of the business. The increase in business systems integration, information security challenges and interconnectivity can result in significant costs and risks. ICT also 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 reappointed external auditor of the Company during the period under review, whose report appears on page 113 of this integrated annual report, 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 Sustainable Development Report.

THE COMMITTEE ASSISTS THE BOARD IN ENSURING THAT MEDICLINIC IS AND REMAINS A GOOD AND RESPONSIBLE CORPORATE CITIZEN

The Board established the Company's Social and Ethics Committee ("the Committee") in February 2012 to assist 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 2012.

COMPOSITION AND MEETINGS

The Committee consists of a non-executive chairman and two executive directors (as set out in the table below), 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. As the Committee was only established by the Board in February 2012, it has met only once during the period under review. Committee meetings will be held biannually in future. Attendance at the Committee meeting during the period under review was as follows:

COMMITTEE MEMBERS

	Mar 2012
Chris van den Heever (Chairman) (Non-executive)	✓
Danie Meintjes (Executive)	✓
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. The Board approved some amendments to the Group's Code of Business Conduct and Ethics, Group Sustainable Development Policy, Group Environmental Policy and the Group Social Affairs Policy 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 is satisfied with the Company's performance in each of the areas listed above, as further reported on in the Sustainable Development Report published on the Company's website at www.mediclinic.com.

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.

MATERIAL SUSTAINABILITY ISSUES

The Committee is responsible for annually revising or determining, in conjunction with senior management, the Group's material sustainability issues. The material issues 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 Governance 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 at www.mediclinic.com. 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 Sustainable Development Report, at the Company's annual general meeting on 26 July 2012. Any specific questions to the Committee may be sent to the Company Secretary prior to the meeting.

ASSESSMENT OF COMMITTEE'S PERFORMANCE

The Board will assess the effectiveness of the Committee annually, as further detailed in the Corporate Governance Report. The first assessment of the Committee will be conducted during the next evaluation process toward the end of the financial year ahead.

CM van den Heever
Chairman: Social and Ethics Committee

Stellenbosch
22 May 2012

SUSTAINABILITY IS THOROUGHLY INTEGRATED INTO MEDICLINIC'S STRATEGY AND RISK MANAGEMENT PROCESS

Sustainability is thoroughly integrated into Mediclinic's strategy and risk management processes. 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 long-term success 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 29.2% in Group revenue and 29.5% in normalised EBITDA, we fully appreciate that this cannot be achieved unless we have the best possible clinical quality standards for our patients; value our employees by following fair labour practices, offering competitive remuneration, training and development opportunities; respect the communities within which we operate and contribute to the well-being of society; 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 our 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 an abridged version of the detailed Sustainable Development Report published on the Company's website at www.mediclinic.com. Please refer to the detailed report for further information relating to the Group's sustainable development performance.

This report is Mediclinic's 10th Sustainable Development Report published as part of our annual report in respect of the financial year ended 31 March 2012. 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 Sustainability Reporting Guidelines developed by the Global Reporting Initiative ("GRI G3") form the basis of this report. This report was prepared in accordance with application level C of the GRI G3. The GRI G3 disclosure index which identifies the location of the standard disclosures required by the Global Reporting Initiative's sustainability reporting guidelines, is published as part of the detailed Sustainable Development Report published on the Company's website at www.mediclinic.com.

As referred to earlier in this integrated annual report, we have also noted and applied various of the recommendations contained in the local and international discussion papers on integrated reporting issued by the Integrated Reporting Committee of South Africa in January 2011 and the International Integrated Reporting Committee in September 2011. 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 4. It is important to understand that our three operating platforms operate separately from one another, each with its own governance bodies and management team. Mediclinic International, as the holding company of the Mediclinic Group, sets the strategic objectives and standards for the Group. The governance bodies of the operating platforms report to those 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**.

MATERIAL ISSUES: PERFORMANCE AGAINST OBJECTIVES

A few highlights of the Group's performance against its key sustainability focus areas or objectives 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 in the detailed Sustainable Development Report published on the Company's website at www.mediclinic.com. For further details on each of the key focus areas listed here, refer to the sections of this integrated annual report, this abridged report or the detailed Sustainable Development Report published on the Company's website.

FIGURE 1: EXTERNAL RECOGNITION AND ACHIEVEMENTS

Group	Included in the 2011 JSE SRI Index for the eighth 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 sustainable development reporting guidelines with a self-declared application level C.
Southern Africa	Thirty-two 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-eight hospitals ISO 14001:2004 (environmental management) certified. Participated in the Carbon Disclosure Project 2011 and the CDP Water Disclosure Project 2011. Externally assessed BBBEE scorecard maintained at Level 3 contributor. Awarded category winner, jointly with communication consultants Stone, at Public Relations Institute of South Africa's PRISM Awards 2012 in both public affairs and healthcare. Submissions focused on Mediclinic Southern Africa's comprehensive public affairs and healthcare thought leadership campaigns around the national healthcare debate. During 2011 Mediclinic Southern Africa hosted an industry forum, held information sessions for media and stakeholders, launched an industry affairs microsite (www.futureofhealthcare.co.za) and engaged with relevant and related academic and business opinion leaders to successfully influence the debate and be regarded as a valued private sector contributor to a future NHI. Recognised by HASA (Hospital Association of South Africa) for its contribution to marketing the private hospital industry at the annual HASA Awards of Excellence in 2011. 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) with distinguishing achievements.
Switzerland	Thirteen hospitals and head office ISO 9001:2008 certified, after the relevant external verification in 2011. Klinik Hirslanden and Klinik Im Park 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. Klinik Hirslanden achieved level R4E (recognised for excellence) and Klinik Im Park achieved level C2E (committed to excellence) under the EFQM (formerly known as the European Foundation for Quality Management) Excellence Model, a global non-profit membership foundation to promote sustainable excellence within organisations based on assessment against the EFQM Excellence Model.
UAE	Both hospitals are JCI (Joint Commission International) accredited. JCI is an international accreditation organisation for healthcare organisations focused on improving the safety of patient care through accreditation. Accreditation of the group's eight clinics is planned for 2013. The pathology laboratories of both hospitals are ISO 15189:2009 certified, with The City Hospital successfully meeting the requirements of its first annual ISO surveillance inspection and all eight clinics in the accreditation process of its laboratory in the year ahead. The City Hospital's pathology laboratory is accredited by the College of American Pathologists (CAP). Emirates Healthcare received the Al Rufaidah Al Aslamiah Award for Welcare Hospital's intensive care nursing service at the 3rd Asia Africa Conference of World Federation of Society of Intensive and Critical Care Medicine held at the 7th PAN Arab Critical Care Medicine Society Conference.

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

OBJECTIVES	INDICATORS OF OUR PERFORMANCE	For more information refer to
KEY FOCUS AREA 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 at all Mediclinic Southern Africa, Hirslanden and Emirates Healthcare hospitals. Clinical audits and surgical safety checklists used throughout Group. Benchmarking of clinical outcomes 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; and APACHE III-J, a hospital mortality prediction methodology for adult intensive care patients used to evaluate the quality of care in this complex setting. Important clinical indicators such as mortality, extended stay and re-admissions are measured and compared within the Group. Thirty-two 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. All Mediclinic Southern Africa hospitals are participating in the "Best Care… Always" patient safety initiative, a collaborative quality initiative to promote patient safety between the public and private sector. Clinical ward pharmacist programme introduced at all Mediclinic Southern Africa hospitals during the year. EFQM model implemented at all 14 Hirslanden hospitals, with 10 of the group's hospitals completing an EFQM self-assessment in 2011. Thirteen Hirslanden hospitals ISO 9001:2008 certified, with Klinik Stephanshorn to follow during the year ahead. All 13 hospitals successfully passed the relevant external verification in 2011. Participation in the International Quality Indicator Project® (IQIP) by Hirslanden aimed at improving performance against set performance indicators. Both Emirates Healthcare hospitals JCI accredited, with accreditation of the group's eight clinics planned for 2013. The pathology laboratory of both Emirates Healthcare hospitals ISO 15189:2009 certified, with The City Hospital successfully meeting the requirements of its first annual ISO surveillance inspection and all eight clinics in the accreditation process of its laboratory in the year ahead. College of American Pathologists (CAP) accreditation of the laboratory of Emirates Healthcare's The City Hospital. A committee was recently established to investigate and determine the required clinical functionality of a Hospital Information System ("HIS") for the future. This committee consists of doctors, nurses and IT people to provide the much-needed information to assist us in selecting an appropriate HIS.	Clinical Governance Report

OBJECTIVES	INDICATORS OF OUR PERFORMANCE	For more information refer to
KEY FOCUS AREA 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: • R797m (2011: R682m) in Southern Africa • R1 165m (CHF138m) (2011: R867m (CHF122m)) in Switzerland • R86m (AED42m) (2011: R77m (AED39m)) in UAE Comprehensive maintenance and asset management systems applied throughout the Group.	Operational Reviews 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 with local and national government authorities assisting with 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 Emirates Healthcare's staff is recruited from abroad.	Operational Reviews Sustainable Development Report: – Key focus area 2: Nursing and general skills shortage in this **Figure 2** – 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 76.35% for Mediclinic Southern Africa (with target at 75%), 93% for Hirslanden (with target at 88%) and 89% for Emirates Healthcare (with target at 90%). **Patient satisfaction levels** 2009/10 / 2010/11 / 2011/12 Mediclinic Southern Africa: 73% / 75% / 76.35% Hirslanden: 86% / 85% / 93%* Emirates Healthcare: 90% / 89% / 89% * *The patient satisfaction results for the period under review are based on the ANQ (the Swiss National Association for Quality Development) satisfaction survey. The average score of the participating hospitals was 91%. Previously the results were based on the Picker review. At the time of preparing this report, the Picker results were not available and the results are therefore not comparable to those of the previous year.* Patient Journey Programme initiated at Mediclinic Southern Africa to improve patient experience. Patient satisfaction survey of Mediclinic Southern Africa to be expanded to include clinical outcomes during the year ahead. Doctor satisfaction surveys conducted throughout the Group. Mediclinic Southern Africa's doctor satisfaction survey completed in 2011 showed an 87% doctor satisfaction level. A survey conducted at EHL's The City Hospital in June 2011 showed a 93% doctor satisfaction level. The next doctor satisfaction survey is planned for 2013. 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.	Chief Executive Officer's Report Clinical Governance Report 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

OBJECTIVES	INDICATORS OF OUR PERFORMANCE	For more information refer to
KEY FOCUS AREA 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% (2011: 4%) by Mediclinic Southern Africa and 0.3% (2011: 0.3%) by Emirates Healthcare. The Group aims to provide comparable data on the training spending of Hirslanden in future. Performance reviews to develop staff and identify training needs conducted with all Hirslanden and Emirates Healthcare employees and with 97.75% of Mediclinic Southern Africa employees. At Mediclinic Southern Africa 35 320 structured learning interventions were recorded, with 5 399 at Emirates Healthcare and 1 001 at Hirslanden. A KPI system to measure the Mediclinic Southern Africa's training performance was developed during the period under review, with the first results available for the next financial year. Strong focus on continuous professional development of medical staff at all three platforms.	Operational Reviews 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. Engagement Task Team established by Mediclinic Southern Africa to improve staff engagement and retention. Mediclinic Southern Africa communicates its Employee Relations Policy with regular training workshops and monthly online-based facilitation sessions. Eight online-based facilitation sessions were presented throughout 2011, dealing with issues such as handling poor work performance, preparing for disciplinary hearings and dealing with employee grievances. Emirates Healthcare is planning the implementation of a succession management programme with particular focus on specific managerial positions during the year ahead.	Remuneration Report 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**. Provisional registration status of all six of Mediclinic Southern Africa's learning centres to offer the Diploma in General Nursing and the Diploma in Operating Room Practice was converted to full registration by the Department of Higher Education and Training. Financial support of more than R5.3m (2011: R5.7m) 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 2011 academic year 641 students completed basic nursing courses; 83 students completed post-basic nursing courses; 911 learners completed other Mediclinic Southern Africa courses in various disciplines.	Operational Reviews Sustainable Development Report: – Our People: Performance management; and Employee recruitment, retention and remuneration – Training and skills development

OBJECTIVES	INDICATORS OF OUR PERFORMANCE	For more information refer to
KEY FOCUS AREA 3:	**BBBEE (SOUTH AFRICA ONLY)**	
Sustainable transformation in all elements of BBBEE scorecard	Maintained Level 3 contributor on generic BBBEE scorecard, as externally verified. Number of black employees increased year-on-year from 60% to 62.7% of total employees. Black management representation increased from 11% in 2006 to 22% at year end, with a year-on-year improvement from 20% in 2011 to 22% at year end. Diversity workshops held at all the facilities throughout the group. Further follow-up workshops will be held with management teams during the year ahead.	Sustainable Development Report: – Broad-based black economic empowerment
KEY FOCUS AREA 4:	**CSI/COMMUNITY INVOLVEMENT**	
Improving the health and well-being of communities in which we operate	Approximately R5m (2011: R4m) spent on CSI in Southern Africa, of which R2.5m (2011: R2m) was donated to 66 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: – 130 cataract operations in the Northern Cape Province, bringing the total number of beneficiaries over the past two financial years to 280; – 60 tonsillectomies in the Gauteng Province; – 56 surgical procedures to reduce waiting lists at the Red Cross War Memorial Children's Hospital in the Western Cape Province; and – 28 cardiac ICU beds donated to Tygerberg Hospital in the Western Cape Province. Hirslanden spent CHF1.65m (2011: CHF1.64m) on CSI projects during the period under review through donations benefiting 70 diverse regionally based organisations. Emirates Healthcare contributed 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 Sustainable Development Report: – Environmental performance
KEY FOCUS AREA 5:	**MANAGING OUR ENVIRONMENTAL IMPACTS**	
Effective environmental management systems to monitor and minimise impacts	ISO 14001 environmental management standards implemented at 51 Mediclinic Southern Africa hospitals, with the aim of expanding it to Mediclinic Otjiwarongo during the year ahead. The extension to Klinik Hirslanden is being constructed according to the MINERGIE® standards, a registered quality label for new and refurbished low-energy consumption buildings. At Hirslanden's Klinik Am Rosenberg various water consumption projects have resulted in an 8.1% reduction of its water consumption from 12 788kl in 2010 to 11 828kl in 2011. The "Ecojets" system at Hirslanden's Klinik Aarau has led to a 12% reduction in the natural gas consumption. The same system was also installed at Klinik Am Rosenberg in 2011. Emirates Healthcare's Welcare Hospital is working towards the ISO 14001:2004 accreditation for environmental management. The installation of movement sensors and low-energy lights at Emirates Healthcare's The City Hospital resulted in a decline in energy consumption. At Emirates Healthcare's Welcare Hospital, the group's initiatives have resulted in the reduction of water consumption by almost 4% and electricity consumption by almost 2% during the reporting period.	Operational Reviews Sustainable Development Report: – Environmental performance

FIGURE 3: COMBINED ASSURANCE

ASSURANCE OUTPUT	BUSINESS PROCESSES ASSURED	PROVIDER
Independent external auditor's report	Financial reporting	PricewaterhouseCoopers Inc.
Internal auditor's report (excluding Emirates Healthcare)	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 38 Mediclinic Southern Africa hospitals	Environmental management system	NQA (National Quality Assurance Limited)/UKAS (United Kingdom Accreditation Service)
COHSASA accreditation of 32 Mediclinic Southern Africa 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 3 contributor verification	Broad-based black economic empowerment	AQRate
ISO 9001:2008 certification of 13 Hirslanden hospitals and Hirslanden Head Office	Quality management	Swiss Association for Quality and Management Systems (SQS)
Klinik Hirslanden achieved level R4E (recognised for excellence) and Klinik Im Park achieved level C2E (committed to excellence) recognition based on assessment against EFQM Excellence Model	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 Emirates Healthcare hospitals	Quality and safety of patient care	JCI (Joint Commission International)
ISO 15189:2009 certification of the pathology laboratories of both Emirates Healthcare hospitals	Pathology laboratories of both Emirates Healthcare hospitals	International Organisation for Standards
College of American Pathologists (CAP) accreditation of the laboratory of Emirates Healthcare's The City Hospital	Laboratory of Emirates Healthcare's The City Hospital	College of American Pathologists

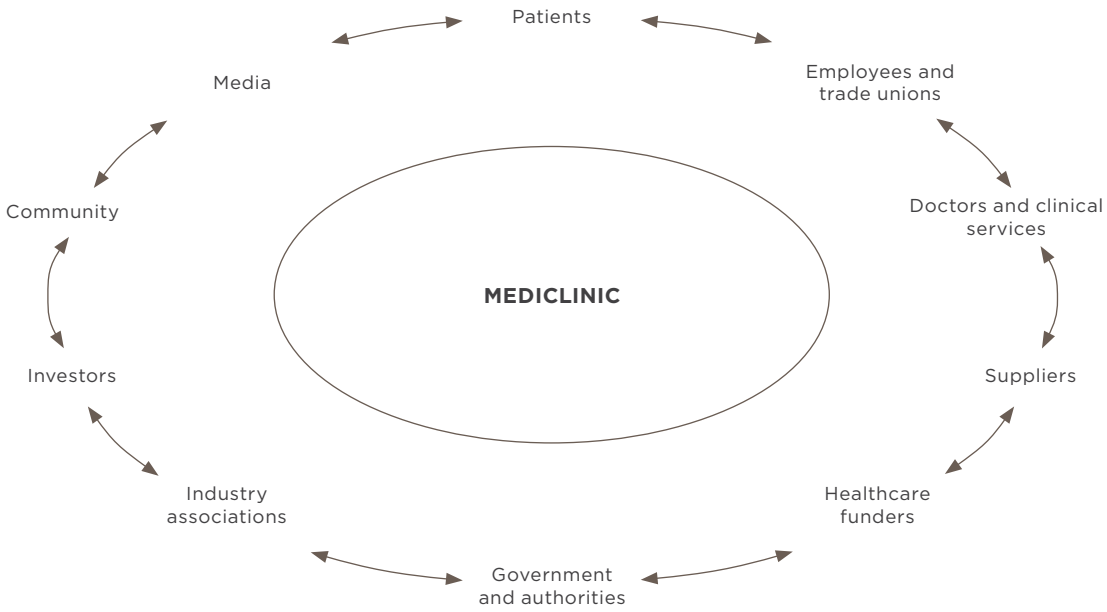
ASSURANCE

The independent assurance of sustainability reporting and disclosure is recommended in King III, the integrated reporting guidelines and GRI G3. 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 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

FIGURE 4: MEDICLINIC'S STAKEHOLDER MAP



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 2012 with no material amendments approved, except the inclusion of the role of the newly established Social and Ethics Committee, as required in terms of the South African Companies Act. The role and function of this committee is dealt with in the Corporate Governance Report and the Social and Ethics Committee Report included in this integrated annual report.

The most senior executive manager responsible for coordinating sustainable development throughout the Group is the 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.

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". We strive to achieve this objective using a wide variety of communication vehicles.

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 operations; www.hirslanden.com for the Swiss operations; and www.ehl.ae for the UAE operations. The Hirslanden website was re-launched in 2011 with new and updated contents offering over 10 000 pages of information to the public. Hirslanden invested in a content management system that enables rapid and easy updates as well as interactive multimedia content. The website will soon be completed with a new baby website for mother and child matters as well as a completely new mobile internet interface for smart phones.

Because of the increasing use and potential of social networking to create relationships through communication, sharing ideas and discussion, and thereby managing our reputation in the digital space, the various platforms are expanding their traditional communication methods to include social networking.

One of Mediclinic's strategic objectives is to position itself as a leading international private hospital group and in this regard we recognise the importance of our brand. The Mediclinic brand identity with its new logo and slogan "Expertise you can Trust." was launched in 2011 in respect of the Company and its Southern African operations. Due to the new corporate identity, the Company's registered name was changed from Medi-Clinic Corporation Limited to Mediclinic International Limited with effect from 5 September 2011, as approved by the Company's shareholders at the annual general meeting on 27 July 2011. A decision on the implementation of the new brand at our operations in Switzerland and the UAE will only be taken at a later stage.

There have been no incidents of material non-compliance with any applicable regulations or legislation concerning marketing communications.

A few requests for medical records were received in terms of the South African Promotion of Access to Information Act, none of which was refused. No similar legislation applies in Switzerland or the UAE.

Our stakeholders' legitimate expectations have been taken into account in setting our material sustainability focus areas, as reported on throughout this report (see **Figure 2**).

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 Governance 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, Mediclinic Southern Africa has in the past year invested approximately R293m (2011: R222m) on capital projects and new equipment to expand and refurbish its facilities, as well as R230m (2011: R224m) on the replacement of existing equipment. In addition, R274m (2011: R236m) was spent on the repair and maintenance of property and equipment. Similarly, Hirslanden has invested approximately R456m (CHF54m) (2011: R312m (CHF44m)) on capital projects and new equipment to enhance its business as well as R413m (CHF49m) (2011: R323m (CHF45m)) on the replacement of existing equipment. In addition, R292m (CHF35m) (2011: R232m (CHF33m)) was spent on the repair and maintenance of equipment. Emirates Healthcare invested R26m (AED13m) (2011: R26m (AED13m)) on capital projects and new equipment to enhance its business and R25m (AED12m) (2011: R20m (AED10m)) on the replacement of existing equipment. In addition, R35m (AED17m) (2011: R31m (AED16m)) was spent on the repair and maintenance of 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.

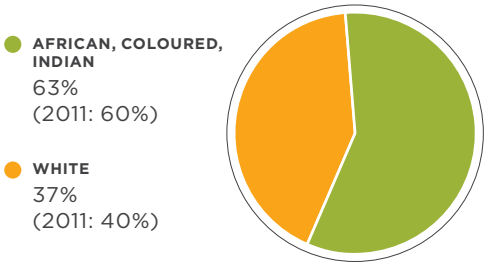
PATIENT SATISFACTION

The well-being of our patients forms the cornerstone of the Group's business, hence our commitment to deliver excellent nursing 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 catering and will add clinical questions in the year ahead. The group's Patient Journey Programme, aimed at improving the patient experience at our hospitals and aligning patient experience with our brand promise "The Science of Care", is gaining momentum. A Patient Journey Manager has been appointed to take

FIGURE 5: MEDICLINIC SOUTHERN AFRICA: RACE DISTRIBUTION



ownership of the programme. Initiatives to improve the patient journey are being identified and prioritised. During the year ahead we will engage with patient focus groups to determine their perception of the programme and aim to have the necessary structures in place in order to implement proposed changes towards the end of 2012.

As referred to earlier, Hirslanden implemented a Customer Relationship Management (CRM) system at Klinik Hirslanden on a pilot basis. The system will be used to manage the data of all doctors employed by Hirslanden and the majority of the general practitioners and specialists supporting Hirslanden. All patient feedback will also be administered through the new CRM system. The common categorisation of feedback will assist with the efficient analysis of data, improving internal patient satisfaction reporting and management. The roll-out of the system commenced in April 2012 with the aim to have it implemented at all of the group's hospitals by the end of 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 the Transformation Executive also being a member of 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 report. This assessment (which is based on the information as at the time of the assessment) indicates that the group has improved its score to 75.27 (2011: 75.21) compared to the initial self-assessed score of 64.98 in 2009. Mediclinic Southern Africa therefore maintained its status as a Level 3 contributor (a Level 1 contributor has a total of 100+ points and a Level 8 contributor has less than 40 points). Our scorecard clearly reflects our commitment to promoting BBBEE with regard to procurement, ownership and enterprise development.

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. A marked increase in black representation at management level has been recorded year on year since 2006 from 11% to 22% at year end. This level, however, still presents a challenge to the group, with low staff turnover remaining a limiting factor. We believe that our employment equity strategy will address this challenge over time. Of all senior appointments (level C5 and above) made during the period under review, 47.7% (2011: 38%) were from the designated groups. The overall racial distribution of Mediclinic Southern Africa's full-time employees is set out in **Figure 5**.

FIGURE 6: MEDICLINIC SOUTHERN AFRICA'S SUMMARISED EMPLOYMENT EQUITY REPORT

	Male				Female				Foreign National		Total
Occupational Levels	**A**	**C**	**I**	**W**	**A**	**C**	**I**	**W**	**Male**	**Female**	
Top management	1	0	1	7	0	0	0	0	0	0	**9**
Senior management	1	1	0	18	0	0	0	2	0	0	**22**
Professionally qualified and experienced specialists and mid-management	7	27	16	169	29	28	12	241	1	2	**532**
Skilled technical and academically qualified workers, junior management, supervisors, foremen and superintendents	132	105	25	188	859	739	181	2 682	34	85	**4 906**
Semi-skilled and discretionary decision-making	521	315	24	136	2 519	1 659	184	1 537	1	15	**6 911**
Unskilled and defined decision-making	124	85	5	26	296	131	8	39	6	15	**735**
TOTAL PERMANENT	**786**	**533**	**71**	**544**	**3 703**	**2 557**	**385**	**4 501**	**42**	**117**	**13 239**

The summarised employment equity report (EEA2) (**Figure 6**), as submitted to the Department of Labour on 27 September 2011, is published here as required in terms of section 22 of the Employment Equity Act. The workforce profile has improved significantly, with an increase in equity candidates appointed to the skilled technical and academically qualified workers, junior management, supervisors, foremen and superintendents category.

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. We are particularly focused on the following, further details of which can be found 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:

- access to and affordability of healthcare;
- efficiency and cost-effectiveness;
- healthcare reform; and
- public private initiatives.

OUR PEOPLE

The success of Mediclinic is dependent on the commitment of our more than 21 900 employees to deliver quality healthcare. The composition of our employees by employment type, gender and age per each of our operating platforms is illustrated in the organisational chart on page 4 and in the detailed Sustainable Development Report published on the Company's website at www.mediclinic.com.

LABOUR RELATIONS

The Group believes in creating and maintaining sound labour relations, which supports 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.

The employee relations policies of the operating platforms – which deal 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. Eight online-based facilitation sessions were presented throughout 2011, dealing with issues such as handling poor work performance, preparing for disciplinary hearings and dealing with employee grievances.

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. Hirslanden has also introduced the review of every manager by one of his/her subordinates. In Hirslanden and Emirates Healthcare 100% of employees received formal performance reviews; in Mediclinic Southern Africa 97.8% (2011: 95.2%) of employees received formal performance reviews.

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 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 and Emirates Healthcare approximately 0.33%. The Group aims to provide comparable data on the training spending of Hirslanden in future. 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.

ETHICS AND COMPLIANCE

Please visit the governance section on our website at www.mediclinic.com for contact details of the relevant Ethics Contact Person 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.

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 Emirates Healthcare.

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, during the year.

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.

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 integral members 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.

Many of the Group's initiatives relate to providing training as well as financial support and donations towards education and training, dealt with elsewhere in this report.

Further details on the Group's corporate social investment and community involvement 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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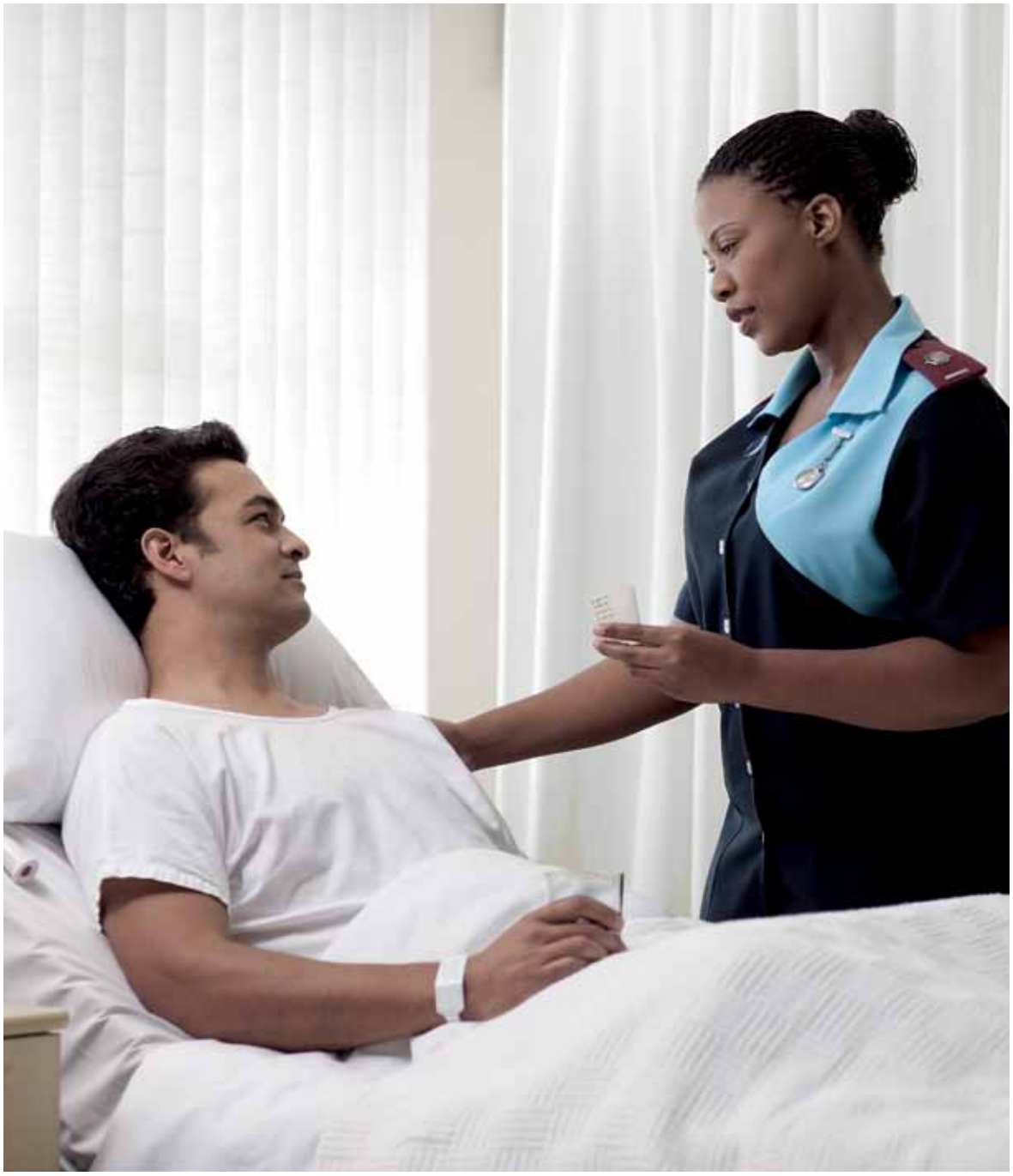
Tel: +27 21 809 6500
Fax: +27 21 809 6703
E-mail: lhs@mediclinic.com
Postal address: Mediclinic Offices,
PO Box 456, Stellenbosch, 7599
Website: www.mediclinic.com

MARKET DATA ARE USED TO BENCHMARK INDIVIDUAL SALARY LEVELS



REMUNERATION AND NOMINATIONS COMMITTEE

Mediclinic's Remuneration and Nominations Committee is responsible for, inter alia, determining the governance of remuneration matters, the Group remuneration philosophy and the remuneration of executive directors and other 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.

REMUNERATION APPROACH

The Group's remuneration policy provides full details of the remuneration approach for directors and senior managers and non-executive directors.

The remuneration offered by the Group needs to be competitive on an international basis in order to attract, retain and incentivise high-calibre staff.

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:

- ensuring that no discrimination occurs;
- recognising exceptional and value-adding performance;
- encouraging 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.

REMUNERATION STRUCTURES

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

- fixed: guaranteed base salary and benefits, as well as a 13th cheque in Mediclinic Southern Africa; and
- variable: short-term and long-term incentive programmes.

BASE SALARY

Market data are used to benchmark individual salary levels for directors and senior managers. 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 defined contribution funds for its Mediclinic Southern Africa and Hirslanden employees, excluding its Emirates Healthcare employees. Retirement benefits are provided to employees of Emirates Healthcare 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 recognition for service, and are applied as applicable in the different operating platforms of the Company.

VARIABLE PAY

SHORT-TERM INCENTIVES

Executive directors and senior managers of the Group participate in management incentive schemes.

TABLE 1: DIRECTORS' FEES

Meeting	Fee per meeting for the year ended 31 March 2012	Proposed fee per meeting for the year ending 31 March 2013
Chairperson: Board	–	R42 800
Board	R27 700	R29 640
Chairperson: Audit and Risk Committee	R32 000	R34 240
Member: Audit and Risk Committee	R22 200	R23 310
Chairperson: Remuneration and Nominations Committee	R24 450	R26 160
Member: Remuneration and Nominations Committee	R16 600	R17 430
Chairperson: Investment Sub-committee	R32 000	R34 240
Member: Investment Sub-committee	R22 200	R23 310
Chairperson: Social and Ethics Committee	R24 450	R26 160
Member: Social and Ethics Committee	R16 600	R17 430
Prof. Dr RE Leu *(annual fee pro-rated based on the number of meetings attended during the year)*	CHF109 450	CHF111 640
Lead Independent Director (annual fee)	R22 200	R23 310

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"). Additional subset indicators were set which were based on specific operating platform criteria.

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

- Mediclinic Southern Africa – 90%
- Hirslanden – 50%
- Emirates Healthcare – 100%

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 71% of the maximum possible bonus.

Employees not participating in a management incentive scheme may be eligible to receive a discretionary bonus where applicable and when affordable.

Payments in terms of short-term incentives to any employee are dependent upon achievement against the business performance targets and remain subject to the final discretionary approval of the Board.

LONG-TERM INCENTIVE PROGRAMMES

In terms of the management incentive scheme for executive directors and senior managers of the Company and Mediclinic Southern Africa, a portion of the after-tax value of the bonus is compulsorily invested in Mediclinic shares, which ensures the retention of participating senior management. In the case of Emirates Healthcare employees, no tax is payable and a portion of the full bonus is compulsorily invested in Mediclinic shares.

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 Sustainable Development Report, available on the website at www.mediclinic.com.

Mediclinic Southern Africa's nursing staff participate in a retention bonus scheme, which has contributed favourably towards the reduction of nursing staff turnover.

EXECUTIVE DIRECTORS' REMUNERATION

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

The bonus payable to executive directors in terms of the management incentive scheme, referred to above, is limited to 80% of their annual base salary, of which 70% of the after-tax value is compulsorily invested in Mediclinic shares, except for the CEO of Hirslanden.

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

Details of the remuneration of individual executive and non-executive directors, as well as the prescribed officers of the Company, are set out in the annual financial statements on pages 153 to 154.

NON-EXECUTIVE DIRECTORS' REMUNERATION

Non-executive directors do not receive any benefits or share options from the Company apart from directors' fees, which fees were approved by the Company's shareholders on 27 July 2011. The Remuneration and Nominations Committee ("the committee") also recommended a fee of R24 450 per meeting payable to the Chairman of the Social and Ethics Committee for the year ended 31 March 2012. The fees payable to the Chairman of the Social and Ethics Committee for the year ended 31 March 2012 are included in the joint remuneration payable to the Company's non-executive directors, as included in Special Resolution Number 1 in the Notice of Annual General Meeting to be held on 26 July 2012.

The directors' fees for the financial year ended 31 March 2012, as well as the proposed fee for the financial year ending on 31 March 2013, are set out in **Table 1**. Only 50% of the respective fee per meeting is payable in the case of non-attendance of a meeting.

MEDICLINIC
INTERNATIONAL

FINANCIAL STATEMENTS

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WWW.MEDICLINIC.COM

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DIRECTORS' RESPONSIBILITY STATEMENT

The directors of the Company are responsible for the maintenance of adequate accounting records and the preparation of the annual financial statements and related information in a manner that fairly presents the state of affairs of the Company. These annual financial statements are prepared in accordance with International Financial Reporting Standards and incorporate full and responsible disclosure in line with the accounting policies of the Group which are supported by prudent judgements and estimates.

The directors are also responsible for the maintenance of effective systems of internal control which are based on established organisational structures and procedures. These systems are designed to provide reasonable assurance as to the reliability of the annual financial statements, and to prevent and detect material misstatement and loss. These systems and procedures are implemented and monitored by suitably trained personnel with an appropriate segregation of authority and duties.

Nothing has come to the attention of the directors to indicate that any material interruption in the functioning of these controls, procedures and systems has occurred during the year under review.

The annual financial statements have been prepared on a going concern basis and the directors believe that the Company and the Group will continue to be in operation in the foreseeable future.

The annual financial statements have been prepared in compliance with the applicable requirements of the Companies Act 71 of 2008. The preparation of the annual financial statements was supervised by the Chief Financial Officer, Mr CI Tingle (CA(SA)).

The annual financial statements and group financial statements as set out on pages 114 to 175, have been approved by the Board of Directors and are signed on their behalf by:

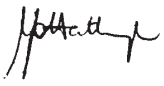
E DE LA H HERTZOG
Chairman

DP MEINTJES
Chief Executive Officer

Stellenbosch
22 May 2012

CERTIFICATE BY THE COMPANY SECRETARY

In terms of Section 88(2)(e) of the Companies Act 71 of 2008, as amended, I certify that the Group has filed with the Commissioner all such returns and notices as are required of a public company in terms of the Companies Act and that all such returns and notices are true, correct and up to date.



GC HATTINGH
Company Secretary

Stellenbosch
22 May 2012

AUDIT AND RISK COMMITTEE REPORT

This report is presented by the Company's Audit and Risk Committee (the "**Committee**") appointed by the Board and the shareholders in respect of the financial year ended 31 March 2012. It is prepared in accordance with the recommendations of King III and the requirements of the South African Companies Act, 71 of 2008, as amended, and describes how the Committee 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 2012.

COMPOSITION AND MEETINGS

The Committee consists of four independent non-executive directors (as set out in the table below), who are suitably skilled and experienced. Three Committee meetings were held during the year. The attendance of the Committee meetings was as follows:

Committee member	Qualifications*	May 2011	Nov 2011	Mar 2012
DK Smith (Chairman)	B.Sc., FASSA	✓	✓	✓
RE Leu	Master in Economics, Ph.D., Professor in Economics	✓	✓	✓
ZP Manase	B.Compt. (Hons), H.Dip. (Tax), CA(SA)	✓	✓	✓
AA Raath	B.Comm., CA (SA)	✓	✓	✓

* *Abridged curricula vitae of the current committee members appear on page 8 of the integrated annual report.*

The Chief Executive Officer, Chief Financial Officer, Group Risk Manager and representatives of the internal and external auditors are invited to attend the Committee meetings.

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 reviewed annually.

The Committee is satisfied that it has fulfilled all its statutory duties and duties assigned to it by the Board during the financial year under review, as further detailed below.

The Audit and Risk Committees of the Group's three operating platform companies, namely Mediclinic Southern Africa, Mediclinic Switzerland (in respect of the Hirslanden group) and Emirates Healthcare, report to the Committee. The Committee has considered their feedback and is satisfied that these committees have fulfilled their roles and responsibilities, which are materially the same as the role and responsibilities of the Committee.

EXTERNAL AUDIT

The Committee has during the period under review nominated independent external auditors, PricewaterhouseCoopers Inc., approved its fee and determined its terms of engagement. The appointment is presented to the shareholders of the Company at the annual general meeting for approval. The Committee is satisfied that the Company's external auditors are independent of the Group and are thereby able to conduct their audit functions without any influence from the Group.

A formal policy in respect of the independence and the provision of non-audit services by the external auditors of the Group and its subsidiaries ensures the maintained independence of the external auditors. In terms of the policy, the Committee is responsible for determining the nature and extent of any non-audit services that the external auditors may provide to the Group and pre-approve any proposed contract with the external auditors for the provision of non-audit services to the Company. Due to the use of different external auditors throughout the Group, the provision of non-audit services by the external auditors of the Company or the Operating Platforms to another Operating Platform or the Company, as the case may be, also requires the specific pre-approval by the Committee.

INTERNAL FINANCIAL AND ACCOUNTING CONTROL

The Committee is responsible for assessing the Group's systems of internal financial and accounting control. In this regard the Committee has, inter alia, considered the reports from the internal and external auditors and satisfied itself about the adequacy and effectiveness of the Group's systems of internal control. The committee also performed a review of the Company's Chief Financial Officer and the Group's finance function. Based on the review, the Committee has satisfied itself of the appropriateness of the expertise, resources and experience of the Group's Chief Financial Officer and finance function.

INTERNAL AUDIT

Internal audit forms an integral part of the Group's Enterprise-wide Risk Management ("ERM") to provide assurance on the effectiveness of the Group's risk management process and system of internal control, covering its operating divisions in Southern Africa and Switzerland, which represent the majority of the Group's operations. The committee is satisfied with the independence, quality and scope of the internal audit process.

Further details on the Group's internal audit functions are contained in the Risk Management Report.

RISK MANAGEMENT

The Committee is integral in the implementation of the Group's ERM Policy by monitoring the risk management processes and systems of internal control for the Group through the review of the activities of its operating divisions in Southern Africa, Switzerland and the Middle East, the Group's internal and external auditors, and the Group's risk management function. Further details on the Group's risk management function are contained in the Risk Management Report.

The Committee is satisfied that the system as well as the process of risk management are effective.

COMPLIANCE

The Committee is responsible for reviewing any major breach of relevant legal, regulatory and other responsibilities. The Committee is satisfied that there has been no material non-compliance with laws and regulations.

PUBLIC REPORTING

The Committee is responsible for considering and making recommendations to the Board relating to the Group's integrated annual report, the financial statements and any other reports (with reference to the financial affairs of the Group) for external distribution or publication, including those required by any regulatory or statutory authority. The integrated annual report of the Company for the period under review has been approved by the Board upon the recommendation of the Committee.

The Committee is satisfied that it has complied with all its legal, regulatory and other responsibilities during the period under review.

DK SMITH
Chairman: Audit and Risk Committee

Stellenbosch
22 May 2012

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

We have audited the group annual financial statements and annual financial statements of Mediclinic International Limited, which comprise the consolidated and separate statements of financial position as at 31 March 2012, and the consolidated and separate income statements, statements of comprehensive income, changes in equity and cash flows for the year then ended, and a summary of significant accounting policies and other explanatory notes, and the directors' report, as set out on pages 114 to 175.

DIRECTORS' RESPONSIBILITY FOR THE FINANCIAL STATEMENTS

The Company's directors are responsible for the preparation and fair presentation of these financial statements in accordance with International Financial Reporting Standards and the requirements of the Companies Act of South Africa, and for such internal control as the directors determine is necessary to enable the preparation of financial statements that are free from material misstatements, whether due to fraud or error.

AUDITOR'S RESPONSIBILITY

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

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgement, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

OPINION

In our opinion, the financial statements present fairly, in all material respects, the consolidated and separate financial position of Mediclinic International Limited as at 31 March 2012, and its consolidated and separate financial performance and its consolidated and separate cash flows for the year then ended in accordance with International Financial Reporting Standards and the requirements of the Companies Act of South Africa.

PRICEWATERHOUSECOOPERS INC.
Director: NH Döman
Registered Auditor

Stellenbosch
22 May 2012

DIRECTORS' REPORT
TO THE SHAREHOLDERS FOR THE YEAR ENDED 31 MARCH 2012

NATURE OF ACTIVITIES
The main business of the Group is to enhance the quality of life of patients by providing comprehensive, high-quality hospital services on a cost-effective basis.

GENERAL REVIEW OF ACTIVITIES
The Group currently operates 52 hospitals in Southern Africa, 14 hospitals in Switzerland and two hospitals and eight clinics in the UAE.

The financial results are fully disclosed in the income statement and discussed in the chief financial officer's report. The business environment of the healthcare industry in Southern Africa, Switzerland and the UAE is discussed in the Operational Reviews. As discussed in Mediclinic Switzerland's Operational Review, the regulatory environment in Switzerland has undergone major changes since 1 January 2012 with a new financing and tariff system for mandatory basic insured patients being implemented. Although the new system is operational, there are still a number of areas that are not concluded and still uncertain (refer to note 4(a)).

SHARE CAPITAL
The authorised share capital remained unchanged during the year under review.

There was no movement in the number of issued ordinary shares during the year, which remains at 652 315 341 shares of 10 cents each.

The Group's treasury shares comprise shares issued to the employee share trust (the Mpilo Trusts) as well as treasury shares held through a wholly owned subsidiary. Further details are given in note 15 and note 29.

DISTRIBUTION TO SHAREHOLDERS
The Board of Directors has declared a final dividend of 55.0 cents (2011: 50.0) per ordinary share on 22 May 2012. This, together with the interim dividend of 23.0 cents (2011: 23.0) per share, brings the total dividend for the year to 78.0 cents (2011: 73.0) per share.

	2012 R'000	2011 R'000
Interim distribution of 23.0 cents (2011: 23.0 cents)	**150 033**	150 033
Final distribution of 55.0 cents (2011: 50.0 cents)	**358 773**	326 158
	508 806	476 191

MANAGEMENT
Remgro Management Services Limited, a wholly owned subsidiary of Remgro Limited, is a service company which provides limited specialised management services on request to the Group. The Group does not own any shares in this company.

HOLDING COMPANY, SUBSIDIARIES, JOINT VENTURES AND ASSOCIATES
Remgro Limited, through a wholly owned subsidiary, presently holds 43.4% (2011: 43.4%) of the issued ordinary shares. Details of subsidiaries, joint ventures and associates appear in the annexure on pages 170 and 172.

DIRECTORS AND SECRETARY
The names of the directors and secretary of the Company, as well as the latter's postal address, appear on pages 8 to 9 and on the inside of the back cover.

There have been no changes to the Board of Directors during the year. On 26 April 2012 Mr Thys Visser who served on the Board as a non-executive director since 2005, tragically passed away.

The Board recommends that directors' fees for services rendered during the past financial year be fixed at R3 248 803 (2011: R2 396 298) as set out on page 153.

DIRECTORS' INTERESTS
Details of the direct and indirect interest in the issued permanent capital structure of the Company by directors are set out on page 174. Indirect interests through listed public companies have not been taken into account. No material change in the interest of directors has taken place between the financial year end and the date of this report, except as indicated.

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.

SPECIAL RESOLUTIONS BY SUBSIDIARIES
As required in terms of section 8.63(i) of the JSE Listings Requirements, the following special resolutions or other shareholder resolutions were passed by the Company's subsidiaries relating to capital structure, borrowing powers, the object clause contained in the Memorandum of Incorporation or other material matter that affects the Company and its subsidiaries for the period under review:

- Emirates Healthcare Limited (BVI): It was resolved to replace the Memorandum and Articles of Association of the company in order to

  a. increase the authorised capital of the company from US$50 000 divided into 50 000 shares with a par value of US$1 each to US$250 000 divided into 250 000 shares with a par value of US$1 each;
  b. amend the required approval necessary to amend or modify the company's Memorandum and Articles of Association;
  c. include more detailed provisions that apply to the transfer of the company's shares;
  d. include more detailed provisions that apply to the appointment of a proxy by any shareholder of the company;

- E Thekwini Private Hospital (Pty) Ltd: The company, a wholly owned subsidiary, will be used for the restructuring of Mediclinic Thabazimbi, which is currently operated through a trust. In order to align the company's Memorandum of Incorporation with the Companies Act, it was resolved to convert the company's ordinary par value shares to ordinary shares having no par value and to replace the company's Memorandum of Incorporation. It was further resolved to increase the company's authorised shares from 1 000 ordinary shares to 100 000 ordinary shares and to change the company's name to "Mediclinic Thabazimbi (Pty) Ltd".

- Mediclinic Tzaneen (Pty) Ltd: It was resolved to convert the company's ordinary par value shares to ordinary shares having no par value and to sub-divide this company's authorised and issued shares through a sub-division of the authorised and issued shares, increasing the authorised shares from 1 000 ordinary shares to 100 000 ordinary shares and increasing the number of issued shares from 180 ordinary shares to 18 000 ordinary shares.

The majority of the Company's subsidiaries which previously had the word "Medi-Clinic" in its name also passed the required special or other shareholder resolutions during the period under review to amend the subsidiary companies' names by replacing the word "Medi-Clinic" with "Mediclinic" in line with the new brand of the Company which was launched in June 2011.

Details of subsidiaries appear in the annexure to the annual financial statements on pages 170 to 172 of this integrated annual report.

STATEMENTS OF FINANCIAL POSITION
AS AT 31 MARCH 2012

COMPANY				GROUP	
2011 R'm	**2012 R'm**		Notes	**2012 R'm**	2011 R'm
		ASSETS			
6 279	**6 273**	**Non-current assets**		**42 033**	36 929
–	**–**	Property, equipment and vehicles	5	**34 808**	30 409
–	**–**	Intangible assets	6	**6 350**	5 565
6 278	**6 273**	Interest in subsidiary	7	**–**	–
–	**–**	Investments in associates	8	**1**	4
–	**–**	Other investments and loans	10	**662**	708
–	**–**	Derivative financial instruments	22	**–**	33
1	**–**	Deferred income tax assets	11	**212**	210
–	**–**	**Current assets**		**8 162**	6 608
–	**–**	Inventories	12	**582**	522
–	**–**	Trade and other receivables	13	**4 815**	3 796
–	**–**	Current income tax assets		**4**	–
–	**–**	Derivative financial instruments	22	**24**	–
–	**–**	Other investments and loans	10	**128**	–
–	**–**	Investment in money market funds	14	**510**	723
–	**–**	Cash and cash equivalents		**2 099**	1 567
6 279	**6 273**	**Total assets**		**50 195**	43 537
		EQUITY			
		Capital and reserves			
65	**65**	Ordinary shares		**65**	65
6 066	**6 066**	Share premium		**6 066**	6 066
–	**–**	Treasury shares		**(269)**	(288)
6 131	**6 131**	Share capital	15	**5 862**	5 843
19	**7**	Retained earnings	16	**4 171**	3 786
129	**135**	Other reserves	17	**83**	(140)
6 279	**6 273**	**Attributable to equity holders of the Company**		**10 116**	9 489
–	**–**	**Non-controlling interests**	18	**1 288**	1 071
6 279	**6 273**	**Total equity**		**11 404**	10 560
		LIABILITIES			
–	**–**	**Non-current liabilities**		**32 969**	27 922
–	**–**	Borrowings	19	**22 864**	20 414
–	**–**	Deferred income tax liabilities	11	**5 303**	4 773
–	**–**	Retirement benefit obligations	20	**823**	383
–	**–**	Provisions	21	**240**	182
–	**–**	Derivative financial instruments	22	**3 739**	2 170
–	**–**	**Current liabilities**		**5 822**	5 055
–	**–**	Trade and other payables	23	**3 460**	2 938
–	**–**	Borrowings	19	**1 930**	1 834
–	**–**	Provisions	21	**121**	89
–	**–**	Derivative financial instruments	22	**–**	48
–	**–**	Current income tax liabilities		**311**	146
–	**–**	**Total liabilities**		**38 791**	32 977
6 279	**6 273**	**Total equity and liabilities**		**50 195**	43 537

INCOME STATEMENTS
FOR THE YEAR ENDED 31 MARCH 2012

COMPANY				GROUP	
2011 R'm	**2012 R'm**		Notes	**2012 R'm**	2011 R'm
486	**507**	**Revenue**		**21 986**	18 625
–	**–**	Cost of sales		**(12 314)**	(10 327)
–	**(5)**	Administration and other operating expenses	24	**(5 003)**	(4 112)
486	**502**	**Operating profit before depreciation (EBITDA)**		**4 669**	4 186
		Depreciation and amortisation		**(910)**	(738)
486	**502**	**Operating profit**		**3 759**	3 448
–	**–**	Other gains and losses	25	**(26)**	13
–	**–**	Income from associates		**1**	4
–	**–**	Finance income		**85**	61
–	**–**	Finance cost	27	**(1 642)**	(1 491)
486	**502**	**Profit before tax**		**2 177**	2 035
(37)	**(38)**	Income tax expense	28	**(693)**	(654)
449	**464**	**Profit for the year**		**1 484**	1 381
		Attributable to:			
		Equity holders of the Company		**1 221**	1 177
		Non-controlling interests		**263**	204
				1 484	1 381
		Earnings per ordinary share attributable to the equity holders of the Company – cents			
		Basic	29	**194.7**	195.3
		Diluted	29	**187.3**	186.9

STATEMENTS OF COMPREHENSIVE INCOME
FOR THE YEAR ENDED 31 MARCH 2012

COMPANY				GROUP	
2011 R'm	**2012 R'm**		Notes	**2012 R'm**	2011 R'm
449	**464**	**Profit for the year**		**1 484**	1 381
		Other comprehensive income			
–	**–**	Currency translation differences	17 & 18	**1 405**	488
–	**–**	Fair value adjustment – cash flow hedges	17	**(1 126)**	246
–	**–**	Actuarial gains and losses	16	**(403)**	(73)
–	**–**	**Other comprehensive income/(loss), net of tax**	30	**(124)**	661
449	**464**	**Total comprehensive income for the year**		**1 360**	2 042
		Attributable to:			
		Equity holders of the Company		**1 035**	1 877
		Non-controlling interests		**325**	165
				1 360	2 042

STATEMENTS OF CHANGES IN EQUITY
FOR THE YEAR ENDED 31 MARCH 2012

	Share capital (note 15) R'm	Share premium (note 15) R'm	Treasury shares (note 15) R'm	Share-based payment reserve (note 17) R'm
Balance at 31 March 2010	59	4 741	(311)	123
Shares issued	6	1 358	–	–
Share issue costs	–	(33)	–	–
Utilised by the Mpilo Trusts	–	–	6	–
Utilised for share option scheme	–	–	17	–
Share-based payment expense	–	–	–	6
Change in shareholding of subsidiaries	–	–	–	–
Total comprehensive income/(loss) for the year	–	–	–	–
Dividends paid	–	–	–	–
Balance at 31 March 2011	**65**	**6 066**	**(288)**	**129**
Utilised by the Mpilo Trusts	**–**	**–**	**7**	**–**
Utilised for employee incentive schemes	**–**	**–**	**21**	**–**
Treasury shares purchased	**–**	**–**	**(9)**	**–**
Share-based payment expense	**–**	**–**	**–**	**6**
Change in shareholding of subsidiaries	**–**	**–**	**–**	**–**
Transactions with non-controlling shareholders	**–**	**–**	**–**	**–**
Total comprehensive income/(loss) for the year	**–**	**–**	**–**	**–**
Dividends paid	**–**	**–**	**–**	**–**
Balance at 31 March 2012	**65**	**6 066**	**(269)**	**135**

Balance at 31 March 2010	59	4 741	–	123
Shares issued	6	1 358	–	–
Share issue costs	–	(33)	–	–
Share-based payment expense	–	–	–	6
Total comprehensive income for the year	–	–	–	–
Dividends paid	–	–	–	–
Balance at 31 March 2011	**65**	**6 066**	**–**	**129**
Share-based payment expense	**–**	**–**	**–**	**6**
Total comprehensive income for the year	**–**	**–**	**–**	**–**
Dividends paid	**–**	**–**	**–**	**–**
Balance at 31 March 2012	**65**	**6 066**	**–**	**135**

GROUP

Foreign currency translation reserve (note 17) R'm	Hedging reserve (note 17) R'm	Retained earnings (note 16) R'm	Share-holders' equity R'm	Non-controlling interests (note 18) R'm	Total equity R'm
1 301	(2 343)	3 080	6 650	966	7 616
–	–	–	1 364	–	1 364
–	–	–	(33)	–	(33)
–	–	–	6	–	6
–	–	–	17	–	17
–	–	–	6	–	6
–	–	–	–	(1)	(1)
527	246	1 104	1 877	165	2 042
–	–	(398)	(398)	(59)	(457)
1 828	**(2 097)**	**3 786**	**9 489**	**1 071**	**10 560**
–	**–**	**–**	**7**	**–**	**7**
–	**–**	**–**	**21**	**–**	**21**
–	**–**	**–**	**(9)**	**–**	**(9)**
–	**–**	**–**	**6**	**–**	**6**
–	**–**	**–**	**–**	**3**	**3**
–	**–**	**3**	**3**	**–**	**3**
1 343	**(1 126)**	**818**	**1 035**	**325**	**1 360**
–	**–**	**(436)**	**(436)**	**(111)**	**(547)**
3 171	**(3 223)**	**4 171**	**10 116**	**1 288**	**11 404**

COMPANY

–	–	17	4 940	–	4 940
–	–	–	1 364	–	1 364
–	–	–	(33)	–	(33)
–	–	–	6	–	6
–	–	449	449	–	449
–	–	(447)	(447)	–	(447)
–	**–**	**19**	**6 279**	**–**	**6 279**
–	**–**	**–**	**6**	**–**	**6**
–	**–**	**464**	**464**	**–**	**464**
–	**–**	**(476)**	**(476)**	**–**	**(476)**
–	**–**	**7**	**6 273**	**–**	**6 273**

STATEMENTS OF CASH FLOWS
FOR THE YEAR ENDED 31 MARCH 2012

COMPANY				GROUP	
2011 R'm Inflow/ (outflow)	**2012 R'm Inflow/ (outflow)**		Notes	**2012 R'm Inflow/ (outflow)**	2011 R'm Inflow/ (outflow)
		CASH FLOW FROM OPERATING ACTIVITIES			
–	**–**	Cash received from customers		**21 704**	18 352
–	**(5)**	Cash paid to suppliers and employees		**(17 438)**	(14 173)
–	**(5)**	Cash generated from operations	31.1	**4 266**	4 179
486	**507**	Dividends received		**–**	–
–	**–**	Interest received		**51**	45
–	**–**	Interest paid	31.2	**(1 576)**	(1 413)
(39)	**(38)**	Tax paid	31.3	**(525)**	(495)
447	**464**	Net cash generated from operating activities		**2 216**	2 316
(1 331)	**12**	**CASH FLOW FROM INVESTMENT ACTIVITIES**		**(1 055)**	(2 563)
–	**–**	Investment to maintain operations	31.4	**(731)**	(645)
–	**–**	Investment to expand operations	31.5	**(742)**	(778)
–	**–**	Proceeds on disposal of property, equipment and vehicles	31.6	**23**	24
–	**–**	Insurance proceeds		**27**	57
(1 331)	**12**	Proceeds from other investments and loans		**5**	120
–	**–**	Proceeds from derivative financial instrument		**24**	–
–	**–**	Proceeds from FVTPL financial assets		**134**	–
–	**–**	Purchases of FVTPL financial assets		**(144)**	(688)
–	**–**	Proceeds from money market funds		**823**	
–	**–**	Purchases of money market funds		**(507)**	(672)
–	**–**	Interest received		**33**	19
(884)	**476**	Net cash generated/(utilised) before financing activities		**1 161**	(247)
884	**(476)**	**CASH FLOW FROM FINANCING ACTIVITIES**		**(735)**	688
1 364	**–**	Proceeds of shares issued		**–**	1 364
(33)	**–**	Share issue costs		**–**	(33)
–	**–**	Distributions to non-controlling interests	18	**(111)**	(59)
(447)	**(476)**	Distributions to shareholders	31.7	**(436)**	(398)
–	**–**	Repayments of borrowings		**(214)**	(208)
–	**–**	Contributions by non-controlling interests		**7**	–
–	**–**	Acquisition of non-controlling interest		**–**	(1)
–	**–**	Treasury shares purchased		**(9)**	–
–	**–**	Proceeds from disposal of treasury shares		**28**	23
–	**–**	Net increase in cash, cash equivalents and bank overdrafts		**426**	441
–	**–**	Opening balance of cash, cash equivalents and bank overdrafts		**1 447**	967
–	**–**	Exchange rate fluctuations on foreign cash		**108**	39
–	**–**	Closing balance of cash, cash equivalents and bank overdrafts	31.8	**1 981**	1 447

NOTES TO THE ANNUAL FINANCIAL STATEMENTS
FOR THE YEAR ENDED 31 MARCH 2012

1. GENERAL INFORMATION
Mediclinic International Limited ("the Company") and its subsidiaries ("the Group") operate multi-disciplinary private hospitals.

The main business of the Group is to enhance the quality of life of patients by providing comprehensive, high-quality hospital services on a cost-effective basis.

The Company is a limited liability company incorporated and domiciled in South Africa. The address of its registered offices is:

Mediclinic Offices, Strand Road, Stellenbosch 7600.

The Company is listed on the JSE Limited.

These annual financial statements have been approved for issue by the Board of Directors on 22 May 2012.

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

2.1 BASIS OF PREPARATION
The annual financial statements of the Group are prepared in accordance with International Financial Reporting Standards (IFRS), the requirements of The South African Companies Act, as amended, and the Listings Requirements of the JSE Limited. The financial statements are prepared on the historical cost convention, as modified by the revaluation of certain financial instruments to fair value.

The preparation of the financial statements in conformity with IFRS requires the use of certain critical accounting estimates. It also requires management to exercise its judgement in the process of applying the Company's accounting policies. The areas involving a higher degree of judgement or complexity, or areas where assumptions and estimates are significant to the annual financial statements, are disclosed in note 4.

2.2 CONSOLIDATION AND EQUITY ACCOUNTING
a) Subsidiaries

Subsidiaries are all entities (including special purpose entities) over which the Group has the power to govern the financial and operating policies generally accompanying a shareholding of more than one half of the voting rights. The existence and effect of potential voting rights that are currently exercisable or convertible are considered when assessing whether the Group controls another entity. Subsidiaries are fully consolidated from the date on which control is transferred to the Group. They are no longer consolidated from the date that control ceases.

The Group uses the acquisition method of accounting to account for business combinations. The consideration transferred for the acquisition of a subsidiary is the fair values of the assets transferred, the liabilities incurred and the equity interests issued by the Group. The consideration transferred includes the fair values of any asset or liability resulting from a contingent consideration arrangement. Acquisition-related costs are expensed as incurred. Identifiable assets acquired and liabilities and contingent liabilities assumed in a business combination are measured initially at their fair values at the acquisition date. On an acquisition-by-acquisition basis, the Group recognises any non-controlling interest in the acquiree either at fair value or at the non-controlling interest's proportionate share of the acquiree's net assets.

Investments in subsidiaries are accounted for at cost less impairment. Cost is adjusted to reflect changes in consideration arising from contingent consideration amendments. Cost also includes any direct attributable costs of investment.

The excess of the consideration transferred, the amount of any non-controlling interest in the acquiree and the acquisition-date fair value of any previous equity interest in the acquiree over the fair value of the Group's share of the identifiable net assets acquired is recorded as goodwill. If this is less than the fair value of the net assets of the subsidiary acquired in the case of a bargain purchase, the difference is recognised directly in the statement of comprehensive income.

Intercompany transactions, balances and unrealised gains on transactions between group companies are eliminated. Unrealised losses are also eliminated. Accounting policies of subsidiaries have been changed where necessary to ensure consistency with the policies adopted by the Group.

b) Transactions and non-controlling interests

The Group treats transactions with non-controlling interests as transactions with equity owners of the Group. For purchases from non-controlling interests, the difference between any consideration paid and the relevant share acquired of the carrying value of net assets of the subsidiary is recorded

in equity. Gains or losses on disposals to non-controlling interests are also recorded in equity.

c) *Joint ventures*
The Group's interests in jointly controlled entities are accounted for by proportionate consolidation. The Group combines its share of the joint venture's individual income and expenses, assets and liabilities and cash flows on a line-by-line basis with similar items in the Group's financial statements. The Group recognises the portion of gains or losses on the sale of assets by the Group to the joint venture that is attributable to the other venturers. The Group does not recognise its share of profits or losses from the joint venture that result from the Group's purchase of assets from the joint venture until it resells the assets to an independent party. However, a loss on the transaction is recognised immediately if the loss provides evidence of a reduction in the net realisable value of current assets, or an impairment loss.

d) *Associates*
Companies and other entities in which the Group has an interest and over which the Group has the ability to exercise significant influence, but not control, are treated as associates on the equity method and are initially recognised at cost. According to the equity method, the share of post-acquisition reserves and retained income is included in the carrying value.

The Group's share of its associates' post-acquisition profits or losses is recognised in the income statement, and its share of post-acquisition movements in other comprehensive income is recognised in other comprehensive income. The cumulative post-acquisition movements are adjusted against the carrying amount of the investment. When the Group's share of losses in an associate equals or exceeds its interest in the associate, including any other unsecured receivables, the Group does not recognise further losses, unless it has incurred obligations or made payments on behalf of the associate.

Unrealised gains on transactions between the Group and its associates are eliminated to the extent of the Group's interest in the associates. Unrealised losses are also eliminated unless the transaction provides evidence of an impairment of the asset transferred. Associates' accounting policies have been changed where necessary to ensure consistency with the policies adopted by the Group.

2.3 SEGMENT REPORTING

Consistent with internal reporting, the Group's segments are identified as Hospital Services and Hospital Properties at the three platforms in Southern Africa, Switzerland and the Middle East. The reportable segments are distinguished by the type of service provided at the different geographical locations. The type of service is as follows:

i) Hospital Services: Operate multi-disciplinary private hospitals.
ii) Hospital Properties: Rent hospitals to Hospital Services.

2.4 PROPERTY, EQUIPMENT AND VEHICLES

Land and buildings comprise mainly hospitals and offices. All property, equipment and vehicles are shown at cost less subsequent depreciation and impairment, except for land, which is shown at cost less impairment. Cost includes expenditure that is directly attributable to the acquisition of the items. Subsequent costs are included in the asset's carrying amount or recognised as a separate asset, as appropriate, only when it is probable that future economic benefits associated with the item will flow to the Group and the cost of the item can be measured reliably. All other repairs and maintenance costs are charged to the income statement during the financial period in which they are incurred.

Land is not depreciated. Depreciation on the other assets is calculated using the straight-line method to allocate the cost of each asset to its residual value over its estimated useful life, as follows:

– Buildings:	50 – 100 years
– Leasehold improvements:	10 years
– Equipment:	3 – 10 years
– Furniture and vehicles:	3 – 8 years

The assets' residual values and useful lives are reviewed, and adjusted if appropriate, at each statement of financial position date.

For a private hospital it is fundamentally important that the earnings potential of a building is placed on a permanent basis. The Group therefore follows a structured maintenance programme with regards to hospital buildings with the specific goal to prolong the useful lifetime of these buildings.

An asset's carrying amount is written down immediately to its recoverable amount if the asset's carrying amount is greater than its estimated recoverable amount.

Profit or loss on disposals is determined by comparing proceeds with carrying amounts. These are included in the income statement.

2.5 INTANGIBLE ASSETS

a) Trade names

Trade names that are deemed to have an indefinite useful life are carried at cost less accumulated impairment losses. Trade names that are deemed to have a finite useful life are capitalised at the cost to the Group and amortised on the straight-line basis over its estimated useful lifetime. No value is placed on internally developed trade names. Expenditure to maintain trade names is accounted for against income as incurred.

b) Goodwill

Goodwill represents the excess of the cost of an acquisition over the fair value of the Group's share of the net identifiable assets of the acquired subsidiary or associate at the date of acquisition. Goodwill on acquisition of subsidiaries is included in intangible assets. Goodwill on acquisition of associates is included in investments in associates. Goodwill is tested annually for impairment and carried at cost less accumulated impairment losses. Impairment losses on goodwill are not reversed. Gains and losses on the disposal of an entity include the carrying amount of goodwill relating to the entity sold.

Goodwill is allocated to cash-generating units (CGUs) for the purpose of impairment testing. The allocation is made to those CGUs or groups of CGUs that are expected to benefit from business combinations in which goodwill arose. CGUs have been defined as certain hospital groupings within the Group.

c) Computer software

Acquired computer software licences and internally developed software programmes are capitalised on the basis of the costs incurred to acquire and bring to use the specific software. These costs are amortised over their estimated useful lives (1 – 5 years). Costs associated with maintaining computer software programmes or development expenditure that does not meet the recognition criteria are recognised as an expense as incurred.

2.6 IMPAIRMENT OF NON-FINANCIAL ASSETS

Assets that have an indefinite useful life are not subject to amortisation and are tested annually for impairment and whenever events or changes in circumstance indicate that the carrying amount may not be recoverable. Assets that are subject to amortisation are tested for impairment whenever events or changes in circumstance indicate that the carrying amount may not be recoverable. An impairment loss is recognised for the amount by which the asset's carrying amount exceeds its recoverable amount. The recoverable amount is the higher of an asset's fair value less costs to sell and value in use. For the purposes of assessing impairment, assets are grouped at the lowest levels for which there are separately identifiable cash flows (CGUs). Non-financial assets other than goodwill that suffered an impairment are reviewed for possible reversal of the impairment at each reporting date.

2.7 FINANCIAL ASSETS

The Group classifies its financial assets in the following categories: loans and receivables, available-for-sale financial assets and financial assets at fair value through profit and loss. The classification depends on the purpose for which the asset was acquired. Management determines the classification of its investments at initial recognition.

Purchases and sales of investments are recognised on trade date – the date on which the Group commits to purchase or sell the asset. Investments are initially recognised at fair value plus transaction costs for all financial assets not subsequently carried at fair value through profit or loss.

Financial assets are derecognised when the rights to receive cash flows from the financial assets have expired or have been transferred and the Group has transferred substantially all risks and rewards of ownership.

Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments that are not quoted in an active market. Loans and receivables are included in current assets, except for maturities greater than 12 months after the statement of financial position date, which are classified as non-current assets. Loans and receivables are carried at amortised cost using the effective interest rate method.

Investments available-for-sale

Other long-term investments are classified as available-for-sale and are included within non-current assets unless management intends to dispose of the investment within twelve months of the statement of financial position date. These investments are carried at fair value. Unrealised gains and losses arising from changes in the fair value of available-for-sale investments are recognised in other comprehensive income in the period in which they arise. When available-for-sale investments are either sold or impaired, the accumulated fair value adjustments are realised and included in profit or loss.

Financial assets at fair value through profit and loss
These instruments, consisting of financial instruments held-for-trading and those designated at fair value through profit and loss at inception, are carried at fair value. Derivatives are also classified as held-for-trading unless they are designated as hedges. Realised and unrealised gains and losses arising from changes in the fair value of these financial instruments are recognised in the income statement in the period in which they arise.

Impairment
The Group assesses at each statement of financial position date whether there is objective evidence that a financial asset or a group of financial assets is impaired. A financial asset is impaired and impairment losses are incurred only if there is objective evidence of impairment as a result of one or more events that occurred after the initial recognition of the asset and that loss has an impact on the estimated future cash flows of the financial asset that can be reliably estimated. In the case of equity investments classified as available-for-sale, a significant or prolonged decline in the fair value of the security below its cost is considered an indicator that the investments are impaired. If any such evidence exists for available-for-sale financial assets, the cumulative loss – measured as the difference between the acquisition cost and the current fair value, less any impairment loss on that financial asset previously recognised in profit or loss – is removed from equity and recognised in the income statement.

Impairment losses recognised in the income statement on equity instruments are not reversed through the income statement.

2.8 INVENTORIES

Inventories are valued at the lower of cost, determined on the first-in, first-out method, or net realisable value. The valuation excludes borrowing costs. Net realisable value is the estimated selling price in the ordinary course of business, less applicable variable selling expenses.

2.9 TRADE AND OTHER RECEIVABLES

Trade and other receivables are recognised at fair value and subsequently measured at amortised cost, less provision for impairment. A provision for impairment of trade receivables is established when there is objective evidence that the Group will not be able to collect all amounts due according to the original terms of the receivables. The amount of the provision is the difference between the asset's carrying amount and the present value of estimated future cash flows. The amount of the provision is recognised in the income statement.

2.10 CASH AND CASH EQUIVALENTS

Cash and cash equivalents consist of balances with banks and cash on hand and are classified as loans and receivables. Bank overdrafts are classified as financial liabilities at amortised cost and are disclosed as part of borrowings in current liabilities in the statement of financial position.

2.11 DERIVATIVE FINANCIAL INSTRUMENTS AND HEDGING ACTIVITIES

Derivatives are initially recognised at fair value on the date a derivative contract is entered into and are subsequently measured at fair value. The method of recognising the resulting gain or loss depends on whether the derivative is designated as a hedging instrument, and if so, the nature of the item being hedged. Hedges of a particular risk associated with a recognised liability or a highly probable forecast transaction is designated as a cash flow hedge.

The Group documents, at inception of the transaction, the relationship between hedging instruments and hedged items, as well as its risk management objectives and strategy for undertaking various hedging transactions. The Group also documents its assessment, both at hedge inception and on an ongoing basis, of whether the derivatives that are used in hedging transactions are highly effective in offsetting cash flows of hedged items.

The fair values of various derivative instruments used for hedging purposes are disclosed in note 22. The hedging reserve in shareholders' equity is shown in note 17. On the statement of financial position hedging derivatives are not classified based on whether the amount is expected to be recovered or settled within, or after, 12 months. The full fair value of a hedging derivative is classified as a non-current asset or liability when the remaining maturity of the hedge relationship is more than 12 months; it is classified as a current asset or liability when the remaining maturity of the hedge relationship is less than 12 months.

Cash flow hedge
The effective portion of changes in the fair value of derivatives that is designated and qualify as cash flow hedges is recognised in other comprehensive income. The gain or loss relating to the ineffective portion is recognised immediately in the income statement.

Amounts accumulated in equity are recycled to the income statement in the periods when the hedged item affects profit or loss (for example, when the forecast sale that is hedged takes place). The gain or loss relating to the effective portion of interest rate swaps hedging variable rate borrowings is recognised in the income statement within finance cost. The gain or loss relating to the effective

portion of forward foreign exchange contracts hedging export sales is recognised in the income statement within sales. However, when the forecast transaction that is hedged results in the recognition of a non-financial asset (for example, inventory or fixed assets), the gains and losses previously deferred in equity are transferred from equity and included in the initial measurement of the cost of the asset. The deferred amounts are ultimately recognised in cost of goods sold in case of inventory, or in depreciation in case of fixed assets.

When a hedging instrument expires or is sold, or when a hedge no longer meets the criteria for hedge accounting, any cumulative gain or loss existing in equity at that time remains in equity and is recognised when the forecast transaction is ultimately recognised in the income statement. When a forecast transaction is no longer expected to occur, the cumulative gain or loss that was reported in equity is immediately transferred to the income statement.

2.12 SHARE CAPITAL

Ordinary shares are classified as equity. Shares in the Company held by wholly owned group companies are classified as treasury shares and are held at cost.

Incremental costs directly attributable to the issue of new shares or options are shown in equity as a deduction from the proceeds, net of tax. Where any Group company purchases the Company's equity share capital (treasury shares), the consideration paid, including any directly attributable incremental costs (net of income taxes), is deducted from equity attributable to the Company's equity holders until the shares are cancelled, reissued or disposed of. Where such shares are subsequently sold or reissued, any consideration received, net of any directly attributable incremental transaction costs and the related income tax effects, is included in equity attributable to the Company's equity holders.

The difference between the fair value of the equity instruments issued in a BEE transaction and the fair value of the cash and other assets received is recognised as an expense on grant date, with a corresponding increase in equity.

2.13 TREASURY SHARES

Treasury shares are deducted from equity. No gains or losses are recognised in profit or loss on the purchase, sale, issue or cancellation of treasury shares. All consideration paid or received for treasury shares is recognised directly in equity.

2.14 TRADE AND OTHER PAYABLES

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

2.15 BORROWINGS

Borrowings are recognised initially at fair value, net of transaction costs incurred. Borrowings are subsequently stated at amortised cost. Any difference between the proceeds (net of transaction costs) and the redemption value is recognised in the income statement over the period of the borrowings using the effective interest rate method. Borrowings are classified as current liabilities unless the Group has an unconditional right to defer settlement of the liability for at least 12 months after the statement of financial position date.

Borrowing costs are expensed when incurred, except for borrowing costs directly attributable to the construction or acquisition of qualifying assets. Borrowing cost directly attributable to the construction or acquisition of qualifying assets is added to the cost of those assets, until such time as the assets are substantially ready for their intended use.

2.16 PROVISIONS

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

2.17 CURRENT AND DEFERRED INCOME TAX

The tax expense for the period comprises current and deferred tax. Tax is recognised in the income statement, except to the extent that it relates to items recognised in other comprehensive income or directly in equity. In this case, the tax is also recognised in other comprehensive income or directly in equity, respectively.

The current income tax charge is calculated on the basis of the tax laws enacted or substantively enacted at the reporting date in the countries where the Company and its subsidiaries operate and generate taxable income. Management periodically evaluates positions taken in tax returns with respect to situations in which applicable tax regulation is subject to interpretation. It establishes provisions where appropriate on the basis of amounts expected to be paid to the tax authorities.

Deferred income tax is recognised, using the liability method, on temporary differences arising between the tax bases of assets and liabilities and their carrying amounts in the consolidated financial statements. However, deferred tax liabilities are not recognised if they arise from the initial recognition of goodwill; deferred income tax is not accounted for if it arises from initial recognition of an asset or liability in a transaction other than a business combination that at the time of the transaction

affects neither accounting nor taxable profit or loss. Deferred income tax is determined using tax rates (and laws) that have been enacted or substantially enacted by the reporting date and are expected to apply when the related deferred income tax asset is realised or the deferred income tax liability is settled.

Deferred income tax assets are recognised only to the extent that it is probable that future taxable profit will be available against which the temporary differences can be utilised.

Deferred income tax is provided on temporary differences arising on investments in subsidiaries and associates, except for deferred income tax liability where the timing of the reversal of the temporary difference is controlled by the Group and it is probable that the temporary difference will not reverse in the foreseeable future.

Deferred income tax assets and liabilities are offset when there is a legally enforceable right to offset current tax assets against current tax liabilities and when the deferred income tax assets and liabilities relate to income taxes levied by the same taxation authority on either the same taxable entity or different taxable entities where there is an intention to settle the balances on a net basis.

Secondary taxation on companies (STC) was provided for in respect of dividend payments, net of dividends received or receivable and is recognised as a taxation charge for the year.

2.18 EMPLOYEE BENEFITS

a) Retirement benefit costs

The Group provides defined benefit and defined contribution plans for the benefit of employees, the assets of which are held in separate trustee administered funds. These plans are funded by payments from the employees and the Group, taking into account recommendations of independent qualified actuaries.

Defined contribution plans

A defined contribution plan is a pension plan under which the Group pays fixed contributions into a separate entity. The Group has no legal or constructive obligations to make further contributions if the fund does not hold sufficient assets to pay all employees the benefits relating to employee service in the current and prior periods. The contributions are recognised as employee benefit expense when they are due.

Defined benefit plans

A defined benefit plan is a plan that is not a defined contribution plan. This plan defines an amount of pension benefit an employee will receive on retirement, dependent on one or more factors such as age, years of service and compensation. The liability recognised in the statement of financial position in respect of defined benefit pension plans is the present value of the defined benefit obligation at the statement of financial position date less the fair value of plan assets. The defined benefit obligation is calculated at least every three years by independent actuaries using the projected unit credit method. The present value of the defined benefit obligation is determined by discounting the estimated future cash outflows using interest rates of high-quality corporate bonds that are denominated in the currency in which the benefits will be paid and that have terms to maturity approximating the terms of the related pension liability. Current service costs are recognised immediately in income.

Actuarial gains and losses arising from experience adjustments and changes in actuarial assumptions are charged or credited to equity in other comprehensive income in the period in which they arise.

Past-service costs are recognised immediately in income, unless the changes to the pension plan are conditional on the employees remaining in service for a specified period of time (the vesting period). In this case, the past-service costs are amortised on a straight-line basis over the vesting period.

b) Post-retirement medical benefits

Some group companies provide for post-retirement medical contributions in relation to current and retired employees. The expected costs of these benefits are accounted for by using the projected unit credit method. Under this method, the expected costs of these benefits are accumulated over the service lives of the employees. Valuation of these obligations is carried out by independent qualified actuaries. All actuarial gains and losses are charged or credited to other comprehensive income in the period in which they arise.

c) Share-based compensation

The Group operates an equity-settled, share-based compensation plan. The fair value of the employee services received in exchange for the grant of the options is recognised as an expense. The total amount to be expensed over the vesting period is determined by reference to the fair value of the options granted, excluding the impact of any non-market vesting conditions.

Non-market vesting conditions are included in assumptions about the number of options that are expected to become exercisable. At

each statement of financial position date, the Company revises its estimates of the number of options that are expected to become exercisable. It recognises the impact of the revision of original estimates, if any, in the income statement, with a corresponding adjustment to equity.

d) *Profitsharing and bonus plans*
The Group recognises an obligation where contractually obliged or where there is a past practice that has created a constructive obligation.

2.19 REVENUE RECOGNITION

Revenue comprises hospital fees and is measured at the fair value of the consideration received or receivable and represents the amounts receivable for services provided in the normal course of business, net of discounts and value added tax.

Other revenues earned are recognised on the following bases:

a) *Interest income*
Interest income is recognised on a time-proportion basis using the effective interest rate method.

b) *Dividend income*
When the shareholders' right to receive payment is established.

c) *Rental income*
Rental income is recognised on a straight-line basis over the term of the lease.

2.20 COST OF SALES

Cost of sales consist of the cost of inventories, including obsolete stock, which have been expensed during the year, together with personnel costs and related overheads which are directly attributable to the provision of services.

2.21 LEASED ASSETS

Leases of property, equipment and vehicles where the Group assumes substantially all the benefits and risks of ownership are classified as finance leases. Finance leases are capitalised at the lease's commencement at the lower of the fair value of the leased property and the present value of the minimum lease payments. Each lease payment is allocated between the liability and finance charges so as to achieve a constant rate on the finance balance outstanding. The corresponding rental obligations, net of finance charges, are included in interest-bearing borrowings. The interest element of the finance charges is charged to the income statement over the lease period. The property, equipment and vehicles acquired under finance leasing contracts are depreciated over the useful lives of the assets or the term of the lease agreement if shorter and transfer of ownership at the end of the lease period is uncertain.

Leases where the lessor retains substantially all the risks and rewards of ownership are classified as operating leases.

Payments made under operating leases (net of any incentives received from the lessor) are charged to the income statement on a straight-line basis over the period of the lease.

2.22 DIVIDEND DISTRIBUTION

Dividend distribution to the Company's shareholders is recognised as a liability in the Group's financial statements in the period in which the dividends are approved by the Company's Board.

2.23 FOREIGN CURRENCY TRANSACTIONS

Functional and presentation currency
Items included in the financial statements of each of the Group's entities are measured using the currency of the primary economic environment in which it operates (the functional currency). The consolidated financial statements are prepared in South African rand which is the Company's functional and presentation currency.

Transactions and balances
Transactions in foreign currencies are translated to the functional currency at the rates of exchange ruling on the dates of the transactions. Foreign exchange gains and losses resulting from the settlement of such transactions and from the translation at year-end exchange rates of monetary assets and liabilities denominated in foreign currencies are recognised in the income statement.

Group entities
The results and financial position of all foreign operations that have a functional currency that is different from the Group's presentation currency are translated into the presentation currency as follows:

- Assets and liabilities are translated at the closing rate at the reporting date.
- Income and expenses for each income statement are translated at average exchange rates for the year.
- All resulting exchange differences are recognised in other comprehensive income.

On consolidation exchange differences arising from the translation of the net investment in foreign operations are taken directly to other comprehensive income. Goodwill and fair value adjustments arising on the acquisition of foreign operations are treated as assets and liabilities of the foreign operation and translated at closing rates at statement of financial position date.

3. FINANCIAL RISK MANAGEMENT
3.1 FINANCIAL RISK FACTORS

Normal business activities of a company exposes it to a variety of financial risks: market risk (including currency risk, interest rate risk and other price risk), credit risk and liquidity risk. The Group's overall risk management programme seeks to minimise potential adverse effects on the Group's financial performance.

a) *Market risk*

i) Currency risk

Investments in foreign operations

The Group has investments in foreign operations, whose net assets are exposed to foreign currency translation risk. Currency exposure arising from the net assets of the Group's foreign operations is managed primarily through borrowings denominated in the relevant foreign currencies. Changes in the rand/Swiss franc and rand/UAE dirham exchange rate over a period of time will result in increased/decreased earnings.

The impact of a 10% change in the rand/Swiss franc and the rand/UAE dirham exchange rates for a sustained period of one year is:

- profit for the year would increase/decrease by R31m (2011: increase/decrease by R34m) due to exposure to the rand/Swiss franc exchange rate;
- profit for the year would increase/decrease by R22m (2011: increase/decrease by R12m) due to exposure to the rand/UAE dirham exchange rate.

The following exchange rates were applicable during the year:

Average SA rand/Swiss franc exchange rate: CHF1 = R8.45 (2011: CHF1 = R7.11)
Closing SA rand/Swiss franc exchange rate: CHF1 = R8.50 (2011: CHF1 = R7.42)
Average SA rand/UAE dirham exchange rate: AED1 = R2.03 (2011: AED1 = R1.96)
Closing SA rand/UAE dirham exchange rate: AED1 = R2.09 (2011: AED1 = R1.85)

Investments in investment grade bonds

The Group has investments in US dollar and euro-denominated investment grade bonds. The investments are earmarked to finance growth opportunities at the Swiss business, and therefore the Group is exposed to currency risk. The Group limits its currency exposure by applying a policy to hedge 100% of the US dollar and euro-denominated investment grade bonds to the Swiss franc by taking out forward contracts.

ii) Interest rate risk

The Group's interest rate risk arises from long-term borrowings as well as the investments in bonds and short-term deposits. Investment grade bonds consist mainly of interest-bearing liquid investments, and although they are measured at fair value, these movements are mainly because of changes in market interest rates; refer to note 10 for further details. Borrowings and short-term deposits issued at variable rates expose the Group to cash flow interest rate risk. Investments in bonds and interest rate derivatives expose the Group to fair value interest rate risk. Group policy is to maintain an appropriate mix between fixed and floating rate borrowings and placings.

The Group manages its interest rate risk by using floating-to-fixed interest rate swaps. Such interest rate swaps have the economic effect of converting borrowings from floating rates to fixed rates. Generally, the Group raises long-term borrowings at floating rates and swaps them into fixed rates. Under the interest rate swaps, the Group agrees with other parties to exchange, at specified intervals (primarily quarterly), the difference between fixed contract rates and floating-rate interest amounts calculated by reference to the agreed notional amounts.

In respect of financial assets, interest rate risk is managed by using approved counterparties that offer the best rates.

Interest rate sensitivity

The sensitivity analyses below have been determined based on the exposure to interest rates for both derivative and non-derivative instruments at the statement of financial position date and the stipulated change taking place at the beginning of the financial year and held constant throughout the reporting period in the case of instruments that have floating rates. If interest rates had been 25 basis points higher/lower and all other variables were held constant, the Group's:

- profit for the year would increase/decrease by R54m (2011: increase/decrease by R45m). This is mainly attributable to the Group's exposure to interest rates on its unhedged variable rate borrowings and cash.

Refer to note 10 for interest rate sensitivity of the bonds.

iii) Other price risk
The Group is not materially exposed to commodity price risk.

b) *Credit risk*
Financial assets which potentially subject the Group to concentrations of credit risk consist principally of cash, short-term deposits, money market funds, bonds and trade and other receivables. The Group's cash equivalents, short-term deposits, money market funds and bonds are placed with quality financial institutions with a high credit rating. Trade receivables are represented net of the allowance for doubtful receivables. Credit risk with respect to trade receivables is limited due to the large number of customers comprising the Group's customer base, which consists mainly of medical schemes and insurance companies. The financial condition of these clients in relation to their credit standing is evaluated on an ongoing basis. Medical schemes and insurance companies are forced to maintain minimum reserve levels. The policy for patients that do not have a medical scheme or an insurance company paying for the Group's service, is to require a preliminary payment instead. The Group does not have any significant exposure to any individual customer or counterparty.

The Group is exposed to credit-related losses in the event of non-performance by counterparties to hedging instruments. The counterparties to these contracts are major financial institutions. The Group monitors its positions and limits the extent to which it enters into contracts with any one party.

The carrying amounts of financial assets included in the statement of financial position represents the Group's maximum exposure to credit risk in relation to these assets. At 31 March 2012 and 31 March 2011, the Group did not consider there to be a significant concentration of credit risk.

c) *Liquidity risk*
The Group manages liquidity risk by monitoring cash flow forecasts to ensure that it has sufficient cash to meet operational needs, while maintaining sufficient headroom on its undrawn borrowing facilities at all times so that the Group does not breach borrowing limits or covenants (where applicable) on any of its borrowing facilities.

	2012 R'm	2011 R'm
The Group's unused overdraft facilities are:	**1 134**	1 073

The following table details the Group's remaining contractual maturity for its financial liabilities. The table has been drawn up based on the undiscounted cash flows of financial liabilities based on the required date of repayment. The table includes both interest and principal cash flows. The analysis of derivative financial instruments has been drawn up based on undiscounted net cash inflows/(outflows) that settle on a net basis.

Financial liabilities	**Contractual cash flows R'm**	**0 – 12 months R'm**	**1 – 5 years R'm**	**Beyond 5 years R'm**
31 March 2012				
Interest-bearing borrowings	**28 371***	**3 312***	**25 013***	**46***
Trade payables	**1 736**	**1 736**	**–**	**–**
Other payables and accrued expenses	**1 112**	**1 112**	**–**	**–**
31 March 2011				
Interest-bearing borrowings	26 362*	3 141*	23 093*	128*
Trade payables	1 678	1 678	–	–
Other payables and accrued expenses	745	745	–	–

* *The Group uses floating-to-fixed interest rate swaps to hedge against interest rate movements which have the economic effect of converting the interest-bearing borrowings to fixed interest rate borrowings. The cash flows for the interest-bearing borrowings and the interest rate swaps have been aggregated. This is consistent with the way the Group monitors the cash flows.*

3.2 FAIR VALUE OF FINANCIAL INSTRUMENTS

The fair value of financial assets and liabilities are determined as follows:

Cash and cash equivalents, trade and other receivables and money market funds: The carrying amounts reported in the statement of financial position approximate fair values because of the short-term maturities of these amounts.

Borrowings and trade and other payables: The carrying amounts reported in the statement of financial position approximate fair values determined on the basis of a discounted cash flow methodology.

Financial assets at fair value through profit and loss: The fair value of the bonds are derived from quoted prices in active markets for identical assets.

Derivative financial instruments: Interest rate swaps are measured at the present value of future cash flows estimated and discounted based on the applicable yield curves derived from quoted interest rates.

3.3 CAPITAL RISK MANAGEMENT

The Group manages its capital to ensure that entities in the Group will be able to continue as a going concern while maximising the return to stakeholders through the optimisation of the debt and equity balance. The capital structure of the Group consists of debt, which includes the borrowings disclosed in note 19, cash and cash equivalents and equity attributable to equity holders of the parent, comprising issued capital, retained earnings and other reserves and non-controlling interest as disclosed in notes 15, 16, 17 and 18 respectively. The Group's Audit and Risk Committee reviews the going concern status and capital structure of the Group annually.

The Group balances its overall capital structure through the payment of dividends, new share issues and share buy-backs as well as the issue of new debt or the redemption of existing debt. The debt-to-adjusted capital ratios at 31 March 2012 and 31 March 2011 were as follows:

	2012 R'm	2011 R'm
Borrowings	**24 794**	22 248
Less: cash and cash equivalents	**(2 099)**	(1 567)
Net debt	**22 695**	20 681
Total equity	**11 404**	10 560
Add back: amounts accumulated in equity relating to cash flow hedges	**3 223**	2 097
Add back: amounts accumulated in equity relating to Swiss pension benefits	**734**	321
Adjusted capital	**15 361**	12 978
Debt-to-adjusted capital ratio	**1.5**	1.6

The debt-to-adjusted capital ratio improved marginally.

4. CRITICAL ACCOUNTING ESTIMATES AND ASSUMPTIONS

The Group makes estimates and assumptions concerning the future. The resulting accounting estimates will, by definition, seldom equal the related actual results. The estimates and assumptions that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year are discussed below.

a) Estimated impairment of goodwill and intangible asset

The Group tests annually whether goodwill and the intangible asset with an indefinite useful life have suffered any impairment, in accordance with the accounting policy stated in note 2.6. The recoverable amounts of cash-generating units have been determined based on value-in-use calculations. These calculations require the use of estimates. The estimated figures assume a stable regulatory and tariff environment. Since 1 January 2012, a new financing and tariff system for mandatory basic insured patients in Switzerland was implemented. Although the new system is operational, there are still a number of areas that are not concluded and still uncertain, namely:

- DRG pricing finalisation for the base rates;
- Hospital lists in some cantons not finalised, under debate or legally challenged;
- Restrictions in cantonal legislation could impact the business;
- Highly specialised medicine developments can impact the future medical mix; and
- Cantons subsidising public hospitals.

These uncertainties can have an impact on the recoverability of the goodwill and intangible asset's recoverable amount. Also refer to the sensitivity analysis in respect of the discount rate and the growth rate in note 6.

b) Income taxes

The Group is subject to income taxes in South Africa, Namibia and Switzerland. Significant judgement is required in determining the provision for income taxes. There are many transactions and calculations for which the ultimate tax determination is uncertain during the ordinary course of business. The Group recognises liabilities for anticipated tax audit issues based on estimates of whether additional taxes will be due. Where the final tax outcome of these matters is different from the amounts that were initially recorded, such differences will impact the income tax and deferred tax provisions in the period in which such determination is made.

The Swiss tax authorities recently expressed a view on the pricing of certain intercompany transactions within the Swiss group which may lead to additional income tax payments. The Group assessed the probability for additional tax liabilities as low, subsequently an additional contingent liability was not recognised.

c) Retirement benefits

The cost of defined benefit pension plans and post-retirement medical benefit liability obligations are determined using actuarial valuations. The actuarial valuation involves making assumptions about discount rates, expected rates of return on assets, future salary increases, mortality rates and future pension increases. Due to the long-term nature of these plans, such estimates are subject to significant uncertainty. Further details are given in note 20.

d) Share-based compensation to employees

The Group uses valuation models to calculate the IFRS 2 expense for share-based compensation to employees. These models require a number of assumptions to be made as inputs. These include financial assumptions as well as various assumptions around individual employee behaviour.

e) Indefinite life trade names

The estimation of the indefinite useful life of the Swiss trade names is based on the expectation that there is no foreseeable limit to the period over which the asset is expected to generate net cash flows for the Group. This expectation requires a significant degree of management judgement.

f) Property, equipment and vehicles

The estimation of the useful lives of property, equipment and vehicles is based on historic performance as well as expectations about future use and therefore requires a significant degree of judgement to be applied by management. These depreciation rates represent management's current best estimate of the useful lives and residual values of the assets.

5. PROPERTY, EQUIPMENT AND VEHICLES

	GROUP	
	2012 R'm	2011 R'm
Land – cost	**9 365**	8 294
Buildings	**21 694**	19 039
Cost	**22 588**	19 652
Accumulated depreciation	**(894)**	(613)
Land and buildings	**31 059**	27 333
Equipment	**2 176**	1 949
Cost	**4 782**	3 988
Accumulated depreciation	**(2 606)**	(2 039)
Furniture and vehicles	**473**	452
Cost	**1 280**	1 049
Accumulated depreciation	**(807)**	(597)
Subtotal	**33 708**	29 734
Capital expenditure in progress	**1 100**	675
	34 808	30 409

Property, equipment and vehicles with a book value of R32 856m (2011: R27 745m) are encumbered as security for borrowings (see note 19).

Included in equipment is capitalised finance lease equipment with a book value of R29m (2011: R28m) (see note 19).

Land and buildings and capital expenditure include capitalised interest of R18m (2011: R6m).

The register containing details of land and buildings is available for inspection by members or their proxies at the registered office of the Company.

5. PROPERTY, EQUIPMENT AND VEHICLES (continued)

	GROUP			
	Land and buildings R'm	**Equipment R'm**	**Furniture and vehicles R'm**	**Total R'm**
At 1 April 2010				
Cost	25 642	3 489	899	30 030
Accumulated depreciation	(422)	(1 764)	(487)	(2 673)
Net book value	25 220	1 725	412	27 357
Year ended 31 March 2011				
Net opening book value	25 220	1 725	412	27 357
Capital expenditure	318	542	158	1 018
Prior year capital expenditure completed	197	–	(3)	194
Exchange differences	1 531	43	18	1 592
Disposals	(5)	(13)	(5)	(23)
Business acquisitions	245	81	23	349
Impairment losses	(18)	(9)	–	(27)
Depreciation per income statement	(155)	(420)	(151)	(726)
Net closing book value	27 333	1 949	452	29 734
At 31 March 2011				
Cost	27 946	3 988	1 049	32 983
Accumulated depreciation	(613)	(2 039)	(597)	(3 249)
Net book value	27 333	1 949	452	29 734
Year ended 31 March 2012				
Net opening book value	**27 333**	**1 949**	**452**	**29 734**
Capital expenditure	**303**	**580**	**170**	**1 053**
Exchange differences	**3 639**	**169**	**24**	**3 832**
Disposals	**(17)**	**(2)**	**(2)**	**(21)**
Depreciation per income statement	**(199)**	**(520)**	**(171)**	**(890)**
Net closing book value	**31 059**	**2 176**	**473**	**33 708**
At 31 March 2012				
Cost	**31 953**	**4 782**	**1 280**	**38 015**
Accumulated depreciation	**(894)**	**(2 606)**	**(807)**	**(4 307)**
Net book value	**31 059**	**2 176**	**473**	**33 708**

	2012 R'm	2011 R'm
Capital expenditure		
Capital expenditure excluding expenditure in progress	**1 053**	1 018
Capital expenditure in progress	**370**	159
Total additions	**1 423**	1 177
To maintain operations	**711**	617
To expand operations	**712**	560

6. INTANGIBLE ASSETS

	GROUP			
	Software and IT Projects R'm	**Trade names R'm**	**Goodwill R'm**	**Total R'm**
At 1 April 2010				
Cost	58	2 779	2 448	5 285
Accumulated amortisation and impairment	(26)	(13)	(3)	(42)
Net book value	32	2 766	2 445	5 243
Year ended 31 March 2011				
Net opening book value	32	2 766	2 445	5 243
Amortisation charge	(12)	–	–	(12)
Additions	28	–	–	28
Exchange differences	3	196	107	306
Net closing book value	51	2 962	2 552	5 565
At 31 March 2011				
Cost	91	2 975	2 555	5 621
Accumulated amortisation and impairment	(40)	(13)	(3)	(56)
Net book value	51	2 962	2 552	5 565
Year ended 31 March 2012				
Net opening book value	**51**	**2 962**	**2 552**	**5 565**
Amortisation charge	**(19)**	**(1)**	**–**	**(20)**
Additions	**20**	**–**	**–**	**20**
Exchange differences	**6**	**432**	**347**	**785**
Net closing book value	**58**	**3 393**	**2 899**	**6 350**
At 31 March 2012				
Cost	**124**	**3 407**	**2 902**	**6 433**
Accumulated amortisation and impairment	**(66)**	**(14)**	**(3)**	**(83)**
Net book value	**58**	**3 393**	**2 899**	**6 350**

6. INTANGIBLE ASSETS (continued)

Impairment testing of goodwill and indefinite life trade names

The carrying amounts of goodwill and the indefinite life trade names allocated to the Swiss hospital operations are significant in comparison to the total carrying amount of intangible assets. The impairment tests for goodwill and the indefinite life trade names are based on value-in-use calculations. These calculations use cash flow projections based on financial budgets covering a five-year period. The discount rates used reflect specific risks related to the hospital industry. These calculations indicate that there was no impairment in the carrying value of goodwill and the trade names.

	GROUP	
	2012 R'm	2011 R'm
Carrying amount of Swiss goodwill	**2 377**	2 075
Carrying amount of Swiss indefinite life trade names	**3 391**	2 960

Key assumptions used for value-in-use calculations are as follows:

- Budgeted margins – the basis used to determine the value assigned to the budgeted margins is based on the margins achieved in the previous years with a slight increase for expected efficiency improvements. The margins are driven by consideration of future admissions and case mix and based on past experience and management's assessment of growth.
- Discount rates – discount rates reflect management's estimate of the time value and the risks associated with the Swiss business. The weighted average cost of capital (WACC) has been determined by consideration of respective debt and equity costs and ratios. The pre-tax discount rate applied to cash flow projections is between 5.0% and 6.0%.
- Growth rates – growth rates are based on budgeted figures and management's estimates. The estimated figures assume a stable regulatory and tariff environment. Cash flows beyond the five-year period are extrapolated using a 1.5% growth rate.

For the goodwill, the recoverable amount calculated based on value in use exceeded the carrying value by approximately R5 100m (2011: R8 904m). A fall in growth rate to 0.9% (2011: 0.4%) or a rise in discount rate to 6.0% (2011: 6.2%) would remove the remaining headroom.

For the indefinite life trade names, the recoverable amount calculated based on value in use exceeded the carrying value by approximately R1 590m (2011: R1 670m). A fall in growth rate to 0% would not affect the headroom significantly, but a rise in discount rate to 8.8% (2011: 7.7%) would remove the remaining headroom.

COMPANY			GROUP	
2011 R'm	**2012 R'm**		**2012 R'm**	2011 R'm
		7. INTEREST IN SUBSIDIARY		
		Unlisted		
6	**12**	Shares at cost less amounts written off		
6 272	**6 261**	Due by subsidiary		
6 278	**6 273**			

Details appear on page 170.

	8. INVESTMENTS IN ASSOCIATES	
	Unlisted	
	Carrying value of investments in associates' equity	
4	Opening balance	11
1	Share in current year profits	4
(5)	Distribution received	(12)
1	Exchange differences	1
1		4

The total profit of associates is R3m (2011: R8m). Total revenue for the associates is R172m (2011: R139m).

	The aggregate statement of financial positions of associates are summarised as follows:	
37	Total assets	28
(34)	Total liabilities	(19)
3	Shareholders' funds	9
(2)	Outside interests	(5)
1	Group's share in net assets of associates	4

Details appear on page 172.

	9. JOINT VENTURE	

The Group has a 49.9% interest in Wits University Donald Gordon Medical Centre (Pty) Ltd.

The following amounts are included in the financial statements as a result of the proportionate consolidation:

17	Current assets	21
104	Non-current assets	91
12	Current liabilities	26
35	Non-current liabilities	31
115	Income	100
109	Expenses	99

	GROUP	
	2012 R'm	2011 R'm
10. OTHER INVESTMENTS AND LOANS		
Listed – active market		
Financial assets designated at fair value through profit and loss (FVTPL): Bonds		
Current portion	**128**	–
Non-current portion	**646**	694
	774	694
Unlisted – no active market		
Loans and receivables	**1**	1
Available-for-sale: Shares	**15**	13
	16	14
	790	708
Other investments and loans are held in the following currencies:		
Euro (2012: €13.6m; 2011: €14.2m)	**139**	137
US dollar (2012: US$82.7m; 2011: US$81.7m)	**635**	557
Swiss franc (2012: CHF2m; 2011: CHF2m)	**15**	13
SA rand	**1**	1
	790	708

The Group holds bonds returning a fixed rate of interest. The weighted average interest rate on these securities is 1.74% (2011: 2.4%) per annum. If interest rates increase/decrease by 100 basis points the return rate changes to 2.41% (-100) or to 1.69% (+100) (2011: 3.46% and 2.07%). The bonds have maturity dates ranging between two and 55 months from the end of the reporting period. The counterparties have a minimum Baa3 credit by Moody's Investors Service, or BBB- or better by Standard & Poor's Corporation.

The bonds are designated as financial assets at fair value through profit and loss (FVTPL). The fair value of the bonds are derived from quoted prices in active markets for identical assets and therefore the degree to which the fair values are observable is grouped as Level 1.

COMPANY			GROUP	
2011 R'm	**2012 R'm**		**2012 R'm**	2011 R'm
		11. DEFERRED TAX		
		Deferred income tax assets and deferred income tax liabilities are offset when there is a legally enforceable right of offset and when the deferred income tax relates to the same fiscal authority.		
		The movement on the deferred tax account is as follows:		
1	**1**	Opening balance	**(4 563)**	(4 179)
–	**(1)**	Income statement charge for the year (note 28)	**(27)**	(60)
–	**(1)**	Provision for the year	**(29)**	(60)
		Tax rate changes (note 28)	**2**	–
		Business acquisition	**–**	(3)
		Exchange differences	**(694)**	(312)
		Charged to other comprehensive income (note 30)	**193**	(9)
1	**–**	Balance at the end of the year	**(5 091)**	(4 563)
		The balance consists of:		
		Property, equipment and vehicles	**(4 783)**	(4 168)
		Intangible assets	**(817)**	(690)
		Financial assets	**–**	(1)
		Current assets	**(18)**	(12)
		Current liabilities	**159**	149
		Long-term liabilities	**97**	–
		Provisions	**(78)**	(50)
		Derivatives	**281**	171
		Tax losses carried forward	**66**	28
		STC credits	**–**	4
		Other	**2**	6
			(5 091)	(4 563)
1	**–**	Deferred income tax assets	**212**	210
		Deferred income tax liabilities	**(5 303)**	(4 773)
1	**–**		**(5 091)**	(4 563)

	GROUP	
	2012 R'm	2011 R'm

12. INVENTORIES

Inventories consist of:

Pharmaceutical products	**496**	450
Consumables	**77**	66
Finished goods and work in progress	**9**	6
	582	522

The cost of inventories recognised as an expense and included in cost of sales amounted to R5 324m (2011: R4 663m).

There are no inventories that are valued at net realisable value.

13. TRADE AND OTHER RECEIVABLES

Trade receivables	**3 025**	2 751
Less provision for impairment of receivables	**(148)**	(141)
Trade receivables – net	**2 877**	2 610
Other receivables	**1 938**	1 186
	4 815	3 796

Trade and other receivables are categorised as loans and receivables.

The carrying amounts of the Group's trade and other receivables are denominated in the following currencies:

SA rand*	**1 194**	1 140
Swiss franc*	**3 304**	2 402
UAE dirham	**317**	254
	4 815	3 796

Included in the Group's trade receivables balance are trade receivables with a carrying value of R921m (2011: R509m) which are past due at the reporting date but which the Group has not impaired as there has not been a significant change in credit quality and the amounts are still considered to be recoverable. The ageing of these receivables are as follows:

Up to 3 months	**745**	417
Over 3 months	**176**	92
	921	509

* In the case of a default on the secured long-term bank loan in Switzerland, debtors that have a turnover of greater than CHF1m will be assigned to the bank (book value R974m (2011: R1 010m), refer to note 18). In addition net trade receivables to the value of R585m (2011: R483m) have been ceded as security for banking facilities.

	GROUP	
	2012 R'm	2011 R'm
13. TRADE AND OTHER RECEIVABLES (continued)		
Movement in the provision for impairment of receivables		
Opening balance	**141**	128
Provision for receivables impairment	**55**	67
Business acquisitions	**–**	1
Exchange differences	**6**	(2)
Amounts written off as uncollectable	**(54)**	(53)
Balance at the end of the year	**148**	141

Amounts written off during the year relate to individually identified accounts that are considered to be irrecoverable.

Management considers the credit quality of the fully performing trade receivables to be high in light of the nature of these trade receivables as described in note 3.1(b).

Included in the Group's other receivables balance are other receivables with a carrying value of R143m (2011: R261m) that are past due at the reporting date. This is the net amount after deducting a provision of R50m (2011: R60m) made by the Group.

14. INVESTMENT IN MONEY MARKET FUNDS

Money market fund investments are held in the following currency:

Swiss franc (2012: CHF60.0m; 2011: CHF97.5m)	**510**	723

The effective interest rate on money market funds is 0.45% (2011: 0.18% to 0.95%) and these funds have a maturity over three months. At the reporting date the Group's investment in money market funds was invested at a financial institution with a Moody's rating of at least A3 (2011: A2).

Investments in money market funds are categorised as loans and receivables.

COMPANY			GROUP	
2011 R'm	**2012 R'm**		**2012 R'm**	2011 R'm
		15. SHARE CAPITAL		
		Ordinary shares		
		Authorised:		
100	**100**	1 000 000 000 ordinary shares of 10 cents each (2011: 1 000 000 000)	**100**	100
65	**65**	Issued:	**65**	65
59	**65**	Opening balance	**65**	59
6	**–**	Shares issued	**–**	6
		652 315 341 ordinary shares of 10 cents each (2011: 652 315 341)		
		Unissued ordinary shares: 5% of the number of the ordinary shares in issue at 31 March 2011 are under the control of the directors in terms of a resolution of members passed at the last annual general meeting. This authority remains in force until the next annual general meeting.		
6 066	**6 066**	**Share premium**	**6 066**	6 066
4 741	**6 066**	Opening balance	**6 066**	4 741
1 358	**–**	Premium on shares issued	**–**	1 358
(33)	**–**	Costs of shares issued	**–**	(33)
		Treasury shares		
		14 494 073 (2011: 15 678 885) ordinary shares of 10 cents each	**(269)**	(288)
		Opening balance	**(288)**	(311)
		Shares acquired by wholly owned subsidiary	**(9)**	–
		Utilised by the Mpilo Trusts	**7**	6
		Utilised for employee incentive schemes	**21**	17
		During the year the Mpilo Trusts, employee share trusts, released 374 390 of its 14 588 338 shares to employees.		
		The Company, through a wholly owned subsidiary, holds 280 125 (2011: 1 090 547) shares in treasury. During the year 418 823 (2011: 575 226) of these shares were utilised in terms of the executive share option scheme and 691 599 (2011: 472 285) of these shares were utilised in terms of the management incentive scheme and 300 000 shares (2011: nil shares) were acquired during the year.		
6 131	**6 131**		**5 862**	5 843

	GROUP	
	2012	2011

15. SHARE CAPITAL (continued)

Share options
To date 23 880 000 share options of the executive share option scheme have been granted, 6 066 692 (2011: 5 641 038) share options have been forfeited and 17 708 144 (2011: 17 449 321) exercised.

No further options will be granted under the share option scheme.
Employees may exercise the existing options from grant date as follows:

- 20% of the options granted, vest each year after 3 to 7 years.

All options lapse after a period of 8 years from the grant date.

Movement in the number of share options outstanding are:	**Average offer price**	**Number**	**Number**
Outstanding at the beginning of the year	R11.21	**789 641**	1 534 167
Options forfeited		**(425 654)**	(169 300)
Options exercised – treasury shares utilised	R10.30	**(258 823)**	(575 226)
Outstanding at the end of the year	R9.96	**105 164**	789 641

COMPANY			GROUP	
2011 R'm	**2012 R'm**		**2012 R'm**	2011 R'm
		16. RETAINED EARNINGS		
19	**7**	Company	**7**	19
		Subsidiaries and joint ventures	**4 164**	3 767
19	**7**		**4 171**	3 786
17	**19**	Opening balance	**3 786**	3 080
449	**464**	Profit for the year	**1 221**	1 177
(447)	**(476)**	Dividends paid	**(436)**	(398)
		Actuarial gains and losses	**(403)**	(73)
		Transactions with non-controlling shareholders	**3**	–
19	**7**	Balance at end of the year	**4 171**	3 786
		17. OTHER RESERVES		
		Share-based payment reserve		
123	**129**	Opening balance	**129**	123
6	**6**	Employees: value of services	**6**	6
129	**135**	Balance at end of the year	**135**	129
14	**14**	Executive share option scheme	**14**	14
30	**36**	Employee share trust	**36**	30
85	**85**	Strategic black partners	**85**	85
		Foreign currency translation reserve	**3 171**	1 828
		Opening balance	**1 828**	1 301
		Currency translation differences	**1 343**	527
		Hedging reserve	**(3 223)**	(2 097)
		Opening balance	**(2 097)**	(2 343)
		Fair value adjustments of cash flow hedges, net of tax	**(1 126)**	246
129	**135**		**83**	(140)
		18. NON-CONTROLLING INTERESTS		
		Opening balance	**1 071**	966
		Increase/(decrease) in non-controlling interests	**3**	(1)
		Distributions to non-controlling interests	**(111)**	(59)
		Share of total comprehensive income	**325**	165
		Share of profit	**263**	204
		Currency translation differences	**62**	(39)
		Non-controlling interests in hospital activities	**1 288**	1 071

19. BORROWINGS

	GROUP	
	2012 R'm	2011 R'm
Secured long-term bank loans	**2 770**	2 769
Long-term portion	**1 375**	1 375
Short-term portion	**1 399**	1 397
Capitalised financing expenses – long-term	**(4)**	(3)

Comprise two loans of R1 375m each. The first loan bears interest at the three-month Jibar variable rate plus a margin of 1.250% compounded quarterly, and is repayable on December 2012. The other loan bears interest at the three-month Jibar variable rate plus a margin of 1.125% compounded quarterly, and is repayable on December 2013. Property and equipment with a book value of R3 842m (2011: R3 798m) are encumbered as security for these loans. The interest on these bank loans has been hedged – note 22 contains information about the interest rate swap agreements.

Secured long-term bank loans	**548**	581
Long-term portion	**500**	534
Short-term portion	**49**	48
Capitalised financing expenses – long-term	**(1)**	(1)

These loans bear interest at an average fixed rate of 9.3% per annum and is repayable in one to four (2011: two to five) years. Net trade receivables of R569m (2011: R469m) has been ceded as security for these borrowings.

Unsecured long-term bank loan	**117**	175
Long-term portion	**60**	115
Short-term portion	**57**	60
Capitalised financing expenses – long-term	**–**	–

This loan bears interest at interest rates linked to the three-month JIBAR plus a margin of 1.4% payable each quarter in arrears. The capital amount is repayable in 8 (2011: 12) equal quarterly instalments, the first having been paid on 1 April 2011.

Secured long-term bank loans	**78**	112
Long-term portion	**63**	106
Short-term portion	**15**	6

These loans bear interest at variable rates linked to the prime overdraft rate and are repayable in periods ranging between one and thirteen years. Property, equipment and vehicles with a book value of R202m (2011: R201m) are encumbered as security for these loans. Net trade receivables of R8m (2011: R7m) has also been ceded as security for these loans.

Bank overdraft	**118**	120

Net trade receivables of R8m (2011: R7m) has been ceded as security for these overdrafts.

Borrowings in Southern African operations	**3 631**	3 757

	GROUP	
	2012 R'm	2011 R'm
19. BORROWINGS (continued)		
Secured long-term bank loans	**440**	408
Long-term portion	**326**	350
Short-term portion	**120**	66
Capitalised financing expenses – long-term	**(6)**	(8)
These loans bear interest at variable rates linked to EIBOR and are repayable in periods ranging between two to nine years. Properties with a book value of R897m (2011: R770m) are encumbered as security for these loans.		
Borrowings in Middle East operations	**440**	408
Secured long-term bank loan	**20 588**	17 963
Long-term portion	**20 625**	18 062
Short-term portion	**168**	134
Capitalised financing expenses – long-term	**(205)**	(233)
This loan bears interest at a variable rate linked to the three-month Swiss LIBOR plus 2% and is repayable in October 2014. The loan is secured by: Swiss properties with a book value of R27 575m (2011: R22 837m); assignment of Swiss receivables with a book value of R974m (2011: R1 010m) in case of default (refer to note 13); and Swiss bank accounts with a book value of R581m (2011: R691m). The interest on this bank loan has been hedged – note 22 contains information about the interest rate swap agreement.		
Secured long-term bank mortgages	**102**	89
Long-term portion	**102**	89
Short-term portion	**–**	–
These mortgages bear interest at interest rates ranging between 1.75% and 2.7% (2011: 1.9% and 2.7%) and are repayable in periods between two and five years. Property with a book value of R310m (2011: R111m) is encumbered as security for these loans.		
Secured long-term finance	**33**	31
Long-term portion	**29**	28
Short-term portion	**4**	3
These loans bear interest at interest rates ranging between 4% and 12% and are repayable in equal monthly payments in periods ranging from one to eleven years. Equipment with a book value of R30m (2011: R28m) is encumbered as security for these loans.		
Borrowings in Swiss operations	**20 723**	18 083
Total borrowings	**24 794**	22 248
Short-term portion transferred to current liabilities	**(1 930)**	(1 834)
	22 864	20 414

	GROUP	
	2012 R'm	2011 R'm
20. RETIREMENT BENEFIT OBLIGATIONS		
Statement of financial position obligations for:		
Pension benefits	**471**	71
Post-retirement medical benefits	**352**	312
	823	383
Income statement charge for:		
Pension benefits	**141**	81
Post-retirement medical benefits	**59**	49
	200	130
(a) Pension benefits		
The Group's Swiss operations has three defined benefit pension plans.		
Statement of financial position		
Amounts recognised in the statement of financial position are as follows:		
Present value of funded obligations	**6 869**	5 326
Fair value of plan assets	**(6 398)**	(5 292)
Funded Status	**471**	34
Restriction to Defined Benefit Asset due to the Asset Ceiling	**–**	37
Deficit	**471**	71
The movement in the defined benefit obligation over the period is as follows:		
Opening balance	**5 326**	4 378
Current service cost	**240**	185
Interest cost	**171**	138
Employee contributions	**234**	181
Benefits paid	**(98)**	(127)
Actuarial loss	**233**	26
Acquisition/Divestiture	**–**	241
Past-service cost	**(14)**	(33)
Exchange differences	**777**	337
Balance at end of year	**6 869**	5 326
The movement of the fair value of plan assets over the period is as follows:		
Opening balance	**5 292**	4 329
Employer contributions	**269**	216
Employee contributions	**234**	181
Benefits paid from fund	**(98)**	(127)
Expected return on assets	**256**	209
Investment gain/(loss)	**(329)**	(61)
Acquisition/Divestiture	**–**	208
Exchange differences	**774**	337
Balance at end of year	**6 398**	5 292
Income statement		
Amounts recognised in the income statement are as follows:		
Current service cost	**240**	185
Past-service cost	**(14)**	(33)
Interest on liability	**171**	138
Expected return on plan assets	**(256)**	(209)
Total expense	**141**	81

	GROUP	
	2012 R'm	2011 R'm

20. RETIREMENT BENEFIT OBLIGATIONS (continued)

Statement of comprehensive income		
Amounts recognised in other comprehensive income are as follows:		
Actuarial gain/(loss) recognised in other comprehensive income	**(562)**	(86)
Change in the effect of the asset ceiling	**43**	(22)
Total of comprehensive income	**(519)**	(108)
Statement of financial position		
Opening net liability	**71**	64
Expense as above	**141**	81
Contributions paid by employer	**(269)**	(216)
Exchange differences	**9**	34
Actuarial (gain)/loss recognised in equity	**519**	108
Closing net liability	**471**	71
Actual return on plan assets	**(72)**	151
Principal actuarial assumptions on statement of financial position		
Discount rate	**2.30%**	2.90%
Expected rate of return on plan assets	**4.18%**	4.55%
Future salary increases	**2.00%**	2.00%
Future pension increases	**0.00%**	0.00%
Inflation rate	**1.50%**	1.50%
Number of plan members		
Active members	**6 311**	5 992
Pensioners	**531**	476
	6 842	6 468
Experience adjustment		
On plan liabilities: (gain)/loss	**(223)**	194
On plan assets: gain/(loss)	**329**	61
Opening balance	**(392)**	(284)
Actuarial gain/(loss) recognised in other comprehensive income	**(519)**	(108)
Cumulative actuarial losses recognised in other comprehensive income	**(911)**	(392)
Asset allocation		
Fixed income investments	**40%**	44%
Equity investments	**21%**	22%
Real estate	**21%**	17%
Other	**18%**	17%
	100%	100%

Historical information	**2010**	**2009**	**2008**
Present value of funded obligations	4 378	5 037	4 621
Fair value of plan assets	(4 329)	(4 272)	(4 155)
Deficit	49	765	466
Experience adjustments			
On plan liabilities: gain	8	(106)	–
On plan assets: loss	(348)	(400)	(412)
Actuarial losses recognised in other comprehensive income	422	(294)	(412)

Expected employer contributions to be paid to the pension plans for the year ended 31 March 2013 are R268m.

	GROUP	
	2012 R'm	2011 R'm

20. RETIREMENT BENEFIT OBLIGATIONS (continued)

(b) Post-retirement medical benefits

The Group's Southern African operations have a post-retirement medical benefit obligation.

The Group accounts for actuarially determined future medical benefits and provide for the expected liability in the statement of financial position. During the last valuation on 31 March 2012 a 7.0% (2011: 7.3%) medical inflation cost and a 8.4% (2011: 9.2%) interest rate were assumed. The average retirement age was set at 63 years (2011: 63 years).

The assumed rates of mortality are as follows:
During employment: SA 1972-77 tables of mortality
Post-employment: PA(90) tables

Amounts recognised in the statement of financial position are as follows:

Opening balance	**312**	282
Amounts recognised in the income statement	**59**	53
Current service cost	**27**	26
Interest cost	**32**	27
Contributions	**(6)**	(4)
Actuarial gain recognised in other comprehensive income	**(13)**	(19)
Closing balance	**352**	312
Present value of unfunded obligations	**352**	312
Unrecognised actuarial differences	**–**	–
	352	312

The effect of a 1% movement in the assumed health cost trend rate is as follows:	**2012 Increase**	**2012 Decrease**
Aggregate of the current service cost and interest cost	**19%**	**(19%)**
Defined benefit obligation	**17%**	**(17%)**

Historical information: The present value of the Group's post-retirement medical benefits at 31 March 2010 was R282m, 2009: R232m and 2008: R173m.

Expected employer contributions to be paid to the post-retirement medical benefit liability for the year ended 31 March 2013 are R7m.

21. PROVISIONS

	GROUP			
	Employee benefits R'm	**Legal cases and other R'm**	**Tariff risks R'm**	**Total R'm**
Year ended 31 March 2011				
Opening balance	156	10	19	185
Charged to the income statement	26	4	49	79
Business acquisitions	5	–	–	5
Utilised during the year	(2)	(4)	–	(6)
Unused amounts reversed	–	(1)	–	(1)
Exchange differences	5	2	2	9
Balance at the end of the year	190	11	70	271
At 31 March 2011				
Current	14	8	67	89
Non-current	176	3	3	182
	190	11	70	271
Year ended 31 March 2012				
Opening balance	**190**	**11**	**70**	**271**
Charged to the income statement	**51**	**2**	**43**	**96**
Utilised during the year	**(19)**	**(1)**	**(18)**	**(38)**
Unused amounts reversed	**–**	**(3)**	**(4)**	**(7)**
Exchange differences	**28**	**–**	**11**	**39**
Balance at the end of the year	**250**	**9**	**102**	**361**
At 31 March 2012				
Current	**16**	**5**	**100**	**121**
Non-current	**234**	**4**	**2**	**240**
	250	**9**	**102**	**361**

(a) Employee benefits
This provision is for benefits granted to employees for long service.

(b) Legal cases and other
This provision relates to third-party excess payments for malpractice claims which are not covered by insurance and other costs for legal claims.

(c) Tariff risks
This provision relates to compulsory health insurance tariff risks, including the Swiss DRG base rates and other tariff disputes at some of the Group's Swiss hospitals. The tariff provision for the Swiss DRG base rates relates to the Swiss tariff system. Swiss DRG base rates have not been finalised, refer to note 4 (a).

	2012 R'm	2011 R'm
Provisions are expected to be payable during the following financial years:		
Within 1 year	**121**	89
After one year but not more than five years	**77**	54
More than five years	**163**	128
	361	271

	GROUP			
	2012 R'm	**2012 R'm**	2011 R'm	2011 R'm

22. DERIVATIVE FINANCIAL INSTRUMENTS

	Assets	**Liabilities**	Assets	Liabilities
Total	**24**	**3 739**	33	2 218
Interest rate swaps – cash flow hedges*	**–**	**3 739**	–	2 214
Forward contracts	**24**	**–**	33	4
Current portion	**(24)**	**–**	–	(48)
Interest rate swaps – cash flow hedges*	**–**	**–**	–	(44)
Forward contracts	**(24)**	**–**	–	(4)
Non-current portion	**–**	**3 739**	33	2 170

* The fair value portion of the interest rate swaps that is due within 1 year amounts to R789m (2011: R762m).

Interest rate swaps

In order to hedge specific exposures in the interest rate repricing profile of existing borrowings, the Group uses interest rate derivatives to generate the desired interest profile. At 31 March 2012, the Group had three interest rate swap contracts (2011: four). The value of borrowings hedged by the interest rate derivatives and the rates applicable to these contracts are as follows:

	Borrowings hedged R'm	**Fixed interest payable**	**Interest receivable**	**Fair value gain/(loss) for the year R'm**
2011				
6 years+*	17 929	3.62%	3 month Swiss LIBOR	239
1 to 6 years**	2 750	8.37 – 10.06%	3 month JIBAR	30
2012				
5 years+*	**20 388**	**3.62%**	**3 month Swiss LIBOR**	**(1 182)**
1 to 5 years**	**2 750**	**8.37 – 9.85%**	**3 month JIBAR**	**33**

* The interest rate swap agreement resets every 3 months on 5 January, 5 April, 5 July and 5 October with a final reset on 5 October 2017. There is no ineffective portion recognised in the profit and loss that arises from the cash flow hedge.

** The interest rate swap agreements reset every 3 months on 1 June, 1 September, 1 December and 1 March with a final reset on 2 December 2013 and 1 December 2015. There is no ineffective portion recognised in the profit and loss that arises from the cash flow hedges.

	GROUP	
	2012 R'm	2011 R'm

22. DERIVATIVE FINANCIAL INSTRUMENTS (continued)

Forward contracts

Realised gain recognised in the income statement	**24**	12
Net unrealised (loss)/gain recognised in the income statement	**(10)**	29

The Group has hedged 100% of its US dollar and Euro-denominated investment grade bond portfolio to the Swiss franc with forward contracts. No hedge accounting was applied. The gain or loss on revaluation is recognised in the income statement. At 31 March 2012, the total contract notional value was R815m (2011: R687m).

Based on the degree to which the fair values are observable, the interest rate swaps and the forward contracts are grouped as Level 2.

23. TRADE AND OTHER PAYABLES

Trade payables	**1 736**	1 678
Other payables and accrued expenses	**1 112**	745
Social insurance and accrued leave pay	**572**	457
Value added tax	**40**	58
	3 460	2 938

	GROUP	
	2012 R'm	2011 R'm
24. EXPENSES BY NATURE		
Auditors' remuneration – external audit	**13**	12
– other services	**3**	3
Cost of inventories	**5 324**	4 663
Depreciation – buildings	**199**	155
– equipment	**520**	420
– furniture and vehicles	**171**	151
Employee benefit expenses	**9 091**	7 530
Wages and salaries	**8 760**	7 278
Post-retirement medical benefits (note 20)	**59**	53
Retirement benefit costs – defined contribution plans	**125**	112
Retirement benefit costs – defined benefit plans (note 20)	**141**	81
Share-based payment expense (note 17)	**6**	6
Impairment of property, equipment and vehicles	**5**	27
Increase/(decrease) in impairment provision for receivables (note 13)	**1**	14
Maintenance costs	**601**	499
Managerial and administration fees	**1**	4
Operating leases – buildings	**264**	196
– equipment	**38**	34
Amortisation of intangible assets	**20**	12
Other expenses	**1 976**	1 457
General expenses	**1 977**	1 511
Profit on sale of equipment	**(1)**	(4)
Other income	**–**	(50)
	18 227	15 177
Classified as:		
Cost of sales	**12 314**	10 327
Administration and other operating expenses	**5 003**	4 112
Depreciation and amortisation	**910**	738
	18 227	15 177
25. OTHER GAINS AND LOSSES		
Net fair value adjustment to FVTPL financial assets	**(15)**	(9)
Realised gains on forward contracts	**24**	12
Realised loss on bonds sold	**(1)**	–
Net unrealised (loss)/gain on forward contracts	**(10)**	29
Unrealised exchange losses	**(24)**	(40)
Gain on purchase of business acquisition (note 32)	**–**	21
	(26)	13

26. DIRECTORS' REMUNERATION

	GROUP	
	2012 R'000	2011 R'000
Executive		
E de la H Hertzog*	**5 945**	5 676
LJ Alberts[5]	**–**	545
DP Meintjes	**6 825**	6 238
KHS Pretorius	**4 814**	4 891
JG Swiegers[6]	**–**	2 309
CA van der Merwe**	**4 061**	2 481
CI Tingle***	**5 715**	3 782
TO Wiesinger	**9 215**	7 990
	36 575	33 912
Non-executive fees	**3 249**	2 396
JC Cohen	**261**	150
RE Leu[2]	**925**	497
MK Makaba	**194**	129
ZP Manase	**246**	191
AR Martin[1]	**–**	155
DK Smith	**312**	232
AA Raath	**363**	304
MA Ramphele	**138**	139
CM van den Heever	**205**	129
WL van der Merwe	**278**	178
MH Visser	**327**	292
	39 824	36 308
Paid by:		
Subsidiaries	**36 298**	33 056
Management company*	**3 526**	3 252
	39 824	36 308

Detail for 2012: (R'000)	**Salaries**	**Retirement fund**	**Other benefits[3]**	**Bonus[4]**	**Share options**	**Total**
Executive						
E de la H Hertzog*	**2 848**	**276**	**160**	**2 661**	**–**	**5 945**
DP Meintjes	**3 997**	**360**	**26**	**2 442**	**–**	**6 825**
KHS Pretorius	**2 792**	**251**	**26**	**1 745**	**–**	**4 814**
CA van der Merwe	**2 171**	**195**	**26**	**1 008**	**661**	**4 061**
CI Tingle	**3 345**	**301**	**26**	**2 043**	**–**	**5 715**
TO Wiesinger	**5 892**	**786**	**374**	**2 163**	**–**	**9 215**
	21 045	**2 169**	**638**	**12 062**	**661**	**36 575**

26. DIRECTORS' REMUNERATION (continued)

Detail for 2011: (R'000)	Salaries	Retirement fund	Other benefits[3]	Bonus[4]	Share options	Total
Executive						
E de la H Hertzog*	2 623	254	152	2 647	–	5 676
LJ Alberts	–	–	545	–	–	545
DP Meintjes	3 648	328	24	2 238	–	6 238
KHS Pretorius	2 559	230	24	1 381	697	4 891
JG Swiegers[6]	1 478	132	699	–	–	2 309
CA van der Merwe**	1 518	137	20	806	–	2 481
CI Tingle***	1 820	164	14	1 784	–	3 782
TO Wiesinger	4 885	661	261	2 183	–	7 990
	18 531	1 906	1 739	11 039	697	33 912

* Dr E de la H Hertzog also earned a further R1.9m (2011: R1.8m) from Remgro Management Services Limited relating to other duties.
** Dr CA van der Merwe was appointed as a director on 26 July 2010. His director's remuneration for the previous reported period is from this date.
*** Mr CI Tingle was appointed as a director on 1 September 2010. His director's remuneration for the previous reported period is from this date.

1 In the prior year Mr AR Martin also earned a further R384 388 from two subsidiaries (Mediclinic Southern Africa (Pty) Ltd and ER24 Holdings (Pty) Ltd) as director's remuneration.
2 Prof. Dr RE Leu also earned a further R540 800 (2011: R376 830) from a subsidiary (Medi-Clinic Switzerland AG) as director's remuneration.
3 Other benefits include medical aid, UIF and payment for accumulated leave.
4 Bonuses consist of the management incentive scheme and a 13th cheque.
5 Mr LJ Alberts retired as a director on 31 March 2010. During the year, Mr LJ Alberts received payment for accumulated leave.
6 Mr JG Swiegers resigned as a director on 15 September 2010.

None of the current executive directors have a fixed-term contract.

Share option scheme
No shares were offered to directors in the financial year ending 31 March 2012.

The number of outstanding share options are:	Offer price	2012 Number	2011 Number
CA van der Merwe**	R12.20	–	10 000
		–	10 000

Prescribed officers
Remuneration and benefits paid and short-term incentives approved in respect of prescribed officers are as follows:

Detail for 2012: (R'000)	Salaries	Retirement fund	Other benefits[3]	Bonus[4]	Share options	Total
GC Hattingh	**1 797**	**162**	**26**	**861**	**–**	**2 846**
DJ Hadley	**2 860**	**238**	**10**	**1 382**	**–**	**4 490**
	4 657	**400**	**36**	**2 243**	**–**	**7 336**
Detail for 2011: (R'000)						
GC Hattingh	1 662	150	26	740	–	2 578
DJ Hadley	2 559	212	–	1 381	–	4 152
	4 221	362	26	2 121	–	6 730

COMPANY			GROUP	
2011 R'm	**2012 R'm**		**2012 R'm**	2011 R'm
		27. FINANCE COST		
		Interest expense	**738**	721
		Interest rate swaps	**841**	698
		Amortisation of capitalised financing fees	**81**	78
		Less: amounts included in the cost of qualifying assets	**(18)**	(6)
			1 642	1 491
		28. INCOME TAX EXPENSE		
		Current tax		
(37)	**(37)**	Current year	**(657)**	(600)
		Previous year	**(9)**	6
–	**(1)**	Deferred tax (note 11)	**(27)**	(60)
(37)	**(38)**	Taxation per income statement	**(693)**	(654)
		Composition		
(1)	**–**	Normal South African tax	**(365)**	(353)
		Foreign tax	**(283)**	(257)
(36)	**(38)**	Secondary tax on companies ("STC")	**(45)**	(44)
(37)	**(38)**		**(693)**	(654)
		Reconciliation of rate of taxation:		
		Standard rate for companies (RSA)	**28.0%**	28.0%
		Adjusted for:		
		Capital gains tax	**(0.1)%**	(0.3)%
		Non-taxable income	**(0.8)%**	(0.3)%
		Non-deductible expenses	**8.4%**	7.5 %
		Non-controlling interests' share of profit before tax	**(0.5)%**	(0.7)%
		Effect of different tax rates	**(5.4)%**	(3.9)%
		Changes to Swiss income tax rates	**(0.4)%**	–
		STC	**2.2 %**	2.1 %
		Prior year adjustment	**0.4 %**	(0.3)%
		Effective tax rate	**31.8 %**	32.1 %

	GROUP		
	Gross	**Income tax effect**	**Net**

29. EARNINGS PER ORDINARY SHARE

	2012 R'm	**2012 R'm**	**2012 R'm**
Earnings reconciliation			
Profit attributable to shareholders			**1 221**
Re-measurements for:	**1**	**–**	**1**
Impairment of property and equipment	**2**	**–**	**2**
Profit on disposal of property, equipment and vehicles	**(1)**	**–**	**(1)**
Headline earnings			**1 222**
Re-measurements for:			
Past-service cost (note 20)	**(14)**	**3**	**(11)**
Normalised headline earnings			**1 211**

	2011 R'm	2011 R'm	2011 R'm
Profit attributable to shareholders			1 177
Re-measurements for:	(77)	10	(67)
Profit on disposal of property, equipment and vehicles	(4)	1	(3)
Gain on purchase of business acquisition (note 32)	(21)	–	(21)
Gain on rights sold	(2)	–	(2)
Impairment of property and equipment	34	(9)	25
Insurance proceeds	(84)	18	(66)
Headline earnings			1 110
Re-measurements for:			
Past-service cost (note 20)	(33)	5	(28)
Normalised headline earnings			1 082

29. EARNINGS PER ORDINARY SHARE (continued)

	GROUP	
	2012	2011
Weighted average number of ordinary shares in issue for basic earnings per share		
Number of ordinary shares in issue at the beginning of the year	**652 315 341**	593 013 946
Weighted average number of ordinary shares issued during the year	**–**	37 530 472
Weighted average number of treasury shares	**(25 035 450)**	(28 077 915)
BEE shareholders*	**(9 927 016)**	(11 796 572)
Mpilo Trusts	**(14 392 872)**	(14 757 847)
Wholly owned subsidiary	**(715 562)**	(1 523 496)
	627 279 891	602 466 503
Weighted average number of ordinary shares in issue for diluted earnings per share		
Weighted average number of ordinary shares in issue	**627 279 891**	602 466 503
Weighted average number of treasury shares held in terms of the BEE initiative not yet released from treasury stock	**24 319 888**	26 554 419
BEE shareholders	**9 927 016**	11 796 572
Mpilo Trusts	**14 392 872**	14 757 847
Adjustment for outstanding share options granted	**179 234**	467 074
	651 779 013	629 487 996
Earnings per ordinary share (cents)		
Basic	**194.7**	195.3
Diluted	**187.3**	186.9
Headline earnings per ordinary share (cents)		
Basic	**194.9**	184.2
Diluted	**187.5**	176.3
Normalised headline earnings per ordinary share (cents)		
Basic	**193.0**	179.6
Diluted	**185.7**	171.9

* Represents the equivalent weighted average number of shares for which no value has been received from the BEE shareholders in terms of the Group's black ownership initiative. To date, no value was received for an equivalent of 9 264 351 (2011: 10 985 296) shares issued to the strategic black partners.

Refer to the glossary in the integrated report for the meaning of headline earnings, headline earnings per share, normalised headline earnings and normalised headline earnings per share.

30. OTHER COMPREHENSIVE INCOME

Components of other comprehensive income

	GROUP	
	2012 R'm	2011 R'm
Currency translation differences	**1 405**	488
Fair value adjustment – cash flow hedges	**(1 126)**	246
Actuarial gains and losses	**(403)**	(73)
Other comprehensive income/(loss), net of tax	**(124)**	661

Tax and non-controlling interest on other comprehensive income

Year ended 31 March 2011	**Gross R'm**	**Tax R'm**	**Non-controlling interest R'm**	**Net R'm**
Currency translation differences	527	–	(39)	488
Fair value adjustment – cash flow hedges	271	(25)	–	246
Actuarial gains and losses	(89)	16	–	(73)
Other comprehensive (loss)/income	709	(9)	(39)	661
Year ended 31 March 2012				
Currency translation differences	**1 343**	**–**	**62**	**1 405**
Fair value adjustment – cash flow hedges	**(1 216)**	**90**	**–**	**(1 126)**
Actuarial gains and losses	**(506)**	**103**	**–**	**(403)**
Other comprehensive income/(loss)	**(379)**	**193**	**62**	**(124)**

	2012 R'm	2011 R'm

31. CASH FLOW INFORMATION

31.1 Reconciliation of profit before taxation to cash generated from operations

Operating profit before interest and taxation	**3 759**	3 448
Non-cash items		
Movement in share-based payment reserve	**6**	6
Depreciation	**890**	726
Intangibles amortised	**20**	12
Impairment losses	**4**	27
Insurance proceeds	**–**	(78)
Movement in provisions	**51**	72
Movement in retirement benefit obligations	**(69)**	(87)
Profit on disposal of property, equipment and vehicles	**(1)**	(4)
Operating income before changes in working capital	**4 660**	4 122
Working capital changes	**(394)**	57
Increase in inventories	**(15)**	(26)
Increase in trade and other receivables	**(670)**	(437)
Increase in trade and other payables	**291**	520
	4 266	4 179

COMPANY			GROUP	
2011 R'm	**2012 R'm**		**2012 R'm**	2011 R'm
		31. CASH FLOW INFORMATION (continued)		
		31.2 Interest paid		
		Finance cost per income statement	**1 642**	1 491
		Non-cash items		
		Amortisation of capitalised financing fees	**(81)**	(78)
		Other non cash-flow finance expenses	**15**	–
			1 576	1 413
		31.3 Tax paid		
		Liability at the beginning of the year	**(146)**	(38)
		Exchange differences	**(20)**	(3)
(37)	**(38)**	Provision for the year	**(666)**	(600)
(37)	**(38)**		**(832)**	(641)
		Liability at the end of the year	**307**	146
(37)	**(38)**		**(525)**	(495)
		31.4 Investment to maintain operations		
		Property, equipment and vehicles purchased	**(711)**	(617)
		Intangible assets purchased	**(20)**	(28)
(1 331)	**12**	Loans to subsidiaries	**–**	–
(1 331)	**12**		**(731)**	(645)
		31.5 Investment to expand operations		
		Property, equipment and vehicles purchased	**(712)**	(560)
		Business acquisitions (note 32)	**(30)**	(218)
			(742)	(778)
		31.6 Proceeds on disposal of property, equipment and vehicles		
		Book value of property, equipment and vehicles sold	**21**	23
		Profit per income statement	**1**	4
		Exchange differences	**1**	(3)
			23	24
		31.7 Distributions paid to shareholders		
(447)	**(476)**	Dividends declared and paid during the year	**(436)**	(398)

The dividends paid in 2012 (dividend number 28 & 29) were 73.0 cents per share (2011: 73.0 cents, dividend number 26 & 27). A final dividend (dividend number 30) in respect of the year ended 31 March 2012 of 55.0 cents per share was declared at a directors' meeting on 22 May 2012. These financial statements do not reflect this dividend payable.

	GROUP	
	2012 R'm	2011 R'm
31. CASH FLOW INFORMATION (continued)		
31.8 Cash, cash equivalents and bank overdrafts		
For the purposes of the statement of cash flows, cash, cash equivalents and bank overdrafts include:		
Cash and cash equivalents	**2 099**	1 567
Bank overdrafts (note 19)	**(118)**	(120)
	1 981	1 447
Cash, cash equivalents and bank overdrafts are denominated in the following currencies:		
SA rand*	**703**	631
Swiss franc**	**951**	702
UAE dirham***	**325**	114
Euros	**2**	-
	1 981	1 447

* The counterparties have a minimum A3 credit rating by Moody's.

** The facility agreement of the Swiss subsidiary restricts the distribution of cash. The counterparties have a minimum Aa3 credit rating by Moody's and a minimum A+ credit rating by Standard & Poor's.

*** The counterparties have a minimum Baa1 credit rating by Moody's and a minimum BBB+ credit rating by Standard & Poor's.

	GROUP	
	2012 R'm	2011 R'm

32. BUSINESS ACQUISITIONS

	Cash flow on acquisition	Cash flow on acquisition
Klinik Stephanshorn	**–**	179
Emaar Clinics	**30**	39
Total	**30**	218

Klinik Stephanshorn
During the prior year, on 4 October 2010, Klinik Hirslanden AG acquired 100% of the voting shares of Klinik Stephanshorn AG, a company based in Switzerland, St. Gallen and specialising in enhancing the quality of life of patients by providing comprehensive, high-quality hospital services.

	Fair value recognised on acquisition
Assets	
Property, equipment and vehicles	280
Inventories	6
Trade and other receivables	97
Cash and cash equivalents	3
Total assets	386
Liabilities	
Trade and other payables	(38)
Other current liabilities	(2)
Borrowings	(102)
Provisions	(5)
Pension liabilities	(33)
Deferred tax liability	(3)
Total liabilities	(183)
Total identifiable net assets at fair value	203
Gain on purchase of business acquisition (note 25)	(21)
Purchase consideration transferred	182
Analysis of cash flow on acquisition	
Purchase consideration	(182)
Net cash acquired with the subsidiary	3
Net cash flow on acquisition	(179)

The fair value of the trade receivables amounts to R90.7m. The gross amount of trade receivables is R91.4m. None of the trade receivables have been impaired and it is expected that the full contractual amounts can be collected.

In the prior year a gain of purchase on business acquisition of R21m was recognised.

In the prior year acquisition-related costs of R2.4m have been expensed and are recognised in the income statement.

	GROUP	
	2012 R'm	2011 R'm

32. BUSINESS ACQUISITIONS (continued)

Emaar clinics

During the prior year, on 15 January 2011, the Group acquired all the equipment of The Dubai Mall Medical Center, Meadows Clinic and Arabian Ranches Clinic for R69m. As part of the agreement, the Group will operate the three clinics from the acquisition date.

		Fair value recognised on acquisition
Assets		
Equipment and vehicles		69
Total identifiable net assets at fair value		69
Purchase consideration transferred		69
Analysis of cash flow on acquisition		
Purchase consideration		(69)
Net cash acquired with the subsidiary		–
Net cash flow on acquisition	**(30)**	(69)
Less outstanding purchase consideration	**–**	30
Net cash flow recognised for the year	**(30)**	(39)

No goodwill arising from the acquisition in the prior year.

In the prior year acquisition-related costs of R0.1m have been expensed and are recognised in the income statement.

	GROUP	
	2012 R'm	2011 R'm
33. COMMITMENTS		
Capital commitments		
Incomplete capital expenditure contracts	**1 179**	1 292
Southern Africa	**556**	452
Switzerland	**592**	831
Middle East	**31**	9
Capital expenses authorised by the Board of Directors but not yet contracted	**982**	1 101
Southern Africa	**871**	1 038
Switzerland	**111**	63
Middle East	**–**	–
	2 161	2 393

These commitments will be financed from group and borrowed funds.

Financial lease commitments

The Group has entered into financial lease agreements on equipment.

The future non-cancellable minimum lease rentals are payable during the following financial years:		
Within 1 year	**7**	6
1 to 5 years	**23**	23
Beyond 5 years	**18**	19
	48	48

Operating lease commitments

The Group has entered into various operating lease agreements on premises and equipment. The future non-cancellable minimum lease rentals are payable during the following financial years:		
Within 1 year	**231**	195
1 to 5 years	**636**	537
Beyond 5 years	**1 501**	1 450
	2 368	2 182

	2012 R'm	2012 R'm	2012 R'm	2012 R'm

34. SEGMENTAL REPORT

The Group is organised into six reportable segments, namely: Southern Africa Hospital Services and Southern Africa Hospital Properties; Swiss Hospital Services and Swiss Hospital Properties; Middle East Hospital Services and Middle East Hospital Properties.

Year ended 31 March 2012:	Southern Africa Hospital Services	Southern Africa Hospital Properties	Adjustments and eliminations	Southern Africa Total
Revenue	9 423	826	(826)	9 423
EBITDA	1 156	801		1 957
Depreciation and amortisation	(256)	–		(256)
EBIT	900	801		1 701
Finance income	41	10	(10)	41
Finance cost	(68)	(315)	14	(369)
Taxation	(295)	(139)		(434)
Segment result	578	357		939
At 31 March 2012:				
Capital expenditure	480	43		523
Total segment assets	5 266	7 468	(6 118)	6 616
Segment liabilities	2 358	4 062	(1 100)	5 320

Year ended 31 March 2012:	Swiss Hospital Services	Swiss Hospital Properties	Adjustments and eliminations	Swiss Total
Revenue	10 732	1 596	(1 596)	10 732
EBITDA	887	1 477		2 364
Depreciation and amortisation	(399)	(157)		(556)
EBIT	488	1 320		1 808
Income from associates	1	–		1
Finance income	9	–		9
Finance cost	(19)	(1 229)		(1 248)
Taxation	(73)	(187)		(260)
Segment result	406	(96)		310
At 31 March 2012:				
Investments in associates	1	–		1
Capital expenditure	430	442		872
Total segment assets	11 538	28 231		39 769
Segment liabilities	3 846	28 929		32 775

Year ended 31 March 2012:	Middle East Hospital Services	Middle East Hospital Properties	Adjustments and eliminations	Middle East Total
Revenue	1 831	59	(59)	1 831
EBITDA	289	59		348
Depreciation and amortisation	(98)	–		(98)
EBIT	191	59		250
Finance income	1	–		1
Finance cost	(13)	(15)		(28)
Segment result	179	44		223
At 31 March 2012:				
Capital expenditure	47	–		47
Total segment assets	1 322	817		2 139
Segment liabilities	613	267		880

	2011 R'm	2011 R'm	2011 R'm	2011 R'm

34. SEGMENTAL REPORT (continued)

Year ended 31 March 2011:	Southern Africa Hospital Services	Southern Africa Hospital Properties	Adjustments and eliminations	Southern Africa Total
Revenue	8 632	760	(760)	8 632
EBITDA	1 150	737		1 887
Depreciation and amortisation	(229)	–		(229)
EBIT	921	737		1 658
Finance income	35	10	(9)	36
Finance cost	(77)	(319)	12	(384)
Taxation	(277)	(120)		(397)
Segment result	602	308		913
At 31 March 2011:				
Capital expenditure	481	43		524
Total segment assets	4 937	6 872	(5 609)	6 200
Segment liabilities	2 381	3 973	(1 059)	5 295

Year ended 31 March 2011:	Swiss Hospital Services	Swiss Hospital Properties	Adjustments and eliminations	Swiss Total
Revenue	8 659	1 326	(1 326)	8 659
EBITDA	834	1 225		2 059
Depreciation and amortisation	(307)	(126)		(433)
EBIT	527	1 099		1 626
Other gains and losses	21	–		21
Income from associates	4	–		4
Finance income	9	–		9
Finance cost	(18)	(1 050)		(1 068)
Taxation	(101)	(156)		(257)
Segment result	442	(107)		335
At 31 March 2011:				
Investments in associates	4	–		4
Capital expenditure	315	320		635
Total segment assets	9 812	24 338		34 150
Segment liabilities	3 176	23 923		27 099

Year ended 31 March 2011:	Middle East Hospital Services	Middle East Hospital Properties	Adjustments and eliminations	Middle East Total
Revenue	1 334	57	(57)	1 334
EBITDA	183	57		240
Depreciation and amortisation	(76)	–		(76)
EBIT	107	57		164
Finance income	1	–		1
Finance cost	(22)	(17)		(39)
Segment result	86	40		126
At 31 March 2011:				
Capital expenditure	46	–		46
Total segment assets	1 005	727		1 732
Segment liabilities	473	263		736

	2012 R'm	2012 R'm	2012 R'm	2012 R'm

34. SEGMENTAL REPORT (continued)

Year ended 31 March 2012:	Total Hospital Services	Total Hospital Properties	Adjustments and eliminations	Total
Revenue	**21 986**	**2 481**	**(2 481)**	**21 986**
EBITDA	**2 332**	**2 337**		**4 669**
Depreciation and amortisation	**(753)**	**(157)**		**(910)**
EBIT	**1 579**	**2 180**		**3 759**
Income from associates	**1**	**–**		**1**
Finance income	**51**	**10**	**(10)**	**51**
Finance cost	**(100)**	**(1 559)**	**14**	**(1 645)**
Taxation	**(368)**	**(326)**		**(694)**
Segment result	**1 163**	**305**		**1 472**
At 31 March 2012:				
Investments in associates	**1**	**–**		**1**
Capital expenditure	**957**	**485**		**1 442**
Total segment assets	**18 126**	**36 516**	**(6 118)**	**48 524**
Segment liabilities	**6 817**	**33 258**	**(1 100)**	**38 975**

	2011 R'm	2011 R'm	2011 R'm	2011 R'm
Year ended 31 March 2011:	**Total Hospital Services**	**Total Hospital Properties**	**Adjustments and eliminations**	**Total**
Revenue	18 625	2 143	(2 143)	18 625
EBITDA	2 167	2 019		4 186
Depreciation and amortisation	(612)	(126)		(738)
EBIT	1 555	1 893		3 448
Other gains and losses	21	–		21
Income from associates	4	–		4
Finance income	45	10	(9)	46
Finance cost	(117)	(1 386)	12	(1 491)
Taxation	(378)	(276)		(654)
Segment result	1 130	241		1 374
At 31 March 2011:				
Investments in associates	4	–		4
Capital expenditure	842	363		1 205
Total segment assets	15 754	31 937	(5 609)	42 082
Segment liabilities	6 030	28 159	(1 059)	33 130

Adjustments and eliminations

The adjustments and eliminations relate to the elimination of the following items on consolidation: intersegmental rent, intersegmental finance cost/income, intersegmental loans and intersegmental revaluation of properties.

	GROUP	
	2012 R'm	2011 R'm

34. SEGMENTAL REPORT (continued)

Reconciliation of segment result, assets and liabilities

Segment result		
Total profit from reportable segments	**1 472**	1 374
Unallocated corporate amounts:		
Other gains and losses	**(26)**	(8)
Interest received	**34**	15
Elimination of intersegment loan interest	**4**	–
Consolidated profit before tax	**1 484**	1 381
Assets		
Total assets from reportable segments	**48 524**	42 082
Unallocated corporate assets	**1 671**	1 455
	50 195	43 537
Liabilities		
Total liabilities from reportable segments	**38 975**	33 130
Elimination of intersegment loan	**(184)**	(157)
Other liabilities	**–**	4
	38 791	32 977

The total non-current assets, excluding property, equipment and vehicles, financial instruments and deferred tax assets per geographical location is:

Southern Africa	**135**	135
Middle East	**384**	344
Switzerland	**5 826**	5 086
	6 345	5 565

COMPANY			GROUP	
2011 R'm	**2012 R'm**		**2012 R'm**	2011 R'm

35. RELATED PARTY TRANSACTIONS

The major shareholder of the Group is Industrial Partnership Investments Limited (Remgro Limited), which owns 43.4% (2011: 43.4%).

The following transactions were carried out with related third parties:

		i) Transactions with shareholders		
		Remgro Management Services Limited (subsidiary of Remgro Limited)		
		Managerial and administration fees	**1**	1
		Internal audit services	**2**	2
		Commitment fees in respect of the rights offer	**–**	6
		Balance due to	**–**	–
		ii) Key management compensation		
		Directors		
		Information regarding the directors' and prescribed officers' remuneration appears in note 26.		
		iii) Transactions with subsidiaries and associates		
		Mediclinic Investments Limited		
415	**476**	Dividend received		
4 938	**6 261**	Balance due from		
		Zentrallabor Zürich (ZLZ)		
		Fees earned	**(15)**	(7)
		Purchases	**76**	58

36. STANDARDS AND INTERPRETATIONS NOT YET EFFECTIVE

Certain new and revised IFRSs have been issued but are not yet effective for the Group. The Group has not early adopted the new and revised IFRSs that are not yet effective.

New and revised IFRSs that could affect reported financial performance and/or financial position:

IAS 19 Employee Benefits (1 January 2013)
The impact on the Group will be as follows: Interest cost and expected return on plan assets will be replaced with a net interest amount that is calculated by applying the discount rate to the net defined liability (asset). The Group is yet to assess the full impact of the amendments.

New and revised IFRSs affecting mainly presentation and disclosure:

IFRS 9 Financial Instruments (Effective 1 January 2015)
The new standard improves and simplifies the approach for classification and measurement of financial assets compared with the requirements of IAS 39. IFRS 9 applies a consistent approach to classifying financial assets and replaces the numerous categories of financial assets in IAS 39, each of which had its own classification criteria. IFRS 9 also results in one impairment method, replacing the numerous impairment methods in IAS 39 that arise from the different classification categories.

IFRS 10 Consolidated Financial Statements, IFRS 11 Joint Arrangements and IFRS 12 Disclosure of Interests in Other Entities (Effective 1 January 2013)
IFRS 10 builds on existing principles by identifying the concept of control as the determining factor in whether an entity should be included within the consolidated financial statements of the parent company and provides additional guidance to assist in the determination of control where this is difficult to assess. IFRS 11 deals with the accounting for joint arrangements and focuses on the rights and obligations of the arrangement, rather than its legal form. The standard requires a single method for accounting for interests in jointly controlled entities. IFRS 12 contains comprehensive disclosure requirements for all forms of interests in other entities, including joint arrangements, associates, special purpose vehicles and other off balance sheet vehicles.

The following new accounting standards, interpretations and amendments will have no material effects on the financial statements:

- IFRS 1 First time Adoption of International Financial Reporting Standards (1 July 2011)
- IFRS 7 Financial Instruments: Disclosures (1 July 2011 and 1 January 2013)
- IFRS 13 Fair Value Measurement (1 January 2013)
- IAS 1 Presentation of Financial Statements (1 July 2012)
- IAS 12 Income taxes (1 January 2012)
- IAS 27 Consolidated and Separate Financial Statements (1 January 2013)
- IAS 28 Investments in Associates and Joint Ventures (1 January 2013)
- IAS 32 Financial Instruments: Presentation (1 January 2014)

There are numerous other new standards or amendments to existing standards that are not yet effective for the Group. Each of these has been assessed, and will not have a material impact on the financial statements.

ANNEXURE – INVESTMENTS IN SUBSIDIARIES AND ASSOCIATES
AS AT 31 MARCH 2012

	Issued share capital		Interest in capital		Book value of shares	
	2012 Rand	2011 Rand	**2012 %**	2011 %	**2012 R'm**	2011 R'm
SUBSIDIARIES						
COMPANY						
Mediclinic Investments Limited	**100**	100	**100.0**	100.0	**1**	1
The loan to the subsidiary amounts to R6 261m (2011: R6 272m) and is repayable on demand.						
GROUP						
Indirectly held through Mediclinic Investments Limited						
Mediclinic Southern Africa (Pty) Ltd			**100.0**	100.0		
Mediclinic Europe (Pty) Ltd			**100.0**	100.0		
Mediclinic Middle East (Pty) Ltd			**100.0**	100.0		
Mecli Properties Limited			**100.0**	100.0		
Mediclinic CHF Finco Limited			**100.0**	100.0		
Mediclinic Group Services (Pty) Ltd			**100.0**	100.0		
Indirectly held through Mediclinic Southern Africa (Pty) Ltd						
Curamed Holdings Limited			**69.8**	70.1		
Howick Private Hospital Holdings Limited*			**49.1**	49.1		
Medical Human Resources (Pty) Ltd			**100.0**	100.0		
Medical Innovations (Pty) Ltd			**100.0**	100.0		
Mediclinic (Pty) Ltd			**100.0**	100.0		
Mediclinic Capital (Namibia) (Pty) Ltd			**100.0**	100.0		
Mediclinic Holdings (Namibia) (Pty) Ltd			**100.0**	100.0		
Mediclinic Properties (Pty) Ltd			**100.0**	100.0		
Mediclinic Properties (Windhoek) (Pty) Ltd			**100.0**	100.0		
Mediclinic Operations (Namibia) (Pty) Ltd			**100.0**	100.0		
Mediclinic Properties (Swakopmund) (Pty) Ltd			**100.0**	100.0		
Mediclinic Finance Corporation (Pty) Ltd			**100.0**	100.0		
Mediclinic Investments (Namibia) (Pty) Ltd			**100.0**	100.0		
Medipark Clinic (Pty) Ltd			**100.0**	100.0		
Newcastle Private Hospital Limited*			**15.1**	15.1		
Mediclinic Paarl (Pty) Ltd*			**74.7**	78.9		
Phodiclinics (Pty) Ltd			**100.0**	100.0		
Legae Medi-Clinic (Pty) Ltd			**100.0**	100.0		
Practice Relief (Pty) Ltd			**100.0**	100.0		
Mediclinic Brits (Pty) Ltd*			**60.1**	60.9		
Tshwane Private Hospitals (Pty) Ltd			**100.0**	100.0		
Mediclinic Tzaneen (Pty) Ltd*			**49.4**	49.4		
Victoria Hospital Limited*			**33.7**	33.3		

	Interest in capital	
	2012 %	2011 %
SUBSIDIARIES (continued)		
Indirectly held through Mediclinic (Pty) Ltd		
Mediclinic Barberton (Pty) Ltd [$*]	**77.0**	77.0
Mediclinic Ermelo (Pty) Ltd[$*]	**50.1**	50.1
Mediclinic Hermanus Limited*	**34.9**	34.9
Mediclinic Kimberley (Pty) Ltd*	**89.7**	89.7
Mediclinic Limpopo Limited[$]	**50.0**	50.0
Mediclinic Potchefstroom (Pty) Ltd*	**94.6**	94.6
Mediclinic Upington (Pty) Ltd*	**40.9**	40.9
Indirectly held through Howick Private Hospital Holdings Limited		
Howick Private Hospital (Pty) Ltd*	**100.0**	100.0
Indirectly held through Curamed Holdings Ltd		
Curamed Hospitals (Pty) Ltd		
Curamed Properties (Pty) Ltd	**100.0**	100.0
	100.0	100.0
Indirectly held through Mediclinic Europe (Pty) Ltd		
Mediclinic Holdings Netherlands B.V.	**100.0**	100.0
Mediclinic Luxembourg S.à r.l.	**100.0**	100.0
Medi-Clinic Switzerland AG	**100.0**	100.0
Indirectly held through Medi-Clinic Switzerland AG		
AndreasKlinik AG	**100.0**	100.0
Beau-Site AG	**100.0**	100.0
Clinique Bois-Cerf SA	**100.0**	100.0
Clinique Cecil SA	**100.0**	100.0
Hirslanden Klinik Aarau AG	**100.0**	100.0
Hirslanden Klinik Am Rosenberg AG	**100.0**	100.0
Klinik am Rosenberg Heiden AG	**99.1**	99.1
Klinik Belair AG	**100.0**	100.0
Klinik Birshof AG	**99.7**	99.7
Klinik Hirslanden AG	**100.0**	100.0
Klinik Im Park AG	**100.0**	100.0
Klinik Stephanshorn AG	**100.0**	100.0
Klinik St. Anna AG	**100.0**	100.0
Salem-Spital AG	**100.0**	100.0
Indirectly held through Mediclinic Middle East (Pty) Ltd		
Emirates Healthcare Holdings Limited BVI	**50.4**	50.4
Indirectly held through Emirates Healthcare Holdings Limited BVI		
Welcare World Holdings Limited BVI	**100.0**	100.0
EHL Management Services FZ LLC	**100.0**	100.0
Welcare Hospital LLC	**49.0**	49.0
American Healthcare Management Systems Limited	**100.0**	100.0
The Creek Hospital Dubai FZ LLC	**100.0**	100.0
Welcare EDC Al Quasis Clinic LLC	**49.0**	49.0
Welcare Clinic Mirdiff LLC	**49.0**	49.0
Welcare Clinic IBN Battuta LLC	**49.0**	49.0

ANNEXURE – INVESTMENTS IN SUBSIDIARIES AND ASSOCIATES
AS AT 31 MARCH 2012 continued

	Interest in capital	
	2012	2011
	%	%
SUBSIDIARIES (continued)		
Indirectly held through Emirates Healthcare Holdings Limited BVI		
Emirates Healthcare Estates Limited BVI	**100.0**	100.0
Emirates Healthcare Limited BVI	**99.3**	99.3
EHL Clinics LLC	**49.0**	49.0
The City Hospital FZ LLC	**100.0**	100.0
Welcare Hospitals Limited BVI	**100.0**	100.0
Welcare World Health Systems Limited BVI	**100.0**	100.0

All increases in the above shareholdings were paid for in cash.
* Controlled through long-term management agreements
$ Operating through trusts or partnerships

Indirectly held through Curamed Holdings Limited		
Thabazimbi Medi-Clinic Trust	**85.0**	85.0
Indirectly held through Medipark Clinic (Pty) Ltd		
ER24 Holdings (Pty) Ltd	**100.0**	100.0
ER24 EMS (Pty) Ltd	**100.0**	100.0
JOINT VENTURES		
Wits University Donald Gordon Medical Centre (Pty) Ltd	**49.9**	49.9

	Interest in capital		Book value of investment		Amount owing by associates	
	2012	2011	**2012**	2011	**2012**	2011
	%	%	**R'm**	R'm	**R'm**	R'm
ASSOCIATES						
GROUP						
Unlisted:						
Zentrallabor Zürich, Zürich (ZLZ)*	**42.0**	50.0	**1**	11	**–**	–
			1	11	**–**	–

The nature of the activities of the associates is similar to the major activities of the Group.

* The Group has not obtained control (voting rights are below 50%).

ANALYSIS OF SHAREHOLDERS
AS AT 25 MARCH 2012

DISTRIBUTION OF ORDINARY SHAREHOLDERS

	Number of shareholders	Number of shares	%
Public shareholders	**5 008**	**286 673 161**	**43.95%**
Non-public shareholders	**22**	**365 642 180**	**56.05%**
– Directors and their associates	**11**	**4 622 451**	**0.71%**
– Directors of major subsidiaries and their associates	**5**	**561 568**	**0.08%**
– Own holdings (held by Medipark Clinic (Pty) Ltd as treasury shares)	**1**	**443 634**	**0.07%**
– Industrial Partnership Investments Limited (Remgro)	**1**	**283 080 915**	**43.40%**
– Black economic empowerment shareholders	**4**	**76 933 612**	**11.79%**
	5 030	**652 315 341**	**100.00%**
Distribution of local and foreign beneficial shareholding:		**652 315 341**	**100.00%**
– South African		**591 784 694**	**90.72%**
– Foreign		**60 530 647**	**9.28%**

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 25 March 2012:

Industrial Partnership Investments Limited (Remgro)	**283 080 915**	**43.40%**
Black economic empowerment shareholders	**76 933 612**	**11.79%**
– Mpilo Investment Holdings 2 (Pty) Ltd (Phodiso Holdings)	**39 332 736**	**6.03%**
– Mpilo Investment Holdings 1 (Pty) Ltd (Circle Capital Ventures)	**23 377 488**	**3.58%**
– The Mpilo Trust & The Mpilo Trust (Namibia)	**14 223 388**	**2.18%**
Government Employees Pension Fund	**60 321 812**	**9.25%**
International Hospitals Network (Trilantic Capital Partners)	**39 231 535**	**6.01%**

SHAREHOLDING SPREAD

	Number of shareholders	%	Number of shares	%
1 – 1 000 shares	**2 523**	**50.16%**	**943 917**	**0.15%**
1 001 – 10 000 shares	**1 698**	**33.76%**	**5 405 386**	**0.83%**
10 001 – 100 000 shares	**529**	**10.52%**	**17 884 032**	**2.74%**
100 001 – 1 000 000 shares	**229**	**4.55%**	**70 986 859**	**10.88%**
Over 1 000 000 shares	**51**	**1.01%**	**557 095 147**	**85.40%**
	5 030	**100.00%**	**652 315 341**	**100.00%**

ANALYSIS OF SHAREHOLDERS
AS AT 25 MARCH 2012 continued

DIRECTORS' INTERESTS*

	2012				2011			
	Direct beneficial	**Indirect beneficial**	**Held by associates**	**% of issued shares**	Direct beneficial	Indirect beneficial	Held by associates	% of issued shares
E de la H Hertzog	**34 845**	**3 760 053**	**384 803**	**0.64%**	34 845	3 724 801	384 803	0.64%
JC Cohen	**–**	**–**	**–**	**0.00%**	–	–	–	0.00%
RE Leu	**–**	**–**	**–**	**0.00%**	–	–	–	0.00%
MK Makaba**	**–**	**–**	**–**	**0.00%**	–	–	–	0.00%
ZP Manase	**–**	**–**	**–**	**0.00%**	–	–	–	0.00%
DP Meintjes	**168 910**	**–**	**–**	**0.03%**	138 622	–	–	0.02%
KHS Pretorius	**129 518**	**–**	**–**	**0.02%**	112 605	–	–	0.02%
AA Raath	**–**	**–**	**–**	**0.00%**	–	–	–	0.00%
MA Ramphele	**–**	**–**	**–**	**0.00%**	–	–	–	0.00%
DK Smith	**–**	**–**	**–**	**0.00%**	–	–	–	0.00%
CI Tingle	**120 988**	**–**	**–**	**0.02%**	98 823	–	–	0.02%
CM van den Heever	**–**	**–**	**–**	**0.00%**	–	–	–	0.00%
CA van der Merwe	**22 377**	**–**	**–**	**0.00%**	10 652	–	–	0.00%
WL van der Merwe	**957**	**–**	**–**	**0.00%**	957	–	–	0.00%
late MH Visser	**–**	**–**	**–**	**0.00%**	–	–	–	0.00%
TO Wiesinger	**–**	**–**	**–**	**0.00%**	–	–	–	0.00%
	477 595	**3 760 053**	**384 803**	**0.71%**	396 504	3 724 801	384 803	0.70%

** There has been no change in the directors' interests between 30 March 2012 and the approval of the annual financial statements on 22 May 2012.*

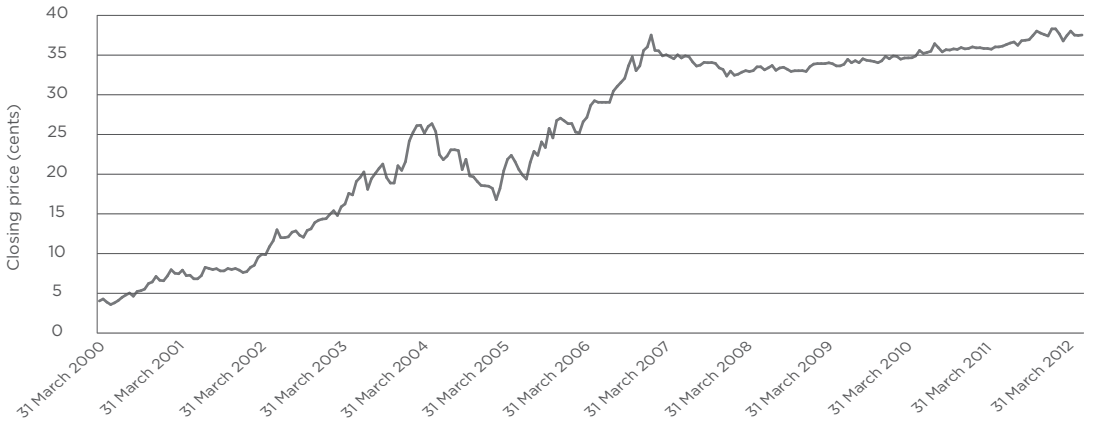
*** Dr MK Makaba holds a 5.08% interest in Phodiso Holdings Limited, which company is the holder of all the issued ordinary shares in Mpilo Investment Holdings 2 (Pty) Ltd (RF), which holds a 6.03% interest in Mediclinic.*

JSE SHARE PERFORMANCE

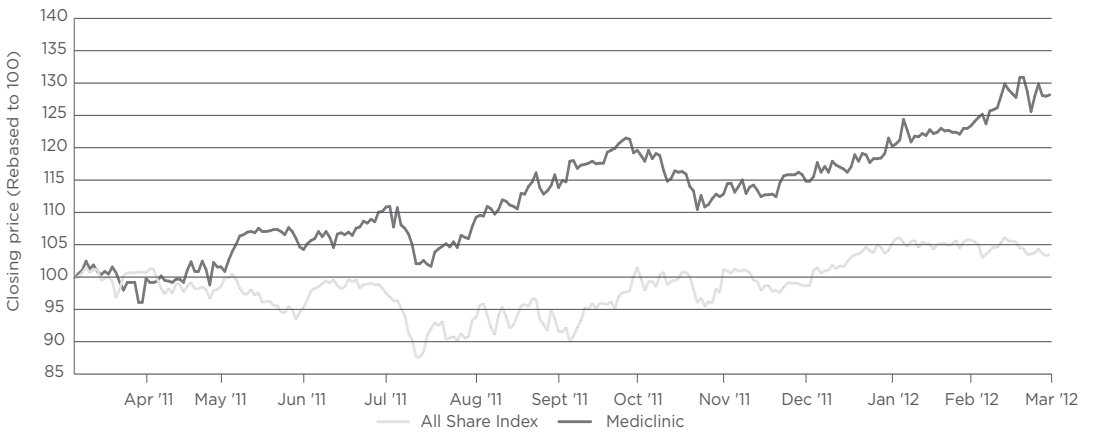
	2012	2011
Market capitalisation as at 31 March (R'000)	**24 461 825**	18 917 145
Price (cents per share)		
31 March	**3 750**	2 900
Highest	**4 199**	3 150
Lowest	**2 810**	2 325
Number of shares traded (000's)	**118 734**	98 979

TRADING STATISTICS (SHARE CLOSING PRICE AND VOLUME)

SHARE CLOSING PRICE FROM 2000 – 2012



SHARE PERFORMANCE COMPARED TO JSE ALL SHARE INDEX (REBASED TO 100)



GLOSSARY

TERM	MEANING
ACTD	Adult Cardio-thoracic Database
adjusted net asset value per ordinary share (cents)	net asset value divided by the number of ordinary shares in issue at year-end excluding the valuation of the derivative financial instruments and the Swiss pension liability
ALS and BLS	advanced and basic life support
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
case weight*	weight attributed to each DRG (reflecting the complexity and associated costs of the treatment)
cash conversion (%)	cash generated from operations divided by normalised EBITDA
CCU	critical care unit
CDC	US Centre for Disease Control
CDLI	Carbon Disclosure Leadership Index
CDP	Carbon Disclosure Project
CMS	Council for Medical Schemes
COHSASA	Council for Health Services Accreditation in South Africa
Companies Act	the South African Companies Act, 71 of 2008, as amended which came into effect on 1 May 2011
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	the Group's operations in the United Arab Emirates, with Emirates Healthcare Holdings Limited BVI as the operating platform's holding company
GRI G3	the G3 Sustainability Reporting Guidelines developed by the Global Reporting Initiative
Group or Mediclinic or Mediclinic International	Mediclinic International and its three operating platforms in Southern Africa, Switzerland and the United Arab Emirates
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. neuro surgery, 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

** these terms relate specifically to the Group's operations in Switzerland.*

TERM	MEANING
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
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 Southern Africa	Mediclinic Southern Africa (Pty) Ltd, the holding company of the Group's operations in South Africa and Namibia
Mediclinic Switzerland	Medi-Clinic Switzerland AG, the intermediary holding company of the Hirslanden group, being 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 2012 and ending on 31 March 2013
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 and Emirates Healthcare 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 2011 and ended on 31 March 2012
Preissmeister (price supervisor)*	based on a federal law, the office of the price supervisor is responsible for ensuring adequate and transparent pricing in areas where there is a lack of competition, which also applies to DRG base rates
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

** these terms relate specifically to the Group's operations in Switzerland.*

NOTICE OF ANNUAL GENERAL MEETING

MEDICLINIC INTERNATIONAL

MEDICLINIC INTERNATIONAL LIMITED
Registration number: 1983/010725/06
Share Code: MDC
ISIN Code: ZAE000074142
("**the Company**")

Notice is hereby given in terms of section 62(1) of the Companies Act, 71 of 2008, as amended ("**the Companies Act**") that the twenty-ninth annual general meeting of the Company will be held at the Neethlingshof Estate, Polkadraai Road, Vlottenburg, Stellenbosch on **Thursday, 26 July 2012** at 15:00 to consider, and if approved, pass the following resolutions with or without modification.

This notice has been sent to shareholders of the Company who were recorded as such in the Company's securities register on Friday, 15 June 2012, being the notice record date set by the Board of the Company in terms of the Companies Act determining which shareholders are entitled to receive notice of the annual general meeting.

ORDINARY RESOLUTIONS

1. CONSIDERATION OF ANNUAL FINANCIAL STATEMENTS

Ordinary Resolution Number 1
Resolved that the audited annual financial statements, including the directors' report, auditor's report and the report by the Audit and Risk Committee, of the Company and the Group for the year ended 31 March 2012 is accepted.

Additional information in respect of Ordinary Resolution Number 1
The complete audited annual financial statements, including the directors' report, auditor's report and the report by the Audit and Risk Committee, of the Company and the Group for the year ended 31 March 2012 is included in the integrated annual report of which this notice forms part of.

2. REAPPOINTMENT OF EXTERNAL AUDITOR

Ordinary Resolution Number 2
Resolved that the reappointment of PricewaterhouseCoopers Inc., as nominated by the Company's Audit and Risk Committee, as the independent external auditor of the Company is approved. It is noted that Mr NH Döman is the individual registered auditor who will undertake the audit for the financial year ending 31 March 2013.

3. RE-ELECTION OF DIRECTORS

Ordinary Resolutions Number 3.1 to 3.5

3.1 **Resolved that** Dr E de la H Hertzog who retires in terms of article 30.1 of the Company's Articles of Association (which together with the Company's Memorandum of Association is defined in the Companies Act as the Company's Memorandum of Incorporation and hereinafter referred to as the Company's "**Memorandum of Incorporation**") and who, being eligible, offers himself for re-election be hereby re-elected as a director of the Company;

3.2 **Resolved that** Mr DP Meintjes who retires in terms of article 30.1 of the Company's Memorandum of Incorporation and who, being eligible, offers himself for re-election be hereby re-elected as a director of the Company;

3.3 **Resolved that** Mr AA Raath who retires in terms of article 30.1 of the Company's Memorandum of Incorporation and who, being eligible, offers himself for re-election be hereby re-elected as a director of the Company;

3.4 **Resolved that** Mr CM van den Heever who retires in terms of article 30.1 of the Company's Memorandum of Incorporation and who, being eligible, offers himself for re-election be hereby re-elected as a director of the Company; and

3.5 **Resolved that** Mr JJ Durand who was appointed by the Board as a non-executive director of the Company on 7 June 2012 and who retires in terms of article 30.10 of the Company's Memorandum of Incorporation and who, being eligible, offers himself for re-election be hereby re-elected as a director of the Company.

Mr JC Cohen, Ms ZP Manase, Dr MA Ramphele and Prof. WL van der Merwe will retire at the annual general meeting and have not offered themselves for re-election as directors of the Company.

Additional information in respect of Ordinary Resolutions Number 3.1 to 3.5
Article 30.1 of the Company's Memorandum of Incorporation provides that one third of the Company's directors shall retire at every annual general meeting. Article 30.10 of the Company's Memorandum of Incorporation provides that any person appointed as a director of the Company by the Board shall retire at the following annual general meeting in addition to the directors retiring by rotation. A brief CV of each of the directors mentioned above, who are considered suitable and eligible for re-election by the Board, appears on page 8 of the integrated annual report of which this notice forms part of.

4. ELECTION OF INDEPENDENT AUDIT AND RISK COMMITTEE

Ordinary Resolutions Number 4.1 to 4.3

4.1 **Resolved that** Prof RE Leu, who is an independent non-executive director of the Company, be hereby elected as a member of the Company's Audit and Risk Committee for the financial year ending 31 March 2013;

4.2 **Resolved that**, subject to the re-election of Mr AA Raath pursuant to Ordinary Resolution Number 3.3, Mr AA Raath, who is an independent non-executive director of the Company, be hereby elected as a member of the Company's Audit and Risk Committee for the financial year ending 31 March 2013; and

4.3 **Resolved that** Mr DK Smith, who is an independent non-executive director of the Company, be hereby elected as a member of the Company's Audit and Risk Committee for the financial year ending 31 March 2013.

Additional information in respect of Ordinary Resolutions Number 4.1 to 4.3
A brief CV of each of the independent non-executive directors mentioned above appears on page 8 of the integrated annual report of which this notice forms part of. As is evident from the CVs of these directors, the committee members have the required qualifications or experience to fulfil their duties.

5. APPROVAL OF GROUP REMUNERATION POLICY

Ordinary Resolution Number 5
Resolved that the Group Remuneration Policy, as described in the Remuneration Report on pages 104 to 107 of the integrated annual report of which this notice forms part of, is hereby approved by way of a non-binding advisory vote, as recommended in the King Code of Governance for South Africa 2009, commonly referred to as King III.

6. GENERAL AUTHORITY TO PLACE SHARES UNDER CONTROL OF THE DIRECTORS

Ordinary Resolution Number 6
Resolved that the unissued ordinary shares in the authorised share capital of the Company be hereby placed under the control of the directors of the Company as a general authority in terms of Company's Memorandum of Incorporation, who are hereby authorised to allot and issue any such shares upon such terms and conditions as the directors of the Company in their sole discretion may deem fit, subject to the aggregate number of ordinary shares available for allotment and issue in terms of this resolution being limited to 5% of the number of ordinary shares in issue at 31 March 2012, and further subject to the provisions of the Companies Act, the Company's Memorandum of Incorporation and the Listings Requirements of the JSE Limited ("**JSE**"), to the extent applicable.

7. GENERAL AUTHORITY TO ISSUE SHARES FOR CASH

Ordinary Resolution Number 7
Resolved that, subject to Ordinary Resolution Number 6, the directors of the Company be and are hereby authorised by way of a general authority, to issue any such number of ordinary shares from the authorised, but unissued shares in the share capital of the Company for cash, as and when the directors in their sole discretion may deem fit, subject to the Companies Act, the Company's Memorandum of Incorporation, the Listings Requirements of the JSE Limited ("**the JSE Listings Requirements**"), when applicable, and the following limitations, namely that –

7.1 the equity securities which are the subject of the issue for cash must be of a class already in issue;

7.2 any such issue will only be made to public shareholders as defined in the JSE Listings Requirements and not to related parties;

7.3 the number of equity securities which are the subject of the issue for cash may not in the aggregate in any one financial year exceed 5% of the Company's relevant number of equity securities in issue of that class. The number of securities which may be issued shall be based on the number of securities of that class in issue added to those that may be issued in future arising from the conversion of options/convertible securities, at the date of such application:

- less any securities of the class issued, or to be issued in future arising from options/convertible securities issued, during the current financial year; and
- plus any securities of that class to be issued pursuant to a rights issue which has been announced, is irrevocable and is fully underwritten or pursuant to an acquisition, the final terms of which has been announced, as though they were securities in issue at the date of application;

7.4 for purposes of determining the number of securities which may be issued in any one year, account must be taken of the dilution effect in the year of issue of options/convertible securities, by including the number of any equity securities which may be issued in future arising out of the issue of such options/convertible securities;

7.5 the equity shares which are the subject of the issue for cash of a particular class, will be aggregated with any securities that are compulsorily convertible into securities of that class, and, in the case of the issue of compulsorily convertible securities, aggregated with the securities of that class into which they are compulsorily convertible;

7.6 this authority is valid until the Company's next annual general meeting, provided that it shall not extend beyond 15 months from the date that this authority is given;

7.7 any such general issues are subject to exchange control regulations and approval at that point in time, where relevant;

7.8 a paid press announcement giving full details, including the impact on the net asset value and earnings per share, will be published at the time of any issue representing, on a cumulative basis within one financial year, 5% or more of the number of shares in issue prior to the issue; and

7.9 in determining the price at which an issue of shares may be made in terms of this authority, the maximum discount permitted will be 10% of the weighted average traded price on the JSE of those shares over the 30 business days prior to the date that the price of the issue is determined or agreed to between the directors of the Company and the party subscribing for the securities. The JSE will be consulted for a ruling if the Company's securities have not traded in such 30 business day period.

Additional information in respect of Ordinary Resolution Number 7
This Ordinary Resolution Number 7 is required under the JSE Listings Requirements. It is further required in terms of the JSE Listings Requirements to be passed by achieving a 75% majority of the votes exercised on such resolution by shareholders present or represented by proxy at the annual general meeting.

SPECIAL RESOLUTIONS

8. APPROVAL OF NON-EXECUTIVE DIRECTORS' REMUNERATION – 2011/2012

Special Resolution Number 1
Resolved that the joint remuneration of the non-executive directors for their services as directors of the Company in the amount of R3 248 803 for the financial year ended 31 March 2012 is approved.

Additional information in respect of Special Resolution Number 1
The reason for and the effect of the special resolution is to approve the remuneration payable by the Company to its non-executive directors for their services as directors of the Company for the period ended 31 March 2012. The fees payable to the non-executive directors are calculated on a fee per meeting basis, with the exception of Prof RE Leu who receives an annual fee, which is pro rated based on the number of meetings attended during the year, which fees were approved by the Company's shareholders at the annual general meeting on 27 July 2011 (except the fee per meeting payable to the chairperson and members of the Company's Social and Ethics Committee which were only established in February 2012), as set out in Special Resolution Number 2 below. The fee payable to each director and further details on the basis of calculation of the remuneration are respectively included in the annual financial statements on pages 153 to 154 and in the Remuneration Report on pages 104 to 107 of the integrated annual report of which this notice forms part of.

9. APPROVAL OF NON-EXECUTIVE DIRECTORS' REMUNERATION – 2012/2013

Special Resolution Number 2
Resolved that the following fees be approved as the basis for calculating the remuneration of the non-executive directors for their services as directors of the Company for the financial year ending 31 March 2013 with only 50% of the respective fee per meeting being payable in the case of non-attendance of a meeting:

Meeting	Approved fee per meeting for the year ended 31 March 2012	Proposed fee per meeting for the year ending 31 March 2013
Chairperson: Board	n/a	R42 800
Member: Board	R27 700	R29 640
Chairperson: Audit and Risk Committee	R32 000	R34 240
Member: Audit and Risk Committee	R22 200	R23 310
Chairperson: Remuneration and Nominations Committee	R24 450	R26 160
Member: Remuneration and Nominations Committee	R16 600	R17 430
Chairperson: Social and Ethics Committee*	R24 450	R26 160
Member: Social and Ethics Committee*	R16 600	R17 430
Chairperson: Investment Sub-committee	R32 000	R34 240
Member: Investment Sub-committee	R22 200	R23 310
Lead Independent Director (annual fee)	R22 200	R23 310
Prof RE Leu**	CHF109 450	CHF111 640

* *The fee per meeting for the year ended 31 March 2012 was approved by the Company's shareholders at the annual general meeting on 27 July 2011 by way of special resolution, except the fee per meeting of the chairperson and members of the Social and Ethics Committee. This committee was only established by the Board in February 2012 and the fee per meeting for the year ended 31 March 2012 and the proposed fee per meeting for the year ending 31 March 2013 are as recommended by the Company's Remuneration and Nominations Committee.*

** *The fee payable to Prof RE Leu is an annual fee, pro rated according to number of meetings attended*

Additional information in respect of Special Resolution Number 2
The reason for and the effect of the special resolution is to approve the basis for calculating the remuneration payable by the Company to its non-executive directors for their services as directors of the Company for the period ending 31 March 2013. The fees payable to the non-executive directors are calculated on a fee per meeting basis, with the exception of Prof Leu who receives an annual fee, as set out in the resolution. The fee is pro rated based on the number of meetings attended during the year. Further details on the basis of calculation of the remuneration are included in the Remuneration Report on pages 104 to 107 of the integrated annual report of which this notice forms part of.

10. GENERAL AUTHORITY TO REPURCHASE SHARES

Special Resolution Number 3
Resolved that the Board is hereby authorised by a way of a renewable general authority, in terms of the provisions of the JSE Listings Requirements and as permitted in the Company's Memorandum of Incorporation, to approve the purchase of its own ordinary shares by the Company, and the purchase of ordinary shares in the Company by any of its subsidiaries, upon such terms and conditions and in such amounts as the Board may from time to time determine, but subject to the Company's Memorandum of Incorporation, the provisions of the Companies Act and the JSE Listings Requirements, when applicable, and provided that:

10.1 the general repurchase by the Company and/or any subsidiary of the Company of ordinary shares in the aggregate in any one financial year do not exceed 5% of the Company's issued ordinary share capital as at the beginning of the financial year, provided that the acquisition of shares as treasury stock by a subsidiary of the Company shall not be effected to the extent that in aggregate more than 10% of the number of issued shares in the Company are held by or for the benefit of all the subsidiaries of the Company taken together;

10.2 any repurchase of securities will be effected through the order book operated by the JSE trading system and done without any prior understanding or arrangement between the Company and the counter party (reported trades are prohibited);

10.3 this authority shall only be valid until the Company's next annual general meeting, provided that it shall not extend beyond 15 months from the date this resolution is passed;

10.4 the Company will only appoint one agent to effect any repurchase(s) on its behalf;

10.5 general repurchases by the Company and/or any subsidiary of the Company in terms of this authority, may not be made at a price greater than 10% above the weighted average of the market value at which such ordinary shares are traded on the JSE, as determined over the 5 business days immediately preceding the date of the repurchase of such ordinary shares by the Company and/or any subsidiary of the Company;

10.6 any such general repurchases are subject to exchange control regulations and approvals at that point in time, where relevant;

10.7 a resolution has been passed by the Board of the Company and/or any subsidiary of the Company confirming that the Board has authorised the repurchase, that the Company satisfied the solvency and liquidity test contemplated in the Companies Act, and that since the test was done there have been no material changes to the financial position of the Group;

10.8 the Company and/or any subsidiary of the Company may not repurchase securities during a prohibited period, as defined in the JSE Listings Requirements, unless the Company has a repurchase programme in place where the dates and quantities of securities to be traded during the relevant period are fixed and not subject to any variation and full details of the programme have been disclosed in an announcement over SENS (the Securities Exchange News Service) prior to the commencement of the prohibited period; and

10.9 a press announcement will be published giving such details as may be required in terms of the JSE Listings Requirements as soon as the Company and/or any subsidiary has cumulatively repurchased 3% of the number of shares in issue at the date of the passing of this resolution, and for each 3% in aggregate of the initial number of shares acquired thereafter.

Opinion and undertaking by the Board
The Board is of the opinion that this authority should be in place should it become appropriate to undertake a share repurchase in the future, in particular the repurchase of shares by a subsidiary of the Company for purposes of employee share schemes.

The Board undertakes that it will not implement the proposed authority to repurchase shares, unless the directors are of the opinion that, for a period of 12 months after the date of the repurchase:

10.10 the Company and the Group will be able in the ordinary course of business to pay its debts;

10.11 the assets of the Company and the Group, fairly valued in accordance with International Financial Reporting Standards, will be in excess of the liabilities of the Company and the Group;

10.12 the share capital and reserves of the Company and the Group will be adequate for ordinary business purposes; and

10.13 the working capital of the Company and the Group will be adequate for ordinary business purposes.

The Company will ensure that its sponsor has confirmed the adequacy of the Company's working capital in writing to the JSE in terms of the JSE Listings Requirements, prior to entering the market to proceed with a repurchase.

Additional information in respect of Special Resolution Number 3
The reason for and the effect of the special resolution is to grant the Company's Board a general authority, up to and including the date of the following annual general meeting of the Company, to approve the Company's purchase of shares in itself, or to permit a subsidiary of the Company to purchase shares in the Company. Please refer to the additional disclosure of information contained in this notice, which disclosure is required in terms of the JSE Listings Requirements.

11. GENERAL AUTHORITY TO PROVIDE FINANCIAL ASSISTANCE TO RELATED AND INTER-RELATED COMPANIES AND CORPORATIONS

Special Resolution Number 4
Resolved that the Board of the Company is hereby authorised in terms of section 45(3)(a)(ii) of the Companies Act, as a general approval (which approval will be in place for a period of two years from the date of adoption of this Special Resolution Number 4), to authorise the Company to provide any direct or indirect financial assistance ("financial assistance" will herein have the meaning attributed to such term in section 45(1) of the Companies Act) that the Board may deem fit to any related or inter-related company or corporation of the Company ("related" and "inter-related" will herein have the meanings attributed to those terms in section 2 of the Companies Act), on the terms and conditions and for the amounts that the Board may determine.

The main purpose for this authority is to grant the Board the authority to provide inter-group loans and other financial assistance for purposes of funding the activities of the Group. The Board undertakes that:

11.1 it will not adopt a resolution to authorise such financial assistance, unless the directors are satisfied that –

11.1.1 immediately after providing the financial assistance, the Company would satisfy the solvency and liquidity test as contemplated in the Companies Act; and

11.1.2 the terms under which the financial assistance is proposed to be given are fair and reasonable to the Company; and

11.2 written notice of any such resolution by the Board shall be given to all shareholders of the Company and any trade union representing its employees –

11.2.1 within 10 business days after the Board adopted the resolution, if the total value of the financial assistance contemplated in that resolution, together with any previous such resolution during the financial year, exceeds 0.1% of the Company's net worth at the time of the resolution; or

11.2.2 within 30 business days after the end of the financial year, in any other case.

Additional information in respect of Special Resolution Number 4
The reason for and the effect of the special resolution is to provide a general authority to the Board of the Company to grant direct or indirect financial assistance to any company or corporation forming part of the Company's group of companies, including in the form of loans or the guaranteeing of their debts. Details of such inter-group financial assistance by the Company to a subsidiary is disclosed in the annual financial statements in note 7 on page 136 and the annexure listing the Company's investments in subsidiaries and associates on page 170 of the integrated annual report of which this notice forms part of.

12. REPLACEMENT OF THE MEMORANDUM OF INCORPORATION

Special Resolution Number 5
Resolved that the Company's existing Memorandum of Incorporation (which currently comprises the Memorandum and Articles of Association) be abrogated in its entirety and replaced in terms of the Companies Act with the new Memorandum of Incorporation, as copy of which has been tabled at the meeting.

Additional information in respect of Special Resolution Number 5
The Company's existing Memorandum of Incorporation consists of the Memorandum of Association which were adopted at the annual general meeting of the Company on 20 July 2000 and the Articles of Association which were adopted at the annual general meeting of the Company on 30 July 2004. Since the adoption of the existing Memorandum of Incorporation, the Companies Act came into effect in May 2011, which replaced the Companies Act, 61 of 1973, as amended, in its entirety. Schedule 10 of the JSE Listings Requirements, which contains the content requirements of a JSE listed company, was also amended in 2011 to, inter alia, align the JSE Listings Requirements with the Companies Act. Both the Companies Act and the JSE Listings Requirements require the Company to amend its Memorandum of Incorporation by no later than 30 April 2013 to harmonise the Memorandum of Incorporation with the Companies Act and the JSE Listings Requirements. The Board of Directors approved the amended Memorandum of Incorporation and recommends the approval thereof by the Company's shareholders.

Where provisions were not required to be amended in terms of the Companies Act or the JSE Listings Requirements, the provisions of the existing Memorandum of Incorporation have been retained as far as reasonably possible. The most important amendments to the Company's Memorandum of Incorporation relate to the following matters: –

- references to the solvency and liquidity test where required in terms of the Companies Act included;
- the making of company rules, as contemplated in the Companies Act, prohibited;
- the setting of record dates for the exercise of shareholder rights in terms of the Companies Act and the JSE Listings Requirement included;
- conduct at annual general meetings expanded to include feedback by the company's Social and Ethics Committee;
- provision for electronic participation at shareholders meetings included;
- right to take shareholder resolutions by way of written resolutions included, subject to certain exclusions (such as the election of directors);
- the process for the nomination of directors, as required in terms of the JSE Listings Requirements, included;
- the rotation of directors, which will in future only be applicable to non-executive directors, as recommended in King III, amended;
- the election by shareholders of alternate directors included;
- the quorum for Board meetings increased from three Board members to the majority of Board members;
- the approval of directors' remuneration by special resolution included;
- the right to access to the Company's information amended; and
- the electronic communication and the giving of notices amended.

The reason for and the effect of the special resolution is to replace the Company's Memorandum of Incorporation with the new amended Memorandum of Incorporation to ensure compliance with the Companies Act and the JSE Listings Requirements.

The existing and the proposed new Memorandum of Incorporation are available for inspection at the registered offices of the Company prior to the meeting and will also be published on the Company's website at www.mediclinic.com.

13. CONVERSION OF ORDINARY PAR VALUE SHARES

Special Resolution Number 6
Resolved that the conversion of each of the Company's authorised ordinary shares and each of the Company's issued ordinary shares having a par value of R0.10 (ten cents) each into ordinary shares having no par value, which shares shall have the same rights and shall rank pari passu in all respects with the ordinary shares having a par value prior to the conversion, is approved;

Resolved further that the necessary amendments to the Company's Memorandum of Incorporation to reflect the nature of the Company's ordinary shares as shares having no par value is approved.

Additional information in respect of Special Resolution Number 5
The reason for and the effect of the special resolution are included in the attached report by the Board prepared in terms of Regulation 31(7) of the Companies Act, marked as ***Annexure A****.*

14. TO TRANSACT ANY OTHER BUSINESS THAT MAY BE TRANSACTED AT AN ANNUAL GENERAL MEETING.

Additional disclosure of information
Further to Special Resolution Number 3, the JSE Listings Requirements require the disclosure of the following information, some of which appears elsewhere in the annual report of which this notice forms part as set out below:

- **Directors and management**
  See pages 8 to 9 of the integrated annual report.

- **Major shareholders of the Company**
  See page 173 of the integrated annual report.

- **Material changes**
  There have been no material changes in the financial or trading position of the Company and its subsidiaries since the date of signature of the independent auditor's report on page 113 of the integrated annual report and the date of this notice.

- **Directors' interests in securities**
  See page 174 of the integrated annual report.

- **Share capital of the Company**
  See page 173 of the integrated annual report.

- **Litigation statement**
  In terms of section 11.26 of the JSE Listings Requirements, the directors, whose names appear on pages 8 to 9 of the integrated annual report, are not aware of any legal or arbitration proceedings, including proceedings that are pending or threatened, that may have or have had in the recent past, being at least the previous 12 months, a material effect on the Group's financial position.

- **Directors' responsibility statement**
  The directors, whose names appear on pages 8 to 9 of the integrated annual report, collectively and individually accept full responsibility for the accuracy of the information pertaining to Special Resolution Numbers 3 and 4 and certify that to the best of their knowledge and belief there are no facts that have been omitted which would make any statement false or misleading, and that all reasonable enquiries to ascertain such facts have been made and that Special Resolution Numbers 3 and 4 contains all information required by law and the JSE Listings Requirements.

APPROVALS REQUIRED FOR RESOLUTIONS

Ordinary Resolutions Number 1 to 6 contained in this notice of annual general meeting require the approval by more than 50% of the votes exercised on the resolutions by shareholders present or represented by proxy at the annual general meeting, and further subject to the provisions of the Companies Act, the Company's Memorandum of Incorporation and the JSE Listings Requirements.

Ordinary Resolution Number 7 (general authority to issue shares for cash) and Special Resolution Numbers 1 to 6 contained in this notice of annual general meeting require the approval by at least 75% of the votes exercised on the resolutions by shareholders present or represented by proxy at the annual general meeting, and further subject to the provisions of the Companies Act, the Company's Memorandum of Incorporation and the JSE Listings Requirements.

ATTENDANCE AND VOTING BY SHAREHOLDERS OR PROXIES

Electronic participation:
Shareholders are also able to attend, but not participate and vote at, the annual general meeting by way of a webcast. Should you wish to make use of this facility, please contact Ms Riana Horne by e-mail at riana.horne@mediclinic.com or telephone at +27 21 809 6500.

The record date on which shareholders of the Company must be registered as such in the Companies' securities register, which date was set by the Board of the Company determining which shareholders are entitled to attend and vote at the annual general meeting is **Friday, 20 July 2012**. Accordingly, the last day to trade in order to be able to attend and vote at the annual general meeting is Friday, 13 July 2012.

Shareholders who have not dematerialised their shares or who have dematerialised their shares with own name registration are entitled to attend and vote at the meeting. Any such shareholder is entitled to appoint a proxy or proxies to attend, speak and vote in their stead. The person so appointed need not be a shareholder of the Company. Proxy forms must be forwarded to reach the Company's transfer secretaries, Computershare Investor Services (Pty) Ltd, 70 Marshall Street, Johannesburg, 2001, South Africa or posted to the transfer secretaries at PO Box 61051, Marshalltown, 2107, South Africa, so as to be received by them by not later than 15:00 on **Tuesday, 24 July 2012**. Proxy forms must only be completed by shareholders who have not dematerialised their shares or who have dematerialised their shares and registered them in their own name. The chairman of the annual general meeting may, in his discretion, accept proxy forms that have been handed to him after the expiry of the aforementioned period up until the time of the commencement of the meeting.

Shareholders who have dematerialised their shares, other than those shareholders who have dematerialised their shares with own name registration, should contact their Central Securities Depository Participant ("CSDP") or broker in the manner and time stipulated in their agreement, in order to furnish them with their

voting instructions or to obtain a letter of representation, in the event that they wish to attend the annual general meeting in person.

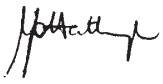
On a show of hands, every shareholder of the Company present in person or represented by proxy shall have one vote only. On a poll, every shareholder of the Company shall have one vote for every share held in the Company by such shareholder.

Shares held by a share trust or scheme will not have their votes at the annual general meeting taken into account for purposes of resolutions proposed in terms of the JSE Listings Requirements. Shares held as treasury shares may also not vote.

PROOF OF IDENTIFICATION REQUIRED

The Companies Act requires that any person who wishes to attend or participate in a shareholders meeting, must present reasonably satisfactory identification at the meeting. Any shareholder or proxy who intends to attend or participate at the annual general meeting must be able to present reasonably satisfactory identification at the meeting for such shareholder or proxy to attend and participate at the meeting. A green bar-coded identification document issued by the South African Department of Home Affairs, a driver's licence or a valid passport will be accepted as sufficient identification.

By order of the Board of Directors.



GC HATTINGH
Company Secretary

Stellenbosch
27 June 2012

ANNEXURE A

MEDICLINIC INTERNATIONAL LIMITED ("the Company")

REPORT BY THE BOARD OF DIRECTORS ("the Board") OF THE COMPANY IN RELATION TO THE PROPOSED CONVERSION OF THE COMPANY'S ORDINARY PAR VALUE SHARES TO ORDINARY SHARES HAVING NO PAR VALUE

Introduction

1. This report has been prepared in accordance with Regulation 31 of the Companies Act, 71 of 2008, as amended ("**the Companies Act**"), which act came into effect on 1 May 2011 ("**the effective date**"), in relation to the proposed conversion of the Company's ordinary par value shares to ordinary shares having no par value.

2. The share capital of a company in terms of the previous Companies Act, 61 of 1973, as amended, that applied prior to the effective date, may have been divided into shares having a par value or may have been constituted as shares having no par value. No such distinction is made in the current Companies Act which provides that shares do not have a par value, subject to the transitional provisions of the Companies Act that provide that any shares of a pre-existing company (i.e. a company that was registered in terms of the previous Companies Act) that have been issued with a par value continue to have the par value assigned to them when issued.

3. Pre-existing companies are able to issue further shares having a par value, provided that it has sufficient authorised par value shares. No pre-existing company may however increase its authorised par value shares on or after the effective date.

4. Although not compulsory, Regulation 31 of the Companies Act provides for the voluntary conversion of any par value shares of pre-existing companies to shares having no par value, in which case the Board must cause a report to be prepared in respect of the proposed conversion.

Authorised and issued shares

5. The Company's authorised and issued shares prior to the proposed conversion are set out below:

Authorised
1 000 000 000 ordinary shares of R0.10 each

Issued
652 315 341 ordinary shares of R0.10 each

Proposed conversion

6. On 22 May 2012, the Board approved:

6.1. this report to the Company's shareholders; and

6.2. subject to the approval by special resolution by the Company's shareholders, the conversion of each of the Company's authorised ordinary shares and each of the Company's issued ordinary shares having a par value of R0.10 each into ordinary shares having no par value, which shares shall have the same rights and shall rank pari passu in all respects with the ordinary shares having a par value prior to the conversion.

7. The proposed conversion will apply to each of the Company's authorised ordinary shares and each of the Company's issued ordinary shares having a par value of R0.10 each and the holders of such issued shares. No other securities have been issued by the Company and the proposed conversion will therefore apply equally to all shareholders.

8. The conversion is not designed to evade the requirements of any applicable tax legislation in any way.

9. The proposed special resolution to approve the proposed conversion is included in the notice of annual general meeting as special resolution number 6. Upon registration of the special resolution approving the proposed conversion, the share certificates as indicated in the share register will be cancelled and replaced by new share certificates.

Rationale for conversion

10. Subject to the provisions of the Company's Memorandum of Incorporation, the Companies Act and the JSE Listings Requirements, the Company is only able to issue ordinary shares from the authorised, but unissued ordinary shares having a par value. Should there be no further authorised, but unissued ordinary shares having a par value available for issue, the Company will be required to increase its authorised shares. In terms of the Companies Act, the Company is only able to increase its authorised shares with shares having no par value.

11. To avoid the potential future position where certain issued shares are shares with a par value and other having no par value, the Board deems it appropriate to convert the Company's ordinary shares having a par value of R0.10 each to shares having no par value in accordance with the Companies Act.

12. The Board also wishes to align the nature of the Company's shares with that of the Companies Act, which no longer makes provision for shares having a par value in respect of companies registered in terms of the Companies Act.

Effects of the conversion

13. Neither the value of the shares, nor the rights of the Company's shareholders is affected in any other way as a result of the conversion.

14. The conversion will have no financial or tax effect on the Company. Shareholders should note that the share premium amount in the Company's books of accounts will be transferred to the share capital account of the Company.

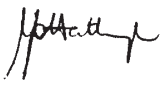
15. The Company does not foresee any tax implications, and in particular not in respect of capital gains tax, for shareholders as a result of the conversion. This has been confirmed by the Company's professional tax advisors.

16. Due to the rights of the Company's shareholders not being affected, no compensation is payable to the Company's shareholders in terms of the proposed conversion.

Recommendation

17. The Board recommends the proposed conversion of the Company's ordinary shares having a par value of R0.10 each to shares having no par value in accordance with the Companies Act.

On behalf of the Board of Directors.



GC HATTINGH
Company Secretary

Stellenbosch
22 May 2012

PROXY FORM

MEDICLINIC INTERNATIONAL LIMITED
Registration number: 1983/010725/06
Share Code: MDC
ISIN Code: ZAE000074142
("**the Company**")

MEDICLINIC INTERNATIONAL

This proxy form is only for use by:

1. **registered shareholders who have not yet dematerialised their shares in the Company, and**

2. **registered shareholders who have already dematerialised their shares in the Company and are registered in their own names in the Company's sub-register***

For use by registered shareholders of the Company at the twenty-ninth annual general meeting of the Company to be held at the Neethlingshof Estate, Polkadraai Road, Vlottenburg, Stellenbosch on Thursday, 26 July 2012 at 15:00 ("the annual general meeting").

I/We (please print) _____ (name)

of _____ (address)

being the holder of _____ ordinary shares in the Company, hereby appoint (see instruction 1 overleaf):

1. _____ or failing him/her,

2. _____ or failing him/her,

3. the chairman of the Annual General Meeting,

as my/our proxy to attend, speak and vote for me/us and on my/our behalf or to abstain from voting at the Annual General Meeting of the Company to be held on the 26th day of July 2012 or at any adjournment thereof, as follows (see note 2 and instruction 2 overleaf):

		Insert the number of votes exercisable (one vote per share)		
		For	Against	Abstain
Ordinary Resolutions				
1.	Consideration of annual financial statements			
2.	Reappointment of external auditor			
3.	Re-election of directors:			
	3.1 E de la H Hertzog			
	3.2 DP Meintjes			
	3.3 AA Raath			
	3.4 CM van den Heever			
	3.5 JJ Durand			
4.	Election of members of the Audit and Risk Committee:			
	4.1 RE Leu			
	4.2 AA Raath			
	4.3 DK Smith			
5.	Approval of Remuneration Policy			
6.	General authority to place shares under control of the directors			
7.	General authority to issue shares for cash			
Special Resolutions				
1.	Approval of non-executive directors' remuneration – 2011/2012			
2.	Approval of non-executive directors' remuneration – 2012/2013			
3.	General authority to repurchase shares			
4.	General authority to provide financial assistance to related and inter-related companies and corporations			
5.	Replacement of the Memorandum of Incorporation			
6.	Conversion of the ordinary par value shares			

Signed at _____ on _____ 2012.

Signature/s _____

Assisted by me (where applicable) _____

Please read the notes and instructions overleaf.

* See explanatory note 3 overleaf.

Notes:

1. A shareholder entitled to attend and vote at the annual general meeting is entitled to appoint one or more proxies to attend, speak and vote in his/her stead. A proxy need not be a shareholder of the Company. Satisfactory identification must be presented by any person wishing to attend the annual general meeting, as set out in the notice.

2. Every shareholder present in person or by proxy and entitled to vote at the annual general meeting of the Company shall, on a show of hands, have one vote only, irrespective of the number of shares such shareholder holds, but in the event of a poll, each shareholder shall be entitled to one vote in respect of each ordinary share in the Company held by him/her.

3. Shareholders who have dematerialised their shares in the Company and are registered in their own names are shareholders who appointed Computershare Custodial Services as their Central Securities Depository Participant (CSDP) with the express instruction that their uncertificated shares are to be registered in the electronic sub-register of shareholders in their own names.

Instructions on signing and lodging the proxy form:

1. A shareholder may insert the name of a proxy or the names of two alternative proxies of the shareholder's choice in the space/s provided overleaf, with or without deleting "the chairman of the annual general meeting", but any such deletion must be initialled by the shareholder. Should this space be left blank, the chairman of the annual general meeting will exercise the proxy. The person whose name appears first on the proxy form and who is present at the annual general meeting will be entitled to act as proxy to the exclusion of those whose names follow.

2. A shareholder's voting instructions to the proxy must be indicated by the insertion of an "X" or the number of votes exercisable by that shareholder in the appropriate spaces provided overleaf. Failure to do so shall be deemed to authorise the proxy to vote or to abstain from voting at the annual general meeting, as he/she thinks fit in respect of all the shareholder's exercisable votes. A shareholder or his/her proxy is not obliged to use all the votes exercisable by his/her proxy, but the total number of votes cast, or those in respect of which abstention is recorded, may not exceed the total number of votes exercisable by the shareholder or by his/her proxy.

3. A minor must be assisted by his/her parent or guardian unless the relevant documents establishing his/her legal capacity are produced or have been registered by the transfer secretaries.

4. To be valid the completed proxy forms must be lodged with the transfer secretaries of the Company, Computershare Investor Services (Pty) Ltd, 70 Marshall Street, Johannesburg, 2001, South Africa or posted to the transfer secretaries at PO Box 61051, Marshalltown, 2107, South Africa, to be received by them not later than **Tuesday, 24 July 2012** at 15:00 (South African time). The chairman of the annual general meeting may, in his discretion, accept proxy forms that have been handed to him after the expiry of the aforementioned period up until the time of the commencement of the meeting.

5. Documentary evidence establishing the authority of a person signing this proxy form in a representative capacity must be attached to this proxy form unless previously recorded by the transfer secretaries or waived by the chairman of the annual general meeting.

6. The completion and lodging of this proxy form shall not preclude the relevant shareholder from attending the annual general meeting and speaking and voting in person thereat to the exclusion of any proxy appointed in terms hereof, should such shareholder wish to do so.

7. The completion of any blank spaces overleaf need not be initialled. Any alterations or corrections to this proxy form must be initialled by the signatory/ies.

8. The provisions of the Companies Act relation to the revocation of the appointment of a proxy apply. A shareholder may accordingly revoke a proxy appointment by cancelling it in writing, or making a later inconsistent appointment of a proxy, and delivering a copy of such revocation to the proxy and the Company.

9. The chairman of the annual general meeting may reject or accept any proxy form which is completed other than in accordance with these instructions provided that he is satisfied as to the manner in which a shareholder wishes to vote.

NOTES

NOTES

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
info@mediclinic.com
www.mediclinic.com

COMPANY SECRETARY
Gert Hattingh (47) B.Acc. (Hons), CA(SA)

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

SHAREHOLDERS' DIARY

ANNUAL GENERAL MEETING	26 July 2012

PUBLICATION OF FINANCIAL REPORTS

Announcement of interim results	November
Interim report	November
Announcement of annual results	May
Annual report	June

PAYMENTS TO SHAREHOLDERS

Interim payment: dividend number 29 (23 cents per share):

Declaration date	Tuesday, 8 November 2011
Last date to trade cum dividend	Friday, 2 December 2011
First date of trading ex dividend	Monday, 5 December 2011
Record date	Friday, 9 December 2011
Payment date	Monday, 12 December 2011

Final payment: dividend number 30 (55 cents per share (46.75 cents net of dividend withholding tax)):

Declaration date	Tuesday, 22 May 2012
Last date to trade cum dividend	Friday, 15 June 2012
First date of trading ex dividend	Monday, 18 June 2012
Record date	Friday, 22 June 2012
Payment date	Monday, 25 June 2012