MEDICLINIC
INTERNATIONAL

EXPERTISE YOU CAN TRUST.




INTEGRATED ANNUAL REPORT 2011

CONTENTS

REPORT PROFILE

SCOPE, BOUNDARY AND REPORTING CYCLE

This integrated annual report of Mediclinic presents the economic, social and environmental performance, as well as the financial results of the Mediclinic Group for the financial year ended 31 March 2011 and covers all our operations in Southern Africa and Switzerland, which is wholly-owned, as well as our operations in the United Arab Emirates, in which have 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), which will explain why there are variances in the level of detail provided. Although the Group's operations in Switzerland is relatively small compared to Southern Africa, the Swiss operations contribute 47% to the Group's revenue and 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 on 28 June 2011.

REPORTING PRINCIPLES

The contents included in the annual report are deemed to be useful and relevant to our stakeholders, which the Group, with regard to our stakeholder 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.

The annual report was prepared in accordance with International Financial Reporting Standards, the Listings Requirements of the JSE Limited, as well as the Companies Act No. 61 of 1973, as amended ("the old Act"), as well as the new Companies Act, 71 of 2008, as amended ("the new Act"), where relevant. As the Company's year-end was prior to the effective date of the new Act, it is important to note that, as required in terms of the transitional arrangements of the new Act, that the audit, approval and publishing of the Company's annual financial statements in respect of the period under review are in accordance with the requirements of the old Act. 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 have not applied are explained, where applicable, in this 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 Paper on the Framework for Integrated Reporting and the Integrated Report issued by the Integrated Reporting Committee of South Africa in January 2011. Although we do support the majority of the recommendations contained in the discussion paper, do not believe that a shortened integrated report with detail on the website is what the readers of our integrated annual report, who are largely our shareholders and the investment community internationally, require. We have therefore maintained the structure of our previous annual reports and extracted many of the recommendations contained in the discussion paper which we regard as appropriate for our business.

SIGNIFICANT EVENTS DURING REPORTING PERIOD

The only significant event during the reporting period compared to the previous financial year, was the successful conclusion by the Company of a rights offer of 59 301 395 Medi-Clinic shares at an issue price of 2 300 cents per share, raising R1 331 million and increasing the total number of issued shares to 652 315 341.

No significant events occurred 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 statement and the Group's consolidated annual financial statement 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 131.

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.

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 (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

PERFORMANCE HIGHLIGHTS

SALIENT FEATURES

SOLID PERFORMANCE BY ALL THREE OPERATING PLATFORMS

RIGHTS OFFER SUCCESSFULLY CONCLUDED

CORE HEADLINE EARNINGS INCREASED BY 27%

CORE HEADLINE EARNINGS PER SHARE INCREASED BY 20%

FINANCIAL		**2011**	2010	% change
Revenue	R'm	**18 625**	17 141	9%
Core EBITDA	R'm	**4 103**	3 736	10%
Cash generated from operations	R'm	**4 179**	3 800	10%
Core headline earnings	R'm	**1 082**	852	27%
Total assets	R'm	**43 537**	38 364	13%
Shareholders' equity	R'm	**9 489**	6 650	43%
Return on shareholders' equity	%	**11.4%**	12.8%	(11%)
Core headline earnings per ordinary share – basic	cents	**179.6**	149.9	20%
Core headline earnings per ordinary share – diluted	cents	**171.9**	142.4	21%
Total distribution per ordinary shares	cents	**73.0**	73.0	0%
Net asset value per ordinary share	cents	**1 516.7**	1 184.4	28%
Adjusted net asset value per ordinary share*	cents	**1 903.1**	1 639.4	16%
** The adjusted net asset value per ordinary share excludes the valuation of the derivative financial instruments and the Swiss pension liability.*				
Share performance:				
– Closing price at year end	cents	**2 900**	2 700	7%
– Market capitalisation**	R'bn	**18.9**	16.0	18%
*** Rights offer conducted in August 2010 for 59 301 395 Mediclinic shares at an issue price of 2 300 cents per share.*				
Capital expenditure on projects, new equipment and replacement of equipment:	R'm	**1 127**	1 300	(13%)
– Southern Africa	R'm	**446**	509	(12%)
– Switzerland	R'm	**635**	742	(14%)
– United Arab Emirates	R'm	**46**	49	(6%)

Hierdie jaarverslag is slegs in Engels beskikbaar. Besoek asseblief ons webblad by www.mediclinic.com vir die Mediclinic Groep se jaareindresultate in Afrikaans, soos in die pers gepubliseer op 25 Mei 2011.

In this annual report "Group" refers to the Mediclinic Group's operations in Southern Africa, Switzerland and the United Arab Emirates, while references to "the group" refers to one of the Mediclinic Group's operating platforms as the context may indicate. A full glossary of terms used in this annual report is included on pages 209 to 210.

PERFORMANCE HIGHLIGHTS (continued)

OPERATIONAL		2011	2010
Number of hospitals in operation:		**68**	67
– Southern Africa		**52**	52
– Switzerland		**14**	13
– United Arab Emirates		**2**	2
Number of clinics in operation (UAE only)		**8**	4
Number of beds:		**8 896**	8 736
– Southern Africa		**7 103**	7 035
– Switzerland		**1 457**	1 365
– United Arab Emirates		**336**	336
Number of theatres:		**339**	333
– Southern Africa		**253**	252
– Switzerland		**76**	71
– United Arab Emirates		**10**	10

SOCIAL		2011	2010
Number of permanent employees:		**21 183**	19 917
– Southern Africa		**13 588**	13 080
– Switzerland		**5 919**	5 380
– United Arab Emirates		**1 676**	1 457
Staff turnover rate:			
– Southern Africa	%	**10.3%**	11.2%
– Switzerland	%	**14.5%**	14.7%
– United Arab Emirates	%	**10.7%**	13.9%
Training spent as % of revenue:			
– Southern Africa	%	**4%**	4%
– Switzerland	%	**4.8%**	*
– United Arab Emirates	%	**0.3%**	0.3%
Spent on corporate social investment** (including donations of equipment):			
– Southern Africa	R'm	**4.0**	3.9
– United Arab Emirates	AED'm	**0.4**	*
BBBEEE (South Africa only):			
– BBBEE scorecard contributor level		**3**	4
– % black employees	%	**60.2%**	58.2%
– % black management employees	%	**20.0%**	19.5%

** not previously reported*

*** not available in respect of operations in Switzerland*

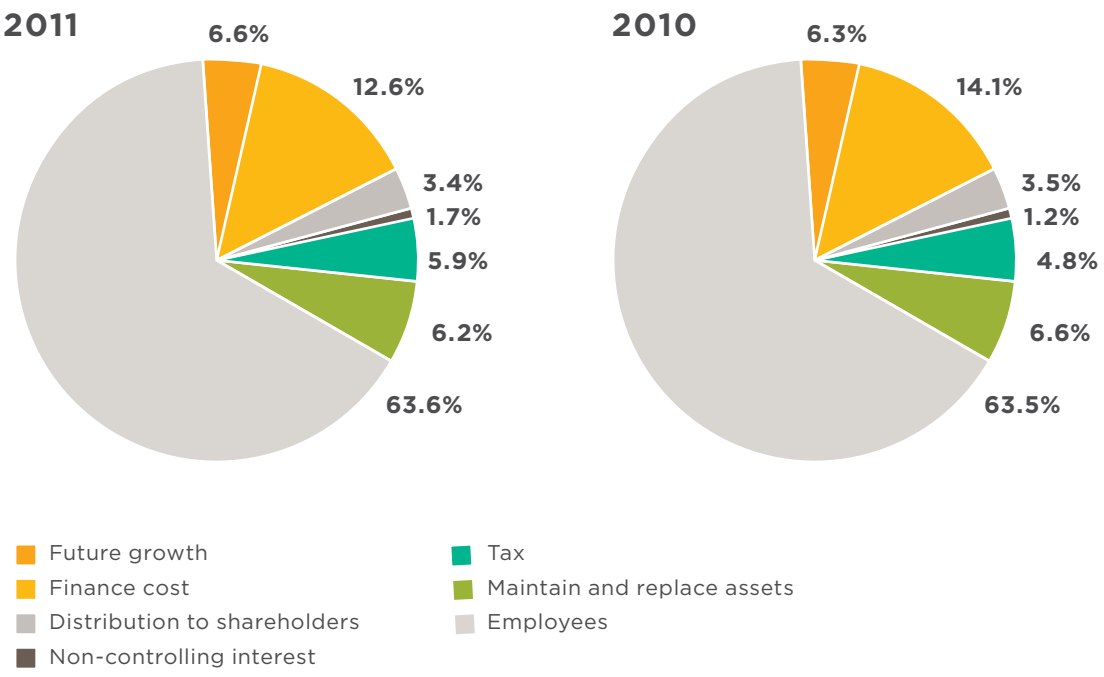
ENVIRONMENTAL		2011	2010
Ranking in Carbon Disclosure Project		**2nd**	16th
Total carbon emissions (CO_2e) (Southern Africa only as per CDP 2010 and 2009)	Tons	**179 948**	160 949
Total energy usage:	Gigajoules	**825 881**	818 318
– Southern Africa		**579 368**	576 988
– Switzerland (in respect of 2010 and 2009 calendar years)		**194 653**	187 976
– United Arab Emirates (hospitals only)		**51 860**	53 354

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

VALUE ADDED STATEMENT
for the year ended 31 March 2011

	2011		2010	
	R'm	**%**	R'm	%
VALUE CREATED				
Revenue	**18 625**		17 141	
Cost of materials and services	**(6 849)**		(6 369)	
Finance income	**61**		41	
	11 837	**100.0**	10 813	100.0
DISTRIBUTION OF VALUE				
To employees as remuneration and other benefits	**7 525**	**63.6**	6 866	63.5
Tax and other state and local authority levies (excluding VAT)	**702**	**5.9**	519	4.8
To suppliers of capital:				
Non-controlling interest	**204**	**1.7**	128	1.2
Finance cost on borrowed funds	**1 491**	**12.6**	1 524	14.1
Distributions to shareholders	**398**	**3.4**	374	3.5
	10 320	**87.2**	9 411	87.1
VALUE RETAINED				
To maintain and replace assets	**738**	**6.2**	718	6.6
Income retained for future growth	**779**	**6.6**	684	6.3
	1 517	**12.8**	1 402	12.9

DISTRIBUTION OF VALUE



ORGANISATIONAL OVERVIEW

WHO WE ARE

Mediclinic, 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.

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 AMBITION

To be the international standard for acute private healthcare.

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 to the extent possible. We believe 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.

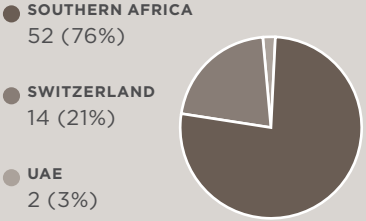
Our focus is on providing the best possible facilities, with technology of an international standard. We therefore continue to invest capital in our facilities for state-of-the-art equipment, expansions, upgrades and maintenance.

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, whilst in Dubai most of the supporting doctors are employed.

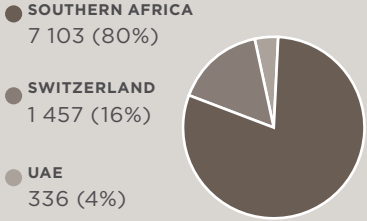
We listen to our stakeholders. Good long-term business relationships is one of the foundations of the continued success of our business.

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

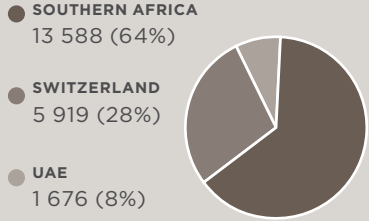
DISTRIBUTION OF THE GROUP'S 68 HOSPITALS



DISTRIBUTION OF THE GROUP'S 8 896 BEDS



DISTRIBUTION OF THE GROUP'S 21 183 EMPLOYEES

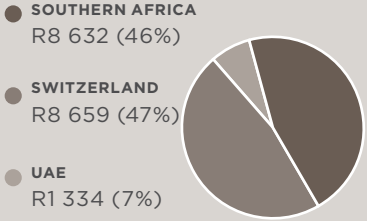


HOW WE GOVERN OUR BUSINESS

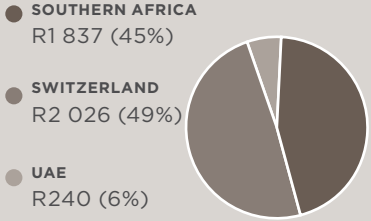
Our governance structures are focused on maintaining and building a sustainable business and support our commitment to being a responsible corporate citizen in every country and community in which the Group does business. The key elements of our governance structures include:

- 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 of the Sustainable Development Report for more information;
- 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).

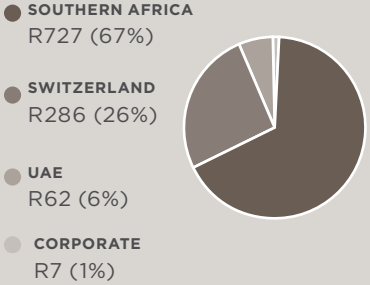
DISTRIBUTION OF GROUP'S REVENUE R18.6BN (R'M)



CONTRIBUTION TO GROUP CORE EBITDA OF R4 103M (R'M)



CONTRIBUTION TO GROUP CORE HEADLINE EARNINGS OF R1 082M (R'M)



BOARD OF DIRECTORS

EDWIN HERTZOG

DANIE MEINTJES

CRAIG TINGLE

RONNIE VAN DER MERWE

KOERT PRETORIUS

OLE WIESINGER

JOSEPH COHEN

KABS MAKABA

EXECUTIVE DIRECTORS

E de la H (Edwin) Hertzog (61)
Chairman
M.B.Ch.B., M.Med., F.F.A. (SA)

Appointed as Managing Director in 1983, as executive Vice-chairman in 1990 and as executive* Chairman of the Company in 1992. Other directorships include Distell, Remgro and Total (SA).

** Please refer to the explanation in respect of the classification of Dr Hertzog as executive chairman on page 67 of this annual report.*

DP (Danie) Meintjes (55)
Chief Executive Officer
B.Pl. (Hons)

Joined the Group in 1985 and appointed as a director of the Company in 1996. Seconded to Dubai in 2006 and appointed as the Chief Executive Officer of Emirates Healthcare in 2007. Appointed as Chief Executive Officer of the Group with effect from 1 April 2010.

CI (Craig) Tingle (52)
Chief Financial Officer
B.Sc. (For), B.Compt. (Hons), CA(SA)

Appointed as the Financial Director of the Company in 1992. 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 Chief Financial Officer of the Company from 1 September 2010.

CA (Ronnie) van der Merwe (48)
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.

KHS (Koert) Pretorius (48)
Chief Executive Officer: Mediclinic Southern Africa
B.Compt., MBL

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

TO (Ole) Wiesinger (48) *(German)*
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 (Hirslanden) and a director of the Company in 2008.

NON-EXECUTIVE DIRECTORS

JC (Joseph) Cohen (45) *(British)*
B.Sc. in Economics

A managing partner of Trilantic Capital Partners. Appointed as a director of the Company in 2008.

MK (Kabs) Makaba (58)
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.

MAMPHELA RAMPHELE

CHRIS VAN DEN HEEVER

THYS VISSER

DESMOND SMITH

ROBERT LEU

ZODWA MANASE

ANTON RAATH

WYNAND VAN DER MERWE

MA (Mamphela) Ramphele (63)
M.B.Ch.B., Diploma in Tropical Health and Hygiene, B.Comm., Diploma in Public Health, Ph.D.

Deputy chairperson of Gold Fields from July 2010. Appointed as a director of the Company in 2005. Other directorships include Remgro and Anglo American.

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 February 2010. Other directorships include Tracker, Tsb Sugar, Wispeco and One Digital Media.

MH (Thys) Visser (57)
B.Comm. (Hons), CA(SA)

Chief Executive Officer of Remgro. Appointed as a director of the Company in 2005. Other directorships include Distell, FirstRand Bank, Nampak, RMB Holdings and Unilever South Africa. Chairman of Rainbow Chicken.

INDEPENDENT NON-EXECUTIVE DIRECTORS

DK (Desmond) Smith (63)
Lead Independent Director
B.Sc., FASSA

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

RE (Robert) Leu (64) *(Swiss)*
Master in Economics, Ph.D., Privatdozent in Economics

Executive director of the Department of Economics at the University of Bern in Switzerland. Also serves on the board of Mediclinic Switzerland. Appointed as a director of the Company in July 2010.

ZP (Zodwa) Manase (49)
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 State Information Technology Agency and Total (SA).

AA (Anton) Raath (55)
B.Comm., CA(SA)

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

WL (Wynand) van der Merwe (59)
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.

GROUP OBJECTIVES

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.

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.

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 with regulatory and legislative bodies.

LEADING AS A RESPONSIBLE CORPORATE CITIZEN

- We will continue to hold ourselves to the highest possible ethical and professional standards in respect of social and environmental issues, which are important to us, our clients and stakeholders.

DEVELOPING AN INTERNATIONAL HOSPITAL GROUP

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

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 an employer of choice, recognising that market competition for talent is increasing.

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.

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.

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.

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.

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.

SEVEN-YEAR REVIEW

	CAGR#	**2011 IFRS R'm**	2010 IFRS R'm	2009 IFRS R'm	2008 IFRS R'm	2007 IFRS R'm	2006 IFRS R'm	2005 IFRS R'm
INCOME STATEMENTS								
REVENUE	29.0%	**18 625**	17 141	16 351	9 579	5 364	4 723	4 040
Core EBITDA	30.8%	**4 103**	3 736	3 431	2 062	1 152	988	820
Past service cost		**33**	97	–	–	–	–	–
Insurance proceeds and related impairment charges		**50**						
BEE share-based payment		**–**	–	–	–	–	(85)	–
EBITDA		**4 186**	3 833	3 431	2 062	1 152	903	820
Depreciation		**(726)**	(705)	(672)	(336)	(146)	(124)	(97)
Amortisation/impairment of goodwill		**(12)**	(13)	(12)	(5)	–	–	(3)
Operating profit	29.8%	**3 448**	3 115	2 747	1 721	1 006	779	720
Other gains and losses		**13**	28	–	–	–	–	–
Income from associates		**4**	7	2	–	1	13	25
Exceptional items		**–**	–	–	–	–	43	50
Finance income		**61**	41	67	49	44	70	58
Finance cost		**(1 491)**	(1 524)	(1 602)	(685)	(88)	(45)	(29)
Profit before tax		**2 035**	1 667	1 214	1 085	963	860	824
Income tax expense		**(654)**	(481)	(502)	(364)	(270)	(428)	(214)
Profit for the year		**1 381**	1 186	712	721	693	432	610
Attributable to:								
Equity holders of the Company	13.8%	**1 177**	1 058	636	610	582	338	543
Non-controlling interests		**204**	128	76	111	111	94	67
		1 381	1 186	712	721	693	432	610
Headline earnings	14.1%	**1 110**	1 028	624	608	581	300	503
Core headline earnings	13.6%	**1 082**	852	624	608	581	553	503
STATEMENTS OF FINANCIAL POSITION								
ASSETS								
Property, equipment and vehicles		**30 409**	28 046	32 479	30 972	3 124	2 327	1 997
Intangible assets		**5 565**	5 243	6 293	6 101	419	48	48
Other investments and loans		**712**	26	32	34	46	119	114
Deferred income tax assets		**210**	220	178	123	120	123	92
Derivative financial instruments		**33**	–	–	43	–	–	–
Current assets		**6 608**	4 829	4 892	4 326	1 780	980	1 510
Total assets		**43 537**	38 364	43 874	41 599	5 489	3 597	3 761
EQUITY								
Equity attributable to owners of parent		**9 489**	6 650	7 091	8 560	2 068	1 641	2 693
Non-controlling interests		**1 071**	966	898	807	752	290	235
LIABILITIES								
Long-term interest-bearing borrowings		**20 414**	20 667	24 349	23 266	996	848	159
Deferred income tax liability		**4 773**	4 399	5 162	5 088	5	5	4
Retirement benefit obligations		**383**	346	997	639	129	102	73
Derivative financial instruments		**2 170**	2 331	2 512	595	–	–	–
Provisions		**271**	185	229	190	–	–	–
Current liabilities		**4 966**	2 820	2 636	2 454	1 539	711	597
Total equity and liabilities		**43 537**	38 364	43 874	41 599	5 489	3 597	3 761
STATEMENTS OF CASH FLOWS								
Cash generated from operating activities	28.6%	**4 179**	3 800	3 346	1 517	1 187	994	923
Net finance income/(cost)		**(1 368)**	(1 396)	(1 438)	(419)	(44)	25	29
Abnormal item		**–**	–	–	–	–	–	50
Tax paid		**(495)**	(444)	(522)	(360)	(306)	(448)	(243)
Cash flow from operating activities		**2 316**	1 960	1 386	738	837	571	759
Cash flow from investment activities		**(2 563)**	(1 271)	(1 380)	(16 898)	(672)	(388)	(178)
Cash flow from financing activities		**688**	(542)	125	16 461	43	(830)	(185)
Cash distributions to minorities		**(59)**	(55)	(54)	(41)	(40)	(39)	(34)
Distributions to shareholders		**(398)**	(374)	(339)	(189)	(178)	(166)	(142)
Special dividend to shareholders		**–**	–	–	–	–	(1 327)	–
Proceeds from issuance of ordinary shares		**1 331**	–	–	4 472	–	–	–
Movement in borrowings		**(208)**	(155)	547	12 219	248	689	(21)
Other		**22**	42	(29)	–	13	13	12
Net movement in cash and bank overdrafts		**441**	147	131	301	208	(647)	396
Opening balance of cash and bank overdrafts		**967**	941	787	357	149	796	400
Exchange rate fluctuations on foreign cash		**39**	(121)	23	129	–	–	–
Closing balance of cash and bank overdrafts		**1 447**	967	941	787	357	149	796

Compounded Annual Growth Rate

	CAGR#	2011	2010	2009	2008	2007	2006	2005
STATISTICS AND PERFORMANCE PER PLATFORM								
Mediclinic Southern Africa								
Number of hospitals		**52**	52	51	51	50	47	46
Licensed beds		**7 103**	7 035	6 855	6 776	6 845	6 613	6 421
Licensed theatres		**253**	252	248	248	243	234	226
Revenue (R'm)	13.5%	**8 632**	7 680	6 792	6 056	5 364	4 723	4 040
Core EBITDA (R'm)	14.4%	**1 837**	1 651	1 458	1 302	1 152	988	820
Core EBIT (R'm)	14.3%	**1 608**	1 445	1 281	1 143	1 006	779	720
Core EBITDA margin (%)		**21.3%**	21.5%	21.5%	21.5%	21.5%	20.9%	20.3%
Hirslanden								
Number of hospitals		**14**	13	13	13			
Licensed beds		**1 457**	1 365	1 334	1 301			
Licensed theatres		**76**	71	71	64			
Revenue (R'm)	11.9%	**8 659**	8 335	8 737	6.185*			
Core EBITDA (R'm)	13.8%	**2 026**	1 953	1 961	1.373*			
Core EBIT (R'm)	15.1%	**1 593**	1 516	1 507	1.046*			
Core EBITDA (CHF'm)	8.7%	**285**	266	245	222			
Core EBIT (CHF'm)	9.8%	**224**	206	188	169			
Core EBITDA margin (%)		**23.4%**	23.4%	22.5%	22.2%*			
Emirates Healthcare								
Number of hospitals		**2**	2	2	1			
Licensed beds		**336**	336	321	120			
Licensed theatres		**10**	10	10	4			
Revenue (R'm)	40.4%	**1 334**	1 126	822	482			
Core EBITDA (R'm)	68.7%	**240**	132	(7)	50			
Core EBIT (R'm)	95.3%	**164**	57	(60)	22			
Core EBITDA (AED'm)	67.4%	**122**	62	(3)	26			
Core EBIT (AED'm)	96.9%	**84**	27	(25)	11			
Core EBITDA margin (%)		**18.0%**	11.8%	(0.9%)	10.3%			
Share ratios								
Headline earnings per ordinary share – cents								
Basic	3.8%	**184.2**	180.8	111.5	144.5	162.2	86.3	146.9
Diluted	3.3%	**176.3**	171.7	105.6	133.6	147.2	76.3	145.0
Core headline earnings per ordinary share – cents								
Basic	3.4%	**179.6**	149.9	111.5	144.5	162.2	159.3	146.9
Diluted	2.9%	**171.9**	142.4	105.6	133.6	147.2	140.9	145.0
Distribution per ordinary share – cents	8.4%	**73.0**	73.0	68.6	61.2	54.1	53.1	45.0
Net asset value per ordinary share – cents	11.6%	**1 516.7**	1 181.4	1 265.5	1 527.5	575.5	460.7	783.7
Adjusted net asset value per ordinary share – cents**	15.9%	**1 903.1**	1 639.4	1 752.2	1 657.6	575.5	460.7	783.7
JSE								
Market capitalisation (R'bn)		**18.9**	16.0	12.7	11.7	9.9	8.1	5.4
Price (cents per share)								
31 March		**2 900**	2 700	2 150	1 970	2 510	2 065	1 530
Highest		**3 150**	2 765	2 575	2 695	2 860	2 230	1 585
Lowest		**2 325**	1 865	1 535	1 811	1 740	1 420	1 150
Number of shares traded (000)		**98 979**	101 801	116 798	131 057	78 700	112 967	43 683
Price-earnings ratio		**15.7**	14.7	19.3	13.6	15.5	23.9	10.4
Core price-earnings ratio		**16.1**	17.8	19.3	13.6	15.5	13.0	10.4
Number of ordinary shares issued (000)		**652 315**	593 014	593 014	394 338	394 338	350 066	350 066
Weighted average number of shares (000):								
basic earnings per share		**602 467**	568 721	559 336	421 437	357 606	347 140	342 368
diluted earnings per share		**629 488**	598 656	590 999	455 748	394 107	392 417	346 749
Exchange rates								
Average rate (Swiss franc)	R/CHF	**7.11**	7.35	8.01	6.18*			
Closing rate (Swiss franc)	R/CHF	**7.42**	6.93	8.32	8.14			
Average rate (UAE dirham)	R/AED	**1.96**	2.13	2.41	1.94			
Closing rate (UAE dirham)	R/AED	**1.85**	2.00	2.58	2.20			

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

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

EDWIN HERTZOG
CHAIRMAN

MEDICLINIC HOLDS TO THE PRINCIPLE THAT GOOD HOSPITAL CARE IS SOMETHING THAT MUST NOT BE LEFT TO CHANCE

Since the listing of Mediclinic on the JSE in 1986, it has been my privilege each year to report to shareholders that the Group has shown consistent growth. I am happy to say that the Group has maintained this pattern.

Being a relatively mature and efficient private hospital company, the number of bed-days sold is the life blood of the Group. During the period under review the Group's growth in bed-days sold was gratifying. Although the business in Dubai is much smaller than at the other two operating platforms, its percentage growth in bed-days sold, as well as in outpatient activities, was by far the biggest. Growth in bed-days sold in Southern Africa and Switzerland was also sound and exceeded our expectations, despite their more established markets and highly competitive environments.

A SOLID BUSINESS MODEL

Such growth can only take place because the Group's business model is based on solid pillars. These include:

- focusing on providing cost-effective, quality healthcare, by operating acute care, specialist-orientated, multi-disciplinary hospitals;
- improving our patients' quality of life and adding value to our communities, by being an ethical and responsible corporate citizen;
- striving to be regarded by doctors, patients and healthcare funders as the most trusted and respected hospital services provider;
- building strong positions in attractive geographic markets;
- becoming an international hospital group, with shared values and the ability to learn from one another, rather than a group of independent hospitals in different locations;
- benefiting from the remarkable stability of the Group's senior management over more than two decades; and
- 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 all of its hospital properties.

CLINICAL GOVERNANCE

In recent years, the importance we place on clinical governance has also become firmly entrenched as one of the Group's pillars. With this in mind, you will find the fourth Clinical Governance Report on pages 45 to 57 of this annual report.

Very few private hospital companies worldwide provide such information, but we believe it is of great importance to all involved and will become even more important in the future.

OPERATIONAL AND FINANCIAL PERFORMANCE

The operational highlights and challenges of the past year can be found in the report of the Group's Chief Executive Officer and the operational reviews of the three operating platforms.

The Chief Financial Officer's Report elaborates on the Group's financial results and the current status of the debt the Group incurred when it acquired the Hirslanden Group in 2007. We are always aware of the importance of this matter and continue to address it accordingly.

BRANDING

Mediclinic is an offspring of Remgro, which originally was also the mother company of Richemont, the international luxury goods business.

As a result, the executives at Mediclinic have always been aware of the importance and value of the Mediclinic brand. Since the year end, the Group has begun to launch the new brand, which will streamline it and position it more closely to the international character the Group has attained over the last five years.

The Group has also decided to use "the Science of Care" as the platform for the new brand. This conveys our management approach and the importance of our clinical governance programme, which are ultimately reflected in the clinical outcomes for the patients treated in our hospitals.

DIRECTORATE MATTERS

The Board of Mediclinic has experienced several changes to its composition during the year. Mr Alwyn Martin retired as an independent non-executive director on 26 July 2010 and Mr Gerhard Swiegers retired as the Group's CFO on 15 September 2010. The Board and I have expressed our heartfelt thanks to them for the huge contribution they have made over a long period to the Group. Mr Swiegers played a pivotal role in many successful transactions of the Group and his prominent role in the acquisition of the Hirslanden group was especially demanding and valuable.

The Board of Mediclinic also welcomes the appointment of Prof. Dr Robert Leu as an independent non-executive director and Dr Ronnie van der Merwe as an executive director, both with effect from 26 July 2010. A special word of appreciation and congratulations must be extended to Mr Danie Meintjes, who took over as the Group's CEO from Mr Louis Alberts on 1 April 2010, as well as Mr Craig Tingle, who took over as the Group's CFO on 1 September 2010.

Mr Meintjes joined the Mediclinic Group from the Human Resources department of the then Rembrandt Group (now Remgro) in 1985. He was the manager of Mediclinic Sandton for some years before he became the head of Mediclinic's Human Resources department, and has been a member of the Company's Executive Committee since 1996. In 2006 he was seconded to Dubai as the CEO of Emirates Healthcare, the company housing Mediclinic's activities in the United Arab Emirates.

Mr Tingle was Mediclinic's CFO from 1992 to 1999. He remained on the Board as a non-executive director until he was appointed CFO of Emirates Healthcare in 2006. He stayed in this role until his appointment as the Group's CFO in 2010.

Prof. Dr Leu is the executive director of the Department of Economics at the University of Bern in Switzerland and also serves on the board of Mediclinic Switzerland.

Dr Van der Merwe is the Group's Chief Clinical Officer. Originally practising as an anaesthesiologist, he joined the Group in 1999 and has been a member of the Company's Executive Committee since 2003.

The Board of Mediclinic stands to benefit from the wealth of knowledge and experience offered by these newly appointed directors.

THE FUTURE

There will always be positive and negative influences on our industry. We know that factors such as ageing populations, new technology, better clinical outcomes, greater affluence and better informed members of the public all support our business.

On the other hand, challenges remain which must continue to receive the diligent and imaginative attention of both management and the Board. These include the regulatory environment in South Africa, the new health insurance system which will be implemented from January 2012 in Switzerland, potential new competitors in Dubai and the overriding issue of the affordability of private hospital care. Improving operational efficiency in individual hospitals as well as in the Group worldwide is also a constant challenge, where much progress has been made but the potential for further progress still exists.

The Group's success and expertise will stand us in good stead to face the year ahead and the longer term with optimism. For this, as well as for all their effort over the last year, I have to express heartfelt thanks to all the Board members, senior executives, other members of management and the staff at our hospitals and regional offices.

Thank you and well done, colleagues!

Edwin Hertzog
Chairman

VIEWING THE DELIVERY OF HEALTHCARE AS A SCIENCE HAS BEEN THE GUIDING PRINCIPLE OF ALL THOSE RESPONSIBLE FOR THE MANAGEMENT OF THE GROUP

DANIE MEINTJES
CHIEF EXECUTIVE OFFICER

CHIEF EXECUTIVE OFFICER'S REPORT

THE GROUP ACHIEVED GROWTH IN ALL THREE OF ITS OPERATING PLATFORMS

The period under review was another pleasing year for Mediclinic. The Group achieved growth in all three of its operating platforms and management believes that it is well positioned for the future.

STRATEGIC PRIORITIES

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 prepared; and
- unlocking synergies between the Group's three operating platforms, within an overall aim of becoming a successful international hospital group, rather than a group of associated hospitals.

The Group made good progress against each of these priorities during the period under review. It also continued to concentrate on being a good corporate citizen in its dealings with all of its stakeholders.

PERFORMANCE AGAINST OBJECTIVES

PATIENT SATISFACTION

Patient satisfaction is one of the Group's highest priorities. 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 an overall patient satisfaction index for in-patients of 74% for Southern Africa, 88% for Switzerland and 83% for Dubai. In 2011, it achieved 75%, 86% and 89% for Southern Africa, Switzerland and Dubai respectively.

FINANCIAL PERFORMANCE

The Group maintained its consistent growth. Revenue increased by 9% to R18 625m (2010: R17 141m). At constant exchange rates, revenue was 11% higher.

Maximising use of the Group's facilities is an important revenue driver. All three operating platforms increased bed-days sold, with growth in the United Arab Emirates being particularly strong.

The Group's core EBITDA margin remains a constant focus, as it shows the effectiveness of its cost management. Core EBITDA was 10% higher at R4 103m (2010: R3 736m), equating to a margin of 22.0%, up from 21.8% in 2010.

The Group aims to convert 100% of core EBITDA into cash. Cash conversion in 2011 was good, at 102% (2010: 102%).

Core headline earnings per ordinary share increased by 20% to 179.6 cents (2010: 149.9 cents), reflecting the growth in EBITDA and the leveraging effect of the Group's capital structure.

The Company's rights offer in August 2010 was fully subscribed and raised R1 331m to finance growth opportunities at the Hirslanden hospitals in Switzerland.

MARKET ENVIRONMENT

Rising healthcare costs 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 participated in numerous research, discussions and lobbying activities in all three operating platforms and met with many stakeholders on regulatory issues.

SOUTHERN AFRICA

Mediclinic Southern Africa's principal market is the members of South African medical schemes. Scheme membership continues to show steady growth. Between 2000 and September 2010, membership rose from 6.7m people to more than 8.1m. The consolidation in the fund administration market continues and 75% of the market is now in the hands of the three largest administrators.

The South African government aims to improve citizens' access to quality healthcare, a goal that Mediclinic Southern Africa supports. With this in mind, the government is considering developing a National Health Insurance model. Mediclinic Southern Africa does not believe that this will significantly affect medical scheme membership.

The repeal of the Reference Price List regulations and benchmark tariffs by the High Court on 28 July 2010 did not have any direct impact on Mediclinic Southern Africa. Private hospitals negotiate tariffs directly with medical aid schemes. This is in line with competition law and has been in place since 2002.

SWITZERLAND

The Swiss market is known for its demand for high-end services and the best available technology and the Group's Hirslanden hospitals are well positioned to meet this need.

Regulatory changes in Switzerland develop rather slowly and there is still little clarity on changes that will be introduced as early as January 2012. These amendments include:

- the introduction of fixed fees for in-patient services, based on diagnosis-related groups ("DRGs");
- a new hospital financing system, which re-defines the funding proportions of the cantons versus health insurance companies; and
- revised hospital lists, which determine which hospitals can treat general insured patients.

No rulings on hospital lists or DRGs have been made, so it is not yet possible to assess the consequences for Hirslanden, including any quantification of its financial effect.

Hirslanden actively participates in regulatory discussions in Switzerland. During the period under review, it intensely lobbied the cantonal regulators and other stakeholders around the practicalities of both the new hospital lists and price reform.

UNITED ARAB EMIRATES

In Dubai, the government supports private healthcare and realises that a vibrant and growing private sector will ease pressure on public services. Although major reform is not imminent, there has been an initiative to implement mandatory minimum healthcare insurance, similar to a scheme introduced in Abu Dhabi. The management of Emirates Healthcare is closely involved with government officials in any regulatory reform initiatives.

SHARING BEST PRACTICE

Mediclinic has established discipline-specific synergy task teams, to evaluate best practices and identify improvements across all three operating platforms. To date, these teams have had a number of successes, including:

- achieving insurance premium savings of more than R30m per annum, by adopting an international approach with a single insurance broker;
- delivering major savings by standardising computer software and using a Group-wide contract with software suppliers;
- comparing prices on all major capital equipment and high-volume items across the three operating platforms, to ensure the best procurement prices;

- transferring best practices related to Mediclinic Southern Africa's model for network marketing for doctors to Dubai and Switzerland;
- adopting the principle of the Swiss focus on centres of excellence in Southern Africa;
- implementing a Group-wide clinical governance system across the three operating platforms, using centralised skills to analyse clinical data on a Group basis; and
- transferring the uniform management bonus system from Southern Africa to Dubai and Switzerland.

The Group expects to deliver further benefits as the task teams continue their work.

CLINICAL GOVERNANCE

The Group's operating platforms make their quality measurements transparent by publishing them once a year in the Clinical Governance Report. With its quality management tools, the Group not only identifies opportunities for improvements but also potential operating risks. Refer to the Clinical Governance Report on pages 45 to 57 for more detail.

CORPORATE GOVERNANCE

The Group aims to be a good corporate citizen and maintains the highest standard of integrity and ethics in its dealings with stakeholders. To ensure the best possible patient care, Mediclinic manages and controls its business by implementing strict governance procedures, and by identifying and managing its risks effectively. More information can be found in the Corporate Governance Report on pages 65 to 71 and the Risk Management Report on pages 59 to 63.

SUSTAINABILITY

Conducting business in a sustainable manner is firmly entrenched in the Group. This means considering not only the Group's financial performance but also its social, environmental and economic impacts. Among the sustainability highlights of the period under review was the Group's inclusion, once again, in the JSE's SRI (Socially Responsible Investment) Index in 2010 and its joint-second ranking in the 2010 Carbon Disclosure Project.

PEOPLE

Mediclinic has an integrated people strategy that supports the Group's business strategy. The framework covers talent, human resource operations, compensation, competency management and learning and development. The Group's human resources vision is to consistently meet the people requirements of Mediclinic and specifically to ensure a fully engaged workforce that lives the brand.

Mediclinic is fortunate to have a very stable management team and senior managers tend to stay with the Group. The Group has initiated a professional talent review process, to ensure it has effective succession planning.

Regular independent surveys assess staff morale, identify "hot-spots" and enable the Group to address areas of concern. The Group also participates in market surveys to benchmark salaries and benefits, and adjusts remuneration to ensure it tracks these benchmarks.

TRAINING AND DEVELOPMENT

Mediclinic has a strong learning culture, supported by formal education, in-service training and mentorship. A performance management system guides individual training and development.

The Group makes meaningful investments in staff development. In addition to training more than 1 000 nurses each year in Mediclinic Southern Africa through formal programmes, the Group trains artisans such as fitters and electricians through registered apprenticeships.

The Group's hospital management development programmes have been very successful in growing the proportion of managers from previously disadvantaged groups. These programmes will be further developed to accommodate all levels of management.

GROUP PERFORMANCE

The Group was pleased with its resilience during the period under review. Despite difficult economic conditions in most parts of the world, all three operating platforms performed well.

SOUTHERN AFRICA

Mediclinic Southern Africa contributed 46% of the Group's revenue and 45% of its core EBITDA (2010: 45% and 44% respectively).

The performance of Mediclinic Cape Gate, which opened in February 2010, was one of the group's highlights in Southern Africa as it exceeded all expectations.

The availability of skilled healthcare professionals is vital to the Group's sustainability, and Mediclinic Southern Africa was pleased to learn that the South African Minister of Health intends to create further capacity for doctor and nurse training. The government and the private sector can work together, to develop the human resources that underpin successful healthcare.

With the continued shortage of skilled nurses in South Africa, Mediclinic Southern Africa remains focused on the retention and recruitment of skilled nurses. To help retain existing staff, Mediclinic Southern Africa has a bonus scheme linked to their length of service. It also has an ongoing need to recruit nurses and has, in the short term, recruited specialised nurses from India, who are trained for intensive care and theatres. The longer-term and more sustainable solution is to train more South Africans to bridge the shortage.

Mediclinic Southern Africa therefore continues to invest in nurse training. It is provisionally registered as a higher education institution and also collaborates with other tertiary education institutions. The national curriculum for nurse training, under the auspices of the Nursing Council, is under review and needs finalising as a matter of urgency.

Mediclinic Southern Africa makes financial contributions to all of South Africa's medical schools to assist in the ever-increasing funds needed to train specialists for the country's needs.

Mediclinic Southern Africa has a dedicated department for recruiting doctors and had a net gain of specialists during the period under review.

Developing and implementing the group's transformation strategy has been a focus area over the last few years. Based on the Department of Trade and Industry's BBBEE scorecard, Mediclinic Southern Africa improved from a Level 4 to a Level 3 contributor during the period under review.

SWITZERLAND

Hirslanden contributed 47% of the Group's revenue and 49% of its core EBITDA (2010: 49% and 52% respectively). As discussed in the Chief Financial Officer's Report, the fluctuation of the Rand against the swiss Franc influenced the reported figures but, on a constant currency basis, Hirslanden's contribution was strong and in line with the Group's expectations.

Hirslanden significantly strengthened its position in eastern Switzerland by acquiring the 85-bed Klinik Stephanshorn, the largest private hospital in the canton of St. Gallen. This was Hirslanden's first acquisition under the Group's ownership. Hirslanden has rapidly embedded the hospital and unlocked quick-win benefits, including reduced insurance and purchasing costs, as well as IT and marketing efficiencies.

Construction also began on a major extension project at the flagship Klinik Hirslanden in Zurich. This will add 71 in-patient and eight ICU beds, as well as new consulting rooms.

The Klinik Aarau continued to pilot an information technology and communications project named "Lighthouse", with the intention of rolling it out across Hirslanden's business during the coming years. The project aims to improve integration and connectivity between doctors, patients and regulatory administration systems, in line with worldwide best practice.

UNITED ARAB EMIRATES

Emirates Healthcare contributed 7% of the Group's revenue and 6% of its core EBITDA (2010: 6% and 4% respectively).

Performance in Dubai was very strong. In particular, the growth of The City Hospital was heartening, with substantial increases in its occupancy levels.

The recent economic crisis had no negative impact on Emirates Healthcare's activities and contributed towards the lowering of costs in the region, including a significant reduction in accommodation costs, making Dubai a more affordable place to live. The recent unrest in some Middle Eastern countries has also resulted in an increased influx of people to Dubai, as the UAE is seen as a safe heaven. Recent reports have also named the UAE as a low-risk country in the Middle East.

In early 2011, Emirates Healthcare acquired three additional clinics from the Emaar Healthcare Group. The Dubai Mall Medical Centre, Arabian Ranches Clinic and Meadows Clinic are premium, ultramodern and stylishly outfitted facilities, catering to a top-tier market. Each of these clinics serves prime high-income areas in Dubai and the acquisition increases Emirates Healthcare's footprint from five referring clinics to eight.

OUTLOOK

The affordability of healthcare is 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. This gives the Group confidence that it will continue to be resilient in the foreseeable future.

Mediclinic will stay focused on meeting the needs of its patients in the most cost-effective way, without ever risking their safety. It will also continuously explore innovative ways to add value to its broader stakeholder community, including shareholders, clinical partners, employees and the communities it serves.

I would like to thank all our supporting doctors, management and staff for their contributions towards a very successful year.

Danie Meintjes
Chief Executive Officer

CRAIG TINGLE
CHIEF FINANCIAL OFFICER

THE GROUP HAS CONTINUED ITS STRONG PERFORMANCE, DESPITE TOUGH OPERATING CONDITIONS

ECONOMIC BACKGROUND

Although economic conditions were difficult in many parts of the world, conditions in the Group's markets were broadly favourable. The South African economy has been relatively protected from the global economic turmoil and delivered real growth in gross domestic product (GDP) of 2.8% during the 2010 calendar year. The Swiss economy recorded real GDP growth of 2.6% and a year-on-year reduction in unemployment.

Dubai saw slower growth than in the past, but still increased GDP by an estimated 2.6%. The unrest in some Middle Eastern countries has not affected the United Arab Emirates and it seems that Dubai is seen as a safe haven for other Arab nationals.

GROUP OVERVIEW

GROUP FINANCIAL PERFORMANCE

The Group uses the concepts of core EBITDA, core headline earnings and core headline earnings per share as a method to provide shareholders with clear and consistent reporting. Core EBITDA, core headline earnings and core headline earnings per share are defined as reportable EBITDA, headline earnings and headline earnings per share in terms of accounting standards, excluding one-off items.

RESULTS OVERVIEW

Group revenue increased by 9% to R18 625m (2010: R17 141m) for the year under review. Core operating income before interest, tax, depreciation and amortisation ("core EBITDA") was 10% higher at R4 103m (2010: R3 736m). Core headline earnings rose by 27% to R1 082m (2010: R852m). The faster growth of core headline earnings compared with core EBITDA reflects the leveraging effect of the Group's capital structure.

FIGURE 1: EBITDA RECONCILIATION

R'm	2011	2010
EBITDA	**4 186**	3 833
Adjusted for:		
Past service cost	**(33)**	(97)
Impairment of property and equipment	**34**	–
Insurance proceeds	**(84)**	–
Core EBITDA	**4 103**	3 736

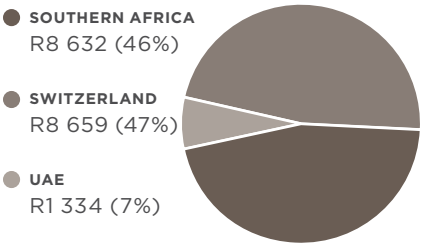
Core basic headline earnings per ordinary share increased by 20% to 179.6 cents (2010: 149.9 cents), reflecting the increase in shares in issue after the rights offer in August 2010.

At constant exchange rates, core EBITDA increased by 12%, core headline earnings increased by 27%, and core headline earnings per share increased by 20%.

The calculations of core EBITDA (see **Figure 1**), core headline earnings and core basic headline earnings per share are before the effects of the following three one-off items:

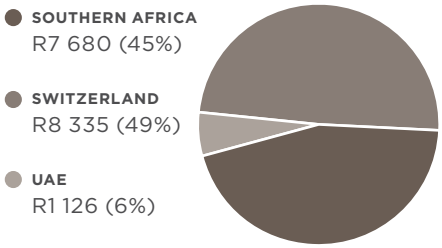
FIGURE 2: REVENUE (R'M)

2011



TOTAL R18.6 BILLION

2010



TOTAL R17.1 BILLION

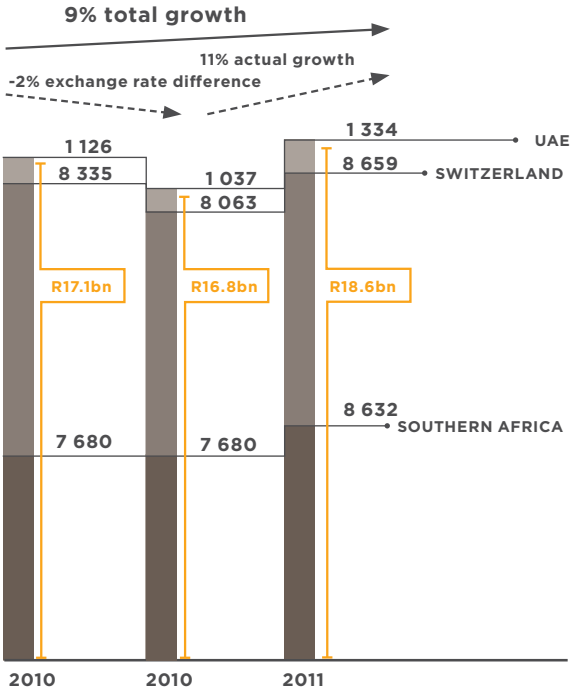
- On 20 December 2010 a fire broke out at Constantiaberg Mediclinic, which caused significant damage to the hospital's theatres. As a result of the fire damage, an impairment loss to property and equipment of R34m (R25m after tax) was recognised together with insurance proceeds of R84m (R66m after tax). The impairment losses and the insurance proceeds were excluded from headline earnings.
- On 4 October 2010 the Group acquired a 100% interest in Klinik Stephanshorn. The fair value of the net assets exceeded the purchase price, resulting in the recognition of a gain on the acquisition of a subsidiary of R21m (CHF3m). The gain is included in 'Other gains and losses' on the income statement and excluded from headline earnings.
- An adjustment to the pension funds' payout ratio of Klinik St. Anna, resulting in a past service cost credit, calculated in terms of IAS 19, to the income statement of R33m (CHF4.7m) and R28m (CHF4m) after provisioning for tax. The past service cost credit was excluded from core headline earnings.

Before the abovementioned one-off adjustments, reported EBITDA increased by 9% to R4 186m (2010: R3 833m).

Excluding current and prior year re-measurements relating to core headline earnings, headline earnings rose by 8% to R1 110m (2010: R1 028m) and basic headline earnings per ordinary share increased by 2% to 184.2 cents (2010: 180.8 cents).

As indicated in previous annual reports, the Group is moving towards a targeted dividend cover of three times, based on Group headline earnings. Therefore, the total dividend per share of 73.0 cents (2010: 73.0 cents) was maintained.

FIGURE 3: REVENUE GROWTH (R'M)



REVENUE

The geographical composition of the Group's revenue for 2011 and 2010 is shown in **Figure 2**.

As shown in **Figure 3**, revenue increased by 9% to R18 625m (2010: R17 141m).

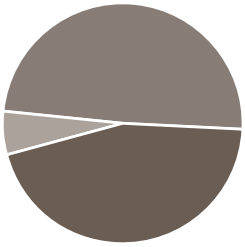
CORE EBITDA

The Group's core EBITDA margin increased from 21.8% in 2010 to 22.0% in 2011. The EBITDA margins of the Group's platforms were 21.3% for Southern Africa, 23.4% for Switzerland and 18.0% for the United Arab Emirates.

FIGURE 4: CORE EBITDA (R'M)

2011

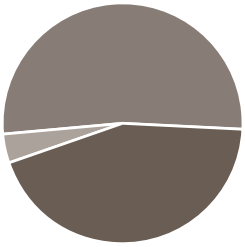
- SOUTHERN AFRICA R1 837 (45%)
- SWITZERLAND R2 026 (49%)
- UAE R240 (6%)



TOTAL R4.1 BILLION

2010

- SOUTHERN AFRICA R1 651 (44%)
- SWITZERLAND R1 953 (52%)
- UAE R132 (4%)



TOTAL R3.7 BILLION

FIGURE 5: CORE EBITDA GROWTH (R'M)

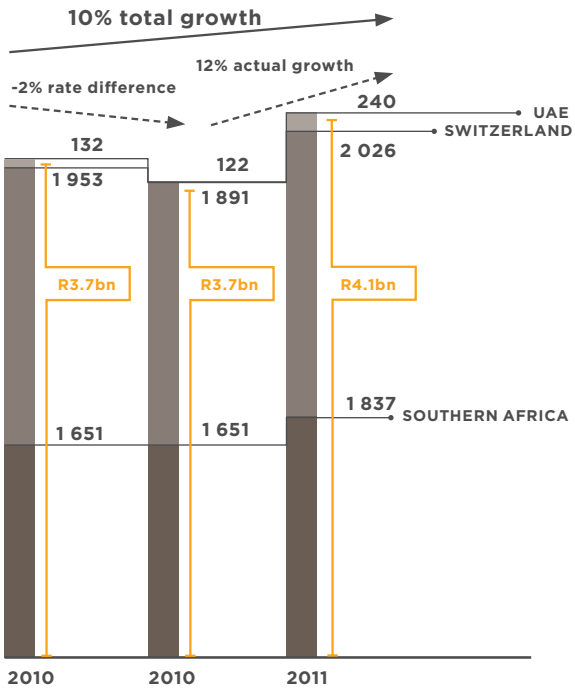
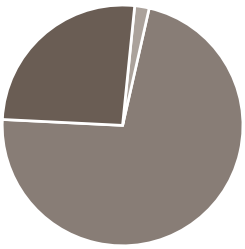


FIGURE 6: FINANCE COST (R'M)

2011

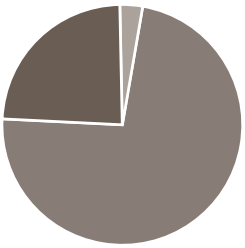
- SOUTHERN AFRICA R384 (26%)
- SWITZERLAND R1 068 (72%)
- UAE R39 (2%)



TOTAL R1.5 BILLION

2010

- SOUTHERN AFRICA R373 (24%)
- SWITZERLAND R1 105 (73%)
- UAE R45 (3%)



TOTAL R1.5 BILLION

The geographical composition of the Group's core EBITDA for 2011 and 2010 is shown in **Figure 4**.

As shown in **Figure 5**, core EBITDA increased 10% to R4 101m (2010: R3 736m).

FINANCE COST

The Group's finance cost was R1 491m, compared with R1 524m in 2010. Included in the finance cost is R78m (2010: R75m) 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 2011 is shown in **Figure 6**.

FIGURE 7: CORE HEADLINE EARNINGS (R'M)

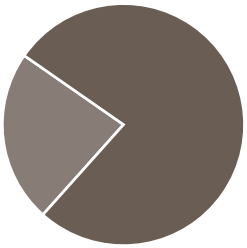
2011

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

TOTAL R1.1 BILLION

2010

- **SOUTHERN AFRICA** R657 (77%)
- **SWITZERLAND** R193 (23%)
- **UAE** R2 (0%)



TOTAL R0.9 BILLION

CONTRIBUTION TO GROUP CORE HEADLINE EARNINGS

The geographical composition of the Group core headline earnings for 2011 and 2010 is shown in **Figure 7**.

CASH FLOW

Cash flow continued to be strong. The Group converted 102% (2010: 102%) of core EBITDA into cash generated from operations, compared with a target of 100%.

Cash and cash equivalents increased to R1 567m at year end, compared with R1 120m at 31 March 2010.

INTEREST-BEARING BORROWINGS

Interest-bearing borrowings ("debt") increased from R21 065m at 31 March 2010 to R22 248m at year end, mainly as a result of the change in the closing rand/CHF exchange rate. The CHF closing exchange rate moved from R6.93 at 31 March 2010 to R7.42 at year end.

The Group has begun the process of refinancing a Southern African bank loan of R1 375m, which matures in December 2011. The Group has taken out a forward starting fixed interest rate swap agreement in respect of this to be refinanced loan in anticipation of an increase in interest rates.

The geographical composition of the Group's debt at 31 March 2011 is shown in **Figure 8**.

The foreign debt of the Group's Swiss and Middle Eastern operations, amounting to R18 491m, 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.

RIGHTS OFFER

Mediclinic raised R1 331m after expenses through a rights offer that closed on 6 August 2010. The proceeds will be used to finance growth opportunities at Hirslanden's hospitals in Switzerland.

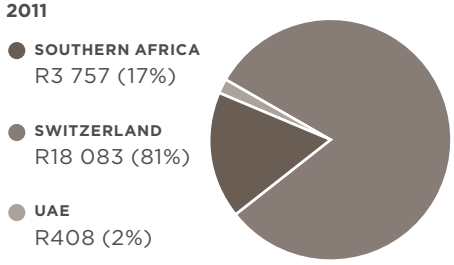
The rights offer was for a total of 59 301 395 Mediclinic shares ("rights offer shares"), at a subscription price of 2 300 cents per rights offer share and in the ratio of 10 rights offer shares for every 100 Mediclinic shares held at the close of trading on 16 July 2010.

The rights offer was fully subscribed and 66.7% excess applications were received. No allocation of rights offer shares was made to the underwriter.

The proceeds were invested in short-term money market funds, as well as in investment grade bonds, with a short-term maturity profile, to enhance the low bank interest yields. Non-Swiss denominated bonds are fully hedged by forward contracts to the Swiss franc. The annualised combined yield on the short-term deposits and investment grade bonds was 0.92%.

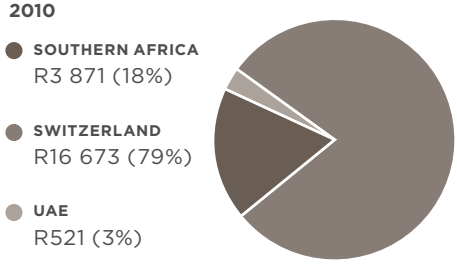
FIGURE 8: DEBT (R'M)

2011



TOTAL R22.2 BILLION

2010



TOTAL R21.1 BILLION

TREASURY SHARES

During the year, the Group utilised 575 226 treasury shares for its executive share option scheme and management incentive scheme. The Group now holds 1 090 547 treasury shares (2010: 2 138 058).

FOREIGN EXCHANGE RATES

The rand experienced some 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 R6.93 at 31 March 2010 to R7.42 at 31 March 2011, and averaged R7.11 for the year (2010: R7.35).

The AED spot rate moved from R2.00 at 31 March 2010 to R1.85 at 31 March 2011, and averaged R1.96 (2010: R2.13) for the year.

Accounting convention requires the Group to convert its offshore balance sheets at the year-end spot rate, while its offshore income statements are converted at the average rate for the year. The difference between the spot rates and the average rates results in distortions, when ratios between the 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 R488m (2010: decrease of R1 401m) and was credited (2010: debited) to the statement of comprehensive income.

IFRS AND TECHNICAL MATTERS

ACCOUNTING FOR THE 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 R71m (CHF9.5m) (2010: R64m (CHF9.3m)), 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 106% (2010: 107%) funded at 31 March 2011. 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 2011.

An amount of R86m (CHF11.6m) was charged (2010: credited R331m (CHF47.8m)) to the consolidated statement of comprehensive income for the year. An amount of R102m (CHF14.3m) (2010: R63m (CHF8.6m)), representing the employer contributions exceeding the current service cost, was credited to the consolidated income statement. In addition, a one-off adjustment to pension funds' payout ratio of Klinik St. Anna was made, resulting in a further decrease in the pension liabilities of R33m (CHF4.7m) in respect of past services and was also credited to the consolidated income statement.

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

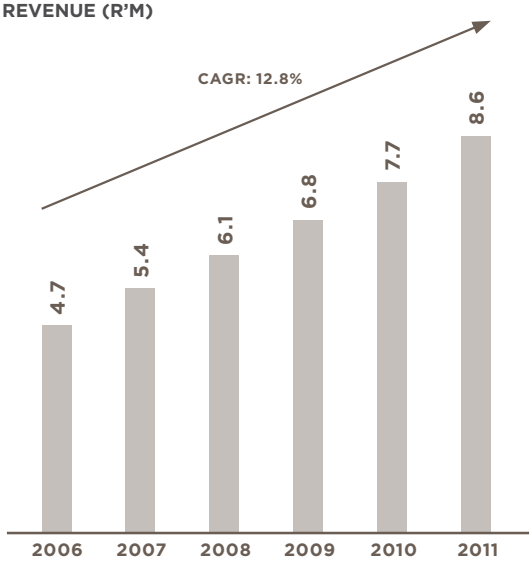
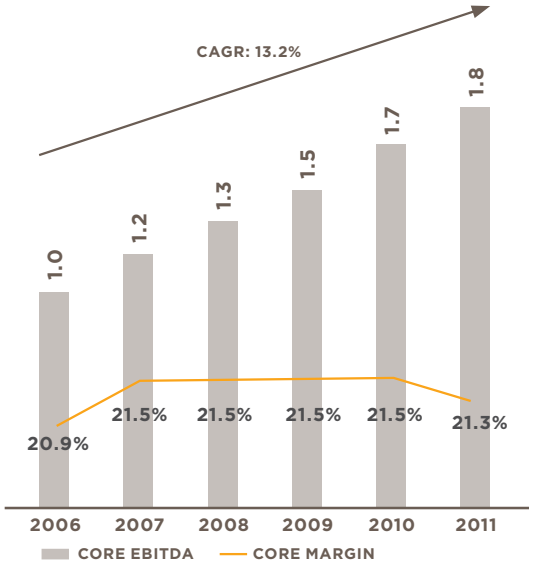


FIGURE 10: MEDICLINIC SOUTHERN AFRICA CORE EBITDA GROWTH AND MARGIN (R'M)



OPERATIONS IN SOUTHERN AFRICA

MEDICLINIC SOUTHERN AFRICA

Mediclinic Southern Africa (MCSA) increased revenue by 12% to R8 632m (2010: R7 680m).

Mediclinic Southern Africa's historical revenue performance is shown in **Figure 9**.

Core EBITDA grew by 11% to R1 837m (2010: R1 651m). This resulted in a slight decrease in the core EBITDA margin from 21.5% to 21.3%, mainly because of rental income, which is now shown as part of revenue; this had a negative impact of 0.2% on the margin.

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

After incurring depreciation charges of R229m (2010: R206m), net finance charges of R348m (2010: R334m), tax of R388m (2010: R326m) and deducting the non-controlling interests' share, the attributable income of the Southern African group amounting to R141m (2010: R126m), the Southern African operations contributed R731m (2010: R659m) to the core attributable income of the Group.

Excluded from the results above and excluded from headline earnings are insurance proceeds of R84m (R66m after tax) for the Mediclinic Constantiaberg fire and the associated impairment charges to property and equipment of R34m (R25m after tax).

The Southern African operations' cash flow continued to be strong as it converted 111% (2010: 102%) of core EBITDA into cash generated from operations. Cash and cash equivalents increased from R486m at 31 March 2010 to R755m at year end. Over this period interest-bearing borrowings decreased from R3 871m to R3 757m.

FIGURE 11: HIRSLANDEN REVENUE GROWTH (CHF MILLION)

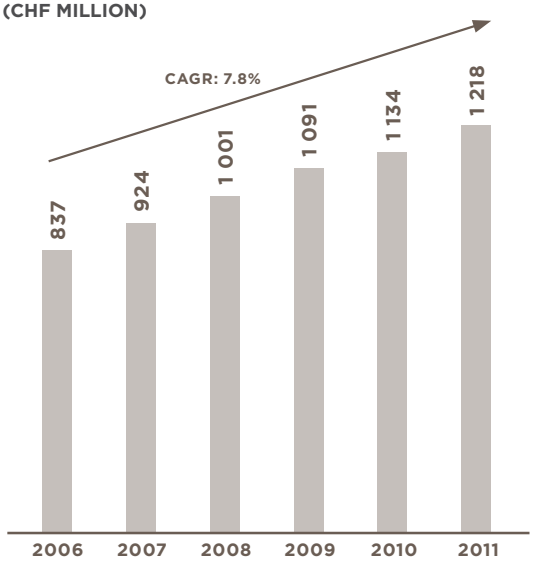
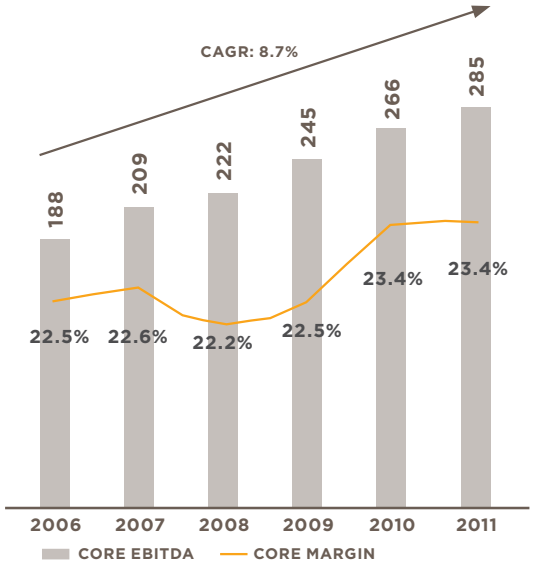


FIGURE 12: HIRSLANDEN CORE EBITDA GROWTH AND MARGIN (CHF MILLION)



OPERATIONS IN SWITZERLAND

HIRSLANDEN

Hirslanden's reported results for 2011 were affected by exchange rate movements. The average rand/CHF exchange rate for the year fell from R7.35 in 2010 to R7.11 in 2011.

Hirslanden's revenue increased by 4% to R8 659m (CHF1 218m), compared with R8 335m (CHF1 134m) in 2010. At constant exchange rates, Hirslanden increased its revenue by 7%.

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

Hirslanden's core EBITDA was 4% lower at R2 026m (CHF285m), against R1 953m (CHF266m) in 2010. At constant exchange rates, Hirslanden recorded a 7% increase in core EBITDA. The core EBITDA margin was 23.4% (2010: 23.4%).

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

After incurring depreciation charges of R433m (CHF61m) (2010: R437m (CHF59m)), net finance charges of R1 060m (CHF149m) (2010: R1 096m (CHF149m)) and tax of R251m (CHF35m) (2010: R234m (CHF32m)) and income from associate of R4m (CHF1m) (2010: R7m (CHF1m)), Hirslanden contributed R286m (CHF41m) (2010: R193m (CHF27m)) to the attributable income of the Group.

Excluded from the results above are two one-off items that Hirslanden incurred during the year:

- The gain on the acquisition of Klinik Stephanshorn of R21m (CHF3m), which was excluded from headline earnings.
- The past service cost credit of R33m (CHF4.7m) and R28m (CHF4m) after adjusting for tax, which was excluded from core headline earnings.

Hirslanden converted 94% (2010: 101%) of core EBITDA generated into cash from operations. An IAS 19 pension fund adjustment of R102m (CHF14.3m) (2010: R63m (CHF8.6m)), representing the employer contributions exceeding the current service cost, was credited to the consolidated income statement. If this IAS 19 non-cash flow pension fund credit was excluded, Hirslanden would have converted 98% of core EBITDA into cash from operations.

Interest-bearing borrowings increased from R16 673m (CHF2 406m) at 31 March 2010 to R18 083m (CHF2 437m) at year end net of capitalised debt transaction fees in rand terms because of the increase in the spot rate of the rand/CHF exchange rate.

ACQUISITION OF KLINIK STEPHANSHORN

Hirslanden acquired a 100% interest in the 85-bed Klinik Stephanshorn with effect from 4 October 2010. The financial results of Klinik Stephanshorn have been included in the Group financial results from 4 October 2010. Klinik Stephanshorn has contributed R171m (CHF 24m) of revenue and R33m (CHF4.7m) to the Group's core EBITDA.

FIGURE 13: EMIRATES HEALTHCARE REVENUE (AED MILLION)

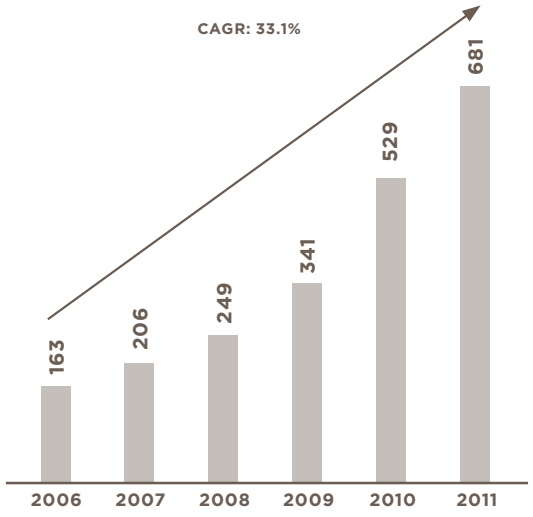
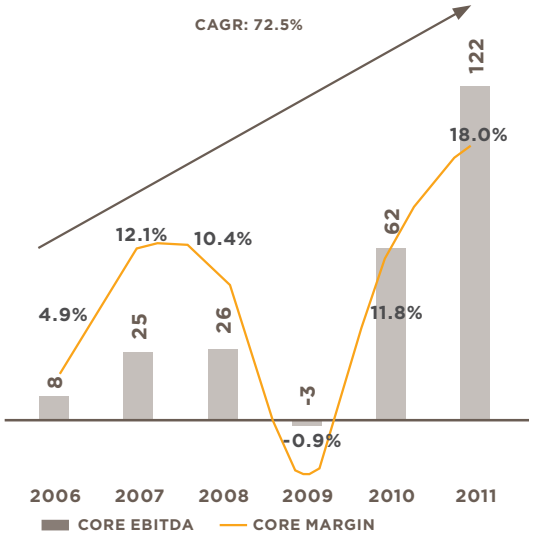


FIGURE 14: EMIRATES HEALTHCARE CORE EBITDA GROWTH AND MARGIN (AED MILLION)



OPERATIONS IN UNITED ARAB EMIRATES

EMIRATES HEALTHCARE

Emirates Healthcare's reported results for 2011 were affected by exchange rate movements. The average rand/AED exchange rate for the year fell from R2.13 in 2010 to R1.96 in 2011.

Revenue increased by 18% to R1 334m (AED681m), compared with R1 126m (AED529m) in 2010. At constant exchange rates, Emirates Healthcare's revenue was 29% higher.

Emirates Healthcare's historical revenue performance is set out in **Figure 13**.

EBITDA increased 82% to R240m (AED122m) (2010: R132m (AED62m)) and the EBITDA margin increased from 11.8% to 18.0%. At constant exchange rates, EBITDA growth was 97%.

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

After incurring depreciation charges of R76m (AED38m) (2010: R75m (AED35m)), net finance charges of R38m (AED19m) (2010: R53m (AED25m)) and the non-controlling interests share, the attributable income of Emirates Healthcare amounting to R63m (AED32m) (2010: R2m (AED1m)), Emirates Healthcare contributed R63m (AED33m) (2010: R2m (AED1m)) to the attributable income of the Group.

Before taking the acquisition of the Emaar clinics into account, Emirates Healthcare converted 100% (2010: 105%) of EBITDA generated into cash from operations. Cash and cash equivalents increased from R108m (AED54m) at 31 March 2010 to R114m (AED61m) at year end.

Interest-bearing borrowings decreased from R521m (AED261m) at 31 March 2010 to R408m (AED221m) at year end.

On 10 October 2010 Emirates Healthcare opened Welcare Clinic Ibn Battuta, a multi-specialty clinic conveniently located in the Ibn Battuta Mall.

ACQUISITION OF EMAAR CLINICS

Emirates Healthcare acquired the following three clinics effective from 15 January 2011: The Dubai Mall Medical Centre, Meadows Clinic and Arabian Ranches Clinic. The clinics have contributed R25m (AED12.7m) of revenue and R0.5m (AED0.3m) to the Group's core EBITDA.

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 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 II and King III reports.

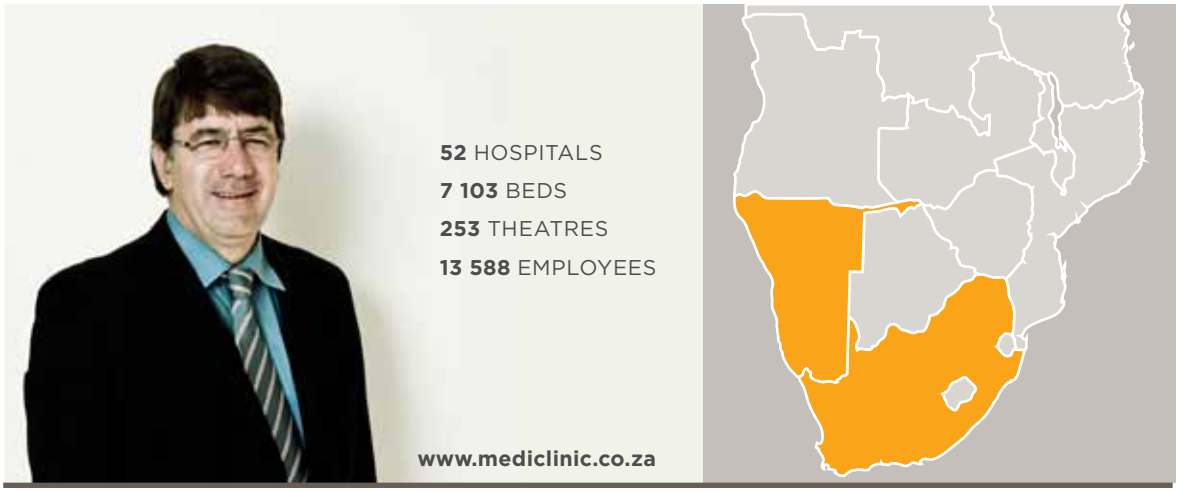
The Group's risk management process is summarised in the Risk Management Report on pages 59 to 63, the Sustainable Development Report on pages 73 to 123 and notes 3.1 and 3.3 to the annual financial statements on pages 127 to 190.

ACCOUNTING POLICIES

The annual financial statements have been prepared in accordance with IFRS. The accounting policies are consistent with those adopted in previous years, except for the adoption of new and revised Standards and Interpretations. In the current year the Group has adopted all the new and revised Standards and Interpretations relevant to its operations on 1 April 2010. The adoption of these new and revised Standards and Interpretations has not had any significant impact on the amounts reported in the financial statements.

Craig Tingle
Chief Financial Officer

OPERATIONAL REVIEW: SOUTHERN AFRICA



KOERT PRETORIUS	CHIEF EXECUTIVE OFFICER: MEDICLINIC SOUTHERN AFRICA

BUSINESS ENVIRONMENT

Mediclinic Southern Africa's principal market is the members of South African medical schemes. A small proportion of its business comes from other sources, such as private patients and international funders.

The South African economy has been relatively insulated from the difficult economic conditions seen in many other parts of the world. In 2010, real growth in gross domestic product was 2.8%. Medical scheme membership rose during the period under review, continuing a longer-term pattern. Since 2000, membership has increased at approximately 2% per annum, taking it to 8.1m people in September 2010. This expansion has allowed the private hospital industry to achieve incremental growth. The market is relatively mature and Mediclinic Southern Africa has seen its market share at least remain steady. Hard numbers for market share are unfortunately not available.

From a financial perspective, the medical scheme industry is highly stable. The Council for Medical Schemes ("CMS") requires all schemes to have a 25% reserve ratio. Reserves have risen beyond this minimum and the last official CMS report showed that schemes had average reserves of 32.9%. This means that the industry as a whole has excess funds of approximately R6.5bn.

Mediclinic Southern Africa supports the South African government's goal of increasing access to affordable quality healthcare. In September 2010, the National General Council of the African National Congress released a discussion document on developing a National Health Insurance ("NHI") model. According to this document, voluntary medical aid membership will continue, after payment of the compulsory additional NHI tax, and contracting with the NHI fund by private sector providers will also be voluntary.

The proposed restructuring of tax subsidies on medical aid contributions – from the current format to a tax credit – should be viewed positively, as it will improve affordability for low-income earners. If and when an NHI tax is introduced, the Group expects the Treasury to phase it in, to minimise the impact on individuals' disposable income and to allow them to adjust their spending patterns.

Furthermore, the mooted NHI payroll tax will be progressive, meaning that higher incomes will attract a higher percentage tax. Since the affordability of medical aid contributions is of greater concern for low-income earners, the smaller impact of a progressive tax on these members should mean that medical aid membership will not be significantly affected.

BUSINESS PERFORMANCE

Mediclinic Southern Africa achieved revenue growth of 12% in 2011. This was the result of:

- a 2.9% increase in bed-days sold;
- a 7.7% increase in the average income per bed-day, driven by a greater proportion of higher-value surgical cases. The rise in the proportion of surgical cases reversed the trend of previous years; and
- a 1.4% increase in other revenue.

The number of patients admitted increased by 1.4%, while the average length of stay increased by 1.2%. The new 140-bed Mediclinic Cape Gate was successfully commissioned as planned during February 2010 and occupancies have been above budget.

The EBITDA margin of Mediclinic Southern Africa decreased slightly to 21.3% because of rental income, which is now shown as part of revenue and which had a negative impact of 0.2% on the margin.

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

- R222m (2010: R315m) in capital projects and new equipment to enhance its business;
- R224m (2010: R194m) in replacing existing equipment;
- R78m on the fire damage at Mediclinic Constantiaberg; and
- R236m (2010: R210m) in repairing and maintaining property and equipment, which was charged through the income statement.

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

- R599m for capital projects and new equipment;
- R237m for replacing existing equipment; and
- R254m for repairs and maintenance.

The incremental EBITDA resulting from capital projects in progress or approved is budgeted at R43m and R65m for 2012 and 2013 respectively.

The number of licensed hospital beds increased from 7 035 to 7103 during the period under review.

Patient satisfaction levels improved from 73% to 75% during the period under review, exceeding the target of 74%.

BUILDING PROJECTS

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

- Mediclinic Constantiaberg (upgrade and a new doctors' consulting block);
- Mediclinic Tzaneen (27 additional beds, including some ICU beds);
- Mediclinic Marapong (upgrade);
- Mediclinic Ermelo (upgrade);
- Mediclinic Medforum (upgrade);
- Mediclinic Muelmed (upgrade of 57 beds);
- Wits Donald Gordon Medical Centre (upgrade of 28-bed ward);
- Mediclinic Panorama (upgrade and a new electro-physiology laboratory).

MEDICLINIC SOUTHERN AFRICA CONTRIBUTED 46% OF THE MEDICLINIC GROUP'S REVENUE AND 45% OF ITS CORE EBITDA

The following building projects are ongoing:

- Mediclinic Nelspruit (66 additional beds, due for completion in May 2011);
- Mediclinic Stellenbosch (10 additional beds, due for completion in July 2011);
- Mediclinic Kimberley (8 additional beds and an upgrade of the existing hospital, due for completion in November 2011);
- Mediclinic Kloof (32 additional beds, due for completion in December 2011);
- Mediclinic Paarl (2 additional beds and 1 theatre, due for completion in May 2011);
- Mediclinic Welkom (36 additional beds and an upgrade of existing hospital, due for completion in February 2012);
- Mediclinic Legae (4 additional beds and an upgrade of existing hospital);
- Mediclinic Cape Town (new doctors' consulting rooms, due for completion in July 2011);
- Mediclinic Limpopo (60 additional beds and upgrade, due for completion in March 2013);
- Mediclinic Louis Leipoldt (major upgrade, due for completion during 2013);
- Mediclinic Hoogland (major upgrade, due for completion in April 2012).

The following projects will begin during the next financial year:

- New hospital in Centurion (174 beds);
- Mediclinic Highveld (27 additional beds);
- Mediclinic Potchefstroom (13 additional beds);
- Mediclinic Pietermaritzburg (80 additional beds, new cardiac unit, two theatres and a cathlab);
- Mediclinic Otjiwarongo (2 additional beds);
- Mediclinic Windhoek (26 additional beds, consulting rooms and parking).

The number of licensed beds is expected to increase from 7 103 to 7 261 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 training of South Africans.

Mediclinic Southern Africa's training and development function is a formal nursing education institution to promote sustainable quality outcomes. Its provisional registration has been extended until December 2011, allowing it to offer a Diploma in General Nursing Science and a Diploma in Operating Theatre Practice. Mediclinic Southern Africa also received provisional registration, until December 2015, to present Enrolled Nursing programmes.

A total of 415 nursing students completed undergraduate programmes last year and 72 professional nurses completed postgraduate programmes. A further 1 200 nurses completed structured education courses.

Mediclinic Southern Africa introduced a formal management succession process during the period under review to prepare for the expected retirement of senior executives over the next five years. In addition, it established a talent review committee.

More than half of the employees took part in an employee relationship assessment, with results in line with international norms for the industry. The data also showed the engagement drivers that need some attention at an operational level and are a guide for focused improvements.

SOCIETY

Mediclinic Southern Africa aims to make a meaningful impact on the communities it supports by helping to alleviate their socio-economic challenges. This programme has three tiers.

- Tier 1: Partnering with the government to provide the community with much needed surgical support. For example, Mediclinic Southern Africa is currently working with the Northern Cape Department of Health to assist with 280 cataract operations.
- Tier 2: Enhancing the role of accredited community organisations in education, sport, health and welfare, by providing monetary and product support. Mediclinic Southern Africa donated money to 45 organisations, and 15 schools and non-profit organisations received computer equipment worth R800 000.
- Tier 3: Providing a platform for employees to make a difference by volunteering their time, expertise and knowledge to community organisations in around the hospitals. A total of 127 employees volunteered their time during the period under review.

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-four of Mediclinic Southern Africa's 52 hospitals are now ISO 14001-certified, an increase of eight during the period under review. The aim is for a further four hospitals to be certified in the coming year. The number of ISO 14001-trained hospitals, which includes the 34 certified hospitals, increased from 35 to 43. 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 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 be derived, for instance, from leveraging technology such as clinical information systems.

Skills shortages are an ongoing challenge that Mediclinic Southern Africa is addressing. Potential regulatory changes also create some uncertainties, but this is a normal part of the healthcare operating environment. Mediclinic Southern Africa continues to monitor the regulatory position so that it can play an appropriate role in decision-making.

OPERATIONAL REVIEW: SWITZERLAND

OLE WIESINGER	CHIEF EXECUTIVE OFFICER: MEDICLINIC SWITZERLAND

BUSINESS ENVIRONMENT

Hirslanden is the largest private hospital group in Switzerland. In recent years it has been able to increase its market share through both organic growth and acquisitions. In general, its most important competitors are public hospitals.

Compared to other industrialised countries, Switzerland's economy proved resilient during the global recession, and the country has also benefited from the subsequent global recovery. Real gross domestic product growth is estimated at 2.6% for the 2010 calendar year. Inflation remains very low.

An amendment to the Swiss Health Insurance Act ("KVG") of 1 January 2009 will come into effect on 1 January 2012. The amendment's implementation and its consequences have dominated recent discussions of public health policy. Its provisions relate primarily to the treatment of patients without supplementary private or semi-private insurance, but the changes are also relevant for private and semi-private patients, since these patients also have mandatory basic insurance.

The new federal Act contains three major changes:

- the introduction of fixed fees for inpatient services, based on diagnosis-related groups ("DRGs");
- a new hospital financing system, which re-defines the funding proportions of the cantons versus the health insurance companies; and
- the revision of the so-called hospital lists, which list the clinics and hospitals that are eligible to treat mandatorily insured patients.

One of the federal authorities' main intentions when adopting the changes was to increase competition between hospitals. Therefore, from 1 January 2012, all private and public hospitals included in the hospital lists will in general be treated equally in terms of financing, and thus receive funding from both cantons and health insurance companies. In addition, patients will then be able to choose any listed hospital in Switzerland for treatment.

A key issue, however, is that the responsibility for implementing the federal Act lies with the cantons. Since the cantons run their own hospitals, this means that they are both regulators and providers.

The federal Act only specifies that the selection of providers for the revised hospital lists needs to be based on criteria of quality and economic efficiency. Not surprisingly, the cantons have started translating the federal Act into cantonal regulations that differ considerably from canton to canton. Moreover, the conflict of interests arising from their dual role has resulted in some questionable cantonal requirements for inclusion in the hospital lists, protecting the public hospitals against private sector competition.

The introduction of a uniform DRG system for all of Switzerland entails the abolition of the former cost compensation system and the introduction of a new fee-for-service system. Hirslanden believes that its hospitals are in general more cost efficient than public hospitals and it is confident that the new system will not negatively affect its business if the base prices are set at realistic levels.

Hirslanden is in regular contact with the health departments in the cantons where it owns hospitals. To date, no rulings on hospital lists or DRGs have been made, so it is not yet possible to assess the consequences of the Act for Hirslanden, including any quantification of the financial effect.

Cost control in the mandatory health insurance arena continues to rank high on the political agenda in Switzerland. Licensing restrictions for new doctors continue and an additional national planning system in respect of high-cost, high-technology specialist treatments is being established. Further regulatory initiatives regarding the proposal for a single national insurer and the extension of managed care are under discussion.

BUSINESS PERFORMANCE

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

- a 6% increase in inpatient admissions;
- a fairly constant length of stay; and
- a 2.4% increase in the average income per bed-day, due to a greater proportion of higher acuity cases.

Hirslanden's core EBITDA margin remained consistent at 23.4% (2010: 23.4%).

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

- R312m (CHF44m) (2010: R318m (CHF43m)) in capital projects and new equipment to enhance its business;
- R323m (CHF45m) (2010: R424m (CHF58m)) in replacing existing equipment; and
- R232m (CHF33m) (2010: R222m (CHF30m)) in repairing and maintaining property and equipment, which was charged through the income statement.

For the next financial year, Hirslanden's budget is:

- CHF72m for capital projects and new equipment;
- CHF53m for replacing existing equipment; and
- CHF33m for repairs and maintenance.

The incremental EBITDA resulting from capital projects in progress or approved is budgeted at CHF8m and CHF5m for 2012 and 2013 respectively.

HIRSLANDEN CONTRIBUTED 47% OF THE MEDICLINIC GROUP'S REVENUE AND 49% OF ITS CORE EBITDA

The number of fully operational inpatient beds increased from 1 365 to 1 457 during the period under review.

Patient satisfaction, which was evaluated by Picker Institute Europe, remained stable at 86%, close to the target of 88%.

ACQUISITION OF KLINIK STEPHANSHORN

Hirslanden acquired a 100% interest in the 85-bed Klinik Stephanshorn, with effect from 4 October 2010. Klinik Stephanshorn is the only private hospital in the city of St. Gallen and the largest in the canton. Its strategic value meant that Hirslanden had always viewed Klinik Stephanshorn as a potential takeover target.

Together with Hirslanden's existing 62-bed Klinik Am Rosenberg, Klinik Stephanshorn significantly strengthens Hirslanden's position in eastern Switzerland. The two hospitals complement each other and will create synergies. This market still offers many growth opportunities and, in order to capitalise on the full growth potential of the transaction, further capital expenditure is planned.

BUILDING PROJECTS

Building projects completed during the period under review were:

- Klinik Hirslanden (neurology and vascular centres);
- Klinik St. Anna (an additional 7 beds).

The major current expansion projects are:

- Klinik Beau-Site (additional 23 beds in 2011, with the hospital also being extensively upgraded and consulting rooms added);
- Klinik Hirslanden (additional 71 inpatient and 8 ICU beds, as well as new consulting rooms); and
- Clinique Bois-Cerf (creation of a radiology and radiotherapy centre, and developing and expanding oncology).

The number of fully operational inpatient beds is expected to increase from 1 457 to 1 478 during the next financial year.

TECHNOLOGY INVESTMENT

Klinik Im Park acquired a new 3.0 tesla magnetic resonance imaging ("MRI") machine in August 2010. Planned investments in technology, which provide for new treatment options and increased case loads, include a 3.0 tesla MRI machine at Klinik Hirslanden and a 1.5 tesla MRI machine at Klinik St. Anna. The acquisition of both machines is planned for spring 2011.

In February 2011, Hirslanden successfully launched its hospital information system, known as project "Lighthouse". All medical and administrative processes can be digitised and simplified, moving Hirslanden closer to its vision of paperless and efficient hospitals. After further evaluating the pilot programme, Hirslanden intends to roll out the system to the rest of the group.

SUSTAINABILITY

QUALITY

In 2010 Hirslanden published its first quality report, making it the only private hospital provider in Switzerland to provide such transparency. The report demonstrated that Hirslanden delivers high-quality care. For example, the analysis showed that the mortality rate for a patient in intensive care in a Hirslanden facility was less than half the expected rate, based on the average figure for Switzerland.

OPERATIONAL REVIEW: SWITZERLAND (CONTINUED)

PEOPLE

Hirslanden needs to recruit and retain sufficient high-quality healthcare professionals. As in other parts of the world, the lack of specialised nurses is an increasing challenge. To differentiate itself as an employer, Hirslanden is piloting a reorganisation of nursing provision to allow an optimal allocation of highly qualified and less qualified nurses.

Implementing a junior talent promotion programme is another strategic goal to ensure that Hirslanden is capable of developing and retaining people with the capacity to contribute to its success.

Hirslanden also makes significant investments in training. At the year end, it had 145 trainee health professionals and approximately 200 apprentices.

SOCIETY

Hirslanden supports and initiates various health awareness programmes. For example, it launched a public awareness campaign for cardiac health in Bern.

To promote health, Hirslanden supports a number of organisations, such as the Swiss Heart Foundation and the Swiss Cancer League. It was medical partner for the Swiss Cancer League's "Race against cancer", which raised money to finance research and raise public awareness.

ENVIRONMENT

Hirslanden's main environmental impact is energy consumption. A top priority is to lower energy use and to follow energy-efficient building standards such as MINERGIE, where this is economically justifiable.

Several clinics made investments to reduce their environmental impact. For example, an "Ecojet" system in the natural gas pipes at Klinik Aarau will reduce its gas consumption by approximately 9%.

During the period under review, Hirslanden started to analyse its clinics' waste management, identifying cost savings of CHF150 000 to CHF200 000. Data will be collected for the next three years to provide comparable figures on performance. The data collection method follows Global Reporting Initiative principles.

OUTLOOK

Hirslanden is well prepared for the future. Changes in the regulatory environment have always been part of everyday business life. Hirslanden manages this changing environment by using an expert panel to assist the Executive Committee. This is coupled with intensive lobbying and co-operation in the political committees, co-ordinated by Hirslanden's public affairs department.

As all hospitals in Switzerland will be affected by these changes, some smaller competitors in the private sector are expected to merge or join forces with an existing group in the short to medium term. This may lead to acquisition opportunities.

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

OPERATIONAL REVIEW: UNITED ARAB EMIRATES

2 HOSPITALS
8 CLINICS
336 BEDS
10 THEATRES
1 676 EMPLOYEES

www.ehl.ae

DAVID HADLEY	CHIEF EXECUTIVE OFFICER: EMIRATES HEALTHCARE

BUSINESS ENVIRONMENT

Although economic growth in Dubai has slowed, real gross domestic product is still estimated to have increased by 2.6% in the 2010 calendar year. Economic growth also contributes to a sharply rising population. The UAE currently has the world's sixth-fastest growing population, and unrest in some Middle Eastern countries has led to a further influx of foreign nationals. The UAE is especially appealing for professionals because of its career opportunities, lifestyle, stability and political neutrality. A significant fall in property prices – as much as 50% – has also made the UAE more attractive, and it is currently home to over three million expatriates. In the UAE healthcare market, demand is seemingly greater than supply.

The effect of the economic and population growth is far higher than the growth in healthcare infrastructure. The UAE's disease burden is also on the rise, with sedentary lifestyles and processed foods meaning that levels of obesity and diabetes are among the highest in the world. Non-communicable diseases such as cancer and cardiovascular disease are responsible for a substantial proportion of deaths. In addition, the population's comparatively low average age of 30.2 years means that maternity and paediatric services make up a much larger percentage of the healthcare market than in other parts of the world.

Over the last few years, Emirates Healthcare has developed a strong reputation in the UAE, attracting many patients to its facilities that previously would have travelled abroad. A level of trust, that was previously not present within the UAE health market, is now being enjoyed with both patients and medical insurers. Emirates Healthcare is confident that this trend will continue.

BUSINESS PERFORMANCE

Emirates Healthcare achieved revenue growth of 18% in 2011. This was the result of:

- a 23% increase in inpatient admissions;
- a 10% rise in hospital outpatient consultations and visits to the emergency units; and
- a 21% increase in clinic outpatient consultations.

Emirates Healthcare's EBITDA margin increased to 18.0% (2010: 11.8%), resulting from its continuous focus on efficiency, particularly at Welcare Hospital and the clinics, on the back of solid revenue growth, specifically at The City Hospital.

During the period under review, Emirates Healthcare invested the following amounts:

- R26m (AED13m) (2010: R13m (AED6m)) in capital projects and new equipment to enhance its business;
- R20m (AED10m) (2010:R36m (AED17m)) in replacing existing equipment; and
- R31m (AED16m) (2010: R28m (AED13m)) in repairing and maintaining property and equipment, which was charged through the income statement.

The number of licensed hospital beds remained constant at 336 during the period under review. As demand increases, The City Hospital has the capacity to add another 40 beds (including 10 beds currently used for dialysis) under its existing licence.

Patient satisfaction was 89% (2010: 90%) at a target of 83%.

ACQUISITION OF EMAAR CLINICS

In early 2011, Emirates Healthcare acquired three clinics from the Emaar Healthcare Group. The Dubai Mall Medical Centre, Arabian Ranches Clinic and Meadows Clinic are ultramodern facilities, serving prime areas of the Dubai community. In addition, over 50 specialised physicians came on board to support existing Emirates Healthcare facilities.

BUILDING PROJECTS

During the period under review, Emirates Healthcare made further enhancements to the Welcare Hospital, upgrading the main reception, inpatient and outpatient receptions, accident and emergency reception, maternity rooms and ground floor corridors.

In response to rising occupancy levels at The City Hospital, parts of Emirates Healthcare's corporate office transferred from the hospital to the Dubai Mall Medical Centre. The vacated space now accommodates an additional 30 beds.

Emirates Healthcare also successfully launched a multi-specialty clinic in the Ibn Battuta Shopping Mall.

The next financial year will see the conversion of The City Hospital's second floor into an outpatient department, the expansion of the pharmacy and the use of the seventh floor to accommodate further patient beds, once the remaining corporate offices have been relocated.

The number of licensed hospital beds is expected to remain consistent at 336 during the next financial year.

SUSTAINABILITY

PATIENT TRUST

Increasing patient trust is vital for Emirates Healthcare's business. Emirates Healthcare achieves this through patient satisfaction surveys, interacting with patients through social media, offering free health checks, talks and seminars, and positioning doctors as healthcare authorities through media appearances.

Emirates Healthcare received a number of accreditations in 2010, which attest to the quality of its services. In particular, Welcare Hospital joined The City Hospital in receiving the prestigious Joint Commission International accreditation. This requires adherence to rigorous standards in areas such as access to and continuity of care, patient and family rights, medication management and use, quality improvement and patient safety.

PEOPLE

Emirates Healthcare constantly works to source the best possible talent through international recruitment drives. It also employs effective retention policies, including training, fair management practices, open communication, enhancing staff wellbeing and a focus on remuneration and benefits.

Emirates Healthcare emphasises ongoing education for all employees. During the period under review, six continuing medical education events took place and Emirates Healthcare also held its first nursing conference, which was attended by nurses from other Dubai hospitals. As part of the training policy, partnerships with the University of Liverpool in the United Kingdom and Wollongong University in Dubai are also in place. A total of 767 study leave days were granted to doctors.

Emirates Healthcare views doctors, many of whom it employs, as partners in its business. To promote strong relationships and effective working, Emirates Healthcare has Clinical Hospital Committees at both hospitals, and communicates through monthly doctors' meetings, a regular Clinical Forum and a doctors' newsletter.

SOCIETY

As part of its social drive, Emirates Healthcare supports numerous causes including cancer, diabetes and heart awareness, the Palestinian Children's Relief Fund, International SOS and the Red Crescent.

The City Hospital participated in a blood donation campaign, in coordination with the Dubai Government Blood Banks. Emirates Healthcare also donated AED30 000 to the Roads and Transport Authority's road safety campaign.

In a new initiative, The City Hospital is taking on engineering students from universities, to enable them to complete the practical component of their study programme.

ENVIRONMENT

Emirates Healthcare has taken steps to improve its environmental performance, including removing non-essential lights, installing timers and energy-saving bulbs, and turning off air conditioning in unoccupied areas. Overall, electricity consumption rose by only 3.4%, despite a 60% increase in bed occupancy at The City Hospital.

Other environmental initiatives include monitoring and controlling water usage, which has fallen by 17%. Monitoring has resulted in an overall reduction in waste of 25%. A liquid oxygen system has delivered up to 75% cost savings since it was installed.

EMIRATES HEALTHCARE CONTRIBUTED 7% OF THE MEDICLINIC GROUP'S REVENUE AND 6% OF ITS CORE EBITDA

OUTLOOK

Emirates Healthcare remains confident that the future will provide attractive opportunities for further expansion. To sustain growth, it will focus on:

- increasing occupancy levels at The City Hospital;
- bringing the newly acquired Emaar Healthcare clinics and the Ibn Battuta clinic to capacity;
- consolidating its brand;
- further developing existing clinical information systems; and
- pursuing new opportunities in the UAE, particularly in Abu Dhabi.

The attractiveness of the Dubai healthcare market means that Emirates Healthcare expects increased competition during the coming financial year which may lead to pricing challenges. However, Emirates Healthcare remains confident that its business model principles within the local healthcare and insurance markets will enable it to realise further success.

MEDICLINIC'S COMMITMENT TO QUALITY CARE IS A KEY FOCUS IN ALL ITS ACTIVITIES THROUGHOUT THE GROUP

INTRODUCTION

Mediclinic's commitment to quality care remains a key focus in all its activities throughout the Group. The Group strives at all times to provide internationally comparable quality care in an environment that is safe to both patients and staff.

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. This enables comparisons to be made, information to be shared, and synergies to be created. 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 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.

SALIENT FEATURES FOR 2011

- Clinical governance structures and approach are now well entrenched throughout the Group.
- Regional clinical management structures at Mediclinic Southern Africa are strengthened by the appointment of doctors as regional clinical managers.
- Surgical checklists are well entrenched at Emirates Healthcare and Hirslanden.
- Clinical audits are now extensively used at Mediclinic Southern Africa and Emirates Healthcare.
- The "Best Care…Always!" campaign is well under way at Mediclinic Southern Africa.

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 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 hospitals are divided into five regions with a clinical manager and clinical information specialist represented 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 subcommittee.

HIRSLANDEN

Every hospital has a quality manager, an infection control specialist, a critical incident manager as well as several subcommittees for quality, infection control and critical incident reporting. The Clinical Services department at the Hirslanden Head Office coordinates the activities of the subcommittees, and clinical key performance indicators monitor their activities. The affiliated doctors are integrated into this structure by established boards in several specialities. The anaesthetic boards play an important role in defining pharmaceutical policies such as antibiotic prophylaxis and treatment.

Hirslanden promotes quality and safety in patient care by participating in the ISO 9001:2008 certification process as well as 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's 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

Each hospital has a full-time medical director coordinating the activities of all the doctors in the facility, as well as an active and functioning clinical hospital committee. These committees are multi-disciplinary, and there is excellent cooperation between doctors, nurses and management. Each committee has six subcommittees covering infection control, clinical risk management, credentialling, research, patient safety and pharmaceutical use.

HEALTHCARE WORKFORCE

Quality and safety of patient care is 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 that 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 follow a rigorous process that includes a rehearsal period of three months during which three assessments take place, and employees are managed by 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 (CPQ) 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 subcommittees.

Doctors are regularly assessed by way of a clinical performance management system in which

different competencies are assessed and graded. Nursing staff are evaluated on a quarterly basis, and succession planning for key nursing staff is done 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.

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 – the International Organisation for Standardisation (ISO) 9001, to determine if applicable quality management standards are met. Certification is received through internal and external audits. Patients receiving treatment in an accredited or certified facility have the peace of mind that quality and safety standards are achieved and continuously monitored.

MEDICLINIC SOUTHERN AFRICA

Mediclinic Southern Africa chose the Council for Health Services Accreditation of Southern Africa (COHSASA), one of only a few agencies around the world 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 to enrol its hospitals in 1996. In 2007 Mediclinic Southern Africa entered into a new arrangement with COHSASA, in which 35 of its facilities participate in a renewable three-year quality improvement and accreditation programme. As hospitals typically receive accreditation status for three years at a time, this arrangement ensures that all participating hospitals maintain their status in the long term. The formal process is not suitable for small hospitals, and in order for these hospitals to benefit from the accreditation process, they are working closely with selected large hospitals to comply with standards. To date 28 of the 35 participating Mediclinic Southern Africa facilities have received a three-year accreditation status, which is most encouraging and in line with the programme's objectives.

HIRSLANDEN

By 2009, 13 Hirslanden hospitals as well as the Hirslanden Head Office had received ISO 9001:2008 certification from the International Organisation for Standards in cooperation with the Swiss Association for Quality and Management Systems. Klinik Stephanshorn will follow in 2012. External verification audits are done on an annual basis, with some of the hospitals that have been undergoing annual audits for more than five years. ISO 9001:2008 focuses on processes and is embraced by each hospital's EFQM objectives.

EMIRATES HEALTHCARE

Joint Commission International (JCI) accreditation is a requirement of the Dubai Healthcare City as well as the Dubai Health Authority, 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 ISO certification in 2010.

TABLE 1: HEALTHCARE-ASSOCIATED INFECTIONS AS A PERCENTAGE OF HOSPITAL ADMISSIONS (CALENDAR YEAR)

	2009	2010	Benchmark
Healthcare-associated infections	1.5%	**1.5%**	1.8 – 2.7%

TABLE 2: ADVERSE EVENTS/NEAR MISSES AS A PERCENTAGE OF HOSPITAL ADMISSIONS (CALENDAR YEAR)

Adverse events/near misses	2009	2010	Benchmark
Medication-related events	1.5%	**1.4%**	1.1 – 1.6%
Falls	0.6%	**0.5%**	0.6 – 0.9%
Skin-related events	0.9%	**1.1%**	0.9 – 1.4%
Other clinical events	3.3%	**3.4%**	2.1 – 3.2%
All events (incl. HAI and non-clinical)	9.2%	**8.9%**	8.0 – 12.0%

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 (HAI) and hospital adverse events. These and other clinical risks are managed through different control measures and continuous process re-engineering.

Healthcare-associated infections, previously known as hospital-acquired infections, 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 hospital event management systems in which all events are reported and analysed, and corrective action is taken to prevent recurrence.

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

MEDICLINIC SOUTHERN AFRICA

HEALTHCARE ASSOCIATED INFECTIONS

Healthcare-associated infections (HAI) remained unchanged. Please note that the figures in **Table 1** reflect the number of infections as opposed to patients who are infected. This implies that any one patient can have more than one infection during a hospital stay, and that this will be reflected in the figures. 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 HAI 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.

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 initiatives. The current focus is on the prevention of HAI and the promotion of the rational use of antibiotics. The campaign entails the implementation of evidence-based interventions shown to reduce HAI, the sharing of information and experiences with other hospitals, and measurement of results.

ADVERSE EVENTS AND NEAR MISSES

Table 2 provides a breakdown of the most prominent adverse event indicators together with incidence rates and benchmarks. The benchmarks were derived from results of studies performed in the USA, UK, Canada, Australia and New Zealand.

Medication errors occur at various points in the medication pathway, such as in the prescribing, dispensing, delivery, storage and administration of medication. Errors decreased from 1.5% to 1.4% of hospital admissions.

Despite a slight decrease in the percentage of falls per admissions, falls and injuries sustained by patients while in hospital remain an enormous

TABLE 3: DEVICE-ASSOCIATED INFECTIONS IN INTENSIVE CARE UNITS PER 1 000 DEVICE DAYS (CALENDAR YEAR)

	Catheter-associated urinary tract infections		Central line-associated infections		Ventilation-associated pneumonia	
Device-associated infections	**2009**	**2010**	**2009**	**2010**	**2009**	**2010**
Hirslanden	1.18	**2.37**	1.90	**2.12**	6.84	**6.19**
European 75th percentile	1.33	**1.25**	1.34	**1.32**	10.88	**10.88**
European average	1.08	**1.05**	1.01	**1.01**	6.46	**6.46**

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

challenge. There are many reasons why patients fall, and hospitals rely on the events management system to record and analyse falls systematically in order to implement preventative measures.

During the period under review 67% of all reported falls occurred in patients' rooms. Approximately 28% of all reported falls resulted in injuries. Most falls occurred amongst stroke patients, knee-replacement patients and patients older than 80 years of age.

Skin-related events increased from 0.9% to 1.1% of admissions. 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 re-assessed 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 the Mediclinic Southern Africa continuous quality improvement programme, and are done 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 HAI 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 HAI. 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.

Table 3 shows the device-associated infection rates in Hirslanden intensive care units. Annual rates have increased and are also higher than the European benchmarks for both catheter-associated urinary tract infections and central line-associated infections. Potential reasons for these increases are being investigated.

Table 4 reports the post-operative wound infection rates. Hirslanden hospitals compare favourably with the European benchmarks to which they are compared.

MRSA (Methicillin-resistant Staphylococcus Aureus) is a bacterium which is well known for developing resistance against multiple antibiotics. 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 intensive care units and nursing homes are thoroughly screened. All patients known to be contaminated are screened again on re-admission. During 2010 about 654 screened cases were primarily isolated, and MRSA infection was detected in another 165 cases.

ADVERSE EVENTS AND NEAR MISSES

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 had used its own unique reporting system, and a standardised reporting system was introduced in 2008. During 2010 a total of 1 239 cases were reported.

TABLE 4: POST-OPERATIVE WOUND INFECTIONS AS A PERCENTAGE OF THESE TYPES OF ADMISSIONS (CALENDAR YEAR)

Post-operative wound infections	Coronary artery bypass graft	Hip replace-ment	Knee replace-ment	Abdominal hyste-rectomy	Caesarean section	Colon-surgery
Number of hospitals participating	5	11	11	4	3	2
Hirslanden	3.04	0.84	0.52	0.00	0.55	5.47
European 75th percentile	3.35	1.46	1.08	2.2	1.17	12.36
European average	3.12	0.88	0.78	1.47	0.73	9.36

TABLE 5: IQIP WEIGHTED AVERAGE FALL RATE PER 1 000 BED-DAYS (CALENDAR YEAR)

Falls	2006	2007	2008	2009	2010
Hirslanden	2.30	1.60	1.90	2.20	**2.40**
Europe	2.22	2.01	2.25	2.83	**3.70**

Hirslanden also participates in the International Quality Indicator Project® (IQIP) indicator for documented falls. Its weighted average figures for the calendar year are reported in **Table 5**. 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 2010 calendar year are reported in **Table 6**. This once again compares favourably with other participating European hospitals.

CHECKLISTS

Hirslanden supports the "Safe Surgery Saves Lives" campaign of the World Health Organisation, and has introduced peri-operative checklists in all hospitals. Some hospitals also implemented bracelets to improve patient identification to prevent medication errors and wrong-sided or wrong-patient surgery.

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 and excellent results. **Table 7** refers.

ADVERSE EVENTS AND NEAR MISSES

The total number of events reported decreased markedly compared to the previous year, as reported in **Table 8**. The medication error rate

TABLE 6: IQIP WEIGHTED AVERAGE SKIN-RELATED EVENTS PER 1 000 BED-DAYS (CALENDAR YEAR)

Skin-related events	2006	2007	2008	2009	2010
Hirslanden	0.32	0.48	0.31	0.54	**0.57**
Europe	1.35	1.18	1.22	1.02	**1.18**

changed considerably because of a definition change in order to bring the indicator more in line with international standards, as well as the implementation of improvements to the medication pathway following prescription audits that highlighted a number of problem areas.

CLINICAL AUDITS

Emirates Healthcare extensively makes 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.

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

TABLE 7: HEALTHCARE-ASSOCIATED INFECTIONS AS A PERCENTAGE OF HOSPITAL ADMISSIONS (CALENDAR YEAR)

Adverse events	2009	2010	Benchmark
HAI	0.5%	**0.4%**	1.8 – 2.7%

TABLE 8: ADVERSE EVENTS AS A PERCENTAGE OF HOSPITAL ADMISSIONS (CALENDAR YEAR)

Adverse events	2009	2010	Benchmark
Medication errors	1.1%	**0.5%**	1.1 – 1.6%
Falls	0.2%	**0.1%**	0.6 – 0.9%
Skin-related events	0.1%	**0.1%**	0.9 – 1.4%
Other clinical events	4.3%	**2.2%**	2.1 – 3.2%
All events (incl. HAI and non-clinical)	6.3%	**3.4%**	8.0 – 12.0%

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 intensive 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 period under review was 22% compared to 18% for the previous year. Hypertension, diabetes mellitus and hypercholesterolemia remain 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 year under review about 69% (68% in 2009) 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 9 reports the mortality rates for the 2010 calendar year. Because of a change in reporting period from financial to calendar year, the figures may differ slightly from those of previous reports.

Although the 2010 mortality index of 0.99 is 1% better than the expected index of 1.0, it has worsened by 1% compared to an index of 0.98 in 2009. Hospitals are continuously focusing on their indexes, supported by detailed monthly reports.

Extended stay

The extended stay indicator measures the percentage of cases with hospital stays that exceeded a calculated extended stay point for the period under review, 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 and complications. This indicator was developed

TABLE 9: MORTALITY AS A PERCENTAGE OF HOSPITAL ADMISSIONS (CALENDAR YEAR)

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

Note: Base re-calculated 2008.

TABLE 10: OVERALL EXTENDED STAY RATE AS A PERCENTAGE OF HOSPITAL ADMISSIONS (CALENDAR YEAR)

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

TABLE 11: RE-ADMISSION RATE AS A PERCENTAGE OF HOSPITAL ADMISSIONS (CALENDAR YEAR)

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

internally; comparable external benchmarks are not available.

Table 10 reports the overall extended stay rate for Mediclinic Southern Africa, which increased slightly as a result of an increase in the mix of cases.

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. Due to 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 11 reports the 30-day re-admission rate for all hospital admissions. The overall re-admission rate increased slightly as a result of an increase in case mix. The indicator was developed internally; comparable external benchmarks are not available.

CLINICAL OUTCOMES

Vermont Oxford Network

Neonatal intensive care units 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 Vermont Oxford Network (VON) is an excellent support vehicle.

The VON is an initiative aimed at measuring and improving the quality of care in neonatal intensive care units. 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 20 Mediclinic Southern Africa hospitals are participating in the initiative.

Although all babies admitted to the neonatal intensive care units 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 12 deals with the general statistics of this subset of the neonatal intensive care population. Mediclinic Southern Africa's statistics for the 2010 and 2009 calendar years are compared with the official VON annual report for the 2009 calendar year, as the VON annual reports only become available six months after year end and the 2010 report was therefore not available in time to be included in this report. A small number of previously unreported cases for 2009 have been included.

Table 13 reports the quality outcomes for the participating Mediclinic Southern Africa 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 2010. The healthcare-associated infection rate decreased significantly during 2010, and was on par with the VON average of 18%. The mortality rate at 17% remained higher than the VON average. This can be attributed to the dissimilar outcome profiles

TABLE 12: VON GENERAL STATISTICS (CALENDAR YEAR)

Very low birth weight Infants (< 1 501g)	2009	2010	VON 2009
Number of cases	519	**543**	55 006
Average birth weight in grams	1 088	**1 105**	1 055
Average gestational age in weeks	29	**29**	28
Average discharge weight in grams	1 923	**1 913**	2 221
Length of stay in days	46	**43**	60

of new, smaller and more rural-based Mediclinic Southern Africa units enrolled in the VON database over the last three years.

Within this group of very low birth weight infants, chronic lung disease, periventricular leukomalacia and retinopathy of prematurity 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, and was implemented at two additional Mediclinic Southern Africa hospitals (Mediclinic Bloemfontein and Mediclinic Vergelegen) during 2009.

Table 14 reports some general volume statistics. It is important to note that some of the procedures reported in **Table 14** were performed simultaneously during the same operation but are reported separately.

Table 15 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 reporting period about 79% of ACTD patients had coronary artery bypass graft procedures compared to 84% the previous year, and 28% had valve surgery compared to 22% last year. Approximately three quarters of all cases in the ACTD database were male.

TABLE 13: VON QUALITY OUTCOMES AS A PERCENTAGE OF CASES ON THE DATABASE (CALENDAR YEAR)

Very low birth weight infants (< 1 501g)	2009	2010	VON 2009
Respiratory support			
Respiratory distress syndrome	80%	**83%**	74%
Pneumothorax	3%	**3%**	4%
Early continuous positive airway pressure (CPAP)	33%	**37%**	39%
Ventilation	46%	**43%**	64%
Chronic lung disease (CLD)			
CLD 36 weeks (gestational age < 33 weeks)	15%	**15%**	26%
Infections			
HAI	26%	**17%**	18%
Other outcomes			
Patent ductus arteriosus	24%	**25%**	38%
Necrotising enterocolitis	6%	**6%**	7%
Periventricular-intraventricular haemorrhage	22%	**21%**	26%
Retinopathy of prematurity	17%	**16%**	34%
Mortality	17%	**17%**	12%

TABLE 14: ADULT CARDIO-THORACIC DATABASE VOLUME STATISTICS (CALENDAR YEAR)

ACTD volume statistics	2009	2010
Total number of cases	482	**653**
Procedures		
Coronary artery bypass graft (CABG)	412	**516**
Valve surgery	104	**181**
Other cardiac procedure	15	**32**
Other non-cardiac procedure	8	**5**

Patient risk factors remained unchanged apart from a decrease in dyslipidemia. The mortality index (actual/expected) increased from 0.53 to 0.66, but remains significantly lower than the benchmark index of 1. The re-admission rate decreased slightly, with 7.8% of all patients in the ACTD database being re-admitted to hospital within 30 days of the original procedure during the period under review. 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 intensive care setting and is a useful tool in evaluating quality of care in this complex setting. Patients are evaluated and scored on a number of clinical parameters within the first 24 hours of admission to intensive care. An expected mortality calculation is therefore based on the clinical condition of each patient.

TABLE 15: GENERAL INDICATORS, RISK FACTORS AND OUTCOMES AS A PERCENTAGE OF CASES ON THE DATABASE (CALENDAR YEAR)

ACTD general indicators, risk factors and outcomes	2009	2010
Gender		
Female	24%	**26%**
Male	76%	**74%**
Age distribution		
< 41	4%	**6%**
41 – 60	41%	**41%**
> 60	55%	**54%**
Risk factors		
Overweight/obese (BMI > 25)	78%	**76%**
Hypertension	71%	**70%**
Dyslipidemia	68%	**62%**
Smoker	48%	**50%**
Diabetes	26%	**27%**
Other post-operative outcomes		
Infections	3.3%	**2.0%**
Re-operation	7.1%	**4.9%**
Mortality		
Expected mortality (EuroSCORE)	7.1%	**7.2%**
Actual mortality	3.7%	**4.7%**
Mortality index	0.53	**0.66**
Re-admission (within 30 days)	8.9%	**7.8%**

During 2009 the APACHE® III-J scoring system was implemented in the adult intensive care units of all qualifying Mediclinic Southern Africa hospitals. During 2010 a total of 34 741 cases were scored in 62 critical care units at 41 participating hospitals.

Table 16 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 0.72 implies that the overall mortality of the scored cases was 28% better than expected. It is also noticeable that the index is 7% lower compared to the previous year.

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

HIRSLANDEN

CLINICAL INDICATORS

International Quality Indicators Project®

Hirslanden has been participating in the International Quality Indicator Project (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

TABLE 16: APACHE® III-J MORTALITY INDEX (CALENDAR YEAR)

APACHE® III-J mortality	2009	2010
Cases	27 881	**34 741**
Average age	56.4	**57.3**
Average length of stay (total hospital stay)	8.1	**7.9**
Average ICU days	1.8	**1.7**
Average high care days	1.8	**1.8**
Mortality index	0.79	**0.72**

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

that facilitate participants' efforts to understand and improve performance. IQIP participants receive quarterly data reports, which allow for longitudinal trending and comparison to regional, national and international aggregate rates. Thirteen Hirslanden hospitals have been participating in a set of five IQIP indicators as directed by the Hirslanden Clinical Governance Committee since 2008. It is important to note that all the IQIP results are reported per calendar year. Klinik Stephanshorn will participate from 2011.

Mortality

Table 17 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 2010 annual rate increased 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 18**. 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 in 2010 is lower than other participating hospitals in Europe. Hirslanden started to collect data on re-admissions in January 2008, and most of the hospitals are still in the process of adapting to this indicator.

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 19**. 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.

TABLE 17: IQIP WEIGHTED AVERAGE MORTALITY RATES AS A PERCENTAGE OF HOSPITAL DISCHARGES (CALENDAR YEAR)

Mortality	2006	2007	2008	2009	2010
Hirslanden	0.90	1.11	0.96	0.88	**0.95**
Europe	2.06	2.38	2.22	2.11	**1.71**

TABLE 18: IQIP WEIGHTED AVERAGE RE-ADMISSION RATES WITHIN 31 DAYS AS A PERCENTAGE OF HOSPITAL DISCHARGES (CALENDAR YEAR)

Re-admission	2008	2009	2010
Hirslanden	1.02	1.49	**1.41**
Europe	1.29	1.27	**1.44**

CLINICAL OUTCOMES

SAPS II

SAPS II is a hospital mortality prediction methodology for patients in the adult intensive 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 intensive care. An expected mortality calculation is therefore based on the clinical condition of each patient.

The SAPS II scoring methodology is used in the intensive care units of all Hirslanden hospitals.

Table 20 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 0.42 implies that the overall mortality of the scored cases was 58% better than expected.

EMIRATES HEALTHCARE

CLINICAL INDICATORS

Mortality

Table 21 reports the actual combined mortality rates for both 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. The figures represent calendar years as compared to financial years in the previous report, and are therefore slightly different.

Mortalities remained constant in the region of 0.3%, which is significantly lower than the actual mortality figures 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.

TABLE 19: IQIP WEIGHTED AVERAGE UNSCHEDULED RETURNS TO THE OPERATING THEATRE AS A PERCENTAGE OF OPERATIONS PERFORMED (CALENDAR YEAR)

Unscheduled returns	2006	2007	2008	2009	2010
Hirslanden	1.29	1.32	1.19	1.07	**1.13**
Europe	1.20	1.44	1.52	1.47	**1.17**

TABLE 20: SAPS II MORTALITY INDEX (CALENDAR YEAR)

SAPS II mortality	2009 Hirslanden		2010 Hirslanden	
Cases	5 056		**5 737**	
Expected	9.7%	7.0%	**10.2%**	**9.0%**
Actual	4.0%	4.0%	**4.3%**	**4.0%**
Mortality Index	0.41	0.57	**0.42**	**0.44**
Average age of patients	67.3	61.0	**66.4**	**64.0**
Average length of stay in ICU (days)	2.40	2.50	**2.38**	**3.60**
Percentage of ventilated patients	44.5%	31.0%	**40.8%**	**32.0%**

Re-admission

Table 22 reports the 30-day re-admission rate for both hospitals. All admission types, except oncology, are included in the calculation. This is the first year in which The City Hospital participated. Comparable external benchmarks are unfortunately not available, and an internal benchmark is used to manage this indicator.

OUTCOMES

Vermont Oxford Network

The Vermont Oxford Network (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.

Although all babies admitted to the neonatal intensive care units 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 23 deals with the general statistics of this subset of the neonatal intensive care population. Emirates Healthcare figures for the 2010 calendar year are compared with the official VON annual report for the 2009 calendar year, as the VON annual reports only become available six months after year end and the 2010 report was therefore not available in time to be included in this report.

TABLE 21: MORTALITY AS A PERCENTAGE OF HOSPITAL ADMISSIONS (CALENDAR YEAR)

Mortality	2007	2008	2009	2010
Actual	0.24%	0.30%	0.33%	**0.29%**

TABLE 22: RE-ADMISSIONS AS A PERCENTAGE OF HOSPITAL ADMISSIONS (CALENDAR YEAR)

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

During 2010 Emirates Healthcare reported on 48 very low birth weight cases. **Table 24** reports the quality outcomes for the participating Emirates Healthcare hospitals.

It is encouraging to note that the respiratory distress syndrome rate decreased significantly, while early CPAP gained acceptance as treatment modality by Emirates Healthcare units. The hospital-acquired infection rate decreased slightly, and the mortality rate compares favourably with the VON 2009 average of 17%.

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 (ACTD)

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 January 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 25 reports some general volume statistics. It is important to note that some of the procedures reported in **Table 25** were performed simultaneously during the same operation but are reported separately.

Table 26 reports on general indicators, patient risk factors and clinical outcomes. Comparable international benchmarks are not freely available, hence the year-on-year comparisons.

TABLE 23: VON GENERAL STATISTICS (CALENDAR YEAR)

Very low birth weight Infants (< 1 501g)	2009	2010	VON 2009
General			
Number of cases	18	**48**	55 006
Average birth weight in grams	1 127	**1 165**	1 055
Average gestational age in weeks	29	**29**	28
Average discharge weight in grams	1 810	**1 768**	2 221
Length of stay in days	43	**34**	60

TABLE 24: VON QUALITY OUTCOMES AS A PERCENTAGE OF CASES ON THE DATABASE (CALENDAR YEAR)

Very low birth weight infants (< 1 501g)	2009	2010	VON 2009
Respiratory support			
Respiratory distress syndrome	94%	**75%**	73%
Pneumothorax	6%	**0%**	4%
Early continuous positive airway pressure (CPAP)	0%	**23%**	39%
Ventilation	56%	**56%**	63%
CLD			
CLD 36 weeks (gestational age < 33 weeks)	6%	**0%**	26%
Infections			
HAI	17%	**15%**	17%
Other outcomes			
Patent ductus arteriosus	11%	**10%**	38%
Necrotising enterocolitis	11%	**0%**	6%
Periventricular-intraventricular haemorrhage	23%	**23%**	26%
Retinopathy of prematurity	36%	**44%**	74%
Mortality	6%	**8%**	12%

Volumes increased by 55% during the 2010 calendar year, and about 83% of patients had coronary artery bypass graft procedures. The patients were younger than their Mediclinic Southern Africa counterparts, and with a different risk profile. There were two re-admissions and mortalities in 2010, 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 195 cases were scored in the critical care units of the two hospitals during 2010.

Table 27 reports some important statistics, the most important being the mortality index, which is the relationship between the actual and predicted mortalities. The mortality index of 0.63 implies that the overall mortality of the scored cases was 37%

TABLE 25: ADULT CARDIO-THORACIC DATABASE VOLUME STATISTICS (CALENDAR YEAR)

Indicator	2009	2010
Total number of cases	49	**76**
Procedures		
Coronary artery bypass graft (CABG)	41	**63**
Valve surgery	11	**14**
Other cardiac procedure	0	**2**
Other non-cardiac procedure	0	**0**

lower than expected, which can be attributed to the lower risk profile of patients compared to those in Mediclinic Southern Africa.

CLINICAL INFORMATION SYSTEMS

Integrated clinical information systems are designed to support and enable clinical care processes at hospital level. These systems, if correctly implemented, create efficiencies, reduce errors and enhance quality of care. They make clinical information available at the bedside, consolidate diagnostic test results, ensure the correct administration of medication, and provide numerous other benefits to patient care.

Emirates Healthcare implemented an integrated clinical information system at The City Hospital at the time of the hospital's opening. It is functioning well and is undergoing continuous refinements. During 2010 Hirslanden embarked on a pilot project to test a new integrated clinical information system at Klinik Aarau. It offers an electronic patient record; the main objective is to become a paperless hospital by taking advantage of integrated documentation. An important feature of the system is the clinical decision support functionality, which assists healthcare professionals in prescribing and administering drugs during hospitalisation. Mediclinic Southern Africa is in the process of evaluating various integrated clinical information systems.

THE WAY FORWARD

Significant progress in improving quality and safety of patient care has once again been made during the year under review and the clinical performance of the Group was satisfactory. This discipline, however, requires continued focus and relentless attention to detail, and a number of further initiatives are under way. A detailed report on all the ongoing clinical governance activities within the Group will in future not form part of the Group's annual report. The most important aspects

TABLE 26: GENERAL INDICATORS, RISK FACTORS AND OUTCOMES AS A PERCENTAGE OF CASES ON THE DATABASE (CALENDAR YEAR)

Indicator	2009	2010
Gender		
Female	20%	**9%**
Male	80%	**91%**
Age distribution		
≤ 40	16%	**9%**
41 – 60	59%	**67%**
> 60	24%	**24%**
Risk factors		
Overweight/obese (BMI >25)	69%	**53%**
Hypertension	71%	**71%**
Dyslipidemia	69%	**62%**
Smoker	33%	**58%**
Diabetes	41%	**41%**
Other post-operative outcomes		
Infections	0.0%	**0.0%**
Re-operation	4.1%	**2.6%**
Mortality		
Expected mortality (EuroSCORE)	4.6%	**23.2%**
Actual mortality	0.0%	**2.6%**
Mortality index	0.00	**0.11**
Re-admit (30 days)	8.2%	**2.6%**

TABLE 27: APACHE® III-J MORTALITY INDEX (CALENDAR YEAR)

APACHE® III-J mortality	2009	2010
Cases	82	**195**
Average age	51.6	**52.7**
Average length of stay (total hospital stay)	5.6	**5.4**
Average ICU days	4.0	**3.2**
Average high care days	0.0	**0.0**
Mortality index	0.2	**0.63**

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

will, however, continue to be published, and more details will be made available to interested parties such as the medical fraternity, universities and research institutions, consumer bodies and public health institutions.

The Group believes that in future the financial success of any private hospital business will increasingly depend on the proven clinical outcomes of the patients receiving treatment. Not only is the dedicated cooperation of highly trained staff and doctors required to measure and analyse the necessary clinical indicators, but also substantial financial investment. We believe this is money well spent in assisting the Group to build a secure future.

THE BOARD IS ULTIMATELY ACCOUNTABLE FOR THE GROUP'S RISK MANAGEMENT PROCESS AND SYSTEM OF INTERNAL CONTROL

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 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 complies with the recommendations of the King III Report, defines the risk management objectives, methodology, process and the responsibilities of the various risk management role players in the Group. The policy was adopted in 2009 by the Company's Audit and Risk Committee, as well as the respective Audit and Risk Committees of Mediclinic Southern Africa, Hirslanden and Emirates Healthcare. The ERM policy is subject to annual review and any amendments are submitted to the Audit and Risk Committee for approval. During the year the policy was updated to incorporate the principles of the King III Report, including the setting of a risk tolerance and risk appetite for the Group.

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 aims to ensure 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**.

OTHER EMERGING RISKS WHICH ARE BEING MONITORED

The Group is exposed to a number of potentially high-impact emerging risk events. Significant uncertainties around the factors which may impact on the development of these risks, or the timeline over which these events could develop, exist. Emerging risk events which are being monitored include the following:

- The continued escalation of healthcare costs above general inflation may impact on the affordability of healthcare in the long term. Refer to the Sustainable Development Report on pages 94 to 95 for more information.
- The recent political turmoil in the Middle East and its potential impact on the Group's operations in the UAE are being monitored. Recent independent studies have indicated that the risk of negative impact on the business environment in the UAE and particularly Dubai is low.
- The development of antibiotics-resistant organisms ("super bugs") in the hospital environment and the ability to effectively deal with the treatment of these organisms are being monitored. Refer to the Clinical Governance Report on page 49 for more information.

TABLE 1: PRIORITY RISK ITEMS

	Risk	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 adverse publicity.	• 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.
	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.	• On pages 100 to 102 the employment, recruitment and retention strategies are explained. • Extensive training and skills development programme, which is further explained on pages 104 to 107. • 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.	• Doctors' retention and recruitment strategies. • Monitoring of doctor satisfaction, movement and doctors' profiles. • Further details on the relationship with doctors are provided on pages 78 to 80.
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. Switzerland is also implementing healthcare reform. Criteria for inclusion of hospital facilities on the cantonal hospital lists, which is a prerequisite for cantonal funding of patients admitted to any hospital, will be implemented.	• 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. • Further details on the regulatory risks impacting on Mediclinic Southern Africa are contained on page 32, and on Hirslanden on pages 36 to 37.
	Availability of capital and financing 	The cost, terms and availability of capital to finance strategic expansion opportunities and/or the re-financing or re-structuring of existing debt which has been affected by prevailing capital market conditions.	• Long-term planning of capital requirements and cash-flow forecasting. • Monitoring of cash-generating capacity within the Group. • Proactive and long-term agreements with banks and other funders on funding facilities. • Monitoring of compliance to the requirements of debt covenants. • Further details on capital risk management and the Group's borrowings are contained on page 150 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.	• All three operating platforms have implemented systems to monitor developments in the economic and business environment of trends and early warning indicators.
	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	Description of risk	Mitigation of risk
Physical and operational risks	**Reputational Risk** 	Adverse events and incidents which may lead to a decline in confidence as a trusted health service provider by patients and supporting doctors.	• Extensive quality control processes are in place in all three operating platforms, which are subjected to external verification: o COHSASA accreditation in Mediclinic Southern Africa; o JCI accreditation in Emirates Healthcare; and o ISO 9001 certification in Hirslanden. • For more information refer to the Clinical Governance Report.
	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 on pages 48 to 50.
	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 pages 45 to 57) and quality control and maintenance processes implemented throughout the Group. • Limitation of liability because of independence of doctor 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.
	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.
	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 on pages 45 to 57.

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 aims to ensure 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 which are in place to evaluate the effectiveness of key controls designed to mitigate the significant risks identified in each operating platform. They were presented to the respective Audit and Risk Committees of each operating platform. During the year the Group extended the scope of the internal audit, which was previously limited to the operations of Mediclinic Southern Africa, to also include the operations of Hirslanden. The internal audit process is an outsourced function and it complies with the principles of the King III Report. 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 by the Mediclinic Quality Assurance Team ("MQAT") and through an extensive controls self-assessment process. The results of these assurance processes are monitored by a central Risk Management Committee consisting of management, representing all disciplines considered core to the business.

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 achieved a level where 13 of its hospitals and its head office were certified in terms of ISO 9000: 2001. 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 on pages 45 to 46. During the year the Group internal audit function performed a review of the work performed by the Swiss Association for Quality and Management Systems ("SQS") and implemented a combined assurance model which enables it to rely on the quality of the audit work performed by the SQS auditors and integrate these together with the work performed by Ernst & Young into its internal audit review of the effectiveness of the controls that are designed to mitigate against significant risks as identified by the ERM process which is in place in Hirslanden. The results of these

THE GROUP'S INTEGRATED RISK MANAGEMENT APPROACH AIMS TO ENSURE THAT RISK MANAGEMENT IS INCORPORATED INTO THE DAY-TO-DAY OPERATIONAL MANAGEMENT PROCESSES.

and other operational assurance processes are monitored by Hirslanden's Executive Committee.

At Emirates Healthcare the effectiveness of the systems of internal control are 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; this is aimed at improving the quality of care. The accreditation is based on international consensus standards and sets uniform, achievable expectations for structures, processes and outcomes for hospitals. This has been achieved atop of its laboratory's ISO15189: 2007 accreditation, as well as the CPQ (Centre for Planning and Quality) accreditation, which was obtained before the opening of the hospital.

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, via the Audit and Risk Committee, regularly receives reports on and considers the activities of the Mediclinic Southern Africa, Hirslanden and Emirates Healthcare's Audit and Risk Committees, internal and external auditors, Mediclinic Southern Africa's Risk Management Committee and the Group Risk Services 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 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. Although some uncertainty remains in the business community on the interpretation of certain sections of the new Companies Act, 71 of 2008 ("the new Companies Act"), which finally became effective on 1 May 2011, we welcome the increased governance requirements contained therein. We believe that the King III principles and the governance requirements of the new Companies Act can only be beneficial to the reputation of South Africa and South African businesses as leaders in corporate governance.

Despite the new Companies Act coming into effect in May 2011, it is important to note that the old Companies Act, 61 of 1973, ("the old Companies Act") applied to the Company during the period under review. The Board is satisfied that the Company has met the requirements of the old Companies Act (which applied during the period under review), 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 comply with the changes relating to King III in respect of financial years commencing on or after 1 March 2010, which means that the period under review is the first financial year in respect of which the Company has to report on the application of the King III principles. The Board however decided to early adopt the reporting requirements on the King III principles as included in last year's annual report in accordance with the "apply or explain" approach of King III. Whilst the vast majority of King III principles are applied by the Company, those principles which have not been applied are explained in this 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 ahead will be the replacement of the Memorandums and Articles of Associations of the Group's companies registered in South Africa with the newly required Memorandums of Incorporation, as is required in terms of the new Companies Act to be completed within two years following the effective date of the Act on 1 May 2011.

BOARD RESPONSIBILITIES

A formal code of conduct ("the Board Charter") sets out the responsibilities of the Board, individual directors and the Company Secretary. Key responsibilities in terms of the Board Charter include:

- 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;
- handling of all aspects that are of a material or strategic nature or that may impact on the Group's reputation;
- monitoring compliance with laws and regulations and the Group's code of business conduct;
- 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 going concern status.

All Group policies, including the Board Charter, are reviewed annually. During the year, the Board Charter was reviewed and updated to include the amendments following King III and the amendments to the JSE Listings Requirements in 2010.

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. During the period under review, as indicated in **Figure 2**, there were only five meetings as the meeting that is normally held end of March was held on 1 April 2011. 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

The Board consists 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 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 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 to appoint 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 the 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, the Board has in compliance with King III and the JSE Listings Requirements appointed Mr Desmond Smith during the previous reporting period as the Lead Independent Director ("LID"). 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.

Mr Danie Meintjes, who has served on the Board since 1996, was appointed as the Chief Executive Officer from 1 April 2010, following the retirement of Mr Louis Alberts on 31 March 2010, and 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 Articles of Association of the Company, one third of the directors must retire on a rotation basis, but may make themselves available for re-election for a further term. There is a clear

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:**
Joseph Cohen
Kabs Makaba
Mamphela Ramphele
Chris van den Heever
Thys Visser
Independent non-executive directors:
Desmond Smith (Lead Independent Director)
Robert Leu
Zodwa Manase
Anton Raath
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
Investment Sub-committee
Edwin Hertzog (Chairman)
All other executive board members
Joseph Cohen
Anton Raath
Thys Visser

** These directors are listed as non-executive directors and not regarded as independent due to their indirect interest in the Company. Mr Joseph Cohen represents Trilantic Capital Partners, which held 10% 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 Messrs Chris van den Heever and Thys Visser represent Remgro, which indirectly held 43.4% at year end.*

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 and individual directors, and of 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.

During the evaluation process conducted during the previous reporting period, the Board identified improved sustainability management and the governance of information technology as the two main areas requiring attention during the year under review. Much improvement has been made in both these areas to the satisfaction of the Board. Our progress in respect of sustainability management is included in the Sustainable Development Report included in this annual report. An Information and Communication Technology management committee is in place which reports to the Audit and Risk Committee. During the year, the inclusion of an information technology report in the Board's agenda pack was also introduced. The most recent Board, committee and director evaluations conducted in April 2011 identified no major areas for improvement.

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 for thirteen and nine years 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 are formally informed of their fiduciary duties by the Chairman and the Company Secretary. An extensive induction programme that includes information sessions with management, as well as visits to the Company's hospitals, ensures that new directors obtain a good understanding of the Company's core business. During the past year Prof. Dr Robert Leu was appointed to the Board and underwent the induction programme.

Upon their appointment directors 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.

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 ensuring the proper administration of the proceedings and matters relating to the Board, the Company and the

FIGURE 2: ATTENDANCE OF REMUNERATION AND NOMINATIONS COMMITTEE MEETINGS

	May 2010	Jun 2010	Oct 2010
Wynand van der Merwe (Chairman) (Independent non-executive)	√	√	√
Edwin Hertzog (Executive)	√	√	√
Anton Raath (Independent non-executive) (appointed as committee member on 9 November 2010)	n/a	n/a	n/a
Mamphela Ramphele (Non-executive) (resigned as committee member on 21 October 2010)	x	x	x
Thys Visser (Non-executive)	x	√	√

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 annual report.

EXECUTIVE MANAGEMENT

The Executive Committee meets regularly 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 in Southern Africa, Switzerland and the United Arab Emirates to ensure effective communication, decision-making and execution of strategies. Executive management's responsibilities are codified in a mandate from the Board, specifically with regard to their authority levels, which is reviewed annually by the Board.

Due to the size of the Group's operations in the United Arab Emirates, the Chief Executive Officer of the Emirates Healthcare is not a member of the Board, nor the Executive Committee. He is however invited to attend all Executive Committee meetings and also any Investment Sub-committee meetings that relate to the Group's operations in the United Arab Emirates.

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. During the year ahead, the Board will review the requirement to appoint a Social and Ethics Committee, as required in terms of the new Companies Act. The matters required by the new Companies Act to be considered by such a committee largely fall within the existing mandate of the Company's Audit and Risk Committee. The main sub-committees are:

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 and attendance of committee meetings are set out in **Figure 2**. 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 on pages 125 to 126. The Group's remuneration policy was formalised and adopted by the Board in May 2011 and will be put forward to the shareholders of the Company for a non-binding advisory vote at the forthcoming Annual General Meeting on 27 July 2011, as recommended in King III.

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 and other functions delegated to it by the Board;

FIGURE 3: ATTENDANCE OF BOARD MEETINGS

		May 2010	Jul 2010	Sep 2010	Nov 2010	Feb 2011
Executive directors						
	Edwin Hertzog* (Chairman)	√	√	√	√	√
	Danie Meintjes (appointed 1 April 2010)	x	√	√	√	√
	Koert Pretorius	√	√	√	√	√
	Gerhard Swiegers (resigned 15 September 2010)	√	√	n/a	n/a	n/a
	Craig Tingle (appointed 1 September 2010)	n/a	n/a	√	√	√
	Ronnie van der Merwe (appointed 26 July 2010)	n/a	√	√	√	√
	Ole Wiesinger	√	√	√	√	√
Non-executive directors						
	Joseph Cohen	√	√	√	√	√
	Kabs Makaba	√	√	√	√	√
	Mamphela Ramphele	√	√	x	√	√
	Chris van den Heever	√	√	√	√	√
	Thys Visser	√	√	√	√	√
Independent non-executive directors						
	Robert Leu (appointed 26 July 2010)	n/a	x	√	√	x
	Zodwa Manase	√	√	√	√	√
	Alwyn Martin (retired 26 July 2010)	√	√	n/a	n/a	n/a
	Anton Raath	√	√	√	√	√
	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 67 of the report.*

- 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 committee's report, describing how it has discharged its statutory duties in terms of the old Companies Act, which applied during the reporting period, and its additional duties assigned to it by the Board in respect of the financial year ended 31 March 2011, is included in the annual financial statements on pages 129 to 130 of this annual report.

The composition of the committee complies with the requirements of the old and new Companies Acts and consists only of independent non-executive directors. The composition and attendance of committee meetings are included in the Audit and Risk Committee Report.

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.

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. The committee consists of all the executive directors as well as Messrs Joe Cohen, Anton Raath and Thys Visser and meets on an ad hoc basis.

ATTENDANCE OF MEETINGS

The attendance of Board meetings is set out in **Figure 3**.

The attendance of Remuneration and Nominations Committee meetings is set out in **Figure 2**. Dr Mamphela Ramphele has been a member of the Company's Remuneration and Nominations Committee since 2008. She made a valuable contribution to the committee, but was unable to meet the requirement to attend the meetings

due to other commitments and subsequently offered her resignation as committee member. Mr Anton Raath was appointed in her place.

The attendance of the Audit and Risk Committee meetings is set out in the report by the committee on page 129 of this 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, 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 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.

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 on pages 59 to 63 of this annual 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 131, 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 on pages 85 to 86 of the Sustainable Development Report.

SUSTAINABILITY IS THOROUGHLY INTEGRATED IN MEDICLINIC'S STRATEGY AND RISK MANAGEMENT PROCESSES

INTRODUCTION

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

Mediclinic's track record on delivering growth and long-term success in all its business operations in Southern Africa, Switzerland and the United Arab Emirates is testament to our strategy of being a long-term player and delivering a sustainable business. Whilst growth, profitability and creating shareholder value are certainly major strategic drivers with a compounded annual growth rate for the past seven years of 29.0% in Group revenue and 30.8% in core 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, of which private healthcare providers are often the key focus group. We manage these risks effectively, as reported in our Risk Management Report and the Operational Reviews. Despite the many challenges facing private healthcare today, we are confident that Mediclinic is a growing and sustainable business delivering value to all our stakeholders in the short, medium and long term.

SCOPE AND BOUNDARY OF REPORT

This report is Mediclinic's ninth Sustainable Development Report published as part of our annual report in respect of the financial year ended 31 March 2011. With this report, we aim to provide our stakeholders with information on the non-financial aspects of 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 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 each heading 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. Previously we have not declared the GRI G3 application level. This year, we have prepared our report in accordance with application level C. Our objective is to reach level B+ in the medium term.

FIGURE 1: EXTERNAL RECOGNITION AND ACHIEVEMENTS

Group	Included in the 2010 JSE SRI Index. First report prepared in accordance with GRI G3 sustainable development reporting guidelines with a self-declared application level C. Received special mention at 2011 Climate Change Leadership Awards for "developing a sound sustainability strategy and venturing into co-generation".
Southern Africa	28 hospitals COHSASA (international quality in healthcare) accredited. 34 hospitals ISO 14001:2004 (environmental management) certified. Externally assessed BEE scorecard improved from Level 4 to Level 3 contributor. Ranked 2nd in the Carbon Disclosure Project 2010.
Switzerland	13 hospitals and head office ISO 9000:2001 certified. Clinic Bois-Cerf and Clinic Cecil both reached level C2E (committed to excellence) under the EFQM Excellence Model.
UAE	Both hospitals JCI accredited, with accreditation of the Welcare Hospital in 2010. The City Hospital's Pathology laboratory received the College of American Pathologists (CAP) accreditation, as well as ISO 15189: 2007 certification. The City Hospital won the 'UAE Social Project of the Year' award at the MEED Quality Awards for Projects in the Gulf Cooperation Council. The City Hospital attained official recognition as a healthcare facility providing the services of International Board Certified Lactation Consultants (IBCLCs).

As referred to earlier in this annual report, we have also noted and applied wherever possible the recommendations contained in the Discussion Paper on Integrated Reporting issued by the Integrated Reporting Committee of South Africa in January 2011. As a constituent of all the JSE SRI (Socially Responsible Investment) Indexes conducted to date, which showcase 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.

ASSURANCE

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 (e.g. BBBEE scorecard verification, ISO 14001, ISO 9000, JCI). We believe that these assurance methods provide the necessary assurance over the quality and reliability of the information presented. There are increasing pressures from regulatory and other guidelines, such as King III, the integrated reporting guidelines and GRI G3, for the external assurance of selected non-financial information. The different options and levels of external assurance available are being considered to determine the way forward on external assurance.

ORGANISATIONAL STRUCTURE

Mediclinic is an international private hospital group with three operating platforms in Southern Africa (South Africa and Namibia), Switzerland and the United Arab Emirates, with its Head Offices situated in Stellenbosch, South Africa. The Group's management and operational structure is also divided into three operating platforms, as illustrated in **Figure 2**. It is important to understand that our three operating platforms operate separately from one another, each with its own governance bodies and management teams. Mediclinic, 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. Due to the Group's structure, reporting on each element included in this report is done per platform, unless Group standards apply.

MANAGEMENT APPROACH

The Group Sustainable Development Policy, Group Environmental Policy and Group Social Affairs Policy, which were adopted in 2010, codify our long-standing commitment to conducting business responsibly. The role of the Group Sustainable Development Manager is fulfilled by the Company Secretary. During the year these policies were also adopted by the boards and/or executive committees of the operating platforms

FIGURE 2: ORGANISATIONAL STRUCTURE

MEDI-CLINIC CORPORATION LIMITED

MEDICLINIC INTERNATIONAL

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 7 103 beds in total.	Operates 14 private hospitals with 1 457 beds in Switzerland.	Operates two hospitals with 336 beds and eight clinics in Dubai in the United Arab Emirates.
NUMBER OF EMPLOYEES		
13 588	5 919	1 676
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.

in Southern Africa, Switzerland and the UAE, with appropriate training on the management and reporting requirements. Each operating platform has also identified a senior manager responsible for the implementation of these policies within its region and reporting to the Group Sustainable Development Manager. The Group Sustainable Development Manager reports material issues to the Mediclinic Board.

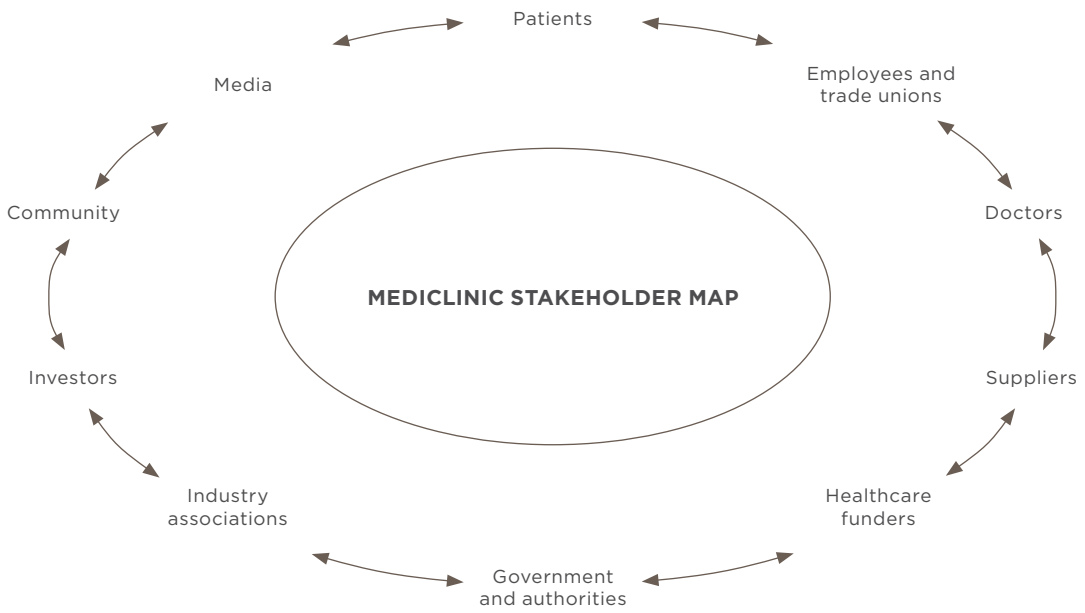
The policies are reviewed annually by management, with recommendations to the Board as part of the annual policy review. A review was performed in 2011 with no material amendments approved.

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 3**). Effective communication with our stakeholders is fundamental in maintaining our corporate reputation as a trusted and respected

FIGURE 3: MEDICLINIC'S STAKEHOLDER MAP



provider of healthcare and we strive to achieve this through a wide variety of communication methods. Our stakeholders' legitimate expectations have been taken into account in setting our material sustainability focus areas, as reported on throughout this report (see **Figure 4**).

One of Mediclinic's strategic objectives is to position itself as a leading international private hospital group and in this regard recognise the importance of our brand. In 2009 we embarked on a journey to develop a new visual identity to align it to the international character that the Group has attained since its expansion to Switzerland and the UAE in 2007. Extensive independent research carried out globally revealed that our stakeholders look to Mediclinic for the highest standards in knowledge, technology and care. This is aligned with the Group's focus on clinical governance and our philosophy that the best modern healthcare places science at its heart. The new Mediclinic brand identity with its new logo and slogan "Expertise you can Trust." would have been launched just prior to the publication of this integrated annual report in respect of the Company and its Southern African operations. Due to the new corporate identity, the change of the Company's registered name from Medi-Clinic Corporation Limited to Mediclinic International Limited is also proposed to our shareholders for approval 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.

The Company and the three operating platforms regularly publish information relevant to their stakeholders on their respective websites: www.mediclinic.com for Mediclinic; www.mediclinic.co.za for the Southern Africa operations; www.hirslanden.com for the Swiss operations; and www.ehl.ae for the UAE operations.

PATIENTS

The well-being of our patients forms the cornerstone of the Group's business; hence its core purpose to enhance the quality of life of 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, among others, our patients. The Group is committed to delivering excellent healthcare focusing on the needs and satisfaction levels of its patients and to communicating with its patients through various media. The Group therefore continuously measures patient satisfaction through ongoing satisfaction surveys to identify potential focus areas for improvement in order to ensure the continuous delivery of a quality service at the Group's hospitals. Its objective is to include a measurement of clinical outcomes in the patient satisfaction survey during the year ahead. Some examples of engagement methods specific to each operating platform include:

SOUTHERN AFRICA

Mediclinic baby and *Mediclinic Senior* are two client alliance programmes aimed at increasing the value-added offering to patients. *Mediclinic baby* provides tailor-made ante- and postnatal services to new parents, ranging from antenatal classes and birth registration services to product bags and baby clinics. Mediclinic Senior, on the other hand, is aimed at people 60 years and older and involves information sessions, health-screening clinics and other hospitalisation value-adds. The group started a 24-hour helpline in March 2010 to answer medical and hospital facility enquiries as well as client alliance programme questions. A third client alliance programme is currently being investigated. Our objective is to build long-term relationships as a trusted healthcare service provider with these programmes.

The *Mediclinic Family* magazine is aimed at our patients and their families as well as the general public and presents healthy lifestyle and general health-related information with a circulation of 70 000 copies per issue.

SWITZERLAND

Health-related information is provided to current and former patients through local hospital magazines, the group's website and a call centre offering information on the group's doctors and hospitals and advice on medical and healthcare matters. The website is recognised as a strong interaction platform, with patients offering relevant healthcare information, including a disease search function based on symptoms. In addition to the website, the group hosts specific sites dedicated to medical centres of expertise such as to oncology, heart diseases, radiotherapy and urology. This was expanded in 2010 by the addition of two additional websites dedicated to radiotherapy and chemotherapy (www.bestrahlung.ch) and dysfunctions of neurological origin in the pelvis (www.neuropelvelogie.ch).

The guest relations department offers additional assistance during the stay in the hospital. Dedicated non-nursing guest relations staff in hospitals take care of patients' needs regarding all non-medical issues. High-class hotel services are offered to privately insured patients.

UAE

Emirates Healthcare's two hospitals have an active presence on Facebook, the widely used social media channel. This has proved to be an extremely effective tool for engaging with patients and the general public. The further development of the hospital pages and the creation of interactive pages for each of the group's clinics during 2011 are under way. Management is currently working towards the development of an integrated social media strategy for the entire Mediclinic Group.

EMPLOYEES AND TRADE UNIONS

Our business at its core is about the people we employ and our employees' trust and respect are therefore vital to our success. Listening to and responding to our employees' needs through effective communication and sound labour relations are important components in being regarded as an employer of choice among existing and prospective employees and vital to maintain a contented, loyal workforce. Our staff members are treated fairly, remunerated competitively and are involved in the day-to-day running of the organisation, contributing to the success of our business. Throughout the Group communication with employees is conducted through a variety of media, including staff magazines providing Group news, staff newsletters updating staff on human resources-related information, e-mail updates, video conferences and staff satisfaction surveys. Leadership Video Conferences are conducted through a satellite communication channel between top management and senior employees across the Group. The inter-platform electronic newsletter, medi-a, shares news and information between the employees of the Group's three operating

LISTENING TO AND RESPONDING TO OUR EMPLOYEES' NEEDS ARE VITAL TO MAINTAIN A CONTENTED, LOYAL WORKFORCE

platforms. Some examples of engagement methods specific to each operating platform include:

SOUTHERN AFRICA

Milieu, a quarterly staff magazine available in print and on the intranet; *Nursing Magazine*, a printed magazine aimed at nursing staff; *People's Interest*, a bimonthly newsletter containing human resources information; and Medi-bytes, short e-mail messages.

SWITZERLAND

Apropos, a staff magazine providing content on business strategy and new developments; local hospital magazines intended primarily for patients, but also distributed to staff with local information.

UAE

Transform is the quality and safety newsletter distributed quarterly to clinical and non-clinical staff of Emirates Healthcare's clinics. *Thoolika* is the bimonthly newsletter to the staff of Welcare Hospital containing human resources news as well as staff and departmental achievements.

Currently 15.7% (2010: 16.1%) of Mediclinic Southern Africa's staff are covered by collective bargaining agreements with trade unions, with no trade union membership among Hirslanden or Emirates Healthcare employees. We maintain good working relationships with trade unions, where we do have recognition agreements, and enter into substantive negotiations annually. These negotiations mainly focus on salary increases and improvements on conditions of employment.

DOCTORS

Supporting doctors are significant stakeholders in the Group and play a vital role in Mediclinic's commitment to quality care, while this simultaneously acknowledges their freedom of association and clinical independence. The ongoing relationship with existing supporting or employed doctors and the recruitment of new doctors remain critical focus areas. Due to the differences in the business models of the Group's three operating platforms relating to the employment of doctors (as detailed in the Organisational Overview on pages 4 to 5), our engagement with doctors differs in each operating platform. The Group's annual Clinical Governance Report included in the annual report is translated into German, French and Afrikaans and made available to the public, but in particular to our affiliated doctors, and on the websites of the operating platforms. Some examples of engagement methods specific to each operating platform include:

SOUTHERN AFRICA

Medi-Dr is a quarterly newsletter sharing information pertaining to the group's developments with doctors.

A referral development model is in place in terms whereof representatives of the group meet regularly with doctors and their staff to obtain an understanding of their needs and build relationships between the hospital and supporting specialists, as well as between the supporting specialist and the referring general practitioner.

A doctor satisfaction survey conducted by an independent research company was launched in November 2010 to determine the satisfaction and loyalty of our supporting specialists.

Mediclinic Southern Africa's leadership annually visits every hospital within the group to present leadership information to staff and associated doctors to discuss industry matters such as the future of healthcare in South Africa, economic prospects, the regulatory environment, skills development and doctor shareholding, and to communicate our service package and offerings to doctors.

The group has also set the objective to host a regional doctors' day from 2011.

SWITZERLAND

Doctor satisfaction surveys are conducted every three years, with the next survey to be conducted in the autumn of 2011.

A comprehensive qualitative and quantitative study has been commissioned to better understand the needs of both general practitioners and specialist doctors regarding the communication and interaction between Hirslanden and the doctor community and between general practitioners and specialists. The results of the study provided us with relevant information in order to better target our media and information aimed towards the doctor community. It is our objective to establish a network marketing function for the group, similar to what is in place in Mediclinic Southern Africa. Consequently new customer relationship management software is also being developed that will enable us to better capture data, as well as information or complaints from affiliated physicians and referring doctors.

Our dedicated internet platform for affiliated doctors (www.hirslandenprofessional.ch) has been redesigned and provides our doctors with relevant information about the medical facilities and technology in the Hirslanden group as well as upcoming events and professional education programmes conducted throughout the group. This online initiative is reinforced by our continuous professional education offering to doctors. In addition to the various local events for doctors, Hirslanden also hosts an annual doctors' congress, bringing 120 of our most active doctors together with Hirslanden's management in order to debate subjects such as public affairs, medical quality standards and other industry matters. During the year a range of active conferences was held throughout the group to give comprehensive information on the political situation regarding the hospital financing system and the introduction of the DRG reimbursement model. After the positive feedback received, Hirslanden will continue with the concept of the doctors' conferences on health politics issues during the year ahead.

There are a number of medical networks in place where affiliated physicians of one specialty get together – anaesthesiology, radiology and general medicine in particular are very active in defining group-wide standards for procedures and materials. These networks are very helpful to learn about the requirements of the participants in their relation to the hospitals. Doctors are involved in different projects of the group, such as the recently launched Lighthouse Project. This project deals mainly with the introduction of electronic patient records in one of the hospitals.

Medical information is communicated to the doctors through a biannual medical periodical, *Aktuelle Medizin*. The Hirslanden annual report is also distributed to affiliated doctors.

UAE

The majority of its doctors are directly employed by Emirates Healthcare, making them participants in the employee engagement initiatives mentioned above. The group's doctors play an instrumental role in the building of consumer confidence and trust in Emirates Healthcare as a healthcare provider of the highest international standard. Monthly doctors' meetings which address current issues and concerns are held at each of the group's facilities. Regular Clinical Forum meetings, chaired by the Chief Clinical Officer, are held and attended by the hospital directors, medical directors and nursing directors of the group's hospitals and clinics. Topics discussed range from continuing medical education proposals to hospital events, systems management, clinical performance management and other relevant issues as they arise.

The *Our Doctors* newsletter is a shared platform to which our doctors contribute their case studies. The quarterly publication is circulated internally as well as externally to doctors in the larger Dubai community to assist clinicians in their daily practice. Continuous learning through shared experience is essential to promote the delivery of quality care to our patients and is therefore a big priority for the group.

SUPPLIERS

In order to deliver our services we are dependent on a large and diverse range of suppliers, who form an integral part of our ability to provide quality hospital care; we believe in building long-term relationships with suitable suppliers establishing a relationship of mutual trust and respect. We rely on our suppliers to deliver products and services of the highest quality in line with our own standards. Various other criteria play an important role in selecting suppliers, such as: compliance with applicable international and local quality standards, price, compliance with appropriate specifications suited for our markets, stability of the organisation and the relevant equipment brand, good-quality and cost-effective solutions, support network, technical advice and training philosophy. In Southern Africa the BBBEE status of a supplier is also a factor in the selection process.

The availability of products and services is imperative in enabling us to deliver quality care to our patients, and it is therefore one of the criteria in our supplier selection process. Although it is not always the case, this often leads to local suppliers being preferred, which also adds to better and quick service delivery and knowledge of local laws and regulations, particularly with regard to pharmaceutical products. In Southern Africa all procurement is done with local suppliers or the local agents of international suppliers. Similarly, in Switzerland approximately 90% of the procurement is from local suppliers or agents. In Dubai all international suppliers and manufacturers are required by law to operate through local agents. As such Emirates Healthcare is legally required to procure from local suppliers or agents, except in cases where a product is not available in the UAE, where permission to import from foreign vendors is granted. Emirates Healthcare procures approximately 97% of its supplies from local agents.

Due to the geographic spread of the Group's operations, the potential of possible cost savings, less administration and improved efficiency, Mediclinic has initiated international procurement initiatives with the aim of unlocking synergies and possibly implementing standardisation for the greater benefit of the Group. International data comparisons remain a key factor in the success of international procurement. A project has been launched to create an international database based on a common international denominator, e.g. a barcode, making international price comparisons easier and faster. We are faced with numerous regulations worldwide, which serve as obstacles to our benefiting from certain procurement strategies as would be the case with non-regulated consumables. However, the Group remains optimistic that cost savings may be achieved. With diverse health policies and laws pertaining to procurement and pricing applying in our three operating platforms and health reforms, especially in Switzerland, our procurement strategies will be more aligned after 2012, allowing us to unlock more synergies. A few key international suppliers have already been approached with the aim of securing similar pricing and conditions across all platforms. We envisage benefiting from the implementation of volume growth incentives based on international purchasing volumes with these suppliers.

Any form of perverse incentives is prohibited and the Group's Ethics Lines are available to all suppliers. Staff members involved in the purchasing of equipment or consumables are also bound to strict ethical principles ensuring that an impeccable

standard of integrity is maintained in the Group's supplier relationships.

Annual Supplier of the Year award ceremonies are established in Southern Africa and the UAE, recognising the important role of our suppliers in our business and honouring their service excellence.

SOUTHERN AFRICA

Formal and uniform procurement processes apply with regard to tenders, contracting and preferred supplier agreements to promote a transparent procurement process and application of sound supplier selection criteria.

SWITZERLAND

The implementation of a Code of Conduct for Hirslanden's supplier relations is planned for the near future.

UNITED ARAB EMIRATES

As mentioned above, unique supply chain regulations apply in the UAE requiring all products and services to be provided by third-party agents rather than directly by international parent companies. As such Emirates Healthcare deals with two parties in all supplier relations: one being the parent company and the other being the local agent.

A tender system for our high-volume products was introduced during the period under review, enabling the group to provide forecasts to suppliers, who in turn are able to improve the supply consistency through better planning. This eliminates the occurrence of stock deficiencies, which are frequently symptomatic of the rudimentary supply chains of the Middle East. The group's suppliers have recognised these efforts as an important aspect of our relationship which helps to improve their service levels.

HEALTHCARE FUNDERS

All role players in healthcare funding, such as the medical schemes, administrators and managed care companies, play a key role in Mediclinic's business, with privately insured patients remaining the Group's largest client base. We aim to maintain our healthy relationship with funders, by meeting regularly with funders to debate possible cost savings and healthcare delivery improvements. We conduct tariff negotiations with funders in a transparent and fair manner.

Healthcare funders most often express concern regarding the price/cost of healthcare in private hospitals, network arrangements, which limit the members' choice of hospitals in exchange for a reduced tariff from the hospitals, quality of care rendered in hospitals, and patient satisfaction with the service rendered. Mediclinic addresses these concerns by continuously trying to find ways to offer our services more efficiently in order to reduce costs and therefore tariff/price inflation. We aim to ensure all our hospitals are, as far as possible, included in all schemes' hospital networks. In terms of quality and patient satisfaction we continuously share studies and information gleaned from both internal and external data to address healthcare funder concerns.

SOUTHERN AFRICA

With just over 90% of Mediclinic Southern Africa's revenue attributable to patients belonging to medical schemes, the local South African medical scheme market remains Mediclinic Southern Africa's largest client base. The group has contracted with 98 South African medical schemes and nine Namibian medical schemes, which are mainly administered by one of the 19 South African or three Namibian administrators in the market. As a result most medical schemes are represented by their administrator and Mediclinic deals directly with the administrator regarding all scheme-related issues. For this reason 75.8% of the market is represented by three administrators. Many medical

THE GROUP CONDUCTS TARIFF NEGOTIATIONS WITH HEALTHCARE FUNDERS IN A TRANSPARENT AND FAIR MANNER

schemes also contract the services of managed care organisations with whom we interact daily on a case management level.

SWITZERLAND

The group has contracted with about 150 funders concerning tariff determination. These contracts cover about 90% of all admissions, with the remaining 10% being self-payers. During our regular formal and informal engagement with funders, the quality of care, infrastructure and increased efficiency are raised as important issues.

UNITED ARAB EMIRATES

Approximately 75% of Emirates Healthcare's revenue is attributable to privately insured patients. The group has entered into agreements with almost 50 funders concerning tariff determination. The role of the group's medical insurers will continue to grow and, as such, Emirates Healthcare has established a dedicated Funder Relations department. The group also has direct contracts with some major UAE organisations regarding the provision of staff healthcare.

GOVERNMENT AND AUTHORITIES

No financial assistance is received from government by any of the Group's operating platforms.

SOUTHERN AFRICA

Department of Health

Mediclinic Southern Africa is involved in ongoing communication and interaction with the national and provincial Departments of Health ("DoH"). Issues pertaining to, inter alia, licence applications, inspection of facilities, approval of building plans and comment on draft legislation and regulations are dealt with on a continuous basis. There are dedicated stakeholder engagement plans by both Mediclinic Southern Africa and the Hospital Association of South Africa. Through the group's engagement initiatives, we aim to create greater understanding of, and insight into, key issues facing the private hospital industry.

The group is assisting the DoH with various of their initiatives, including the revision of staffing norms for nurses, as well as the "Best Care... Always!" initiative, a collaborative quality initiative to promote patient safety between the public and private sector launched in 2009.

All available information pertaining to government's planned implementation of a National Health Insurance ("NHI") to provide healthcare to all citizens in an equitable manner is monitored closely. The group's health policy unit focuses on research and the development of a suitable NHI position paper. The health policy unit will also take part in public debates and individual engagement opportunities with the DoH and other health stakeholders such as non-governmental organisations and universities' Health Economics departments.

South African Nursing Council

Mediclinic Southern Africa engages with the South African Nursing Council on all issues relevant to the profession. The council continues to struggle to unite the different stakeholders, resulting in a situation where the proposed new nursing qualifications have not been finalised, which continues to impact on the group's ability to train nurses.

Council for Medical Schemes

The Council for Medical Schemes is an autonomous statutory body established by the Medical Schemes Act tasked with the responsibility to provide regulatory supervision of private health financing through medical schemes in order to ensure that the best interests of medical scheme members are attended to by all South African medical schemes. The council monitors, among other factors, the financial stability of medical schemes and reports

thereon annually in September (data relating to the preceding year). This data, albeit delayed, is of great value to Mediclinic Southern Africa in terms of trends in healthcare spending and financial stability of individual medical schemes. We have, however, raised concerns with the Council regarding the consistency, accuracy and conclusions reached from their data – specifically pertaining to spending in private hospitals.

Health Professions Council of South Africa

The Health Professions Council of South Africa ("HPCSA") has very specific ethical rules that guide the relationship between medical practitioners and private hospitals, inter alia, prohibiting the employment of doctors by private hospitals in general. Although it is the responsibility of the individual health professionals to adhere to the ethical rules governing their profession, Mediclinic Southern Africa endeavours to structure its relationships with medical practitioners according to these guidelines. Interaction between Mediclinic Southern Africa and the HPCSA takes place from time to time in order to discuss issues of interpretation and application of the ethical guidelines.

South African Pharmacy Council

Mediclinic Southern Africa supports the statutory South African Pharmacy Council's objective to, inter alia, promote the provision of pharmaceutical care, with the protection of the public being paramount. Mediclinic Southern Africa's Executive: Pharmacy Services also serves as an elected member of the council. Specific areas of focus are pharmacy practice and legislative process. The group strives to ensure compliance with all legislative requirements as well as provide input on the issues surrounding the Good Pharmacy Practice guidelines of the group's pharmacies, which are assessed by means of regular internal audits, as well as inspections by the inspectorate of the Council as well as that of the Department of Health. Continuing professional development ("CPD") will become mandatory for pharmacists and pharmacist assistants in order to remain registered. We have embarked on an initiative to provide internal CPD to our pharmacy professionals with the appointment of a Group Clinical Pharmacist. By 2012 the current pharmacist assistants training programme will become a full-time curriculum provided by accredited training provider/s, which will also allow for a greater scope of practice for pharmacist assistants registered on the new programme.

Engineering councils

Mediclinic Southern Africa participates in working groups through various associations to develop health technology regulations relating to the management of healthcare. Through the South African Federation of Hospital Engineering ("SAFHE") the group has been in discussions with the Department of Health to discuss how we can assist with training of technical and clinical personnel working in the health sector. The Clinical Engineering Association of South Africa ("CEASA") is participating in talks with the Engineering Council of South Africa ("ECSA") regarding the proposed regulation of the registration of clinical engineering practitioners.

SWITZERLAND

Hirslanden's strategy on communication with government and authorities includes, in particular, the intention to be the supplier of first choice to obtain cantonal service mandates as listed hospitals after the amendments to the regulations will come into effect in January 2012. As the prime responsibility for healthcare lies with the cantons in the federal set-up of the Swiss political system, meetings between management and the cantonal authorities take place on a regular basis on all relevant issues. The current situation regarding the political environment in the Swiss healthcare sector is further elaborated upon in the Hirslanden Operational Review.

The group's public affairs structures have been developed on both group and hospital level. As a consequence several internal and external communication channels have been defined and political monitoring has been implemented. Newsletters and political position papers support the board and management of Hirslanden in remaining informed and engaged with the authorities.

UNITED ARAB EMIRATES

Emirates Healthcare's senior management holds regular meetings with the Ministry of Health, Dubai Health Authority, Dubai Healthcare City and the federal government authorities, and actively participates in many public private forums where healthcare legislation and protocols are discussed. The unique nature of certain systems in Dubai warrants a more detailed explanation of our engagement with government and authorities in the UAE.

Ministry of Health

As required in terms of UAE laws, management engages regularly with the Ministry of Health ("MoH") to obtain approval of the group's marketing material, including electronic, printed or broadcast media, prior to distribution, publication or broadcasting. Emirates Healthcare strives to comply at all times with all MoH rules and regulations and enjoys a mutually agreeable working relationship.

Dubai Healthcare City

The City Hospital is located within the Dubai Healthcare City ("DHCC") free zone. Free zones have been uniquely designed to contribute to Dubai's growth and development, allowing the companies operating within them to be legally treated as foreign companies or companies operating outside the UAE. EHL engages regularly with the DHCC's Centre for Healthcare Planning and Quality ("CPQ"), which sets and maintains international best practice in healthcare delivery and patient care within its precincts about matters such as the issuing of licenses for our facilities and healthcare professionals, licensing criteria, as well as the approval of building alterations and advertisements.

Dubai Health Authority

Emirates Healthcare maintains a close working relationship with the Dubai Health Authority ("DHA") from whom licenses enabling healthcare professionals to practise at each of its Dubai facilities, apart from The City Hospital, are obtained. Matters of concern such as licensing criteria and examination processes are debated and private sector input is highly valued. Infection control and notification of disease issues are handled closely with the DHA. Welcare Hospital was one of three private hospitals selected by the DHA for inclusion in its H1N1 survey and for independent collection of specimens.

Welcare Hospital's nursing unit contributed towards the scope of services and licensing criteria for the DHA's Central Sterile Supply Department and is regularly requested to offer advice to the DHA regarding the scope of practice. During the period under review a Private Directors of Nursing Forum was introduced by Welcare Hospital in collaboration with the DHA. Attendance of the forum has since been made mandatory for all directors of nursing.

Nursing Council

Emirates Healthcare is highly regarded as a key player by the DHA's nursing department, particularly concerning nursing education and training. Emirates Healthcare is the only company whose nurses are all enrolled in the Emirates Nursing Association, which is part of the newly formed Nursing Council.

Pharmacy authorities

As there is no independent pharmacy council in the UAE, the inspection and licensing of pharmacies, as well as the registration and licensing of pharmacists and pharmacist assistants, are governed by the pharmacy regulatory authorities that form part of the MoH and the DHCC. We engage regularly with these authorities in this respect.

INDUSTRY ASSOCIATIONS

Hospital associations

HASA (Hospital Association of South Africa) is an industry association which represents the collective interests of the more than 200 private hospitals representing over 90% of the private hospital industry in South Africa. Mediclinic Southern Africa is a member of HASA and also has representation on its board. We continually engage in constructive debate on issues pertaining to the private healthcare industry, such as proposed legislation and healthcare developments.

Hirslanden is an active member of PKS (Privatkliniken Schweiz), the Swiss private hospital industry association, as well as H+ (H+ Die Spitäler der Schweiz), the overall industry association for hospitals in Switzerland, ensuring that the group's concerns and suggestions are heard and in order to participate in the development of legislation and regulation in the healthcare industry in Switzerland. PKS represents the political interests of private hospitals and clinics in Switzerland. H+ represents the interests of public and private hospitals and clinics in Switzerland's healthcare industry and politics. A member of Hirslanden's Executive Committee serves as the President of PKS and also serves on the board of H+, with two senior management members also serving on the board of PKS.

Engineering associations

Mediclinic Southern Africa, through the South African Federation of Hospital Engineering ("SAFHE")/Clinical Engineering Association of South Africa ("CEASA"), has initiated a training initiative for delegates from East Africa, with representatives from Uganda, Rwanda, Tanzania and Kenya. Discussions were held with the World Health Organisation's Department of Health System Governance & Service Delivery, which has indicated a willingness to participate in similar training programmes that SAFHE/CEASA will organise in one the abovementioned African countries in the coming year. Mediclinic is well represented in these associations, with the roles of President of SAFHE, Chairman of the SAFHE branch in the Central region and Vice-President of the Clinical Engineering Association of South Africa being fulfilled by Mediclinic management. SAFHE and CEASA are recognised as voluntary associations with the Engineering Council of South Africa.

Hirslanden regularly engages with IHS (Ingenieur Hospital Schweiz), the Swiss Association for Hospital Engineering; SWKI (Schweizerische Verein von Gebäudetechnik-Ingenieuren), the Swiss Society of Building Technology Engineers; Electrosuisse, a professional organisation for electrical, energy and information technology; as well as SIA (Schweizerischer Ingenieur- und Architektenverein), the Swiss Engineering and Architecture Association, on matters such as policy and requirements relating to construction (buildings, heating, ventilation, cooling, etc.) with which Hirslanden complies.

INVESTORS

Mediclinic's primary objective is to create value for our shareholders as the owners and providers of equity capital to the business. We are accountable to our stakeholders and reporting to our shareholders and the public is aimed to provide a clear understanding of the Company's financial, economic, social and environmental performance, both positive and negative. Firm protocols are in place to control the nature, extent and frequency of communication with analysts and

financial institutions, and to ensure that shareholder information is made available to all parties timeously and simultaneously. The Group interacts openly on regulatory and topical matters with its shareholders at its annual general meeting. Our shareholders that hold a significant interest in the Company, namely Remgro holding a 43.4% equity interest; Trilantic Capital Partners holding a 10% equity interest; as well as our black partners, Circle Capital Ventures and Phodiso Holdings, holding a 3.58% and 6.03% equity interest respectively, are represented on the Board of Directors of the Company, which leads to regular engagement at the Company's Board meetings. The Group further interacts with investment funds and the analyst community at the year end and interim results presentations, where access to operational management is provided, as well as regular one-on-one sessions (about 20 per year) and visits by this community to the Group's operations.

Our objective is to continue engaging with our investors in a transparent way. In order to reach a wider audience than in the past, the year-end results were presented in Johannesburg this year, with the option to also participate via a webcast.

The most recent and historical financial and other information is published on the Company's website at www.mediclinic.com.

COMMUNITY

Mediclinic is committed to close, enduring and long-term relations with communities and follows a policy based on mutual understanding, trust and reliability. For more information regarding the Group's engagement with the community, please refer to the section dealing with our community involvement through our corporate social investment initiatives on pages 108 to 111.

MEDIA

The media play an important role in the Group's engagement with all our stakeholders. We interact with the media mainly by issuing press releases on company and industry developments.

In Hirslanden, for example, a range of active media events such as press conferences were held during the year, providing information on the quality strategy of the group and in particular the political situation regarding the hospital financing system and the introduction of the DRG reimbursement model.

The Emirates Healthcare doctors regularly interact with the media. Ongoing television and radio interviews and the provision of editorial comment in national and other publications is seen as an important means of educating and engaging with our existing and potential patients.

MATERIAL ISSUES: PERFORMANCE AGAINST OBJECTIVES

A few highlights of the Group's performance against its sustainability focus areas or objectives for the period under review are summarised in **Figure 4**. All of these focus areas are dealt with in greater detail in this annual report.

FIGURE 4: PERFORMANCE AGAINST OBJECTIVES

KEY SUSTAINABILITY FOCUS AREAS/OBJECTIVES		INDICATORS OF OUR PERFORMANCE
Product responsibility		
Quality and safety of patient care	**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. EFQM model implemented at all 14 Hirslanden hospitals, with goals to complete an EFQM self-assessment of all 14 hospitals by the end of 2011. 13 Hirslanden hospitals ISO 9001:2008 certified, with Klinik Stephanshorn to follow in 2012. 28 Mediclinic Southern Africa hospitals COHSASA accredited. Both Emirates Healthcare hospitals JCI accredited. 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. Participation in the Vermont Oxford Network (VON) aimed at improving quality of neonatal intensive care by Mediclinic Southern Africa and Emirates Healthcare. Participation in the International Quality Indicator Project® (IQIP) by Hirslanden aimed at improving performance against set performance indicators. Integrated hospital information systems piloted at both Hirslanden and Emirates Healthcare.
	Provide and maintain high-quality hospital infrastructure	Spent on capital projects and new equipment to expand and refurbish facilities, as well as repairs and maintenance of facilities during period under review: • R682m (2010: R719m) in Southern Africa • R867m (CHF122m) (2010: R964m (CHF131m)) in Switzerland • R77m (AED39m (2010: R77m (AED36m)) in UAE Comprehensive maintenance and asset management systems applied throughout the Group.
	Ensure adequate supply and optimal utilisation of skilled and experienced employees	Continuous training and development of our employees (see "employee training and development" below). Human Capital Management Strategy focusing on training and retention of staff in Mediclinic Southern Africa, where skills shortage is most critical. Foreign recruitment drives of nurses from India to alleviate critical nurse shortage in Southern Africa. Various initiatives with local and national government authorities assisting with training needs.

KEY SUSTAINABILITY FOCUS AREAS/OBJECTIVES		INDICATORS OF OUR PERFORMANCE
Product responsibility (continued)		
Quality and safety of patient care (continued)	**Excellent patient and doctor satisfaction levels**	Patient satisfaction surveys conducted throughout the Group's hospitals, with the average patient satisfaction levels at 75% (2010: 73%) for Mediclinic Southern Africa (with target at 74%), 86% (2010: 86%) for Hirslanden (with target at 88%) and 89% (2010: 90%) for Emirates Healthcare (with target at 83%). Patient satisfaction survey to be expanded to include clinical outcomes. Doctor satisfaction surveys conducted throughout the Group. In Autumn 2011 the implementation of Hirslanden Customer Relationship Management System will start, which will include systematic complaint management and the integration of the existing Hirslanden Healthline.
Labour practices		
Shortage of nurse and general skills shortage	**Development and training of staff to maintain and improve quality service delivery**	Average spend on training expressed as a percentage of payroll was 4% by Mediclinic Southern Africa, 4.8% by Hirslanden and 0.3% by Emirates Healthcare. Performance reviews to develop staff and identify training needs conducted with all Hirslanden and Emirates Healthcare employees and with 95% of Mediclinic Southern Africa employees. 28 884 learning interventions within Mediclinic Southern Africa and 4 223 within Emirates Healthcare. Accurate data are not available in respect of Hirslanden.
	Alleviate shortage of nurses and general skills shortage through in-service training and support of external training institutions	See performance under "development and training of staff to maintain and improve quality service delivery". Financial support of more than R5.7m provided to academic institutions in Southern Africa. Mediclinic Southern Africa approved as International Training Centre of the American Heart Association; accredited as Chartered Institute of Management Accountants training partner. Public private partnership ("PPP") established with Western Cape Department of Health to train Operating Theatre Practitioners. Establishment of a PPP with Namibian Ministry of Health regarding the training of nurses in advanced stage. During 2010 academic year, 643 students completed basic nursing courses; 84 students completed post-basic nursing courses; 845 learners completed other Mediclinic courses in various disciplines.
BBBEE (South Africa only)	**Sustainable transformation in all elements of BBBEE scorecard**	Improved from a Level 4 to Level 3 contributor on generic BEE scorecard, as externally verified. Number of black employees increased from 58% to 60% of total employees. Black management representation increased from 11% in 2006 to 20% at year end, with a year-on-year improvement from 18% to 20%. Diversity workshops held with all management teams throughout the group, which will be rolled out to include more employees during year ahead.

KEY SUSTAINABILITY FOCUS AREAS/OBJECTIVES		INDICATORS OF OUR PERFORMANCE
Society		
CSI/community involvement	**Improving health and well-being of communities in which we operate**	Approximately R3.2m (2010: R3.5m) spent on CSI in Southern Africa, of which R1.95 m was donated to 45 charitable community organisations. Emirates Healthcare in process of developing a formal Corporate Social Responsibility Programme to be launched in 2012. Mediclinic Southern Africa partnered with the Northern Cape Department of Health to remove cataracts for 150 indigent patients, with a further 130 operations to be performed during the year ahead. Various health awareness campaigns throughout the Group.
Economic		
Promoting access to and affordability of healthcare	**Public private initiatives**	A few successful public private initiatives implemented throughout Southern Africa, Switzerland and UAE, as set out on pages 97 to 98. Mediclinic Southern Africa's CSI programme involves three tiers, one of which being joint initiatives with government, such as the partnership with the Northern Cape Department of Health for cataract operations mentioned above.
	Efficiency and cost-effectiveness	Ongoing research throughout the Group focuses on benchmarking hospital efficiencies internationally. Tariff negotiations done with integrity to ensure fair tariff to patients, based on local and international research on private hospital tariffs. International procurement initiatives commenced for standardisation of cost savings.
	Monitoring national and local health policies with engagement with government	Dedicated research on health policy matters and regular engagement with government on appropriate models. Represented on the Ministerial Advisory Committee for the proposed NHI in South Africa. Regular discussion by Hirslanden management with cantonal authorities regarding amendments to the Swiss Health Insurance Act.
Environment		
Managing our environmental impacts	**Effective environmental management systems to monitor and minimise impacts**	ISO 14001 environmental management standards implemented at 43 Mediclinic Southern Africa hospitals, with the aim of expanding it to all hospitals within the group during the year ahead. ISO 14001 environmental management standards partially implemented in Emirates Healthcare, with full implementation planned for the year ahead. Hirslanden achieved FSC (Forest Stewardship Council) certification for all printed matters with all printing done only via a FCS-certified partner. Measures taken at EHL's two largest facilities, The City Hospital and Welcare Hospital, have resulted in a 26% decrease in waste generation.

COMMITMENT TO QUALITY

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 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. The Group's commitment to quality in healthcare is reported on in the annual Clinical Governance Report, published since 2008 as part of the annual report. For more details on the Group's clinical quality initiatives see the report from pages 45 to 57.

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 R222m (2010: R315m) on capital projects and new equipment to expand and refurbish its facilities, as well as R224m (2010: R194m) on the replacement of existing equipment. In addition, R236m (2010: R210m) was spent on the repair and maintenance of property and equipment. Similarly, Hirslanden has invested approximately R312m (CHF44m) (2010: R318m (CHF43m)) on capital projects and new equipment to enhance its business as well as R323m (CHF45m) (2010: R424m (CHF58m)) on the replacement of existing equipment. In addition, R232m (CHF33m) (2010: R222m (CHF30m)) was spent on the repair and maintenance of equipment. Emirates Healthcare invested R26m (AED13m) (2010: R13m (AED6m)) on capital projects and new equipment to enhance its business and R20m (AED10m) (2010: R36m (AED17m)) on the replacement of existing equipment. In addition, R31m (AED16m) (2010: R28m (AED13m)) was spent on the repair and maintenance of equipment. Details of expansions and upgrades planned for the year ahead are included in the Operational Reviews.

SOUTHERN AFRICA

Mediclinic Southern Africa's planned maintenance system applies to three categories of equipment with varying degrees of maintenance requirements, from maintenance by our technical staff in accordance with internal policies to maintenance by an agent to the manufacturer's specifications.

The implementation of the Enterprise Asset Management System ("EAMS") throughout the group is nearing completion. The system monitors and plans the life cycle of assets by electronic means.

Mediclinic Southern Africa's facilities are also subjected to a comprehensive maintenance audit on an annual basis that covers three categories of plant and equipment as well as the aesthetics of the facilities. The audit is performed by trained head office staff, who objectively assess the facilities and equipment. The average overall score achieved by all hospitals over the last 10 years is 73.1%. The period under review was no different, with the average score achieved being 82.3% (2010: 82%).

SWITZERLAND

The group invests heavily in providing the highest-quality medical infrastructure, including theatre facilities, equipment and nursing staff, to enable doctors to perform procedures using the best available technology. In the beginning of 2011 Hirslanden successfully launched an integrated hospital information system at one of the group's hospitals. The aim of the new framework is to provide optimal support to all (direct and indirect) near-patient processes, from admittance to invoicing. After evaluation of the pilot project, the roll-out to the rest of the group is intended.

Hirslanden attaches particular importance to quality management and is committed to the total quality management approach according to the European Foundation for Quality Management ("EFQM"), as further detailed in the Clinical Governance Report.

Hirslanden's head office and 13 hospitals are ISO 9000: 2001 certified, with Klinik Stephanshorn to follow in 2012. With their ISO certification the hospitals will put into practice continual improvements in process quality and services provided in all areas, above all in nursing and medical technology.

Although each hospital has a local team that is responsible for technical items and maintenance works, the central technical department ensures that common technical standards are applied; monitors compliance with regulations regarding, inter alia, safety and environment; ensures that new regulatory requirements are implemented; and facilitates knowledge transfer within the group. Especially larger projects are jointly handled with the centralised investment and maintenance team at the Hirslanden head office. A computer-aided facility management system for controlling all medical devices aids the management of the group's facilities, including cleaning and technical infrastructure such as HVACR (heating, ventilation, air-conditioning and refrigeration), elevators and security aspects.

UNITED ARAB EMIRATES

Emirates Healthcare follows the same planned maintenance system as Mediclinic Southern Africa. Comprehensive facility management and equipment maintenance programmes are adhered to, while performance audits are conducted regularly.

The City Hospital laboratory is certified in line with the ISO 15189: 2007 set of international quality management standards and was previously accredited by CAP (College of American Pathologists), as well as the Dubai Healthcare City's CPQ (Centre for Planning and Quality) before the opening of the hospital.

PATIENT SATISFACTION

As mentioned under the section dealing with our patient engagement, 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 measure 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 at the group's hospitals. The results are reviewed daily and reported on monthly and serve as a tool to improve service delivery. Its objective is to include a measurement of clinical outcomes in the patient satisfaction survey during the year ahead. In the UAE, Emirates Healthcare improved its system by introducing a cost-effective automated data capturing programme for the efficient collation of survey responses. The system facilitates the generation of reporting that is useful to the business.

The overall patient satisfaction levels of the Group's operating platforms are included in **Figure 4**.

In addition to the focus on patient satisfaction levels, 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.

Hirslanden will also implement a Customer Relations Management (CRM) System during 2011, which will include a complaint management system.

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 is regularly reviewing 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 was assessed by an accredited verification agency against the generic scorecard criteria set by the Department of Trade and Industry ("DTI"), the results of which are set out in **Figure 5**. This assessment indicates that the group has a total score of 75.27 (compared to 71.38 in 2010 and 64.98 in 2009), which means that it has improved from a Level 4 to 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. A copy of the scorecard is published on the website of Mediclinic Southern Africa (www.mediclinic.co.za).

FIGURE 5: BBBEE SCORECARD

ELEMENT	INDICATOR	WEIGHTING	SCORE 2011	SCORE 2010
Equity ownership	Percentage share of economic benefits	20	**19.21**	16.55
Management control	Percentage black persons in executive management and/or executive board and board committees	10	**5.76**	5.11
Employment equity	Weighted employment equity analysis	15	**2.17**	2.12
Skills development	Skills development expenditure as a proportion of total payroll	15	**11.68**	12.00
Preferential procurement	Procurement from black-owned and empowered enterprises as a proportion of total assets	20	**16.45**	15.60
Enterprise development	Average value of enterprise development contributions as a percentage of the target of 3% of net profit after tax	15	**15.00**	15.00
Socio-economic development	Corporate social investment for the benefit of black persons	5	**5.00**	5.00
TOTAL POINTS		**100**	**75.27**	**71.38**

We are committed to actively support the Black Management Forum's Joint Mentoring Initiative, whose aim is to facilitate skills transfer as well as bridging the cultural divide. Mediclinic Southern Africa sponsored the launch of the project during 2011, with select senior management also offering to act as mentors for managers selected by the Forum.

EQUITY OWNERSHIP

Mediclinic implemented a R1.1 billion black ownership initiative in 2005, which had the effect of introducing 15% black shareholding in Mediclinic. The black ownership initiative introduced Phodiso Holdings Limited ("Phodiso") and Circle Capital Ventures (Proprietary) Limited ("Circle Capital") as the Group's strategic black partners and shareholders in Mediclinic. Following this initiative, Mediclinic's strategic black partners jointly held approximately 11%, with Phodiso holding approximately 6.87% (currently 6.03%) and Circle Capital holding approximately 4.12% (currently 3.58%), of the issued shares. All employees up to and including first line management level were also introduced as shareholders of the Company through the issue of Mediclinic shares to the Mpilo trusts, two employee share trusts formed in South Africa and Namibia specifically for that purpose. The trusts subscribed for approximately 4% (2.24% at year end) of Mediclinic's issued shares held for the benefit of almost 11 000 participating employees (of whom 52% were black and 89% women) at the time, which include, inter alia, nursing staff, support staff and administrative staff.

By applying the specific rules of the DTI's BBBEE Codes of Good Practice in respect of multinationals, Mediclinic meets the Codes' targets of 25% exercisable voting rights in the hands of black people and 25% economic interest of black people for purposes of calculating Mediclinic's ownership scorecard with reference to the Group's South African operations.

MANAGEMENT CONTROL

Mediclinic's strategic black partners have been well represented within Mediclinic since 2005, with two of Phodiso's directors involved in key positions within the Group: Dr Nkaki Matlala as Executive: Government Relations and Industry Affairs and board member of Mediclinic Southern Africa, and Dr Kabs Makaba as board member of Mediclinic; and Circle Capital's previous chairperson, Dr Mamphela Ramphele, as board member of Mediclinic.

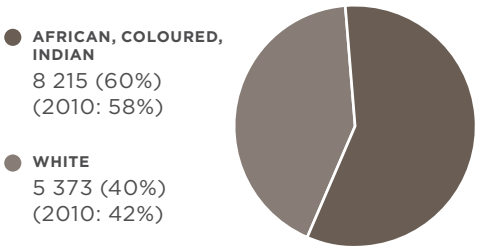
Mediclinic Southern Africa's board is well represented, with six of the eleven (66%) board members being black. On management level, three of the nineteen (39%) Executive Committee members are black.

EMPLOYMENT EQUITY

Mediclinic Southern Africa's focus on employment equity is in line with the group's overall transformation objectives. In support of the group's employment equity plans, the group has, inter alia, commenced with diversity workshops for senior management, which will be rolled out to more employees during the year ahead. Although a marked increase in black representation at management level has been recorded year on year since 2006 from 11% to 20%, this level still presents the biggest 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.

The overall race distribution of Mediclinic Southern Africa's full-time employees is set out in **Figure 6**. The summarised employment equity report (EEA2) (**Figure 7**) as at 1 October 2010 is published here as required in terms of section 22 of the Employment Equity Act.

FIGURE 6: **MEDICLINIC SOUTHERN AFRICA: RACE DISTRIBUTION**



SKILLS DEVELOPMENT

Mediclinic's stated commitment to quality care has the effect that skills development is a priority at all levels, which is reflected in the number of learning initiatives undertaken each year. During the past year Mediclinic Southern Africa has facilitated in excess of 28 884 (2010: 25 827) structured learning interventions, many of which involve skills assessments. The group continues to invest about 4% of payroll annually in support of its commitment to training and skills development. To improve the representation of designated groups on management levels, the group's management development programmes include various functional disciplines and aims to increase the management talent pools. See the section relating to Mediclinic's training and development initiatives on pages 104 to 107 for more details.

PREFERENTIAL PROCUREMENT

An improvement in the generic BBBEE scorecard in respect of preferential procurement from 15.6 in the previous year to 16.45 out of 20 points was achieved. Mediclinic Southern Africa uses the BBBEE status of a supplier in the selection process. The improvement of the preferential procurement score remains a focus area for Mediclinic Southern Africa and a system to monitor and manage procurement in the QSE (Qualifying Small Enterprises), EME (Exempted Micro-Enterprises) and black-owned categories more accurately is currently being developed.

ENTERPRISE DEVELOPMENT

In terms of Mediclinic Southern Africa's contributions towards this element, it achieved the target of 3% of net profit after tax. This has largely been achieved through the favourable terms of loans to Mediclinic's two strategic black partners, Phodiso and Circle Capital, and the Mpilo trusts. The loans enabled these entities' acquisition of equity in Mediclinic.

SOCIO-ECONOMIC DEVELOPMENT

The success of the group's Corporate Social Investment ("CSI") strategy and initiatives is reflected in the group scoring full marks for this element in the BBBEE scorecard. Further details on our CSI initiatives can be found on pages 108 to 111 of this report.

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.

ACCESS TO AND AFFORDABILITY OF HEALTHCARE

In the healthcare industry, however, we face the challenge of access to and affordability of healthcare, which affects each and every member of society. Providing proper access to healthcare is a challenge facing all governments, even more so in developing countries such as South Africa. With deteriorating service delivery, facilities and equipment, there is an ever-increasing demand from the private healthcare industry to assist government in the provision of access to healthcare and we accept that the private healthcare industry has an important role to play. We contribute in various ways towards a sustainable healthcare system with improved access to and affordability of healthcare by, inter alia, continuously focusing on ways in which we can improve our cost-effectiveness, conducting tariff negotiations in a fair and transparent manner, expanding our facilities based on need, pursuing joint initiatives with government, such as public private partnerships, and actively participating in healthcare reform.

FIGURE 7: 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	17	0	0	0	2	0	0	**21**
Professionally qualified and experienced specialists and mid-management	8	25	10	169	29	27	8	240	1	2	**519**
Skilled technical and academically qualified workers, junior management, supervisors, foremen and superintendents	112	104	17	189	819	742	116	2 740	5	62	**4 906**
Semi-skilled and discretionary decision-making	470	315	11	144	2 366	1 608	90	1 594	1	13	**6 612**
Unskilled and defined decision-making	119	81	1	34	317	148	1	51	7	19	**778**
TOTAL PERMANENT	**711**	**526**	**40**	**560**	**3 531**	**2 525**	**215**	**4 627**	**14**	**96**	**12 845**

Similarly, affordability remains a critical issue in the healthcare industry internationally, but especially in developing countries, such as in the Group's Southern African operations. The Group will therefore continue its efforts to improve the affordability of healthcare with a specific focus on Southern Africa, where this issue is of critical importance.

In order to reach a sustainable solution, the focus on access to and affordability of healthcare cannot be done without the necessary focus maintaining the highest standard in quality of patient care and providing an adequate return to our capital providers.

EFFICIENCY AND COST-EFFECTIVENESS

The Group continuously identifies and evaluates areas for operational improvement. Such efficiency gains are passed on to our patients and funders with a view to increasing the affordability of healthcare. In this regard, our ongoing research focuses on benchmarking hospital efficiencies internationally.

As further detailed in the section of this report dealing with our engagement with healthcare funders on pages 81 to 82, our tariff negotiations are concluded in a fair and transparent manner.

To improve our cost-effectiveness we are continuously investigating and implementing new cost-saving efficiencies to reduce our input costs and therefore ultimately our tariff inflation. An example of this includes the review and enhancement of the admission process in Mediclinic Southern Africa, which resulted in significant changes to the way in which admissions take place, with benefits to patients who book for hospitalisation prior to admission. The enhanced process also allowed for a reduction in admission documentation, reduced patient waiting times (compared to the past), and an upgrade to the patient administration system. Benefits of this project have already been experienced by patients and hospitals, with a marked improvement in the process outcomes.

Although all Swiss residents have comprehensive mandatory healthcare insurance, Hirslanden is committed to cost-efficiency in healthcare by way of supporting market-orientated initiatives and reforms to reduce the increase in healthcare insurance premiums.

The benchmarking of staff utilisation between Emirates Healthcare's facilities has seen significant cost reductions, particularly at Welcare Hospital. Operational expenditures have also decreased in direct relation to our energy conservation projects.

HEALTHCARE REFORM

SOUTHERN AFRICA

Mediclinic Southern Africa supports the South African government's drive to enhance the affordability of and access to quality healthcare through the planned National Health Insurance ("NHI"). The effects of the planned NHI system still remain to be seen, with much public debate and uncertainty at this stage. There are currently a number of legislative initiatives in progress that have the potential of impacting on the group, such as the private sector price determination reform, the introduction of the NHI, the establishment of the Office of Health Standards and Compliance (OHSC) and the interpretation of the Prescribed Minimum Benefit (PMB) regulations. We continue to dedicate considerable resources and effort in the formal and informal consultation processes to ensure that the eventual legislation promotes the efficiency and sustainability of healthcare in South Africa. During these consultation processes we highlighted a number of critical structural market reforms required in order to improve the affordability of private healthcare such as:

- making medical scheme membership mandatory above a certain income threshold, which will substantially increase the proportion of medical scheme members who are young and healthy, thereby increasing cross-subsidies and reducing average medical scheme contributions, and also facilitate the introduction of income-related contribution rates, thereby promoting income cross-subsidies and affordability for low-income individuals;
- restructuring the Tax Expenditure Subsidy (TES) to disproportionately favour lower-income earners; and
- introducing a Risk Equalisation Fund (REF) to promote competition in the medical scheme industry based on cost-effective delivery of healthcare as opposed to the selection of healthy individuals.

We have participated in the commissioning and publication of research via HASA to address critical challenges facing the healthcare industry. Examples include two series of research notes by economic consulting firm Econex. The first focused on the potential cost of a NHI and provided relevant information on the capacity and challenges of the South African healthcare system. The second addressed the practicalities of healthcare reform and covered topics such as contracting with public and private providers, accreditation of providers, and modelling of human resources for healthcare, including the current public versus private distribution of doctors and nurses.

In addition, Mediclinic Southern Africa initiates and participates in both bilateral and multilateral engagements with government, industry stakeholders, academics and civil society groups. Examples include participation in round table discussions, delivering presentations, responding to media requests and hosting healthcare reform research workshops.

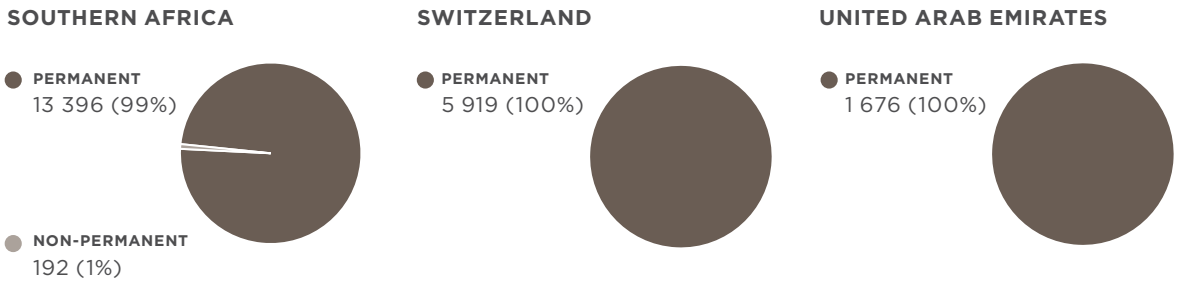
Government is exploring alternative provider reimbursement mechanisms that promote transparency and efficiency. In this regard they have specifically mentioned diagnosis related groupings (DRGs) as a potential alternative to the current reimbursement mechanisms employed in the private hospital sector. Mediclinic Southern Africa has invested extensively in developing both strategic and technical expertise in the development, implementation and management of DRGs and the potential financial and operational implications for our business. We will continue our focus in this regard going forward.

In order for medical schemes to develop more affordable benefit options, rationing of health care services in order to control utilisation will be of critical importance. However, unless hospitals are permitted to employ doctors, hospitals are incapable of rationing care. By allowing the employment of doctors by private hospitals, low-cost integrated delivery models such as HMOs can be developed. Such models foster the management of all aspects of healthcare services to improve standardisation of services and products and to manage utilisation of services. It is important to note that while this constraint on the employment of doctors is upheld by the Health Professions Council of South Africa (HPCSA), there is no evidence of this restriction being applicable to other healthcare systems internationally.

SWITZERLAND

The impact of the amendments to the Swiss Health Insurance Act of 1 January 2009, which will come into effect on 1 January 2012, has dominated recent discussions of public health policy in Switzerland. Its provisions relate primarily to the treatment of patients with mandatory insurance, who comprise approximately 30% of Hirslanden's inpatients. The amendments are also very relevant for the segment of patients with complementary insurance, since the payment for every KVG treatment (apart from treatment covered by accident or military

FIGURE 8: WORKFORCE COMPOSITION PER EMPLOYMENT TYPE



insurance) consists of a part from the mandatory insurance of the patient.

The major changes include the introduction of fixed fees (DRGs) and the revision to the lists of hospitals that are eligible to treat patients with mandatory insurance. The implementation of the amended Act will be defined at cantonal level. Hirslanden is in regular contact with the health departments in the cantons where it owns hospitals, with much uncertainty still prevailing. To date no rulings on hospital lists or DRGs have been made, so even at this late stage it is not possible to assess the significance of the amendments to the Act for Hirslanden with certainty.

UNITED ARAB EMIRATES

Whilst the healthcare policies of the UAE are still relatively immature in relation to more developed markets, the government is increasingly cooperating with private companies throughout the policy development process. Medical insurers continue to play a major role in the industry's success and the group anticipates significant development and consolidation in this area over the next few years. Emirates Healthcare is preparing for these changes by gathering significant healthcare data and by continuously focusing on cost-effective healthcare delivery.

PUBLIC PRIVATE INITIATIVES

The Group believes that public private partnerships ("PPPs") and other joint initiatives with government may play a meaningful role in increasing access to affordable quality healthcare services. It also believes that meaningful health PPPs would involve the private hospital sector's core competencies, namely the delivery of quality healthcare and management services. It continues to look for meaningful opportunities for PPP participation. Some examples of successful joint initiatives are included below.

SOUTHERN AFRICA

Ministry of Health, Namibia

Negotiations are in an advanced stage with the Namibian Ministry of Health to establish a PPP in terms of which Mediclinic will assist with the training of nurses in Namibia. Although the agreement has not been finalised, we are committed to this initiative. In terms of the proposed PPP, Mediclinic will provide funding for our learners through the University of Namibia. The Nursing Council of Namibia has already issued us with the Certificate of Registration as an approved training facility. This enables Mediclinic Windhoek to provide the required practical training to these learners, as well as learners from other institutions. The second area of partnership involves the training of enrolled nurses by the National Health Training Centre for Mediclinic, with Mediclinic providing practical experience opportunities for National Health learners.

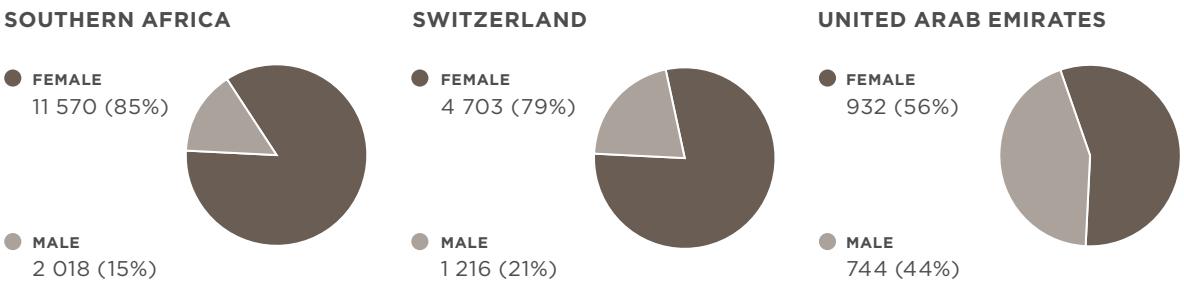
Western Cape Department of Health

A partnership agreement has been implemented with the Western Cape Department of Health in terms of which Mediclinic assists the department by serving as a nurse training provider. An initial group of nine learners commenced with training in February 2011.

Wits Donald Gordon Medical Centre

One of our more established partnerships was our investment in 2005 of R65 million in the Wits Donald Gordon Medical Centre ("WDGMC"), obtaining a 49.9% share in the hospital. This investment has enhanced the ability of the University of Witwatersrand in Johannesburg ("Wits") to support specialist and sub-specialist training without requiring any government subsidy. The significant partnership with the public sector is designed to support the training of specialists and sub-specialists for both public and private sectors, and to make the best clinical staff available to the Johannesburg academic hospitals. The academic

FIGURE 9: WORKFORCE COMPOSITION PER GENDER DISTRIBUTION



programme of the hospital is functioning well and the hospital currently supports the training of four registrars and 14 sub-specialists. The management services by Mediclinic Southern Africa have added significant value to the operations of the hospital with improved occupancy levels. The hospital focuses on specialised services and the transplant programme, Colorectal Unit, Hepatobiliary Unit, Women's Health Unit, Intensive Care Unit, Geriatric Unit, Endovascular Unit and Oncology Unit can be described as centres of excellence.

Stellenbosch Biokinetics Centre

The successful joint venture between Mediclinic Southern Africa and Stellenbosch University in respect of the management of the Stellenbosch Biokinetics Centre since 2004 was unfortunately terminated during the year. Mediclinic provided the initial funding required to upgrade the equipment of the centre and prior to the termination provided marketing, administrative and financial support to the centre. The partnership produced very positive results with hundreds of undergraduate and postgraduate students, interns, biokineticists and doctors, as well as the thousands of patients benefiting from the centre. Management skills were transferred to the University, enabling it to continue with the management of the centre on a commercial basis.

2010 World Cup

During the year the 2010 FIFA World Cup was a highlight for all South Africans and we are proud that we were able to support government in offering quality and affordable medical care for the duration of this historic event in South Africa. We were involved from the outset with the preparations and were also represented on the Department of Health's National Health Technical Task Team. The group participated in formulating disaster management strategies for the tournament with other private and state healthcare providers.

SWITZERLAND

University hospital of Zurich

There are two important partnerships with the university hospital of Zurich. The first is the intrabeam system, which allows intra-operative radiation in the case of breast cancer treatment. The system is used by the breast cancer centre of Hirslanden in Zurich and the Department of Gynaecology at the university hospital. The second is a fast-cut laboratory run by the Department of Pathology of the university hospital, which was opened at Klinik Hirslanden in 2009, providing a fast diagnostic procedure in the case of fast cuts in the operating theatre.

University hospital of Vaud

The university hospital of the canton Vaud (CHUV) collaborated with Clinique Bois-Cerf and Clinique Cecil in Lausanne until the end of 2010, with the Hirslanden hospitals providing bed capacity aiming to take acute care patients from the CHUV during peak periods.

UAE

Dubai Fertility and Gynaecology Centre

The City Hospital signed the first public private partnership agreement with the government-owned Dubai Fertility and Gynaecology Centre ("DFGC"), the only fertility centre in Dubai. This allows the DFGC doctors to admit patients, operate in and use The City Hospital facilities to treat infertility patients and is in line with The City Hospital's vision to provide comprehensive maternity services as well as with the government's aim to provide high-calibre services to its customers.

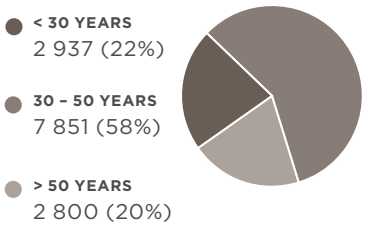
OUR PEOPLE

EMPLOYEE COMPOSITION AND TURNOVER RATE

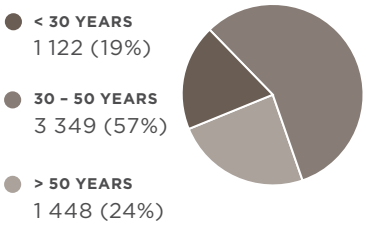
The success of Mediclinic is dependent on the commitment of our more than 21 000 employees to deliver quality healthcare. The composition of our

FIGURE 10: WORKFORCE COMPOSITION PER AGE DISTRIBUTION

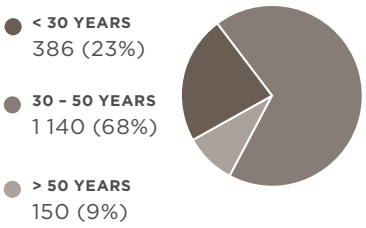
SOUTHERN AFRICA



SWITZERLAND



UNITED ARAB EMIRATES



employees by employment type, gender and age per each of our operating platforms is illustrated in **Figures 8** to **10**.

The total number and rate of employee turnover by age group and gender per each of our operating platforms are provided in **Figure 11**. The annual turnover rate was 10.3% (2010: 11.2%) in respect of Mediclinic Southern Africa, 14.5% (2010: 14.7%) in respect of Hirslanden (which excludes Klinik St Anna and Klinik Stephanshorn) and 10.7% (2010: 13.9%) in respect of Emirates Healthcare. The turnover rates are calculated using the total employee numbers at year end.

EMPLOYEE REMUNERATION

The Group offers market-related salaries and benefits to our employees, based on the principles of internal equity, external equity and fairness. The Group's Remuneration Policy was formalised and adopted subsequent to year end setting out our remuneration approach of senior management and directors of the Company and its three platforms. Further details are provided below and in the Remuneration Report on pages 125 to 126.

The Group's operating platforms participate regularly in salary surveys to provide management with a reference for evaluating its current remuneration packages. Remuneration is determined based on the employee's qualifications, expertise, experience and job level with no discrimination based on gender or other forms of differentiation. We do not regard minimum wages as determined in the geographic areas of operation as a relevant benchmark, as our employees' remuneration exceed these minimum wage requirements.

The Group offers retirement plans to its employees in Southern Africa and Switzerland. These are defined contribution plans for the benefit of employees, the assets of which are held in separate trustee-administered funds. Both employee and employer contribute a percentage of the employee's salary. In Southern Africa the employee contribution ranges from 2.5% to 7.5%, whilst the employer contribution ranges between 3% and 9%. In Switzerland the employee contribution ranges from 6.5% to 15.5%, whilst the employer contribution ranges between 9.5% and 15.5%. The retirement benefits of expatriate employees of Emirates Healthcare in the UAE are limited by federal law to the provision of severance pay calculated according to a specified formula. Employees who are UAE nationals are entitled to enrol in the national pension scheme. A total contribution of 20% of the pensionable salary is required for every UAE national employed in the company, with the employee contributing 5%, the employer 12.5% and government 2.5%.

Employee benefits and the value they add to the overall employment proposition are key factors in attracting and retaining high-calibre staff. Details of benefits offered to our permanent employees per operating platform are included in **Figure 12**. Various other benefits are offered throughout the Group, such as uniform subsidies, loans, administrative assistance with housing and vehicle financing and insurance, and free financial wellness assistance.

DIVERSITY AND EQUAL OPPORTUNITIES

Mediclinic believes in providing equal opportunities for all and does not tolerate any form of unfair discrimination based on gender, race, nationality, religion or other form of differentiator. In line with this, no differentiation is made in the basic salary offered to men compared to that offered to women throughout the Group. The representation on the board of Mediclinic as well as the operating platforms are illustrated in **Figure 13**.

FIGURE 11: EMPLOYEE TURNOVER BY AGE AND GENDER

	Southern Africa		Switzerland		United Arab Emirates	
	Number	Rate	Number	Rate	Number	Rate
Age						
< 30	335	11.4%	222	19.8%	58	15.0%
30-50	903	11.5%	492	14.7%	102	8.9%
> 50	165	5.9%	144	11.3%	19	12.7%
Gender						
Male	193	9.6%	178	14.6%	58	7.8%
Female	1 210	10.5%	680	14.5%	121	13.0%
Total	**1 403**	**10.3%**	**858**	**14.5%**	**179**	**10.7%**

Mediclinic Southern Africa's focus on employment equity in line with the group's overall transformation objectives is dealt with in the section relating to BBBEE on page 93 of the report. Hirslanden and Emirates Healthcare also focus on employment equity matters in respect of gender and their overall gender and age distribution is set out in **Figures 9** and **10**.

A differentiator in our operations in the UAE is nationality, with employees from 52 nationalities and the majority of the employees being expatriates.

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

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 referred to on page 77 to 78.

Mediclinic Southern Africa's trade union membership has declined from 16.1% to 15.7% of employees covered by collective bargaining agreements, with no trade union membership by the Hirslanden or Emirates Healthcare employees. Mediclinic Southern Africa maintains good working relationships with trade unions with which it has recognition agreements. No strike days were experienced during the reporting period. The disciplinary and grievance procedures of the operational platforms 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.

The minimum notice periods for significant operational changes, as provided in the employment contracts, are one month in Southern Africa, three months in Switzerland and in the UAE it is 90 days for clinical practitioners (physicians, nurses and paramedical staff) and 60 days for administrative staff.

PERFORMANCE REVIEWS

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. Hirslanden has even 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 95.22% of employees received formal performance reviews.

RECRUITMENT AND RETENTION OF SKILLED STAFF

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 driving Group performance in the intensely competitive and dynamic business environment in which it operates. Some examples of our initiatives to retain staff include:

FIGURE 12: BENEFITS OFFERED TO PERMANENT EMPLOYEES

Benefit description	Southern Africa	Switzerland	United Arab Emirates
Retirement fund	√	√	X
Medical insurance	√	√	√
Performance-related incentives and bonuses	√	√	√
Nursing bonus for nursing staff (introduced in Southern Africa due to local nurse shortage)	√	X	X
Mpilo employee share scheme (introduced as part of BBBEE within Southern Africa)	√	X	X
Indemnity cover/liability insurance for nursing/medical staff	√	√	√

- 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.

Due to the unique circumstances that apply in each of the operating platforms, the Group does not have a uniform approach towards local hiring. In Southern Africa and Switzerland the Group is committed to providing employment and development opportunities to citizens of the country in which the business unit is located and employment of a foreign national will only be considered where no suitable local candidates with permanent residence can be found. In Southern Africa, however, a foreign recruitment drive is in place due to the critical skills shortage. In terms of Mediclinic Southern Africa's policy, foreign appointment is limited only to pre-identified scarce skill categories, including professional nurses, technical managers and pharmacists. In Dubai the majority of employees are not UAE nationals and the workforce is represented by 52 nationalities. However, Emirates Healthcare supports the government's Emiratisation programme, which aims to see its citizens employed in a meaningful and efficient manner. Sourcing suitably qualified Emiratis and attracting them to work in the private healthcare sector has thus far proved to be challenging. Our strategy for 2011 is therefore to focus on training and education, with tie-ups with several nursing schools planned. This will create work experience opportunities and establish a pool of potential candidates for permanent employment.

SOUTHERN AFRICA

Skills shortages remain a challenge throughout Mediclinic Southern Africa. Our Human Capital Management Strategy strives to ensure that Mediclinic Southern Africa will have the ability to be responsive to the talent challenges that the industry faces, and it defines and commits priority resources to very specific deliverables in eight main human capital management processes. If these deliverables are met and optimal results are achieved, we believe that retention will be the desired outcome.

An internal Employee Relations Assessment was conducted in October 2010 by Ipsos Markinor. The outcome of this research has provided clear and challenging insights into our employee experience of our employment offering, their engagement levels and our projected staffing challenges. Follow-up research is being conducted, after which action plans will be compiled. The nature of the issues identified suggests that appropriate plans will need to be structured over a significant period of time. However, this research has presented the opportunity to act decisively as a group in a way which will have a positive impact on the recruitment, retention and engagement of our people.

The period under review has witnessed a significant quieting in the recruitment activities of semi-skilled and general management positions, as employees have acted more conservatively in their career movement. The retention of good-quality staff, especially in nursing and pharmacy services, remains a challenge for Mediclinic Southern Africa. To this end, various formal recruitment campaigns were conducted during the year.

The recruitment of nursing candidates from abroad has continued through 2010, with a significant increase in the number of nurses from India from 39 the previous year to 88 now working at the group's hospitals, some of whom have

FIGURE 13: RACE AND GENDER REPRESENTATION ON MAIN BOARDS OF DIRECTORS

	Black		White		Male		Female		Total members
	Number	%	Number	%	Number	%	Number	%	Number
Mediclinic	3	19%	13	81%	14	88%	2	12%	16
Mediclinic Southern Africa	6	55%	5	45%	9	82%	2	18%	11
Hirslanden	n/a	n/a	n/a	n/a	8	100%	0	0%	8
Emirates Healthcare	n/a	n/a	n/a	n/a	7	100%	0	0%	7

been re-contracted for a further three years. The candidates were initially only placed in three hospitals in the Western Cape, where the need was the most critical, but are now placed in 11 hospitals across the country.

SWITZERLAND

Hirslanden follows a strategic mission statement aimed at being the employer of choice in the industry; this is monitored by employee satisfaction surveys every three years. The results of the surveys are used as a basis for focused organisational development projects.

Switzerland, like many other European countries, is facing the expected shortage of nurses. Hirslanden is not only engaged in training and education or positioning itself as an attractive employer – it also actively promotes the general attractiveness of healthcare professions through the National Association of Hospitals (H+) and the National Association of Private Hospitals (PKS).

UNITED ARAB EMIRATES

The sourcing and recruitment of staff in the UAE, specifically doctors, nurses and other clinical practitioners, present a major challenge, primarily in terms of the scarcity of qualified candidates. Consequently the majority of staff is sourced from abroad. To address this challenge, various initiatives have been implemented, which include an annual general recruitment drive and increasing the number of, and engagement with, recruitment agencies used. Another limiting factor has been the Dubai Healthcare City's demographic requirements, which stipulate that the nationality breakdown should reflect 30% Arabic, 30% Western and 40% Asian representation.

In a new initiative, The City Hospital has agreed to accommodate engineering students completing their internship programmes. The hospital has thus far assisted two candidates through its Biomedical Engineering Department.

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

All Mediclinic Southern Africa's and Emirates Healthcare's facilities have health and safety committees which represent all the employees in the facilities. These committees are managed by joint management-worker representation. In Southern Africa the management representation in these committees is limited to 50%, resulting in the majority of the committees having worker representation of between 50 and 75%. In Emirates Healthcare all the facilities' committees have up to 25% worker representation, except Welcare Hospital, which has more than 75% worker representation. No dedicated health and safety committees are implemented in Hirslanden, although this is managed at hospital level.

INJURIES AND ABSENTEEISM

The Group's statistics on injuries and absenteeism are illustrated in **Figure 14**.

HEALTH ASSESSMENTS, TRAINING AND PROGRAMMES

Southern Africa

Mediclinic Southern Africa's Corporate Health Programme provides a framework for the management of occupational health services and primary care to employees. This includes legal compliance with the Occupational Health and Safety Act, primary medical care, chronic disease monitoring and support, as well as social and personal problem solving and counselling provided

FIGURE 14: INJURIES AND ABSENTEEISM

	Southern Africa	Switzerland	UAE
Total injuries	996	362	36
Injury rate	0.1%	not available	2.1%
Absenteeism due to injuries (business days)	26 051	not available	not available
Occupational diseases	0	not available	not available
Work-related fatalities	0	not available	not available
Total sick days/shifts	109 257	not available	5 134
Absenteeism due to sickness	2.4%	not available	0.9%

by an Employment Assistance Programme ("EAP"). The EAP offers a 24-hour emergency helpline service for employees that caters for medical as well as social challenges that the group's employees might face. During the period under review 2 575 cases were handled by the EAP.

Health risk assessments were undertaken at certain hospitals in all the regions within the group. The results of these assessments form the basis of the medical surveillance programmes in all hospitals, which are utilised to mitigate specific health and safety risks. Comprehensive in-house health services are rendered to employees free of charge at the health clinics that have been established at various hospitals, with more clinics being established in order to extend this service. During the period under review the clinics received 49 173 (2010: 39 945) visits, which relate to health evaluations, injuries on duty and primary health-care. The management of these clinics has been outsourced to Incon Health, an independent occupational health and safety provider.

Annual health and safety audits are conducted by Mediclinic Southern Africa to monitor the function of the Health and Safety Committees and verify the competence of the responsible staff members. A legal register is maintained to ensure that all relevant legislation, regulations, municipal by-laws and national standards applicable to the healthcare industry are adhered to.

During the year 128 new health and safety representatives received training.

It is planned to integrate the ISO 14001 Environmental Management System of six hospitals with the OHSAS 18001 Health and Safety Management System during the year ahead.

Switzerland

Hirslanden is fully compliant with Swiss legal standards, best practices and industry recommendations in respect of workplace safety. The health of Hirslanden's employees also receives the necessary attention through an extensive personal health awareness campaign among employees, a smoke-free working environment and free vaccination programmes for all employees. The group complies with the guidelines of the EKAS, the Swiss coordination agency for workplace safety.

United Arab Emirates

Policy and procedures regarding Facilities Management and Safety as well as Prevention and Control of Infection are in place throughout the group. Staff health and safety are enhanced through various initiatives, including, inter alia, pre-employment medical screening; staff immunisations for employees in direct contact with patients; procedural management of injuries on duty, which is supported by guidelines on compensation of staff undergoing treatment and recuperation; defined procedures for the safe handling of specimens and sharps; orientation of new staff regarding the extreme weather conditions of the UAE; and training regarding the different disaster codes. Continuous importance is placed on health and safety education and various awareness campaigns are held throughout the year.

HIV/AIDS

With the low prevalence and risk of HIV/AIDS in Switzerland and the United Arab Emirates, the Group's initiatives are geared towards its operations in Southern Africa, which is regarded as a high-risk area. So far the group is fortunate to have escaped the negative impacts of HIV/AIDS, with available statistics indicating that the prevalence of HIV/AIDS is low compared to other service-related companies. We believe our policies and training programmes contribute positively to this experience. Mediclinic Southern Africa's HIV/AIDS Programme consists of the following elements, as stated in the group's HIV/AIDS policy:

FIGURE 15: MEDICLINIC SOUTHERN AFRICA IN-SERVICE TRAINING HOURS

Employment category	Actual training hours per category	Number of training interventions	Hours per employee
Unskilled and defined decision-making	1 702	812	2.10
Semi-skilled and discretionary decision-making	36 190	13 645	2.65
Skilled technical and academically qualified workers, junior management, supervisors, foreman and superintendents	48 012	13 413	3.58
Professionally qualified and experienced specialists and mid-management	4 971	996	4.99
Senior management	90	13	6.92
Top management	21	5	4.20
TOTAL	**90 986**	**28 884**	

- education on HIV/AIDS combined with awareness programmes;
- voluntary counselling and testing;
- prevention of HIV infection and re-infection;
- access to appropriate treatment and monitoring; and
- continuous support through the EAP as well as early intervention.

A total review of Mediclinic Southern Africa's HIV/AIDS Programme is planned for this year to ensure that the group complies with the latest best practices and provides an effective service to its employees and customers. The policy review will include an HIV/AIDS risk assessment that will form the basis of the new policy.

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.

EMPLOYEE TRAINING

We continue to invest significantly in our training, with Mediclinic Southern Africa investing approximately 4% of payroll, Hirslanden approximately 4.8% and Emirates Healthcare approximately 0.3%. During the year Mediclinic Southern Africa has facilitated 28 884 structured learning interventions, as illustrated in **Figure 15**. Similarly, Emirates Healthcare facilitated 4 173 learning interventions. No accurate data are available in respect of Hirslanden.

The performance management system that is applied throughout the Group as referred to earlier is also utilised to identify and manage training needs of employees and to discuss career development.

Southern Africa

With regard to Mediclinic Southern Africa's nursing training initiatives, its training department is well positioned to meet the requirements of the Nursing Act, and to participate in any opportunities that may arise in training-related PPPs. We are confident that the private sector has a meaningful role to play, in particular with regard to training to address the acute nursing shortage in the country (see details of PPPs on pages 97 to 98). Mediclinic Southern Africa is provisionally registered as a private higher education institution and as a private further education and training college by the Department of Education. The group is therefore able to establish itself as an independent training provider for all levels of the higher education framework. This offers the potential to grow the group's nursing education to new levels once the nursing qualifications are aligned with the Nursing Act and the new National Qualifications Framework Act. Our success can be measured by the pass rate of the Mediclinic learners being above the national average pass rate.

During the 2010 academic year 643 (2009: 404) students successfully completed basic nursing courses, 84 (2009: 150) students completed post-basic courses and 845 (2009: 916) learners completed other Mediclinic courses in various disciplines. The decline in student numbers is mainly due to uncertainty around the new nursing qualifications, which have not yet been finalised by the South African Nursing Council.

Mediclinic Southern Africa's internal technical training programmes successfully address the shortage of skilled technical personnel. Electrical apprenticeship programmes continue in line with the MERSETA (Manufacturing, Engineering and Related Services Education and Training Authority) standards. This success opens opportunities for further artisan training. Other programmes include the training of pharmacist assistants, both basic and post-basic, in an effort to address the shortage of pharmacists.

Switzerland

Hirslanden's education and training programme covers a broad spectrum and opportunities are offered to employees at all levels. The group's career building is geared towards performance management, leadership building, quality control and client relationship building. Training initiatives are in support of these areas and many special courses are offered to staff, some of which are mandatory. The results of the patient satisfaction surveys are also taken into account to determine training needs.

During the year 140 management employees attended various in-house leadership and management courses.

United Arab Emirates

Emirates Healthcare's learning and development philosophy is centred on providing strategic support to the performance requirement of the group. The Clinical and Nursing Education departments provide training programmes for nursing staff and other healthcare providers, while the Training Department continues to use Mediclinic Southern Africa's nurse training programme. Approximately 1 583 learning interventions were recorded during the reporting period.

Partnerships with reputable institutions such as the University of Liverpool in the United Kingdom and Wollongong University in Dubai provide a means of support to staff members who are interested in furthering their studies.

Our training objectives for the year ahead include the centralisation of group training initiatives, pursuing tie-ups with educational institutions to further promote continued education and the development of a partnership with nursing colleges in Dubai and Sharjah as part of the Emiratisation programme.

CONTINUING PROFESSIONAL DEVELOPMENT OF DOCTORS

Throughout Mediclinic Southern Africa more than 400 continuous professional development ("CDP") functions were held for doctors during the period under review, which were attended by just over 6 400 doctors. These functions serve as valuable training opportunities aimed at keeping the group's associated specialists and referring general practitioners abreast of the latest developments in the medical field.

No professional development for doctors is organised by Hirslanden, as the public education institutions and professional associations fulfil the role of training and development of doctors in Switzerland.

Unlike Mediclinic Southern Africa and Hirslanden, Emirates Healthcare directly employs the majority of its doctors. Continuous medical education ("CME") for doctors, including some mandatory courses, is facilitated internally by the respective medical directors of the business units. In compliance with federal regulations concerning licensing, doctors, nurses and other clinical staff are expected to attend various CME events. During the past financial year six internal CME events were held covering topics such as Oncology, Anaesthesia, Dry Needling and Cardiology, as well as an Ian Donald Ultrasound course. A total of 76 of the group's doctors attended various local and international CME events.

Emirates Healthcare established a referral programme which will allow its Dubai physicians to draw on their international associations within the Mediclinic Group and channel the highly specialised cases to Hirslanden. This also offers an opportunity for the up-skilling of our doctors through their visits to the Swiss platform and in dealing with post-operative care back in Dubai.

MEDICLINIC HAS A STRONG LEARNING CULTURE AND MAKES SIGNIFICANT INVESTMENTS IN THE TRAINING AND DEVELOPMENT OF ITS EMPLOYEES

SUPPORTING ACADEMIC INSTITUTIONS

The Group is committed to educational development in all three of its operating platforms and continues to provide financial and other support towards healthcare education. A few examples of our sponsorships are listed below.

SOUTHERN AFRICA

Stellenbosch University

Stellenbosch University has been recognised as one of the four top research universities in South Africa and Mediclinic Southern Africa is proud of its ongoing association with this premier academic institution located in the Group's hometown. For a number of years the group has made and continues to make annual financial contributions of R1.2 million to the Stellenbosch University Health Sciences Faculty for this purpose. Among the departments and disciplines benefiting from this partnership are:

- Microbiology – The university's microbiology division is conducting research to establish local benchmarks on hospital-acquired infections and MRSA (methicillin-resistant staphylococcus aureus), which are key areas for risk management. The results will assist both the public sector and Mediclinic to develop policies and procedures to mitigate the risks associated with hospital-acquired infections and MRSA.
- Clinical pharmacology – We sponsor one registrar post in clinical pharmacology.
- Infection prevention and control – Our collaboration involves financial support towards the development of the training and education infrastructure of the unit for infection prevention and control.

University of the Western Cape

Mediclinic Southern Africa is in partnership with the University of the Western Cape's School of Pharmacy to support its efforts to provide management training to pharmacy students over a three-year period and has donated R143 000 annually to these courses, confirming the group's commitment towards an improved healthcare system. A further donation of R50 000 was made to the university in support of its partnership project with the Good Hope Education and Welfare Organisation (Getwel) to provide primary healthcare and early childhood development services to the community of Khayelitsha. Mediclinic will continue with its support during the year ahead.

University of the Witwatersrand, Johannesburg

Mediclinic Southern Africa continues to support the training of specialists at the Wits Donald Gordon Medical Centre, and contributed more than R2.5 million in 2009 towards the academic activities of the centre. A bursary to the value of R250 000 was provided for a fellowship in Maternal Foetal Medicine in 2009 and 2010 and we will continue with our support going forward.

University of Pretoria

Mediclinic Southern Africa once again provided support to the Health Sciences Faculty of the University with the sponsorship of R324 000 for a fellowship in the vascular surgery unit during the past year.

University of Limpopo – Medunsa

Mediclinic Southern Africa increased its annual financial contribution from R210 000 to R250 000 in 2010, thereby creating 50 bursary opportunities as opposed to 30 in the previous academic year. These bursaries were awarded to MMed students who are completing specialist training and Mediclinic Southern Africa will continue this support in the future.

University of the Free State
Mediclinic Southern Africa sponsors the R200 000 subscription to the UpToDate clinical information resource service on behalf of the University of the Free State. This service offers associated academics and medical professionals access to evidence-based, peer-reviewed medical information that contains a vast selection of literature, latest evidence and specific recommendations for patient care. A sponsorship of R185 000 was also made towards an endoscopic laboratory and practice dolls for training registrars and students.

SWITZERLAND

Hirslanden cooperates with different regional and local education centres for the education of health professionals in nursing. The group also provides assistance to various public hospitals, for example, sharing the education of intensive care professionals. In addition there are a number of nurses studying for the master's degree in nursing who are supported by the group.

ETHICS AND COMPLIANCE

CODE OF BUSINESS CONDUCT AND ETHICS

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"), which was adopted in March 2010. The code provides a framework for employees of the standards of business conduct and ethics that are required of all business divisions, directors and employees within the Group in order to promote and enforce ethical business practices and standards throughout the Group. The code is included in the on-boarding information for new employees and is available on the intranets of the operating platforms. To promote a clear understanding of the code throughout the Group, management is in the process of finalising a user-friendly guide to the code for employees.

ETHICS LINES

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. The number of calls received through the ethics lines during the year is as follows: eight by Mediclinic, 21 by Mediclinic Southern Africa, none by Hirslanden and three by Emirates Healthcare, with the majority of the calls being of a grievance nature. To date no information has been received that has led to the discovery of fraudulent behaviour – a clear indication of an overall commitment to ethical behaviour throughout all levels of the Group.

Mediclinic Southern Africa's Ethics Line is managed by an independent service provider, which ensures that each call will be treated with the utmost confidentiality; the service is available on a 24-hour basis to all staff and outside stakeholders. All complaints are investigated according to a set protocol.

CORRUPTION

The Group adopts a no-tolerance policy with regard to unethical business conduct, in particular also fraud and corruption, which is addressed in the

code. Strict policies relating to any invitations, gifts or donations received from suppliers or any other party, in terms of which personnel are compelled to declare these to management for approval, apply throughout the Group. Staff members involved in the purchasing of equipment or consumables are also bound to strict ethical principles, ensuring that an impeccable standard of integrity is maintained in the Group's business relationships.

The code further prohibits the making of donations to political parties, unless it has been pre-approved by the board of the relevant operating platform and reported to the Executive Committee of Mediclinic. No donations to political parties were made by Mediclinic Southern Africa or Emirates Healthcare during the period under review. An insignificant amount of CHF5 500 was made available by Hirslanden towards donations to political parties and politicians. Political donations by business companies are a common and accepted practice in Switzerland. In particular, contributions to campaigns for popular legislative initiatives and referendums are widespread. Hirslanden makes political donations only in selected cases and in a very limited volume.

The Audit and Risk Committee of the Group's three operating platforms considers any incidents of attempted fraud or corruption at each committee meeting. Any material issues are reported to the Audit and Risk Committee of Mediclinic. There were no material incidents of fraud or corruption during the reporting period.

COMPETITION

The Group supports and adheres to the relevant competition and anti-trust laws applicable in the various countries in which the Group operates. These laws are complex and the Group has therefore issued guidelines to its employees on competition law compliance within their relevant jurisdiction. No legal action for anti-competitive, anti-trust or similar conduct was instituted against the Group during the year.

CUSTOMER PRIVACY

There were no substantiated complaints regarding a breach of customer privacy or loss of customer data against the Group during the year.

COMPLIANCE

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.

INVESTING IN THE COMMUNITY

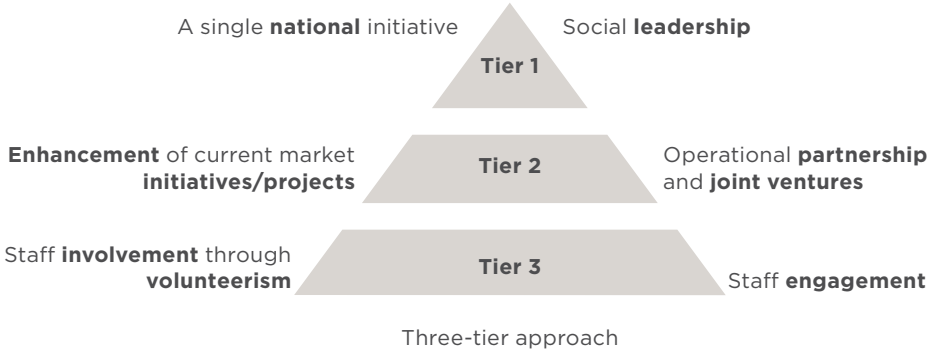
Mediclinic's contribution to a healthy community starts within our own facilities, where we strive to provide clinical excellence and quality care. We contribute to the well-being of the communities within which we operate by investing in ongoing initiatives that address socio-economic problems or risks 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. Please refer to the section dealing with our training and development initiatives, in particular also our support of academic institutions, on pages 104 to 107.

SOUTHERN AFRICA

Mediclinic Southern Africa believes that it could have a meaningful impact on the greater South African society, with much to contribute to previously disadvantaged communities and

FIGURE 16: MEDICLINIC SOUTHERN AFRICA'S CSI APPROACH



Three-tier approach

destitute families in South Africa through its skills, technical expertise, financial resources and employee time. Mediclinic Southern Africa has successfully implemented a comprehensive CSI strategy at both corporate and hospital level in the past year. This strategy, which is in line with the group's business objectives, aims to facilitate the best use of the group's resources to address the healthcare needs of many more South Africans. Our CSI projects are also aimed towards broad-based transformation, with the vast majority of the beneficiaries being black.

The group's CSI strategy centres on four core areas of involvement, namely health, education, sport and welfare, and operates on three tiers, as illustrated in **Figure 16**. By developing these three tiers, we aim to offer social leadership, operational partnerships and staff engagement for the benefit of society in areas which are aligned with our core business offering. Approximately R3.2m (2010: R3.5m), which excludes the donation of various used equipment to the value of about R0.8m (2010: R0.4m) and our operational costs, was spent across the three tiers of the CSI strategy during the year. A brochure highlighting the myriad projects Mediclinic Southern Africa is involved in was published in 2010, and serves as another form of engagement with our stakeholders. Some examples of our initiatives during the year include:

- Tier 1: 150 cataract operations performed at Mediclinic Kimberley, with a further 130 planned for the year ahead. Cataract procedures with the KwaZulu-Natal Department of Health, as well as support of this department's Medical Male Circumcision project, are planned for the year ahead. We assisted the national Department of Health by providing health-screening services at the department's international conference on violence against women. We also assisted the department with its campaign for HIV/AIDS counselling and voluntary testing by printing the marketing leaflets to the value of R0.5m which were provided to the South African National AIDS Council for distribution.
- Tier 2: Mediclinic Southern Africa allocated R1.95m (2010: R2.3m) in donations to 45 charitable community organisations that met our requirement to illustrate support within health, education, sport or welfare. In addition to this, in-kind donations of used computers with a second-hand value of about R0.8m were made to various schools and organisations throughout the regions in which the group operates.
- Tier 3: The group's staff members regularly volunteer time to support social upliftment efforts and community-based projects. Many of the group's nursing personnel participate in community-based antenatal classes, breastfeeding clinics and well baby clinics. The roll-out of the staff volunteerism programme to all hospitals within the group is planned for the year ahead.

In addition to our CSI initiatives, our hospitals provide annual and ad hoc sponsorships of community, school and regional sporting and cultural events, and also take part in many annual national health awareness days by providing free health screenings, discussions and workshops during national awareness initiatives such as breast cancer month, heart and stroke week, diabetes and pregnancy education months, and many others. A few examples include our ongoing sponsorship of the National Cancer Survivors' Day, contributing R50 000 in addition to the participation of the individual hospitals in regional Cancer Survivors' Day activities. The group's three Namibian hospitals raised N$40 152 with the 2010 Mediclinic Breast Cancer Awareness Walk for the Cancer Association of Namibia. We will also provide R1m for the World Congress of Paediatric Cardiology due to take place in Cape Town in 2013.

WE CONTRIBUTE TO THE WELL-BEING OF THE COMMUNITIES WITHIN WHICH WE OPERATE BY INVESTING IN ONGOING INITIATIVES THAT ADDRESS SOCIO-ECONOMIC RISKS

Our corporate events department is focused on event, disaster and medical support management. The number of events supported is growing annually, with some 30 events supported during the year under review. Some of the high-profile sporting and cultural events being supported include the Absa Cape Epic Mountain Bike Challenge, the Cape Argus Pick n Pay Cycle Tour, the Kalahari Augrabies extreme marathon, the Cape Times Big Walk and the Cadiz Freedom Swim between Robben Island and Milnerton.

SWITZERLAND

Hirslanden is committed to close, enduring and long-term relations with communities and follows a policy based on mutual understanding, trust and reliability. The group's communication with the community is based on the principles of clarity and transparency: different mediums such as the group's website, events and printed media are used to inform the public and maintain a dialogue.

In support of Hirslanden's aim to promote health, we support and provide medical support to various foundations such as:

- The Swiss Heart Foundation which promotes research on cardiovascular diseases, and the Swiss Cancer League. We supported the Swiss Cancer League project "Race against cancer" as a medical partner. The "Race against cancer" project was launched to raise money for the Cancer League to finance research and public awareness. Hirslanden made a donation and was responsible for the medical support and emergency unit during the one-day cycling race in the Swiss Alps. Through the event, the Swiss Cancer League was able to raise over CHF220 000, which will be used for prevention campaigns.
- The Solar Impulse Project, which aims to have an airplane take off and fly around the world propelled by solar energy only, day and night, without using fuel or producing pollution. Hirslanden is the official medical advisor of the Solar Impulse Project. Hirslanden organised various medical tests and sessions for the pilots in order to prepare for the first-ever 24-hour solar flight in October 2010. Hirslanden organised a moving exhibition in all hospitals providing information to the public about the project and the Hirslanden contribution to medical safety.

Public information events are held on a regular basis, providing first-hand information about a variety of medical conditions and their treatment. Our affiliated specialists are involved in each of them and we were able to attract over 12 000 individuals to these public sessions in 2010, 35% more than the previous year. All sessions are advertised in the local press as well as in printed programmes and hospital magazines. Our website shows the comprehensive list of all events, with the possibility for a visitor to register online for a session. This initiative enables our specialists to deliver high-end medical information in a way the public understands it and is gaining widely in popularity.

UNITED ARAB EMIRATES

Emirates Healthcare is actively involved in various community activities, providing medical support, donations and health education and awareness campaigns.

Examples of the group's sponsorships, donations, medical support and health awareness activities during the reporting period include:

- Pro bono medical assistance provided to a patient of Welcare Hospital;
- Free health screenings of almost 4 000 patients as part of health awareness campaigns, including World Heart Day, World Diabetes Day, World Health Day, DHL Health Week, World Glaucoma Day, Diabetes Awareness Week and Fitness First Wellness Day;

- Free public health talks and seminars to encourage health awareness;
- Free public nutritional assessments provided at The City Hospital in October 2010;
- Donation of AED30 000 towards Dubai's Roads and Transport Authority for its road safety campaign;
- Participation in awareness sessions with local businesses;
- Sponsorship of the Dubai Ultimate Charity Event.

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.

This section of the report includes the environmental performance of the entire Group. In the case of Hirslanden the performance of Klinik Stephanshorn has been excluded as this hospital was only acquired in the second half of the financial year.

ENVIRONMENTAL POLICY

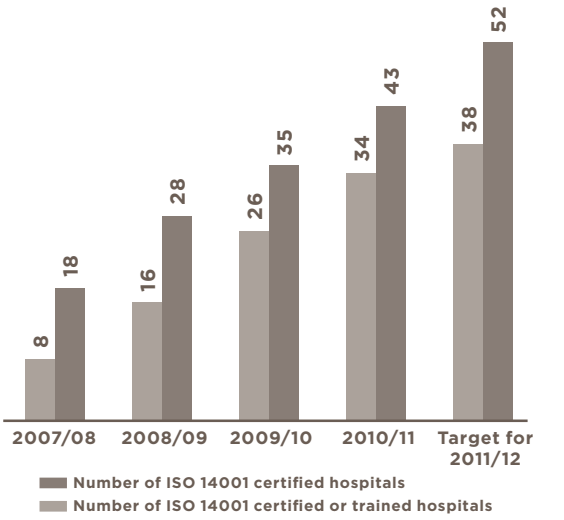
The Group Environmental Policy, aimed at minimising Mediclinic's environmental impacts, requires each operating platform of the Group to:

- 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 an 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 medical 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.

The policy assists the Group to identify aspects of its business that could have a significant impact on the environment, and to set objectives and targets with a review process to eliminate or reduce the impact of these aspects on the environment. It formally documents the Group's commitment, strategy, reporting standards and governance approach to manage its environmental impacts and performance. All business divisions within the Group are required to implement appropriate environmental management systems and (where appropriate) have them certified by an internationally recognised body.

The Group Chief Executive Officer and the Chief Executive Officers of the operating platforms are responsible for the implementation of the policy, the duties of which may be delegated to an appropriate manager of sufficient seniority.

FIGURE 17: ISO 14001:2004 CERTIFIED AND TRAINED HOSPITALS (MEDICLINIC SOUTHERN AFRICA)



ENVIRONMENTAL MANAGEMENT AND RISK ASSESSMENT

SOUTHERN AFRICA

Mediclinic Southern Africa is committed to ensuring that its environmental management systems and practices are aligned with international best practices, which are based on the ISO 14001:2004 Specification for Environmental Systems. The group's performance is assessed through certification by an external assurance provider (the National Quality Assurance London), as accredited by the United Kingdom Accreditation Services. We have nearly achieved our objective of having 35 of our 52 hospitals ISO 14001 certified, with 34 (2010: 26) hospitals certified to date. We aim to have four additional hospitals ISO 14001 certified during the year, increasing the total number of certified hospitals to 38. The number of ISO 14001 certified trained hospitals, which includes the 34 certified hospitals, increased from 35 to 43. These hospitals follow the same environmental management practices and are also subject to annual internal audits. The group aims to have all 52 hospitals trained during the year ahead. Our progress in certification and training is illustrated in **Figure 17**.

The main environmental impacts being managed are the utilisation of resources and waste management. These have a direct effect on the carbon emissions of the group.

Mediclinic Southern Africa's performance assessment criteria, performance during the year and objectives going forward in line with the Group Environmental Policy are illustrated in **Figure 18**, which elements are required under ISO 14001.

Risks associated with climate change are assessed annually by Mediclinic Southern Africa and managed in terms of the group's risk management procedure. These potential risks include:

- Regulatory risks: Operational costs of running of facilities could be affected by risks relating primarily to energy supply, with 85% of our carbon emissions from electricity purchased;
- Physical risks: Access to facilities and interruptions in service resulting from risks of water shortage, electricity load shedding or incidents of extreme weather conditions.

The financial implications of these risks have been considered and appropriate control measures are in place, such as installation of generators at all facilities to ensure uninterrupted service delivery; monitoring equipment to monitor damage caused by load shedding; bulk water-storage facilities; and a Major Incident Medical Management System.

SWITZERLAND

Strict and comprehensive environmental legislation and regulations apply in Switzerland, with which Hirslanden complies, ensuring that the group maintains the highest degree of environmental care. The technical teams at the hospitals, under the guidance of the group's Head of Technical Services, continue to focus on improving existing measures. The group's main environmental impact is energy consumption. Therefore, a top priority for Hirslanden is to lower energy consumption and to follow energy-efficient building standards such as MINERGIE®, where this is economically justifiable, such as the planned building project at Klinik Hirslanden.

Hirslanden does not follow environmental management systems such as ISO14001 or EMAS (Edo-Management and Audit Scheme). However, having a certified quality management system (ISO 9001) in place throughout the group,

FIGURE 18: ENVIRONMENTAL MANAGEMENT PERFORMANCE AND OBJECTIVES

Criteria	Specific assessment criteria	Performance	Revision and planning
Compliance with environmental and other legislation	29 applicable national laws Four applicable provincial laws 55 applicable municipal by-laws, excluding tax, business, medical and finance legislation	Environmental legal register (version 9) established. Province/region-specific legal register established for: Free State, Western Cape, Gauteng, Northern Cape, KwaZulu-Natal, Tshwane, Mpumalanga and Namibia. Confirmation of legal compliance at 36 hospitals. Audits completed at 36 hospitals.	SHE (safety, health and environmental) integrated legal register to be finalised during next financial year.
Environmental Management Systems	ISO 14001:2004	34 hospitals ISO 14001 certified, with certification of additional four hospitals in progress. 43 hospitals ISO 14001-trained	Four additional hospitals to be ISO 14001-certified. Nine additional hospitals to be ISO 14001-trained.
	JSE SRI Index	Inclusion in JSE SRI Index 2010 maintained. Best performer with regard to environmental matters.	Maintain inclusion in JSE SRI index 2011.
	Carbon Disclosure Project 2010	Overall joint 2nd ranking.	Participation in Carbon Disclosure Project 2011.
	CDP Water Disclosure Project 2011	Committed to participate in first project.	Establish and verify baseline data.
Environmental awareness	ISO 14001:2004	Network between 43 hospitals. Programme for continuous environmental awareness in place. An ISO 14001 awareness calendar in place in line with international awareness programmes. Yearly environmental awareness competitions at hospitals and exhibitions.	Environmental awareness entrenched in all business activities.
Prevention and minimising of impacts	ISO 14001:2004	43 ISO 14001-trained hospitals with programmes.	Implementation of a Sustainable Culture Course at 11 hospitals to enhance the preventions and minimising of impacts.
Aspect identification	Aspect register	43 ISO 14001-trained hospitals with aspect registers. New user-friendly aspect register implemented at 10 hospitals.	A generic aspect register with baselines including medical waste, water, electricity, paper, hazardous waste and normal waste to be established. New user-friendly aspect register to be implemented at an additional 10 hospitals during year ahead.
Recycling of general waste	ISO 14001:2004	43 ISO 14001-trained hospitals with processes. Waste recycling programmes in progress at all ISO-trained hospitals.	Compiling Waste Management Plans at hospitals.

FIGURE 18: ENVIRONMENTAL MANAGEMENT PERFORMANCE AND OBJECTIVES (CONTINUED)

Criteria	Specific assessment criteria	Performance	Revision and planning
Management of hazardous waste	ISO 14001:2004 Local by-laws	43 ISO 14001-trained hospitals with processes. Hazardous waste register established at 43 hospitals. Various other processes in place.	Implementation of ISO 14001 hazardous waste management/minimisation processes at all hospitals.
Influencing suppliers and service providers	ISO 14001:2004	43 ISO 14001-trained hospitals with processes. Internal audit programme for service providers established at 43 hospitals.	Continued green approach to suppliers and providers, targeting the top 5 suppliers for technical, housekeeping, kitchen and laundry at each hospital.
Nursing of resources	ISO 14001:2004	Various energy and resources saving projects completed and in progress. Best practices and cost-effective projects rolled out to all hospitals.	Benchmark against healthcare industry in South Africa and abroad. Highlight excessive use and inefficient plant.

Hirslanden strives to operate according to standardised environmental management principles.

To manage these we record and monitor key environmental performance indicators, such as CO_2 emissions, energy and water consumption, paper usage and waste.

Hirslanden achieved FSC (Forest Stewardship Council) certification for all printed matters during the period under review. FSC certification is a voluntary, market-based tool that supports responsible forest management worldwide.

United Arab Emirates

EHL Management Services participated in a thorough carbon footprint analysis of all its Dubai facilities by sustainability experts. The analysis and subsequent recommendations have been taken into account and a strategy has been formulated to enhance the impact of the promising start already made during 2010. Following the implementation of some ISO 14001 environmental management standards during the period under review, our objective is to have it fully implemented throughout the group during the year ahead.

It is planned to update the supplier selection criteria to also give due consideration to eco-friendly products.

EMISSIONS

The Carbon Disclosure Project ("CDP") is a global initiative established in 2000 to measure companies around the world and their reporting on greenhouse gas emissions and climate change strategies. It is regarded as a global leader in capturing and analysing data that record business response to climate change, including management of risks and opportunities, absolute emissions levels, performance over time and governance. Participation and disclosure of the results are voluntary. Following the evaluation process, qualifying participants are ranked in the Carbon Disclosure Leadership Index ("CDLI"), which recognises companies with leading disclosure practices. The project was launched in South Africa in 2007 in partnership with the National Business Initiative in which JSE-listed companies are measured. Mediclinic has participated in the project since 2008, initially only in respect of Mediclinic Southern Africa. With the most recent CDP 2010, limited information of Emirates Healthcare was also included, although it still remains an initiative focusing mainly on Mediclinic Southern Africa's data. During the most recent CDP 2010, Mediclinic was awarded the joint 2nd ranking out of the 74 JSE-listed companies that participated (**Figure 19**). Mediclinic's CDP reports can be accessed on the CDP website at www.cdproject.net.

FIGURE 19: RESULTS OF SOUTH AFRICAN CARBON DISCLOSURE PROJECT

CDP6 (2008)	CDP 2009	CDP 2010
Ranked 7th amongst CDLI leaders in low carbon sector.	Ranked amongst top 16 performers, although not included in CDLI.	Ranked joint second position in CDLI.

FIGURE 20: CARBON EMISSIONS PER HOSPITAL-SPECIFIC ACTIVITIES (MEDICLINIC SOUTHERN AFRICA)

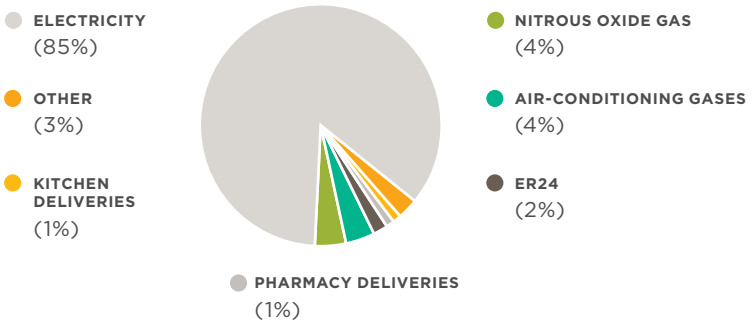


FIGURE 21: CDP 2010: TOTAL GREENHOUSE GAS FOOTPRINT (MEDICLINIC SOUTHERN AFRICA)

	CDP6 (2008)		CDP 2009		CDP 2010	
Emission source	**Tonnes of CO_2e**	**%**	**Tonnes of CO_2e**	**%**	**Tonnes of CO_2e**	**%**
Direct emissions from anaesthetics, ER24, pool cars, incinerators, generators and kitchen	13 008	8%	11 915	7%	**11 804**	**7%**
Indirect emissions from electricity	145 428	87%	141 356	88%	**154 237**	**85%**
Indirect emissions from company supply chain, business travel and waste removal	8 572	5%	7 677	5%	**7 023**	**4%**
Non-Kyoto Protocol	–	0%			**6884**	**4%**
Total	167 008	100%	160 949	100%	**179 948**	**100%**
kg CO_2e/occupied bed-day	110		104		**112**	

Participation in the project provides companies with an opportunity to identify climate change-related management aspects which require further attention and this has assisted Mediclinic Southern Africa to implement measurements and processes to monitor its carbon emissions. Our participation further enabled our commitment to be transparent by providing detailed information to interested stakeholders about its initiatives to reduce the group's carbon footprint and environmental impact. The group will continue to participate in this project in future.

The carbon footprint of Mediclinic Southern Africa is measured using the GHG Protocol and includes direct emissions, which in the healthcare industry will refer mainly to the emissions of anaesthetics gases (scope 1 emissions); indirect emissions from the consumption of electricity (scope 2 emissions); indirect emissions from suppliers, which in the healthcare industry will refer mainly to pharmaceutical, bulk oxygen and waste-removal suppliers (scope 3 emissions); as well as non-Kyoto Protocol greenhouse gas emissions such as freon, which is used in air-conditioning and refrigerant equipment. With the assistance of external consultants, these emissions data were converted to a carbon dioxide equivalent (CO_2e) using recognised calculation methods, emission factors and stating assumptions made, where relevant. Mediclinic Southern Africa's carbon footprint as reported in our Carbon Disclosure Report 2010 is set out in **Figures 21** and **22**, evidencing that electricity is the main contributor to our carbon footprint. Our operations in Switzerland and the UAE are not yet able to provide the information with accuracy.

FIGURE 22: CDP 2010: REPORTED DIRECT AND INDIRECT GHG EMISSIONS (MEDICLINIC SOUTHERN AFRICA)

Description	Tonnes of CO_2e
Scope 1: Direct emissions	**11 803.60**
Fuel used in ER24 (Emergency vehicles)	2 587.09
Fuel used in generators	207.19
Fuel used in incinerators	130.84
Air-conditioning and refrigeration gas refills	631.56
Gas (N_2O) consumed by anaesthetists	7 120.36
Gas (LPG) consumed in kitchens	176.37
Gas (CO_2) consumed in the hospitals	5.71
Natural gas consumed in hospitals	8.05
Pool cars and fleet owned by MCSA	936.44
Scope 2: Indirect emissions from electricity purchased	**154 237.28**
Scope 3: Indirect emissions from supply chain, business travel and waste removal	**7 022.70**
Business travel in rental cars	92.48
Business travel in commercial airlines	1 325.87
Hotel accommodation	94.84
Travel claims (use of private vehicles for business purposes)	420.66
Third party: Pharmaceutical deliveries	1 812.82
Third party: Gas deliveries	539.80
Third party: Waste collections (normal and hazardous/medical)	432.88
Third party: Kitchen deliveries	1 530.20
Third party: Laundry deliveries	245.95
Consumption of office paper	527.20
Total direct and indirect emissions	**173 063.58**

In South Africa greenhouse gases like HCFC22 (Freon or R22) and R406 continue to be used as gas refills in air-conditioning and refrigerant equipment. They are, however, not included among Kyoto Protocol greenhouse gases as it is presumed that they and other HCFC gases are being phased out under the international Montreal Protocol on Ozone Depleting Gases. While the GHG Protocol's scope 1, 2 and 3 emissions are strictly for greenhouse gases that fall under the Kyoto Protocol, provision is made for separate reporting on other GHGs that might be under consideration by international treaties. Mediclinic Southern Africa's data on these emissions were included for the first time in our CDP 2010 report as set out in **Figure 23**.

Only seven of Mediclinic Southern Africa's 52 hospitals have their own incinerators. Of these seven hospitals, only four incinerators are operational. Currently the carbon emissions caused by the activities of these incinerators are measured in the consumption of diesel usage. Currently no verified data exist to calculate the different pollutants. The group is investigating the upgrade process of these incinerators. This upgrade process includes the installation of monitoring and measuring equipment.

Some of the measures implemented in Mediclinic Southern Africa to reduce its emissions include:

- Healthcare risk waste is treated via the ETD (electrothermal deactivation) process at 12 hospitals with the benefit of lower formation of harmful dioxins and furans.
- Air-conditioning gases at various hospitals are being monitored and measured at various hospitals. Various air-conditioning gases capturing plant models and procedures are also being tested.
- Anaesthetic gases at various hospitals are being monitored and measured at all hospitals. All anaesthetic delivery units were upgraded to measure flow per millimetre of anaesthetic gases. Only low-flow anaesthetic delivery units are considered for purchase.
- Heatpumps were replaced at 11 hospitals during the reporting period.
- Replacement of fluorescent fittings at nine hospitals during the reporting period.

FIGURE 23: DIRECT EMISSIONS FROM AIR CONDITIONING AND REFRIGERATION GAS REFILLS

Description	Tonnes of CO_2e
R22 (Freon)	6 840.03
R406	43.91
Total non-Kyoto Protocol GHG emissions	**6 883.94**

The increase in emissions from the CDP2009 and CDP2010 results is due to an increase in bed-days sold, which provides data that are more accurate than in previous years. An example of this is electricity, where previous electricity data for some hospitals were estimated. Mediclinic Southern Africa now has in-house meters in over 50% of the hospitals, ensuring the accurate measurement of electricity usage. The addition of new data is another factor: examples of this are air-conditioning and refrigeration gas refills, natural gas and paper consumption for Practice Relief.

A carbon emission reduction in respect of scope 2 emissions of 2.12% was achieved during the reporting period by Mediclinic Southern Africa against a target of 3.09 %, despite an increase of 2.9% in bed-days sold. This target was set based on the group's electricity consumption during the previous financial year. If the additional bed-days sold are excluded, a reduction of 5.15% was achieved.

WASTE MANAGEMENT AND RECYCLING

Stringent protocols are followed to ensure that refuse removal within the Group complies with all legislation, regulations and by-laws. During the reporting period, there were no incidents at the Group's facilities or offices leading to significant spills.

SOUTHERN AFRICA

The implementation of ISO 14001 standards and principles at Mediclinic Southern Africa's ISO-certified and/or trained hospitals contributes to waste management with sustainable processes in place to ensure continuous improvement and control. The reduction of normal waste is achieved through recycling and waste separation programmes, which include optimal use of paper and printers, and staff awareness training in compliance with ISO 14001:2004.

Ten hospitals have full recycling programmes in place, with five hospitals having a waste minimisation programme in place. All other hospitals are investigating recycling opportunities in their area. A programme of continuous training on waste segregation has been implemented at hospital level to ensure the correct disposal of waste.

SWITZERLAND

Hirslanden complies with the ordinance relating to the treatment and movement of medical waste. The federal and cantonal acts also regulate certain ecological matters, requiring the group to comply with the principle of product-specific disposal. During the year the group commenced with close analysis of our waste management system. Abfallboerse, a company for the waste exchange market, assessed the waste processes of the group's hospitals and collected the group's waste management costs. The outcomes of the tendering procedure resulted in estimated annual savings of between CHF150 000 and CHF200 000 for the group. For the next three years the same company will continue to collect waste data in order to provide sustainable key figures.

UNITED ARAB EMIRATES

Medical waste is handled by a professional waste removal firm to ensure minimum risk to the environment. The City Hospital also has an ongoing contract with a recycling company to collect recyclables such as waste paper, old corrugated cardboard, plastics and cans from the premises.

The management of paper waste through stricter controls of ordering and by segregating the medical and general waste correctly has led to a reduction in our medical waste costs, with Welcare Hospital achieving a 25% reduction in medical waste costs.

FIGURE 24: WATER USAGE FROM WATER UTILITIES (KILOLITRES)

	2009/10	2010/11
Southern Africa	967 237	**1 145 527**
Switzerland (data only available in respect of 2009 and 2010 calendar years)	266 018	**267 421**
UAE (hospitals only)	64 522	**73 846**
Total	**1 297 777**	**1 486 794**

WATER CONSUMPTION AND RECYCLING

The total volume of water withdrawn from water utilities throughout the Group is provided in **Figure 24** in respect of the period under review.

Various initiatives are in place throughout Mediclinic Southern Africa to reduce water consumption, including the use of grey water and recycled water. During the year 205 598 kilolitres of water was recycled, representing 17.95% of total water usage. Recycling of water is done through recycling of laundry water, autoclave water and cooling tower water. Measurement equipment was installed at new water-savings initiatives during the year, which will assist in measuring results and savings achieved. Other initiatives to reduce water consumption include employee awareness training, monitoring of uncontrolled leakages and monitoring garden irrigation cycles.

Hirslanden mainly makes use of water withdrawn from water utilities, but during the year Klinik Beau-Site commenced using rain water as well (1 218 kl). No water recycling initiatives are in place at Hirslanden and Emirates Healthcare. Within Hirslanden waste water is directly treated by the municipality and is monitored locally by the group's hospitals.

At Emirates Healthcare various measures are in place to reduce water consumption, such as monitoring of water usage in specific areas such as gardens and kitchens, installation of control sensors on taps in hospital wards, reducing pressure of water points, and recycling of water for irrigation purposes. With these measures in place, Welcare Hospital experienced a 17% saving in water costs year on year and in The City Hospital water consumption increased by only 8%, despite the almost doubling of bed-days sold.

Water discharged at Mediclinic Southern Africa's operations is defined as industrial effluent, which is mostly sewerage. Currently no measuring system is in place to measure the volume of industrial effluent at any of the group's operations. The volume of water discharged (industrial effluent) is calculated by the water utility in the different localities where Mediclinic Southern Africa operates. The average calculation of these utilities for our operations is 89% of the treated water supplied.

The volume of waste water discharged by Hirslanden equals the full volume of water withdrawal. The waste water is treated by the treatment plants of the municipalities following the common practice in Switzerland.

The same applies to waste water at Emirates Healthcare.

ENERGY CONSERVATION

The direct and indirect energy consumption for the Group is illustrated in **Figure 25** for the period under review. The main sources for direct energy consumption are gas/diesel oil, motor gasoline, liquefied petroleum gas and natural gas. Indirect energy sources refer to electricity consumption.

Energy is a key risk across all three operating platforms of the Group. Various energy conservation and cost-efficient initiatives are implemented throughout the Group, examples of which are provided below.

SOUTHERN AFRICA

- Implementation of ISO 14001 management standards has a positive effect on reduction of energy consumption and also improves staff awareness. Year-to-year continuous improvement in energy consumption was achieved by 12 ISO 14001-certified hospitals, achieving a further reduction in energy consumption of 5.12% for the period under review.

FIGURE 25: DIRECT AND INDIRECT ENERGY CONSUMPTION (GIGAJOULES)

	Direct energy purchased	Direct energy produced	Indirect energy consumed	Total energy consumption
Southern Africa	57 950gj	0	521 418gj	579 368gj
Switzerland (in respect of 2010 calendar year)	93 192gj	127gj (through solar collectors)	101 334gj	194 653gj
UAE (hospitals only)	19gj	0	51 860gj	51 879gj

- The Energy Initiative Committee measures the energy utilisation within the group to determine where savings can be achieved and it evaluates various new energy efficiency and renewable technologies. Examples of projects planned for the year ahead include: the replacement of heat pumps at 11 hospitals at an estimated cost of R5m with an anticipated annual energy saving of 5 224 081 kWh; the replacement of chillers with ice storage and heat recovery at Mediclinic Morningside at an estimated cost of R3.7m with an anticipated annual energy saving of 1 519 333 kWh; the replacement of fluorescent fittings at nine hospitals at an estimated cost of R2.9m with an anticipated annual energy saving of 3 782 197 kWh (it is expected to achieve only 50% of the cost due to the installation period falling within the year).
- Mediclinic Southern Africa application to Eskom for registration as an Energy Services Company was approved during the year. Our role will be to identify opportunities, compile proposals for submission to Eskom's Demand Side Management (DSM) for funding, implementation and maintenance of DSM projects in Mediclinic Southern Africa's hospitals.
- The autoclave centralised boiler systems of four hospitals, found to be energy-intensive consumers, are being replaced with an integrated boiler system for each autoclave.

SWITZERLAND

- With energy consumption being the main environmental impact of Hirslanden, performance indicators, such as energy consumption per bed and energy consumption per patient are monitored on an ongoing basis. To mitigate the environmental impact several investments were made during the year, such as:
  - Klinik Aarau: an "Ecojet" system was installed within the natural gas pipes to change the ratio between oxygen and natural gas. The system will reduce the natural gas consumption by approximately 9%.
  - Andreas Klinik: the control system of the central-heating boiler was changed from a static to a dynamic system. This measure regulates the boiler temperature according to the current needs.
  - Klinik Belair: energy consumption is expected to decline following the replacement of windows by high-standard insulated windows.
  - Klinik St. Anna: the temperature of the heating oil has been lowered from 210°C to 190°C.
  - Optimising of day-to-day practices, such as adjusted operating hours of the ventilation system, replacement of light bulbs with energy-saving bulbs, or halogen bulbs with LED, installation of motion sensors for lighting of less used areas.
  - Klinik Am Rosenberg: use of solar protectors to produce hot water.
- For the year ahead, the following further investments are planned, most of which can be replicated and implemented at the group's other hospitals:
  - Klinik Hirslanden: the ongoing expansion project of Klinik Hirslanden is built in accordance with Swiss energy-efficiency standards or new and refurbished buildings, MINERGIE®, which requires that the general energy consumption may not to be higher than 75% of that of average buildings and that fossil-fuel consumption must not to be higher than 50% of the consumption of such buildings.
  - Clinique Bois-Cerf: the replacement of windows with high-standard insulated windows.
  - Klinik Belair: the installation of a reactive current machine and the replacement of windows with high-standard insulated windows.
  - Klinik Am Rosenberg: the installation of a heat-recovery system; the extension of the

operating theatre building by having a highly insulated shell; the installation of the latest lighting technology; and use of rain water.
- Klinik St. Anna: the installation of an automated shutter system.

UNITED ARAB EMIRATES

- Replacement of lighting fixtures in various buildings with energy-efficient lights.
- Welcare Hospital: achieved close to 10% savings in energy costs through various initiatives such as optimal usage of air conditioners; control of lights with timers; replacement of bulbs with energy-efficient lighting.
- The City Hospital: projected monthly saving in electricity costs of approximately AED2 470 through removal of non-essential lighting from patient rooms; projected monthly saving of approximately AED18 000 following the launch of an air handling unit project in October 2010, in which the air-conditioning in the outpatient block is turned off at night and over the weekend.

MATERIAL USE

In Mediclinic Southern Africa various hospitals are mercury free, whilst the remaining hospitals are in the process of becoming mercury-free hospitals. In the procurement of new equipment, mercury-free equipment is purchased. Mercury disposal is done according to a corporate environmental procedure with records kept of all mercury disposals. Quantitative data for the environmental impacts of mercury will be compiled during the next financial year.

BIODIVERSITY

All new building projects in Mediclinic Southern Africa are only undertaken after an Environmental Impact Assessment has been performed. An investigation is planned for the year ahead to determine the location and size of land owned, leased, managed in, or adjacent to, protected areas and areas of high biodiversity value outside protected areas in Southern Africa. None of the facilities of Hirslanden and Emirates Healthcare are owned, leased, managed in, or adjacent to, protected areas and areas of high biodiversity value outside protected areas.

COMPLIANCE

There were no incidents of material non-compliance with any environmental laws, regulations, accepted standards or codes applicable to the Group, with no significant fines being imposed during the year.

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 any matter relating to the Group's sustainable development practices. Please contact:

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GRI G3 DISCLOSURE INDEX

The table below identifies the location of the standard disclosures required by the Global Reporting Initiative's sustainability reporting guidelines, although all may not be entirely in accordance with the GRI guidelines. The reports meet the requirements for an application Level C in terms of the GRI G3 requirements.

GRI G3 disclosure reference	Description	Section of annual report	Page reference
	STRATEGY AND ANALYSIS		
1.1	CEO statement on sustainability	Chief Executive Officer's Report	19
1.2	Key impacts, risks and opportunities	Group Objectives	8
		Chief Executive Officer's Report	17 – 21
		Clinical Governance Report	45
		Risk Management Report	59 – 61
		Sustainable Development Report	86 – 89
	ORGANISATIONAL PROFILE		
2.1 – 2.8	Name; primary brands, products and services; operational structure; location of headquarters; countries where organisation operates; nature of ownership and legal form; markets served; scale of the organisation	Organisational Overview	4 – 5
		Sustainable Development Report: Organisational structure	74 – 75
2.9	Significant changes regarding size, structure or ownership	Report Profile	IFC*
2.10	Awards received	Sustainable Development Report: Figure 1	74
	REPORT PARAMETERS		
Report profile			
3.1 – 3.4	Reporting period; date of previous report; reporting cycle; contact person	Report Profile	IFC*
3.5 – 3.8	Process for defining report content; boundary of the report; limitations on scope or boundary of report; basis for reporting on joint ventures, subsidiaries, leased facilities, outsourced operations and other entities	Report Profile	IFC*
		Sustainable Development Report: Scope and boundary of report	73 – 74
3.9	Data measurement techniques and bases of calculations	Not reported	–
3.10	Explanation of the effect of any re-statements of information provided in earlier reports	Not applicable	–
3.11	Significant changes from previous reporting periods in the scope, boundary or measurement methods applied	Not applicable	–
GRI content index			
3.12	Location of the standard GRI disclosures	Sustainable Development Report: GRI G3 Disclosure Index	121 – 123
Assurance			
3.13	Policy and practice regarding external assurance	Report Profile	IFC*
		Sustainable Development Report: Assurance	74
	GOVERNANCE, COMMITMENTS AND ENGAGEMENT		
Governance			
4.1 – 4.3	Governance structure of the organisation, including Board committees; indication if Chairman also executive; number of independent and/or non-executive Board members	Corporate Governance Report	66 – 70
4.4	Mechanism for shareholders and employees to provide recommendations to Board	Sustainable Development Report: Engagement with our stakeholders	75 – 86
4.5	Linkage between compensation for Board members, senior managers and executives and the organisation's performance	Remuneration Report	125 – 126
4.6	Processes of Board to ensure conflicts of interest are avoided	Corporate Governance Report: Conflicts of interests	71
4.7	Process for determining the qualifications and expertise of Board members for guiding the organisation's strategy on economic, environmental and social topics	Corporate Governance Report: Board evaluations	68
4.8 – 4.9	Internally developed statements of mission or values, codes of conduct and principles relevant to economic, environmental and social topics; procedures of Board for overseeing the organisation's identification and management of economic, environmental and social performance	Our values	IFC*
		Sustainable Development Report: Management approach; Ethics and compliance	74 – 75 107 – 108
4.10	Processes for evaluating Board's own performance, particularly with regard to economic, environmental and social performance	Corporate Governance Report: Board evaluations	68
Commitments to external initiatives			
4.11	Whether and how precautionary approach or principle is addressed	Risk Management Report	59 – 63
4.12	Externally developed economic, environmental and social charters, principles or other initiatives to which the organisation subscribes or endorses	Sustainable Development Report: Reporting principles	73 – 74
4.13	Memberships in associations	Sustainable Development Report: Engagement with our stakeholders	85
Stakeholder engagement			
4.14 – 4.17	List of stakeholder groups engaged by organisation; basis for identification and selection of stakeholders with whom to engage; approaches to stakeholder engagement; key topics and concerns that have been raised through stakeholder engagement and how organisation responded	Sustainable Development Report: Engagement with our stakeholders	75 – 86
	MANAGEMENT APPROACH AND PERFORMANCE INDICATORS (core indicators in bold)		
Environmental			
Materials			
EN1 **EN2**	**Materials used by weight or volume; percentage of materials used that are recycled input materials**	Not reported	–
Energy			
EN3 **EN4** *EN5* *EN6* *EN7*	**Direct energy consumption by primary energy source; indirect energy consumption by primary source;** *energy saved due to conservation and efficiency improvements; initiatives to provide energy-efficient or renewable energy based products and services, and reductions in energy requirements as a result of these initiatives; initiatives to reduce indirect energy consumption and reductions achieved*	Sustainable Development Report: Environmental performance – Energy conservation	118 – 120
Water			
EN8 *EN9* *EN10*	**Total water withdrawal by source;** *water sources significantly affected by withdrawal of water; percentage and total volume of water recycled and reused*	Sustainable Development Report: Environmental Performance – Water consumption and recycling	118
Biodiversity			
EN11 **EN12** *EN13* *EN14* *EN15*	**Location and size of land owned, leased, managed in, or adjacent to, protected areas and areas of high biodiversity value outside protected areas; description of significant impacts of activities, products, and services on biodiversity in protected areas and areas of high biodiversity value outside protected areas;** *habitats protected or restored; strategies, current actions, and future plans for managing impacts on biodiversity; number of IUCN Red List species and national conservation list species with habitats in areas affected by operations, by level of extinction risk*	Sustainable Development Report: Environmental Performance – Biodiversity	120

GRI G3 disclosure reference	Description	Section of annual report	Page reference
Emissions, effluents and waste			
EN16 **EN17** *EN18* **EN19** **EN20** **EN21** **EN22** **EN23** *EN24* *EN25*	**Total direct and indirect greenhouse gas emissions by weight; other relevant indirect greenhouse gas emissions by weight;** *initiatives to reduce greenhouse gas emissions and reductions achieved;* **emissions of ozone-depleting substances by weight; NO, SO, and other significant air emissions by type and weight; total water discharge by quality and destination; total weight of waste by type and disposal method; total number and volume of significant spills;** *weight of transported, imported, exported, or treated waste deemed hazardous under the terms of the Basel Convention Annex I, II, III, and VIII, and percentage of transported waste shipped internationally; identity, size, protected status, and biodiversity value of water bodies and related habitats significantly affected by the reporting organisation's discharges of water and runoff*	Sustainable Development Report: Environmental performance – Emissions and Waste management and recycling	114 – 117
Products and services			
EN26	**Initiatives to mitigate environmental impacts**	Sustainable Development Report: Environmental performance	111 – 120
EN27	**Products sold and their packaging materials reclaimed**	Not applicable	–
Compliance			
EN28	**Fines and non-monetary sanctions for non-compliance with environmental laws and regulations**	Sustainable Development Report: Environmental performance – Compliance	120
Transport			
EN29	*Significant environmental impacts of transporting products and other goods and materials used for the organisation's operations, and transporting members of the workforce*	Not applicable	–
Overall			
EN30	*Total environmental protection expenditures and investments by type*	Not reported	–
Social: human rights			
Investment and procurement practices			
HR1 **HR2**	**Percentage and total number of significant investment agreements that include human rights clauses or that have undergone human rights screening; percentage of significant suppliers and contractors that have undergone screening on human rights and actions taken**	Not reported	–
HR3	*Total hours of employee training on policies and procedures concerning aspects of human rights that are relevant to operations, including the percentage of employees trained*	Sustainable Development Report: Broad-based black economic empowerment – Employment equity	93
Non-discrimination			
HR4	**Total number of incidents of discrimination and actions taken**	Sustainable Development Report: Social performance – Our people: Diversity and equal opportunities	100
Freedom of association and collective bargaining			
HR5	**Operations identified in which the right to exercise freedom of association and collective bargaining may be at significant risk, and actions taken to support these rights**	Sustainable Development Report: Social performance – Our people: Labour relations	100
Child and forced/compulsory labour			
HR6 **HR7**	**Operations identified as having significant risk for incidents of child or forced/compulsory labour, and measures taken to contribute to the elimination of child or forced/compulsory labour**	Not applicable	–
Security practices			
HR8	*Percentage of security personnel trained in the organisation's policies or procedures concerning aspects of human rights that are relevant to operations*	Not applicable	–
Indigenous rights			
HR9	*Total number of incidents of violations involving rights of indigenous people and actions taken*	See HR4 above	100
Social: Labour practices and decent work			
Employment			
LA1– LA2	**Total workforce by employment type, employment contract and region; total number and rate of employee turnover by age group, gender and region**	Sustainable Development Report: Our people – Employee composition and turnover rate (Figures 8 to 10)	97 – 100
LA3	*Benefits provided to full-time employees that are not provided to temporary or part-time employees, by major operations*	Sustainable Development Report: Employee remuneration (Figure 12) Remuneration Report	99; 101 125 – 126
Labour/management relations			
LA4 **LA5**	**Percentage of employees covered by collective bargaining agreements; minimum notice period(s) regarding operational changes, including whether it is specified in collective agreements**	Sustainable Development Report: Labour relations	100
Occupational health and safety			
LA6	*Percentage of total workforce represented in formal joint management–worker health and safety committees that help monitor and advise on occupational health and safety programmes*	Sustainable Development Report: Our people – Health and safety at work	102 – 104
LA7	**Rates of injury, occupational diseases, lost days, and absenteeism and number of work-related fatalities by region**		
LA8	**Education, training, counselling, prevention and risk control programmes in place to assist workforce members, their families or community members regarding serious diseases**		
LA9	*Health and safety topics covered in formal agreements with trade unions*		
Training and education			
LA10 *LA11* *LA12*	**Average hours of training per year per employee by employee category;** *programmes for skills management and lifelong learning that support the continued employability of employees and assist them in managing career endings; percentage of employees receiving regular performance and career development reviews*	Sustainable Development Report: Training and skills development	104 – 107
Diversity and equal opportunity			
LA13 – LA14	**Composition of governance bodies and breakdown of employees per category according to gender, age group, minority group membership and other indicators of diversity; ratio of basic salary of men to women by employee category**	Sustainable Development Report: Our people – Diversity and equal opportunities	99 – 100
Social: Society			
Community			
SO1	**Nature, scope, and effectiveness of any programmes and practices that assess and manage the impacts of operations on communities**	Sustainable Development Report: Engagement with our stakeholders; Investing in the community	75 – 86 108 – 111

GRI G3 disclosure reference	Description	Section of annual report	Page reference
Corruption			
SO2 – SO4	**Percentage and total number of business units analysed for risks related to corruption; percentage of employees trained in organisation's anti-corruption policies and procedures; actions taken in response to incidents of corruption**	Sustainable Development Report: Broad-based black economic empowerment: Employment equity	107 – 108
Public policy			
SO5	**Public policy positions and participation in public policy development and lobbying**	Operational reviews Sustainable Development Report: Stakeholder engagement: Government and authorities; Healthcare reform	32 – 43 82 – 85 95 – 97
SO6	Total value of financial and in-kind contributions to political parties, politicians, and related institutions by country	Sustainable Development Report: Ethics and compliance – Corruption	108
Anti-competitive behaviour			
SO7	Total number of legal actions for anti-competitive behaviour, anti-trust, and monopoly practices and their outcomes	Sustainable Development Report: Ethics and compliance – Competition	108
Compliance			
SO8	**Fines and non-monetary sanctions for non-compliance with laws and regulations**	Sustainable Development Report: Ethics and compliance – Compliance	108
Social: product responsibility			
Customer health and safety			
PR1	**Life cycle stages in which health and safety impacts of products and services are assessed for improvement, and percentage of significant products and services categories subject to such procedures**	Clinical Governance Report Sustainable Development Report: Commitment to quality	45 – 57 90 – 92
PR2	*Incidents of non-compliance with regulations and voluntary codes concerning health and safety impacts of products and services during their life cycle, by type of outcomes*	Sustainable Development Report: Ethics and compliance	108
Product and service labelling			
PR3	**Type of product and service information required by procedures, and percentage of significant products and services subject to such information requirements**	Not applicable	–
PR4	*Incidents of non-compliance with regulations and voluntary codes concerning product and service information and labelling, by type of outcomes*	Not applicable	–
PR5	*Practices related to customer satisfaction, including results of surveys measuring customer satisfaction*	Sustainable Development Report: Engaging with stakeholders – Patients; Commitment to quality – Patient satisfaction	76 – 77 92
Marketing communications			
PR6	**Programmes for adherence to laws, standards, and voluntary codes related to marketing communications, including advertising, promotion and sponsorship**	Not reported	–
PR7	*Incidents of non-compliance with regulations and voluntary codes concerning marketing communications, including advertising, promotion and sponsorship by type of outcomes*	Sustainable Development Report: Ethics and compliance – Compliance	108
Customer privacy			
PR8	*Total number of substantiated complaints regarding breaches of customer privacy and losses of customer data*	Sustainable Development Report: Ethics and compliance – Customer privacy	108
Compliance			
PR9	**Fines for non-compliance with laws and regulations concerning the provision and use of products and services**	Sustainable Development Report: Ethics and compliance – Compliance	108
Economic			
Economic performance			
EC1	**Direct economic value generated and distributed.**	Value Added Statement	3
EC2	**Financial implications and other risks and opportunities for the organisation's activities due to climate change**	Sustainable Development Report: Environmental performance – Environmental management and risk assessment; Emissions	112 – 117
EC3	**Coverage of the organisation's defined benefit plan obligations**	Sustainable Development Report: Recruitment and retention of skilled staff Remuneration Report	99 125 – 126
EC4	**Significant financial assistance received from government**	None	–
Market presence			
EC5	*Range of ratios of standard entry-level wage compared to local minimum wage at significant locations of operation*	Sustainable Development Report: Employee remuneration	99
EC6	**Policy, practices, and proportion of spending on locally-based suppliers at significant locations of operation**	Sustainable Development Report: Engaging with stakeholders – Suppliers	80 – 81
EC7	**Procedures for local hiring and proportion of senior management hired from the local community at locations of significant operation**	Sustainable Development Report: Recruitment and retention of skilled staff	100 – 102
Indirect economic impacts			
EC8	**Development and impact of infrastructure investments and services provided primarily for public benefit through commercial, in-kind or pro bono engagement**	Sustainable Development Report: Investing in the community	108 – 111
EC9	*Understanding and describing significant indirect economic impacts, including the extent of impacts*	Sustainable Development Report: Economic impacts	94-98

** Inside front cover*

REMUNERATION REPORT

REMUNERATION AND NOMINATIONS COMMITTEE

Mediclinic has a dedicated board committee that, inter alia, determines the governance of remuneration matters, group remuneration philosophy, remuneration of executive directors and other senior managers, as well as the compensation of non-executive directors, which is ultimately approved by the shareholders.

Detail on the mandate, composition and attendance of meetings held by the Remuneration and Nominations Committee is 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, on an international basis, needs to be competitive 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 furthermore guides the level of salaries of all directors and senior management is 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

Management remuneration structures of the Group comprise of fixed and variable components:

- fixed pay: base salary and benefits; and
- variable pay: short 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, are the key considerations for the annual salary reviews.

RETIREMENT BENEFITS

The Group offers membership to defined contribution funds for its Mediclinic Southern Africa and Hirslanden 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 Mediclinic Southern Africa, Hirslanden and Emirates Healthcare participate in management incentive schemes.

The key business performance criterium for the financial year in respect of the management incentive schemes was operating income before interest, taxation, depreciation and amortisation ("EBITDA").

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.

TABLE 1: DIRECTORS' FEES PER MEETING*

Meeting	Fee per meeting for the year ended 31 March 2010	Fee per meeting for the year ended 31 March 2011	Proposed fee per meeting for the year ending 31 March 2012
Board	R23 890	R25 800	R27 700
Chairperson: Audit and Risk Committee	R25 480	R27 520	R32 000
Member: Audit and Risk Committee	R19 115	R20 645	R22 200
Chairperson: Remuneration and Nominations Committee	R19 115	R20 645	R24 450
Member: Remuneration and Nominations Committee	R14 335	R15 480	R16 600
Chairperson: Investment Sub-committee	R25 480	R27 520	R32 000
Member: Investment Sub-committee	R19 115	R20 645	R22 200

** Only 50% of the respective fee per meeting is payable in the case of non-attendance of a meeting.*

LONG-TERM INCENTIVE PROGRAMMES

In terms of the management incentive scheme for executive directors and senior managers of 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 are set out in more detail in the Sustainable Development Report.

Mediclinic Southern Africa's nursing staff participates 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.

Executive directors have standard service contracts with a one-month notice period.

Details of the remuneration of individual executive and non-executive directors are set out in the annual financial statements on pages 172 to 173. The Board regards the disclosure of the three most highly paid employees, other than executive directors, as recommended in King III, as impractical given the management structure of the Group through the three operating platforms and the concomitant exchange rate differences.

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 26 July 2010. The Remuneration and Nominations Committee ("the committee") recommended an annual fee of R20 645 payable to the Lead Independent Director ("LID"), for the year ended 31 March 2011. The proposed annual LID fee for the next financial year is R22 200. The Group's remuneration policy provides that non-resident directors' fees will, where applicable, be set in accordance with directors' fees payable in their countries of residence and their travel implications. In this regard the committee recommended an annual non-resident director's fee of CHF100 000 payable to Prof. RE Leu in respect of his appointment as a member of the Board and the Audit and Risk Committee for the year ended 31 March 2011. The annual fee is prorated based on the number of meetings attended during the year. The proposed annual fee for the next financial year is CHF109 450. The LID and non-resident director's fees for the year ended 31 March 2011 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 27 July 2011.

The directors' fees per meeting, which exclude the LID and non-resident director's fees as detailed above, for the financial years ended 31 March 2010 and 31 March 2011, as well as the proposed fee per meeting for the financial year ending on 31 March 2012, are set out in **Table 1**.

MEDICLINIC
INTERNATIONAL

FINANCIAL STATEMENTS

CONTENTS	




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 and group financial statements as set out on pages 132 to 196, have been approved by the Board of Directors and are signed on their behalf by:

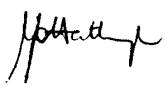
E DE LA H HERTZOG
Chairman

DP MEINTJES
Chief Executive Officer

Stellenbosch
24 May 2011

CERTIFICATE BY THE COMPANY SECRETARY

In terms of section 268G(d) of the Companies Act 1973, as amended, I certify that the Company has lodged with the Registrar all such returns as required by the Companies Act and that all such returns are true, correct and up to date.



GC HATTINGH
Company secretary

Stellenbosch
24 May 2011

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 2011. It is prepared in accordance with the recommendations of King III and the requirements of the South African Companies Act, 61 of 1973, 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 2011.

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*	Number of meetings held during time in office	Number of meetings attended
DK Smith (Chairman)	B.Sc., FASSA	3	3
RE Leu (appointed by the Board on 26 July 2010)	Master in Economics, Ph.D., Privatdozent in Economics	2	2
ZP Manase	B.Compt. (Hons), H.Dip. (Tax), CA(SA)	3	3
AR Martin (resigned 26 July 2010)	B.Comm., CA(SA)	1	1
AA Raath	B.Comm., CA(SA)	3	3

* *Abridged curricula vitae of the current committee members appear on pages 6 to 7 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.

More information about the functioning of the Committee and the matters dealt with in this report can be found in the Corporate Governance Report and the Risk Management Report included in the annual report.

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 require 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.

ETHICS AND COMPLIANCE

The Committee is responsible for reviewing any major breach of the Group Code of Business Conduct and Ethics and relevant legal, regulatory and other responsibilities. The Committee is satisfied that there has been no material breach of these standards or 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
24 May 2011

INDEPENDENT AUDITOR'S REPORT
TO THE MEMBERS OF MEDI-CLINIC CORPORATION LIMITED

We have audited the group annual financial statements and annual financial statements of Medi-Clinic Corporation Limited, which comprise the consolidated and separate statements of financial position as at 31 March 2011, 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 132 to 196.

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 in the manner required by 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 Medi-Clinic Corporation Limited as at 31 March 2011, 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 in the manner required by the Companies Act of South Africa.

PRICEWATERHOUSECOOPERS INC.
Director: NH Döman
Registered Auditor

Stellenbosch
24 May 2011

DIRECTORS' REPORT
TO THE SHAREHOLDERS FOR THE YEAR ENDED 31 MARCH 2011

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.

SHARE CAPITAL

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

After deduction of expenses, the Company raised R1 331m through a rights offer that closed on 6 August 2010. The proceeds of the rights offer will be used to finance growth opportunities available at hospitals currently owned in Switzerland. The rights offer was for a total of 59 301 395 Medi-Clinic shares ("rights offer shares") at a subscription price of 2 300 cents per rights offer share in the ratio of 10 rights offer shares for every 100 Medi-Clinic shares held at the close of trade on Friday, 16 July 2010.

The Group's treasury shares comprise shares issued to the employee share trusts (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 50.0 cents (2010: 50.0) per ordinary share on 24 May 2011. This, together with the interim dividend of 23.0 cents (2010: 23.0) per share, brings the total dividend for the year to 73.0 cents (2010: 73.0) per share.

	2011 R'000	2010 R'000
Interim distribution of 23.0 cents (2010: 23.0 cents)	**150 033**	136 393
Final distribution of 50.0 cents (2010: 50.0 cents)	**326 158**	296 507
	476 191	432 900

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% (2010: 43.4%) of the issued ordinary shares. Details of subsidiaries, joint ventures and associates appear in the annexure on pages 191 and 193.

DIRECTORS AND SECRETARY

The names of the directors and secretary of the Company, as well as the latter's postal address, appear on pages 6 to 7 and on the inside of the back cover of this annual report.

Dr CA van der Merwe and Prof. RE Leu were appointed to the Board with effect from 26 July 2010. Mr CI Tingle was appointed as a director on 1 September 2010. Mr JG Swiegers retired as a director with effect from 15 September 2010. Mr AR Martin resigned as a director on 26 July 2010.

The Board recommends that directors' fees for services rendered during the past financial year be fixed at R2 396 298 (2010: R1 846 758) as set out on page 172.

DIRECTORS' INTERESTS

Details of the direct and indirect interest in the issued permanent capital structure of your Company by directors are set out on page 195. 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 were passed by the Company's Southern African subsidiaries relating to capital structure, borrowing powers, the object clause contained in the Memorandum of Association or other material matter that affects the Company and its subsidiaries for the period under review:

- Newcastle Private Hospital Limited: It was resolved to sub-divide this company's authorised and issued share capital through a sub-division of the authorised and issued shares, increasing respectively the number of authorised and issued shares from 20 000 and 14 980 ordinary shares with a par value of R0.10 each to 200 000 and 149 800 ordinary shares with a par value of R0.01 each.
- Paarl Medi-Clinic (Pty) Ltd: It was resolved to increase the authorised share capital of this company from 10 000 ordinary shares with a par value of R1.00 each to 15 000 ordinary shares with a par value of R1.00 each; and further to replace this company's Memorandum of Association in order to make provision for the increase in the authorised share capital.
- Tzaneen Private Hospital Investments (Pty) Ltd (then Cyndara 123 (Pty) Ltd): It was resolved to change this company's name from Cyndara 123 to Tzaneen Private Hospital Investments. The main business and main object clauses contained in the Memorandum of Association were also amended to the investment, development and management of hospitals or any other business in the healthcare industry.

No shareholder resolutions were passed by the Company's other subsidiaries not located in South Africa relating to capital structure, borrowing powers, the object clause contained in the memorandum of association or other material matter during the period under review.

Details of subsidiaries appear in the annexure to the annual financial statements on pages 191 and 193 of this annual report.

STATEMENTS OF FINANCIAL POSITION
AS AT 31 MARCH 2011

COMPANY				GROUP	
2010 R'm	**2011 R'm**		Notes	**2011 R'm**	2010 R'm
		ASSETS			
4 940	**6 279**	**Non-current assets**		**36 929**	33 535
–	**–**	Property, equipment and vehicles	5	**30 409**	28 046
–	**–**	Intangible assets	6	**5 565**	5 243
4 939	**6 278**	Interest in subsidiary	7	**–**	–
–	**–**	Investments in associates	8	**4**	11
–	**–**	Other investments and loans	10	**708**	15
–	**–**	Derivative financial instruments	22	**33**	–
1	**1**	Deferred income tax assets	11	**210**	220
–	**–**	**Current assets**		**6 608**	4 829
–	**–**	Inventories	12	**522**	481
–	**–**	Trade and other receivables	13	**3 796**	3 211
–	**–**	Current income tax assets		**–**	17
–	**–**	Investment in money market funds	14	**723**	–
–	**–**	Cash and cash equivalents		**1 567**	1 120
4 940	**6 279**	**Total assets**		**43 537**	38 364
		EQUITY			
		Capital and reserves			
59	**65**	Ordinary shares		**65**	59
4 741	**6 066**	Share premium		**6 066**	4 741
–	**–**	Treasury shares		**(288)**	(311)
4 800	**6 131**	Share capital	15	**5 843**	4 489
17	**19**	Retained earnings	16	**3 786**	3 080
123	**129**	Other reserves	17	**(140)**	(919)
4 940	**6 279**	**Attributable to equity holders of the Company**		**9 489**	6 650
–	**–**	**Non-controlling interests**	18	**1 071**	966
4 940	**6 279**	**Total equity**		**10 560**	7 616
		LIABILITIES			
–	**–**	**Non-current liabilities**		**27 922**	27 898
–	**–**	Borrowings	19	**20 414**	20 667
–	**–**	Deferred income tax liabilities	11	**4 773**	4 399
–	**–**	Retirement benefit obligations	20	**383**	346
–	**–**	Provisions	21	**182**	155
–	**–**	Derivative financial instruments	22	**2 170**	2 331
–	**–**	**Current liabilities**		**5 055**	2 850
–	**–**	Trade and other payables	23	**2 938**	2 367
–	**–**	Borrowings	19	**1 834**	398
–	**–**	Provisions	21	**89**	30
–	**–**	Derivative financial instruments	22	**48**	–
–	**–**	Current income tax liabilities		**146**	55
–	**–**	**Total liabilities**		**32 977**	30 748
4 940	**6 279**	**Total equity and liabilities**		**43 537**	38 364

INCOME STATEMENTS
FOR THE YEAR ENDED 31 MARCH 2011

COMPANY				GROUP	
2010 R'm	**2011 R'm**		Notes	**2011 R'm**	2010 R'm
445	**486**	**Revenue**		**18 625**	17 141
–	**–**	Cost of sales		**(10 327)**	(9 573)
–	**–**	Administration and other operating expenses	25	**(4 112)**	(3 735)
445	**486**	**Operating profit before depreciation (EBITDA)**		**4 186**	3 833
		Depreciation and amortisation		**(738)**	(718)
445	**486**	**Operating profit**		**3 448**	3 115
–	**–**	Other gains and losses	26	**13**	28
–	**–**	Income from associates		**4**	7
–	**–**	Finance income		**61**	41
–	**–**	Finance cost	27	**(1 491)**	(1 524)
445	**486**	**Profit before tax**		**2 035**	1 667
(39)	**(37)**	Income tax expense	28	**(654)**	(481)
406	**449**	**Profit for the year**		**1 381**	1 186
		Attributable to:			
		Equity holders of the Company		**1 177**	1 058
		Non-controlling interests		**204**	128
				1 381	1 186
		Earnings per ordinary share attributable to the equity holders of the Company – cents			
		Basic	29	**195.3**	186.1
		Diluted	29	**186.9**	176.8

STATEMENTS OF COMPREHENSIVE INCOME
FOR THE YEAR ENDED 31 MARCH 2011

COMPANY				GROUP	
2010 R'm	**2011 R'm**		Notes	**2011 R'm**	2010 R'm
406	**449**	**Profit for the year**		**1 381**	1 186
		Other comprehensive income			
–	**–**	Currency translation differences	17 & 18	**488**	(1 401)
–	**–**	Fair value adjustment – cash flow hedges	17	**246**	(183)
–	**–**	Actuarial gains and losses	16	**(73)**	331
–	**–**	**Other comprehensive income/(loss), net of tax**	30	**661**	(1 253)
406	**449**	**Total comprehensive income/(loss) for the year**		**2 042**	(67)
		Attributable to:			
		Equity holders of the Company		**1 877**	(88)
		Non-controlling interests		**165**	21
				2 042	(67)

STATEMENTS OF CHANGES IN EQUITY
FOR THE YEAR ENDED 31 MARCH 2011

	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 2009	59	4 741	(326)	116
Utilised by the Mpilo Trusts	–	–	4	–
Utilised for share option scheme	–	–	11	–
Share-based payment expense	–	–	–	7
Change in shareholding of subsidiaries	–	–	–	–
Total comprehensive income/(loss) for the year	–	–	–	–
Dividends paid	–	–	–	–
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**

Balance at 31 March 2009	59	4 741	–	116
Share-based payment expense	–	–	–	7
Total comprehensive income for the year	–	–	–	–
Dividends paid	–	–	–	–
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**

					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**
2 595	(2 160)	2 066	7 091	898	7 989
–	–	–	4	–	4
–	–	–	11	–	11
–	–	–	7	–	7
–	–	(1)	(1)	102	101
(1 294)	(183)	1 389	(88)	21	(67)
–	–	(374)	(374)	(55)	(429)
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**
					COMPANY
–	–	26	4 942	–	4 942
–	–	–	7	–	7
–	–	406	406	–	406
–	–	(415)	(415)	–	(415)
–	**–**	**17**	**4 940**	**–**	**4 940**
–	**–**	**–**	**1 364**	**–**	**1 364**
–	**–**	**–**	**(33)**	**–**	**(33)**
–	**–**	**–**	**6**	**–**	**6**
–	**–**	**449**	**449**	**–**	**449**
–	**–**	**(447)**	**(447)**	**–**	**(447)**
–	**–**	**19**	**6 279**	**–**	**6 279**

STATEMENTS OF CASH FLOWS
FOR THE YEAR ENDED 31 MARCH 2011

COMPANY				GROUP	
2010 R'm Inflow/ (outflow)	**2011 R'm Inflow/ (outflow)**		Notes	**2011 R'm Inflow/ (outflow)**	2010 R'm Inflow/ (outflow)
		CASH FLOW FROM OPERATING ACTIVITIES			
–	**–**	Cash received from customers		**18 352**	17 048
–	**–**	Cash paid to suppliers and employees		**(14 173)**	(13 248)
–	**–**	Cash generated from operations	31.1	**4 179**	3 800
445	**486**	Dividends received		**–**	–
–	**–**	Interest received		**45**	40
–	**–**	Interest paid	31.2	**(1 413)**	(1 436)
(39)	**(39)**	Tax paid	31.3	**(495)**	(444)
406	**447**	Net cash generated from operating activities		**2 316**	1 960
9	**(1 331)**	**CASH FLOW FROM INVESTMENT ACTIVITIES**		**(2 563)**	(1 271)
–	**–**	Investment to maintain operations	31.4	**(645)**	(654)
–	**–**	Investment to expand operations	31.5	**(778)**	(649)
–	**–**	Proceeds on sale of property, equipment and vehicles	31.6	**24**	25
–	**–**	Insurance proceeds		**57**	–
9	**(1 331)**	Proceeds from other investments and loans		**120**	7
–	**–**	Purchases of FVTPL financial assets		**(688)**	–
–	**–**	Purchases of money market funds		**(672)**	–
–	**–**	Interest received		**19**	–
415	**(884)**	Net cash (utilised)/generated before financing activities		**(247)**	689
(415)	**884**	**CASH FLOW FROM FINANCING ACTIVITIES**		**688**	(542)
	1 364	Proceeds of shares issued		**1 364**	–
	(33)	Share issue costs		**(33)**	–
–	**–**	Distributions to non-controlling interests	18	**(59)**	(55)
(415)	**(447)**	Distributions to shareholders	31.7	**(398)**	(374)
–	**–**	Repayments of borrowings		**(208)**	(155)
–	**–**	Contributions by non-controlling interests		**–**	27
–	**–**	Acquisition of non-controlling interest		**(1)**	–
–	**–**	Proceeds from disposal of treasury shares		**23**	15
–	**–**	Net increase in cash, cash equivalents and bank overdrafts		**441**	147
–	**–**	Opening balance of cash, cash equivalents and bank overdrafts		**967**	941
–	**–**	Exchange rate fluctuations on foreign cash		**39**	(121)
–	**–**	Closing balance of cash, cash equivalents and bank overdrafts	31.8	**1 447**	967

1. GENERAL INFORMATION

Medi-Clinic Corporation 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:

Medi-Clinic 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 24 May 2011.

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 CHANGES IN ACCOUNTING POLICY

The following new and revised IFRSs have been applied for the first time in the current period in these financial statements:

- IFRS 3 (revised), 'Business combinations', and consequential amendments to IAS 27, 'Consolidated and separate financial statements', are effective prospectively to business combinations for which the acquisition date is on or after the beginning of the first annual reporting period beginning on or after 1 July 2009.

  The revised standard continues to apply the acquisition method to business combinations but with some significant changes compared with IFRS 3. For example, all payments to purchase a business are recorded at fair value at the acquisition date, with contingent payments classified as debt subsequently re-measured through the statement of comprehensive income. There is a choice on an acquisition-by-acquisition basis to measure the 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. All acquisition-related costs are expensed.

  The revised standard was applied to the acquisition of Klinik Stephanshorn Group on 4 October 2010 and the acquisition of the Emaar clinics on 15 January 2011. Acquisition-related costs of R2.5m have been recognised in the consolidated income statement, which previously would have been included in the consideration for the business combination.

- IAS 27 (revised) requires the effects of all transactions with non-controlling interests to be recorded in equity if there is no change in control and these transactions will no longer result in goodwill or gains and losses. The standard also specifies the accounting when control is lost. Any remaining interest in the entity is re-measured to fair value, and a gain or loss is recognised in profit or loss. IAS 27 (revised) has had no impact on the current period, as none of the non-controlling interests have a deficit balance; there have been no transactions whereby an interest in an entity is retained after the loss of control of that entity, and there have been no transactions with non-controlling interests.

2.3 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 deconsolidated 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 value 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 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.

2.4 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.

2.5 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 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.

2.6 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. Gains and losses on the disposal of an entity include the carrying amount of goodwill relating to the entity sold. Impairment losses on goodwill are not reversed.

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.

2.7 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.

2.8 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 carried at fair value through profit or loss.

Investments are derecognised when the rights to receive cash flows from the investments 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 non-distributable reserves 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 income.

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.

2.9 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.

2.10 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.

2.11 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 on the statement of financial position.

2.12 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. The full fair value of a hedging derivative is classified as a non-current asset or liability when the remaining hedged item's maturity is more than 12 months; it is classified as a current asset or liability when the remaining maturity of the hedged item is less than 12 months.

Cash flow hedge

The effective portion of changes in the fair value of derivatives that are 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.

2.13 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.

2.14 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 taxes 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) is 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 pay further contributions if the fund does not hold sufficient assets to pay all employees the benefits relating to employee service in the current and prior periods. The 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-employment medical benefits

Some group companies provide for actuarially determined post-employment 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 equity in 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 a liability and an expense for bonuses. 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 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 R34m (2010: increase/decrease by R37m) due to exposure to the rand/Swiss franc exchange rate;
- profit for the year would increase/decrease by R12m (2010: increase/decrease by R0m) 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 = R7.11 (2010: CHF1 = R7.35)
Closing SA rand/Swiss franc exchange rate:
CHF1 = R7.42 (2010: CHF1 = R6.93)
Average SA rand/UAE dirham exchange rate:
AED1 = R1.96 (2010: AED1 = R2.13)
Closing SA rand/UAE dirham exchange rate:
AED1 = R1.85 (2010: AED1 = R2.00)

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. Borrowings issued at variable rates expose the Group to cash flow interest rate risk. 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 R45m (2010: increase/decrease by R47m). This is mainly attributable to the Group's exposure to interest rates on its variable rate borrowings and cash.

iii) Other price risk

Exposure to price risk is due to investment in investment grade bonds. 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 3.1 (a) ii and note 10 for further details. 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, bonds and trade and other receivables. The Group's cash equivalents, short-term deposits 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 exposure to credit risk in relation to these assets. At 31 March 2011 and 31 March 2010, the Group did not consider there to be a significant concentration of credit risk which had not been adequately provided for.

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. The borrowing powers of the Group can only be limited by the Company's holding company. No such limitation currently exists.

	2011 R'm	2010 R'm
The Group's unused overdraft facilities are:	**1 073**	860

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.

Financial liabilities	**Contractual cash flows R'm**	**0 – 12 months R'm**	**1 – 5 years R'm**	**Beyond 5 years R'm**
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**	**–**	**–**
31 March 2010				
Interest-bearing borrowings	28 698*	1 967*	26 537*	194*
Trade payables	1 287	1 287	–	–
Other payables and accrued expenses	658	658	–	–

* *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, money market funds and other investments and loans: The carrying amount 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 amount reported in the statement of financial position approximate fair values.

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 2011 and 31 March 2010 were as follows:

	2011	2010
	R'm	R'm
Borrowings	**22 248**	21 065
Less: cash and cash equivalents	**(1 567)**	(1 120)
Net debt	**20 681**	19 945
Total equity	**10 560**	7 616
Add back: amounts accumulated in equity relating to cash flow hedges	**2 097**	2 343
Add back: amounts accumulated in equity relating to Swiss pension benefits	**321**	235
Adjusted capital	**12 978**	10 194
Debt-to-adjusted capital ratio	**1.6**	2.0

The debt-to-adjusted capital ratio improved mainly because of the rights offer.

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. There are currently uncertainties regarding the new financing and tariff system for mandatory basic insured patients in Switzerland beyond 2012 which are not reflected in the underlying calculations, since to date no rulings on hospitals' lists or DRGs have been made, so it is therefore not possible to assess the consequences for the Swiss business.

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.

c) Retirement benefits

The cost of defined benefit pension plans and post-employment 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.

	GROUP	
	2011	2010
	R'm	R'm

5. PROPERTY, EQUIPMENT AND VEHICLES

Land – cost	**8 294**	7 712
Buildings	**19 039**	17 508
Cost	**19 652**	17 930
Accumulated depreciation	**(613)**	(422)
Land and buildings	**27 333**	25 220
Equipment	**1 949**	1 725
Cost	**3 988**	3 489
Accumulated depreciation	**(2 039)**	(1 764)
Furniture and vehicles	**452**	412
Cost	**1 049**	899
Accumulated depreciation	**(597)**	(487)
Subtotal	**29 734**	27 357
Capital expenditure in progress	**675**	689
	30 409	28 046

Property, equipment and vehicles with a book value of R27 746m (2010: R26 077m) are encumbered as security for borrowings (see note 19).

Included in equipment is capitalised finance lease equipment with a book value of R28m (2010: R19m) (see note 19).

Land and buildings and capital expenditure include capitalised interest of R6m (2010: R22m).

The register containing details of land and buildings is available for inspection by members or their proxies at the registered office of the Company. The directors are of the opinion that the market value of land and buildings exceeds their book value.

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 2009				
Cost	29 830	3 282	810	33 922
Accumulated depreciation	(323)	(1 496)	(382)	(2 201)
Net book value	29 507	1 786	428	31 721
Year ended 31 March 2010				
Net opening book value	29 507	1 786	428	31 721
Capital expenditure	470	517	173	1 160
Prior year capital expenditure completed	96	38	–	134
Exchange differences	(4 678)	(196)	(54)	(4 928)
Disposals	(7)	(17)	(1)	(25)
Depreciation per income statement	(168)	(403)	(134)	(705)
Net closing book value	25 220	1 725	412	27 357
At 31 March 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**

	2011 R'm	2010 R'm
Capital expenditure		
Capital expenditure excluding expenditure in progress	**1 018**	1 160
Capital expenditure in progress	**159**	120
Total additions	**1 177**	1 280
To maintain operations	**617**	652
To expand operations	**560**	628

6. INTANGIBLE ASSETS

	GROUP			
	Software and IT Projects R'm	Trade names R'm	Goodwill R'm	Total R'm
At 1 April 2009				
Cost	49	3 334	2 943	6 326
Accumulated amortisation and impairment	(17)	(13)	(3)	(33)
Net book value	32	3 321	2 940	6 293
Year ended 31 March 2010				
Net opening book value	32	3 321	2 940	6 293
Amortisation charge	(13)	–	–	(13)
Additions	18	–	2	20
Exchange differences	(5)	(555)	(497)	(1 057)
Net closing book value	32	2 766	2 445	5 243
At 31 March 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**

GROUP

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.

	2011 R'm	2010 R'm
Carrying amount of Swiss goodwill	**2 075**	1 938
Carrying amount of Swiss indefinite life trade names	**2 960**	2 764

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 5.5%.
- 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 R8 904m. A fall in growth rate to 0.4% or a rise in discount rate to 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 670m. A fall in growth rate to 0% would not affect the headroom significantly, but a rise in discount rate to 7.7% would remove the remaining headroom.

COMPANY			GROUP	
2010 R'm	**2011 R'm**		**2011 R'm**	2010 R'm

7. INTEREST IN SUBSIDIARY

		Unlisted		
1	**6**	Shares at cost less amounts written off		
4 938	**6 272**	Due by subsidiary		
4 939	**6 278**			

Details appear on page 191.

8. INVESTMENTS IN ASSOCIATES

Unlisted		
Carrying value of investments in associates' equity		
Opening balance	**11**	12
Associate recognised as subsidiary	**–**	(5)
Associate sold	**–**	(2)
Share in current year profits	**4**	7
Distribution received	**(12)**	–
Exchange differences	**1**	(1)
	4	11
Directors' valuation	**4**	11

The total profit of associates is R8m (2010: R11m). Total revenue for the associates is R139m (2010: R163m).

The aggregate statement of financial positions of associates are summarised as follows:		
Total assets	**28**	40
Total liabilities	**(19)**	(20)
Shareholders' funds	**9**	20
Outside interests	**(5)**	(9)
Group's share in net assets of associates	**4**	11

Details appear on page 193.

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:

Current assets	**21**	15
Non-current assets	**91**	79
Current liabilities	**26**	21
Non-current liabilities	**31**	20
Income	**100**	86
Expenses	**99**	87

	GROUP	
	2011	2010
	R'm	R'm

10. OTHER INVESTMENTS AND LOANS

Listed – active market		
Financial assets at fair value through profit and loss (FVTPL): Bonds	**694**	–
Unlisted – no active market		
Loans and receivables	**1**	2
Available-for-sale: Shares	**13**	13
	14	15
	708	15
Other investments and loans are held in the following currencies:		
Euro (2011: €14.2m; 2010: €nil)	**137**	–
US dollar (2011: US$81.7m; 2010: US$nil)	**557**	–
Swiss franc (2011: CHF2m; 2010: CHF2m)	**13**	14
SA rand	**1**	1
	708	15

The Group holds bonds returning a fixed rate of interest. The weighted average interest rate on these securities is 2.4% per annum. If interest rates increase/decrease by 100 basis points the return rate changes to 3.46% (-100) or to 2.07% (+100). The bonds have maturity dates ranging between two and 18 months from the end of the reporting period. The counterparties have a minimum Baa3 credit by Moody's Investors Service, or BBB- or better 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.

Directors' valuation of unlisted investments	**14**	15

COMPANY			GROUP	
2010 R'm	**2011 R'm**		**2011 R'm**	2010 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	**(4 179)**	(4 984)
–	**–**	Income statement charge for the year (note 28)	**(60)**	14
–	**–**	Provision for the year	**(60)**	(86)
		Tax rate changes (note 29)	**–**	100
		Business acquisition	**(3)**	–
		Exchange differences	**(312)**	868
		Charged to other comprehensive income	**(9)**	(77)
1	**1**	Balance at the end of the year	**(4 563)**	(4 179)
		The balance consists of:		
		Property, equipment and vehicles	**(4 168)**	(3 864)
		Intangible assets	**(690)**	(626)
		Financial assets	**(1)**	(3)
		Current assets	**(12)**	(12)
		Current liabilities	**149**	133
		Provisions	**(50)**	(31)
		Derivatives	**171**	187
		Tax losses carried forward	**28**	28
		STC credits	**4**	3
		Other	**6**	6
			(4 563)	(4 179)
1	**1**	Deferred income tax assets	**210**	220
		Deferred income tax liabilities	**(4 773)**	(4 399)
1	**1**		**(4 563)**	(4 179)

	GROUP	
	2011	2010
	R'm	R'm

12. INVENTORIES

Inventories consist of:

Pharmaceutical products	**450**	418
Consumables	**66**	56
Finished goods and work in progress	**6**	7
	522	481

The cost of inventories recognised as an expense and included in cost of sales amounted to R4 663m (2010: R4 394m).

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

13. TRADE AND OTHER RECEIVABLES

Trade receivables	**2 751**	2 344
Less provision for impairment of receivables	**(141)**	(128)
Trade receivables – net	**2 610**	2 216
Other receivables	**1 186**	995
	3 796	3 211

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	**1 140**	1 191
Swiss franc*	**2 402**	1 820
UAE dirham	**254**	200
	3 796	3 211

Included in the Group's trade receivables balance are trade receivables with a carrying value of R509m (2010: R365m) which have been past due at the reporting date for 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	**417**	312
Over 3 months	**92**	53
	509	365

	GROUP	
	2011	2010
	R'm	R'm

13. TRADE AND OTHER RECEIVABLES (continued)

Movement in the provision for impairment of receivables		
Opening balance	**128**	121
Provision for receivables impairment	**67**	64
Business acquisitions	**1**	–
Exchange differences	**(2)**	(7)
Amounts written off as uncollectable	**(53)**	(50)
Balance at the end of the year	**141**	128

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

Included in the Group's other receivables balance are other receivables with a carrying value of R261m (2010: R296m) that have been past due at the reporting date, 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. This is the net amount after deducting a provision of R60m (2010: R14m) made by the Group.

* 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 R1 010m (2010: R921m), refer to note 18). In addition net trade receivables to the value of R483m (2010: R453m) have been ceded as security for banking facilities.

14. INVESTMENT IN MONEY MARKET FUNDS

Money market fund investments are held in the following currency:

Swiss franc (2011: CHF97.5m; 2010: CHFnil)	**723**	–

The effective interest rate on short-term bank deposits ranged from 0.18% to 0.95% and these deposits have a maturity over three months. At 31 March 2011 the Group's investment in money market funds was invested at a financial institution with a Moody's rating of A2.

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

COMPANY			GROUP	
2010 R'm	**2011 R'm**		**2011 R'm**	2010 R'm

15. SHARE CAPITAL

		Ordinary shares		
		Authorised:		
100	**100**	1 000 000 000 ordinary shares of 10 cents each (2010: 1 000 000 000)	**100**	100
59	**65**	Issued:	**65**	59
59	**59**	Opening balance	**59**	59
–	**6**	Shares issued	**6**	–
		652 315 341 ordinary shares of 10 cents each (2010: 593 013 946)		
		Unissued shares: 5% of the number of ordinary shares in issue are under the control of the directors until the next annual general meeting.		
		The directors are authorised, in the form of a general authorisation until the next annual general meeting, to buy back issued share capital of the Company.		
4 741	**6 066**	**Share premium**	**6 066**	4 741
4 741	**4 741**	Opening balance	**4 741**	4 741
–	**1 358**	Premium on shares issued	**1 358**	–
–	**(33)**	Costs of shares issued	**(33)**	–
		Treasury shares		
		26 664 181 (2010: 30 144 990) ordinary shares of 10 cents each		
			(288)	(311)
		Opening balance	**(311)**	(326)
		Utilised by the Mpilo Trust	**6**	4
		Utilised for share option scheme	**17**	11
		During the year the Mpilo Trusts, employee share trusts, released 319 480 of its 14 907 818 shares to employees.		
		The Company, through a wholly owned subsidiary, holds 1 090 547 (2010: 2 138 058) shares in treasury. During the year 575 226 (2010: 691 910) of these shares were utilised in terms of the executive share option scheme and 472 285 (2010: nil) of these shares were utilised in terms of the management incentive scheme. No shares (2010: nil shares) were acquired during the year.		
4 800	**6 131**		**5 843**	4 489

15. SHARE CAPITAL (continued)

Share options
In terms of the executive share option scheme 34 472 230 (2010: 34 472 230) ordinary shares are kept in reserve. To date 23 880 000 share options have been granted, 5 641 038 (2010: 5 441 738) share options have been forfeited and 17 449 321 (2010: 16 904 095) 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 after 3 years;
- a further 20% of the options granted vest after 4 years;
- a further 20% of the options granted vest after 5 years;
- a further 20% of the options granted vest after 6 years;
- a further 20% of the options granted vest after 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	R10.51	**1 534 167**	2 288 915
Options forfeited		**(169 300)**	(62 838)
Options exercised – treasury shares utilised	R10.73	**(575 226)**	(691 910)
Outstanding at the end of the year	R11.21	**789 641**	1 534 167

COMPANY			GROUP	
2010 R'm	**2011 R'm**		**2011 R'm**	2010 R'm
		16. RETAINED EARNINGS		
17	**19**	Company	**19**	17
		Subsidiaries and joint ventures	**3 767**	3 063
17	**19**		**3 786**	3 080
26	**17**	Opening balance	**3 080**	2 066
406	**449**	Profit for the year	**1 177**	1 058
(415)	**(447)**	Dividends paid	**(398)**	(374)
		Actuarial gains and losses	**(73)**	331
		Share issue cost	**–**	(1)
17	**19**	Balance at end of the year	**3 786**	3 080
		17. OTHER RESERVES		
		Share-based payment reserve		
116	**123**	Opening balance	**123**	116
7	**6**	Employees: value of services	**6**	7
123	**129**	Balance at end of the year	**129**	123
13	**18**	Executive share option scheme	**14**	13
25	**26**	Employee share trust	**30**	25
85	**85**	Strategic black partners	**85**	85
		Foreign currency translation reserve	**1 828**	1 301
		Opening balance	**1 301**	2 595
		Currency translation differences	**527**	(1 294)
		Hedging reserve	**(2 097)**	(2 343)
		Opening balance	**(2 343)**	(2 160)
		Fair value adjustments of cash flow hedges, net of tax	**246**	(183)
123	**129**		**(140)**	(919)
		18. NON-CONTROLLING INTERESTS		
		Opening balance	**966**	898
		Capital contributed by non-controlling interests	**–**	108
		Decrease in non-controlling interests	**(1)**	(6)
		Distributions to non-controlling interests	**(59)**	(55)
		Share of total comprehensive income	**165**	21
		Share of profit	**204**	128
		Currency translation differences	**(39)**	(107)
		Non-controlling interests in hospital activities	**1 071**	966

	GROUP	
	2011	2010
	R'm	R'm

19. BORROWINGS

Secured long-term bank loans	**2 769**	2 765
Long-term portion	**1 375**	2 750
Short-term portion	**1 397**	22
Capitalised financing expenses – long-term	**(3)**	(7)

These loans bear interest at variable rates linked to the three month JIBAR plus a margin of 1.025% to 1.125% (2010: 1.025% to 1.125%) compounded quarterly. The capital portion is repayable after one and three years (2010: two and four years). Property and equipment with a book value of R3 798m (2010: R3 756m) 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	**581**	612
Long-term portion	**534**	572
Short-term portion	**48**	42
Capitalised financing expenses – long-term	**(1)**	(2)

These loans bear interest at an average fixed rate of 9.3% per annum and is repayable in two to five (2010: three to six) years. Net trade receivables of R469m (2010: R440m) has been ceded as security for these borrowings.

Unsecured long-term bank loan	**175**	234
Long-term portion	**115**	173
Short-term portion	**60**	62
Capitalised financing expenses – long-term	**–**	(1)

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 12 (2010: 16) equal quarterly instalments, the first having been paid on 1 April 2010.

Secured long-term bank loans	**112**	107
Long-term portion	**106**	98
Short-term portion	**6**	9

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 R201m (2010: R208m) are encumbered as security for these loans. Net trade receivables of R7m (2010: R5m) has also been ceded as security for these loans.

Bank overdraft	**120**	153

Net trade receivables of R7m (2010: R8m) has been ceded as security for these overdrafts.

Borrowings in Southern African operations	**3 757**	3 871

	GROUP	
	2011 R'm	2010 R'm
19. BORROWINGS (continued)		
Secured long-term bank loans	**408**	520
Long-term portion	**350**	447
Short-term portion	**66**	81
Capitalised financing expenses – long-term	**(8)**	(8)
These loans bear interest at variable rates linked to EIBOR and are repayable in periods ranging between three and ten years. Properties with a book value of R770m (2010: R781m) are encumbered as security for these loans.		
Vehicle loans	**–**	1
Long-term portion	**–**	–
Short-term portion	**–**	1
These loans bear interest at rates ranging between 3.5% and 4.5% (2010: 3.5% and 4.5%) and are repayable in equal monthly payments in periods ranging from four to six years. Vehicles with a book value of R1m (2010: R1m) are encumbered as security for these loans.		
Borrowings in Middle East operations	**408**	521
Secured long-term bank loan	**17 963**	16 651
Long-term portion	**18 062**	16 907
Short-term portion	**134**	27
Capitalised financing expenses – long-term	**(233)**	(283)
The loan is secured by: Swiss properties with a book value of R22 837m (2010: R21 312m); assignment of Swiss receivables with a book value of R1 010m (2010: R921m) in case of default (refer to note 13); and Swiss bank accounts with a book value of R691m (2010: R520m). The interest on this bank loan has been hedged – note 22 contains information about the interest rate swap agreement.		
Secured long-term bank mortgages	**89**	–
Long-term portion	**89**	–
Short-term portion	**–**	–
These mortgages bear interest at interest rates ranging between 1.9% and 2.7% and are repayable in periods between two and five years. Property with a book value of R111m is encumbered as security for these loans.		
Secured long-term finance	**31**	22
Long-term portion	**28**	21
Short-term portion	**3**	1
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 R28m (2010: R19m) is encumbered as security for these loans.		
Borrowings in Swiss operations	**18 083**	16 673
Total borrowings	**22 248**	21 065
Short-term portion transferred to current liabilities	**(1 834)**	(398)
	20 414	20 667

	GROUP	
	2011	2010
	R'm	R'm

20. RETIREMENT BENEFIT OBLIGATIONS

Statement of financial position obligations for:		
Pension benefits	**71**	64
Post-employment medical benefits	**312**	282
	383	346
Income statement charge for:		
Pension benefits	**81**	44
Post-employment medical benefits	**48**	50
	129	94

(a) Pension benefits

The Group's Swiss operations have four (2010: 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	**5 326**	4 378
Fair value of plan assets	**(5 292)**	(4 329)
Funded Status	**34**	49
Restriction to Defined Benefit Asset due to the Asset Ceiling	**37**	15
Deficit	**71**	64

The movement in the defined benefit obligation over the period is as follows:

Opening balance	**4 378**	5 037
Current service cost	**185**	188
Interest cost	**138**	126
Employee contributions	**181**	174
Benefits paid	**(127)**	(136)
Actuarial gain	**26**	(89)
Acquisition/Divestiture	**241**	48
Past-service cost	**(33)**	(97)
Settlements	**–**	(14)
Exchange differences	**337**	(859)
Balance at end of year	**5 326**	4 378

The movement of the fair value of plan assets over the period is as follows:

Opening balance	**4 329**	4 272
Employer contributions	**216**	204
Employee contributions	**181**	174
Benefits paid from fund	**(127)**	(136)
Expected return on assets	**209**	173
Investment gain/(loss)	**(61)**	348
Settlements	**–**	(14)
Acquisition/Divestiture	**208**	48
Exchange differences	**337**	(740)
Balance at end of year	**5 292**	4 329

Income statement

Amounts recognised in the income statement are as follows:

Current service cost	**185**	188
Past service cost	**(33)**	(97)
Interest on liability	**138**	126
Expected return on plan assets	**(209)**	(173)
Total expense	**81**	44

	GROUP	
	2011	2010
	R'm	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	**(86)**	437
Change in the effect of the asset ceiling	**(22)**	(15)
Total of comprehensive income	**(108)**	422
Statement of financial position		
Opening net liability	**64**	765
Expense as above	**81**	44
Contributions paid by employer	**(216)**	(204)
Exchange differences	**34**	(119)
Actuarial (gain)/loss recognised in equity	**108**	(422)
Closing net liability	**71**	64
Actual return on plan assets	**151**	542
Principal actuarial assumptions on statement of financial position		
Discount rate	**2.90%**	3.10%
Expected rate of return on plan assets	**4.55%**	4.55%
Future salary increases	**2.00%**	2.00%
Future pension increases	**0.00%**	0.50%
Inflation rate	**1.50%**	1.50%
Number of plan members		
Active members	**5 992**	5 478
Pensioners	**476**	399
	6 468	5 877
Experience adjustment		
On plan liabilities: (gain)/loss	**194**	8
On plan assets: gain/(loss)	**61**	(348)
Opening balance	**(284)**	(706)
Actuarial gain/(loss) recognised in other comprehensive income	**(108)**	422
Cumulative actuarial losses recognised in other comprehensive income	**(392)**	(284)
Asset allocation		
Fixed income investments	**44%**	49%
Equity investments	**22%**	22%
Real estate	**17%**	16%
Other	**17%**	13%
	100%	100%

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

Expected employer contributions to be paid to the pension plans for the year ended 31 March 2012 are R200m.

	GROUP	
	2011	2010
	R'm	R'm

20. RETIREMENT BENEFIT OBLIGATIONS (continued)

(b) Post-employment medical benefits

The Group's Southern African operations have a post-employment 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 2011 a 7.3% (2010: 7.2%) medical inflation cost and a 9.2% (2010: 9.2%) interest rate were assumed. The average retirement age was set at 63 years (2010: 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	**282**	232
Amounts recognised in the income statement	**49**	50
Current service cost	**26**	23
Interest cost	**27**	31
Contributions	**(4)**	(4)
Actuarial loss recognised in other comprehensive income	**(19)**	–
Closing balance	**312**	282
Present value of unfunded obligations	**312**	282
Unrecognised actuarial differences	**–**	–
	312	282

The effect of a 1% movement in the assumed health cost trend rate is as follows:	**2011 Increase**	**2011 Decrease**
Aggregate of the current service cost and interest cost	**19%**	**(16%)**
Defined benefit obligation	**17%**	**(14%)**

Historical information: The present value of the Group's post-employment medical benefits at 31 March 2009 was R232m, 2008: R173m and 2007: R129m.

Expected employer contributions to be paid to the post-employment medical benefit liability for the year ended 31 March 2012 are R60m.

21. PROVISIONS

	GROUP			
	Employee benefits R'm	**Legal cases and other R'm**	**Tariff risks R'm**	**Total R'm**
Year ended 31 March 2010				
Opening balance	166	28	35	229
Charged to the income statement	27	–	–	27
Utilised during the year	(4)	(13)	(6)	(23)
Unused amounts reversed	(1)	(2)	(5)	(8)
Exchange differences	(32)	(3)	(5)	(40)
Balance at the end of the year	156	10	19	185
At 31 March 2010				
Current	8	5	17	30
Non-current	148	5	2	155
	156	10	19	185
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**

(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 at some of the Group's Swiss hospitals.

	2011 R'm	2010 R'm
Provisions are expected to be payable during the following financial years:		
Within 1 year	**89**	30
After one year but not more than five years	**54**	54
More than five years	**128**	101
	271	185

	GROUP			
	2011 R'm	**2011 R'm**	2010 R'm	2010 R'm

22. DERIVATIVE FINANCIAL INSTRUMENTS

	Assets	**Liabilities**	Assets	Liabilities
Total	**33**	**2 218**	–	(2 331)
Interest rate swaps – cash flow hedges	**–**	**2 214**	–	(2 331)
Forward contracts	**33**	**4**	–	–
Current portion	**–**	**(48)**	–	–
Interest rate swaps – cash flow hedges	**–**	**(44)**	–	–
Forward contracts	**–**	**(4)**	–	–
Non-current portion	**33**	**2 170**	–	(2 331)

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 2011, the Group had four interest rate swap contracts (2010: three). 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**
2010				
6 years+*	16 873	3.62%	3 month Swiss LIBOR	(182)
1 to 6 years**	2 750	9.8 – 10.1% fixed	3 month JIBAR	(15)
2011				
6 years+*	**17 927**	**3.62%**	**3 month Swiss LIBOR**	**239**
1 to 6 years**	**2 750**	**8.4 – 10.1% fixed**	**3 month JIBAR**	**30**

* 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 1 December 2011, 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	
	2011	2010
	R'm	R'm

22. DERIVATIVE FINANCIAL INSTRUMENTS (continued)

Forward contracts

Realised gain recognised in the income statement	**12**	–
Net unrealised gain recognised in the income statement	**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 2011, the total contract value was 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	**1 678**	1 287
Other payables and accrued expenses	**745**	658
Social insurance and accrued leave pay	**457**	365
Value added tax	**58**	57
	2 938	2 367

24. DIRECTORS' REMUNERATION

	GROUP	
	2011	2010
	R'000	R'000
Executive		
E de la H Hertzog*	**5 676**	5 076
LJ Alberts[6]	**545**	6 209
DP Meintjes	**6 238**	5 510
KHS Pretorius	**4 891**	3 637
JG Swiegers	**2 309**	5 161
CA van der Merwe**	**2 481**	–
CI Tingle***	**3 782**	–
TO Wiesinger	**7 990**	7 263
	33 912	32 856
Non-executive fees	**2 396**	1 847
JC Cohen	**150**	143
RE Leu[3]	**497**	–
MK Makaba	**129**	143
ZP Manase	**191**	189
AR Martin[1]	**155**	248
DK Smith	**232**	239
AA Raath	**304**	246
MA Ramphele	**139**	182
CM van den Heever	**129**	48
WL van der Merwe[2]	**178**	208
MH Visser	**292**	201
	36 308	34 703
Paid by:		
Subsidiaries	**33 056**	31 687
Management company*	**3 252**	3 016
	36 308	34 703

Detail for 2011: (R'000)	**Salaries**	**Retirement fund**	**Other benefits[4]**	**Bonus[5]**	**Share options**	**Total**
Executive						
E de la H Hertzog*	**2 623**	**254**	**152**	**2 647**	**–**	**5 676**
LJ Alberts[6]	**–**	**–**	**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	**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**

24. DIRECTORS' REMUNERATION (continued)

Detail for 2010: (R'000)	Salaries	Retirement fund	Other benefits[4]	Bonus[5]	Share options	Total
Executive						
E de la H Hertzog*	2 429	235	146	2 266	–	5 076
LJ Alberts	3 644	328	22	2 215	–	6 209
DP Meintjes	3 363	437	474	1 236	–	5 510
KHS Pretorius	2 292	211	71	1 063	–	3 637
JG Swiegers	3 020	272	29	1 840	–	5 161
TO Wiesinger	4 410	684	118	2 051	–	7 263
	19 158	2 167	860	10 671	–	32 856

* Dr E de la H Hertzog also earned a further R1.8m (2010: R1.6m) 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 is from this date.

*** Mr CI Tingle was appointed as a director on 1 September 2010. His director's remuneration is from this date.

1 Mr AR Martin also earned a further R384 388 (2010: R371 963) from two subsidiaries (Medi-Clinic Southern Africa Ltd and ER24 Holdings (Pty) Ltd) as director's remuneration.

2 In the prior year Prof. WL van der Merwe also earned a further R10 815 from a subsidiary (Medi-Clinic Limited) as consultancy fees.

3 Prof. Dr RE Leu also earned a further R376 830 from a subsidiary (Medi-Clinic Switzerland AG) as director's remuneration.

4 Other benefits include medical aid, UIF and payment for accumulated leave.

5 Bonuses consist of a 13th cheque as well as the management incentive scheme.

6 Mr LJ Alberts retired as a director on 31 March 2010. During the year, Mr LJ Alberts received payment for accumulated leave.

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 2011.

The number of outstanding share options are:	Offer price	**2011 Number**	2010 Number
KHS Pretorius	R9.80	**–**	40 000
CA van der Merwe	R12.20	**10 000**	–
		10 000	40 000

	GROUP	
	2011	2010
	R'm	R'm

25. EXPENSES BY NATURE

Auditors' remuneration – external audit	**12**	11
– other services	**3**	3
Cost of inventories	**4 663**	4 394
Depreciation – buildings	**155**	168
– equipment	**420**	403
– furniture and vehicles	**151**	134
Employee benefit expenses	**7 526**	6 866
Wages and salaries	**7 278**	6 654
Post-employment medical benefits (note 20)	**49**	50
Retirement benefit costs – defined contribution plans	**112**	111
Retirement benefit costs – defined benefit plans (note 20)	**81**	44
Share-based payment expense (note 17)	**6**	7
Impairment of property, equipment and vehicles	**27**	–
Increase in impairment provision for receivables (note 13)	**14**	14
Maintenance costs	**499**	460
Managerial and administration fees	**4**	6
Operating leases – buildings	**196**	184
– equipment	**34**	32
Amortisation of intangible assets	**12**	13
Other expenses	**1 461**	1 338
General expenses	**1 515**	1 437
Profit on sale of equipment	**(4)**	(3)
Other income	**(50)**	(96)
	15 177	14 026
Classified as:		
Cost of sales	**10 327**	9 573
Administration and other operating expenses	**4 112**	3 735
Depreciation and amortisation	**738**	718
	15 177	14 026

26. OTHER GAINS AND LOSSES

Gain on sale of interest in subsidiary	**–**	28
Net fair value adjustment to FVTPL financial assets	**(9)**	–
Realised gains on forward contracts	**12**	–
Net unrealised gain on forward contracts	**29**	–
Unrealised exchange loss on FVTPL financial assets	**(43)**	–
Unrealised exchange gain on money market funds	**3**	–
Gain on purchase of business acquisition (note 32)	**21**	–
	13	28

COMPANY			GROUP	
2010 R'm	**2011 R'm**		**2011 R'm**	2010 R'm
		27. FINANCE COST		
		Interest expense	**721**	816
		Interest rate swaps	**698**	655
		Amortisation of capitalised financing fees	**78**	75
		Less: amounts included in the cost of qualifying assets	**(6)**	(22)
			1 491	1 524
		28. INCOME TAX EXPENSE		
		Current tax		
(39)	**(37)**	Current year	**(600)**	(493)
		Previous year	**6**	(2)
–	**–**	Deferred tax (note 11)	**(60)**	14
(39)	**(37)**	Taxation per income statement	**(654)**	(481)
		Composition		
(1)	**(1)**	Normal South African tax	**(353)**	(284)
		Foreign tax	**(257)**	(155)
(38)	**(36)**	Secondary tax on companies ("STC")	**(44)**	(42)
(39)	**(37)**		**(654)**	(481)
		Reconciliation of rate of taxation:		
		Standard rate for companies (RSA)	**28.0%**	28.0%
		Adjusted for:		
		Capital gains tax	**(0.3)%**	(0.1)%
		Non-taxable income	**(0.3)%**	(1.7)%
		Non-deductible expenses	**7.5 %**	9.1 %
		Non-controlling interests' share of profit before tax	**(0.7)%**	(0.8)%
		Effect of different tax rates	**(3.9)%**	(2.4)%
		Changes to Swiss income tax rates	**–**	(5.7)%
		STC	**2.1 %**	2.4 %
		Prior year adjustment	**(0.3)%**	0.1 %
		Effective tax rate	**32.1 %**	28.9 %

	GROUP		
	Gross	Income tax effect	Net

29. EARNINGS PER ORDINARY SHARE

	2011 R'm	2011 R'm	2011 R'm
Earnings reconciliation			
Profit attributable to shareholders			**1 177**
Re-measurements for:	**(77)**	**10**	**(67)**
Profit on sale 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)**
Core headline earnings			**1 082**

	2010 R'm	2010 R'm	2010 R'm
Profit attributable to shareholders			1 058
Re-measurements for:	(31)	1	(30)
Profit on sale of property, equipment and vehicles	(3)	1	(2)
Gain on sale of interest in subsidiary	(28)	–	(28)
Headline earnings			1 028
Re-measurements for:	(197)	21	(176)
Past-service cost (note 20)	(97)	21	(76)
Tax rate changes (note 11)	(100)	–	(100)
Core headline earnings			852

29. EARNINGS PER ORDINARY SHARE (continued)

	GROUP	
	2011	2010
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	**593 013 946**	593 013 946
Weighted average number of ordinary shares issued during the year	**37 530 472**	–
Adjustment for rights issue (IAS 33 para 26)	**–**	7 468 002
Weighted average number of treasury shares	**(28 077 915)**	(31 760 784)
BEE shareholders*	**(11 796 572)**	(13 923 173)
Mpilo Trusts	**(14 757 847)**	(15 217 182)
Wholly owned subsidiary	**(1 523 496)**	(2 620 429)
	602 466 503	568 721 164
Weighted average number of ordinary shares in issue for diluted earnings per share		
Weighted average number of ordinary shares in issue	**602 466 503**	568 721 164
Weighted average number of treasury shares held in terms of the BEE initiative not yet released from treasury stock	**26 554 419**	29 140 355
BEE shareholders	**11 796 572**	13 923 173
Mpilo Trusts	**14 757 847**	15 217 182
Adjustment for outstanding share options granted	**467 074**	794 826
	629 487 996	598 656 345
Earnings per ordinary share (cents)		
Basic	**195.3**	186.1
Diluted	**186.9**	176.8
Headline earnings per ordinary share (cents)		
Basic	**184.2**	180.8
Diluted	**176.3**	171.7
Core headline earnings per ordinary share (cents)		
Basic	**179.6**	149.9
Diluted	**171.9**	142.4

* 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 10 985 296 (2010: 13 099 114) shares issued to the strategic black partners.

	GROUP	
	2011 R'm	2010 R'm

30. OTHER COMPREHENSIVE INCOME

Components of other comprehensive income

Currency translation differences	**488**	(1 401)
Fair value adjustment – cash flow hedges	**246**	(183)
Actuarial gains and losses	**(73)**	331
Other comprehensive income/(loss), net of tax	**661**	(1 253)

Tax and non-controlling interest on other comprehensive income

Year ended 31 March 2010	**Gross R'm**	**Tax R'm**	**Non-controlling Interest R'm**	**Net R'm**
Currency translation differences	(1 294)	–	(107)	(1 401)
Fair value adjustment – cash flow hedges	(197)	14	–	(183)
Actuarial gains and losses	422	(91)	–	331
Other comprehensive loss	(1 069)	(77)	(107)	(1 253)
Year ended 31 March 2011				
Currency translation differences	**527**	**–**	**(39)**	**488**
Fair value adjustment – cash flow hedges	**271**	**(25)**	**–**	**246**
Actuarial gains and losses	**(89)**	**16**	**–**	**(73)**
Other comprehensive income/(loss)	**709**	**(9)**	**(39)**	**661**

	2011 R'm	2010 R'm

31. CASH FLOW INFORMATION

31.1 Reconciliation of profit before taxation to cash generated from operations

Operating profit before interest and taxation	**3 448**	3 115
Non-cash items		
Movement in share-based payment reserve	**6**	7
Depreciation	**726**	705
Intangibles amortised	**12**	13
Impairment losses	**27**	–
Insurance proceeds	**(78)**	–
Movement in provisions	**72**	(3)
Movement in retirement benefit obligations	**(87)**	(110)
Profit on sale of property, equipment and vehicles	**(4)**	(3)
Operating income before changes in working capital	**4 122**	3 724
Working capital changes	**57**	76
Increase in inventories	**(26)**	(39)
Increase in trade and other receivables	**(437)**	(151)
Increase in trade and other payables	**520**	266
	4 179	3 800

COMPANY			GROUP	
2010 R'm	**2011 R'm**		**2011 R'm**	2010 R'm
		31. CASH FLOW INFORMATION (continued)		
		31.2 Interest paid		
		Finance cost per income statement	**1 491**	1 524
		Non-cash items		
		Amortisation of capitalised financing fees	**(78)**	(75)
		Accrued finance cost	**–**	(13)
			1 413	1 436
		31.3 Tax paid		
		Liability at the beginning of the year	**(38)**	6
		Exchange differences	**(3)**	5
(39)	**(37)**	Provision for the year	**(600)**	(493)
(39)	**(37)**		**(641)**	(482)
		Liability at the end of the year	**146**	38
(39)	**(37)**		**(495)**	(444)
		31.4 Investment to maintain operations		
		Property, equipment and vehicles purchased	**(617)**	(652)
		Intangible assets purchased	**(28)**	(2)
9	**(1 331)**	Loans to subsidiaries	**–**	–
9	**(1 331)**		**(645)**	(654)
		31.5 Investment to expand operations		
		Property, equipment and vehicles purchased	**(560)**	(628)
		Intangible assets purchased	**–**	(18)
		Business acquisitions (note 32)	**(218)**	–
		Acquisition of minority interests in hospital activities	**–**	(3)
			(778)	(649)
		31.6 Proceeds on sale of property, equipment and vehicles		
		Book value of property, equipment and vehicles sold	**23**	25
		Profit per income statement	**4**	3
		Exchange differences	**(3)**	(3)
			24	25
		31.7 Distributions paid to shareholders		
(415)	**(447)**	Dividends declared and paid during the year	**(398)**	(374)

	GROUP	
	2011	2010
	R'm	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	**1 567**	1 120
Bank overdrafts (note 19)	**(120)**	(153)
	1 447	967

Cash, cash equivalents and bank overdrafts are denominated in the following currencies:

SA rand*	**631**	333
Swiss franc**	**702**	526
UAE dirham***	**114**	108
	1 447	967

* 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
	2011 R'm

32. BUSINESS ACQUISITIONS

2011	Cash flow on acquisition
Klinik Stephanshorn	179
Emaar Clinics	39
Total	218

Klinik Stephanshorn
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 26)	(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.

Due to successful negotiations and strong market values of the underlying assets a gain of purchase on business acquisition of R21m was recognised.

From the date of acquisition, Klinik Stephanshorn AG has contributed R169.6m of revenue and R20.3m to profit before tax of the Group. If the combination had taken place at the beginning of the year, revenue from continuing operations would have been R18 790m and the profit before tax for the Group would have been R2 047m.

Acquisition-related costs of R2.4m have been expensed and are recognised in the income statement.

	GROUP
	2011 R'm

32. BUSINESS ACQUISITIONS (continued)

Emaar clinics

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	**(69)**
Less: outstanding purchase consideration	**30**
Net cash flow recognised for 2011	**(39)**

No goodwill arising from the acquisition.

From the date of acquisition, The Dubai Mall Medical Center, Meadows Clinic and Arabian Ranches Clinic have contributed R25.0m of revenue and (R3.4m) to the profit before tax of the Group. If the combination had taken place at the beginning of the year, revenue from continuing operations would have been R18 715m and the profit before tax for the Group would have been R2 028m.

Acquisition-related costs of R0.1m have been expensed and are recognised in the income statement.

	GROUP	
	2011	2010
	R'm	R'm

33. COMMITMENTS

Capital commitments

Incomplete capital expenditure contracts	**1 292**	452
Southern Africa	**452**	309
Switzerland	**831**	133
Middle East	**9**	10
Capital expenses authorised by the Board of Directors but not yet contracted	**1 101**	641
Southern Africa	**1 038**	558
Switzerland	**63**	83
Middle East	**–**	–
	2 393	1 093

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	**6**	4
1 to 5 years	**23**	13
Beyond 5 years	**19**	19
	48	36

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	**195**	151
1 to 5 years	**537**	342
Beyond 5 years	**1 450**	934
	2 182	1 427

	2011 R'm	2011 R'm	2011 R'm	2011 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 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
Gain on sale of interest in subsidiary	–	–		–
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)
Taxation	–	–		–
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

	2010 R'm	2010 R'm	2010 R'm	2010 R'm

34. SEGMENTAL REPORT (continued)

Year ended 31 March 2010:	Southern Africa Hospital Services	Southern Africa Hospital Properties	Adjustments and eliminations	Southern Africa Total
Revenue	7 680	687	(687)	7 680
EBITDA	985	666		1 651
Depreciation and amortisation	(206)	–		(206)
EBIT	779	666		1 445
Gain on sale of interest in subsidiary	28	–		28
Finance income	39	7	(7)	39
Finance cost	(61)	(319)	7	(373)
Taxation	(227)	(99)		(326)
Segment result	558	255		813
At 31 March 2010:				
Capital expenditure	322	187		509
Total segment assets	4 495	6 048	(4 785)	5 758
Segment liabilities	2 287	3 962	(931)	5 318

Year ended 31 March 2010:	Swiss Hospital Services	Swiss Hospital Properties	Adjustments and eliminations	Swiss Total
Revenue	8 335	1 330	(1 330)	8 335
EBITDA	806	1 244		2 050
Depreciation and amortisation	(307)	(130)		(437)
EBIT	499	1 114		1 613
Other gains and losses	–	–		–
Income from associates	7	–		7
Finance income	10	–		10
Finance cost	(17)	(1 089)		(1 106)
Taxation	(62)	(93)		(155)
Segment result	437	(68)		369
At 31 March 2010:				
Investments in associates	11	–		11
Capital expenditure	431	311		742
Total segment assets	8 323	22 555		30 878
Segment liabilities	2 361	22 289		24 650

Year ended 31 March 2010:	Middle East Hospital Services	Middle East Hospital Properties	Adjustments and eliminations	Middle East Total
Revenue	1 126	62	(62)	1 126
EBITDA	71	61		132
Depreciation and amortisation	(75)	–		(75)
EBIT	(4)	61		57
Finance income	1	–		1
Finance cost	(33)	(21)		(54)
Taxation	–	–		–
Segment result	(36)	40		4
At 31 March 2010:				
Capital expenditure	49	–		49
Total segment assets	942	786		1 728
Segment liabilities	468	312		780

	2010 R'm	2010 R'm	2010 R'm	2010 R'm

34. SEGMENTAL REPORT (continued)

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**

Year ended 31 March 2010:	Total Hospital Services	Total Hospital Properties	Adjustments and eliminations	Total
Revenue	17 141	2 079	(2 079)	17 141
EBITDA	1 862	1 971		3 833
Depreciation and amortisation	(588)	(130)		(718)
EBIT	1 274	1 841		3 115
Gain on sale of interest in subsidiary	28	–		28
Income from associates	7	–		7
Finance income	50	7	(16)	41
Finance cost	(111)	(1 429)	16	(1 524)
Taxation	(289)	(192)		(481)
Segment result	959	227		1 186
At 31 March 2010:				
Investments in associates	11	–		11
Capital expenditure	802	498		1 300
Total segment assets	13 760	29 389	(4 785)	38 364
Segment liabilities	5 116	26 563	(931)	30 748

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	
	2011	2010
	R'm	R'm

34. SEGMENTAL REPORT (continued)

Reconciliation of segment result, assets and liabilities

Segment result		
Total profit from reportable segments	**1 374**	1 186
Unallocated corporate amounts:		
Other gains and losses	**(8)**	–
Interest received	**15**	–
Consolidated profit before tax	**1 381**	1 186
Assets		
Total assets from reportable segments	**42 082**	38 364
Unallocated corporate assets	**1 455**	–
	43 537	38 364
Liabilities		
Total liabilities from reportable segments	**33 130**	30 748
Elimination of intersegment loan	**(157)**	–
Other liabilities	**4**	–
	32 977	30 748

The total non-current assets, excluding property, equipment and vehicles, financial instruments and deferred tax assets per geographical location is:

Southern Africa	**135**	136
Middle East	**344**	372
Switzerland	**5 086**	4 735
	5 565	5 243

COMPANY			GROUP	
2010 R'm	**2011 R'm**		**2011 R'm**	2010 R'm

35. RELATED PARTY TRANSACTIONS

The major shareholder of the Group is Industrial Partnership Investments Limited (Remgro Limited), which owns 43.4% (2010: 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**	6
		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' remuneration appears in note 24.		
		iii) Transactions with subsidiaries and associates		
		Medi-Clinic Investments Limited		
415	**447**	Dividend received		
4 938	**6 272**	Balance due from		
		Zentrallabor Zürich (ZLZ)		
		Fees earned	**(7)**	(7)
		Purchases	**58**	61

	2010 R'm	2010 R'm	2010 R'm

36. RECLASSIFICATION OF COMPARATIVE INFORMATION

GROUP	As previously reported	Adjust-ments	As adjusted
Administration and other operating expenses	4 425	(690)	3 735
Gain on sale of interest in subsidiary		28	
Depreciation and amortisation		(718)	
Other gains and losses	–	28	28

To enhance reporting, the Group has reclassified two amounts on the face of the income statement. The gain on sale of interest in subsidiary was previously included as administrative and other operating expenses and is now shown as part of other gains and losses. Depreciation and amortisation was previously included as administrative and other operating expenses and are now also shown separately on the face of the income statement.

COMPANY	As previously reported	Adjust-ments	As adjusted
Revenue	–	445	445
Dividends received	445	(445)	–

To enhance reporting, the Company has reclassified dividends received on the face of the income statement. Dividends received are now shown as part of revenue, on the face of the Company's income statement.

37. STANDARDS AND INTERPRETATIONS NOT YET EFFECTIVE

Certain new standards, amendments and interpretations to existing standards have been published that are mandatory for the Group's accounting periods beginning on or after 1 April 2011 or later periods but which the Group has not early adopted.

The following standards, interpretations and amendments will affect the financial statements mainly by additional disclosures:

IFRS 9 (AC 146) Financial Instruments (Effective 1 January 2013)
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.

The following new accounting standards, interpretations and amendments will have no material effects on the financial statements:

- IFRIC 19 (AC 452) Extinguishing Financial Liabilities with Equity (Effective 1 July 2010)
- Amendments to IAS 24 (AC 126) Related Party Disclosures (Effective 1 January 2011)
- Amendments to IFRIC 14 (AC 447) Prepayments of a Minimum Funding Requirement (Effective 1 January 2011)
- Revision to AC 504: IAS 19 (AC 116) The limit on a defined benefit asset, Minimum funding requirements and their interaction in the South African pension fund environment (Effective 1 January 2011)
- Amendment to IFRS 7 (AC 144) Financial instruments: Disclosures (Effective 1 July 2011)
- Amendments to IAS 12 (AC 102) Deferred Tax: Recovery of Underlying Assets (Effective 1 January 2012)

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 2011

	Issued share capital		Interest in capital		Book value of shares	
	2011	2010	**2011**	2010	**2011**	2010
	Rand	Rand	**%**	%	**R'm**	R'm
SUBSIDIARIES						
COMPANY						
Medi-Clinic Investments Limited	**100**	100	**100.0**	100.0	**1**	1
The loan to the subsidiary amounts to R6 272m (2010: R4 938m) and is repayable on demand.						
The information required by the 4th Schedule of the Companies Act is only provided for those subsidiaries of which the financial position and results are material. A detailed list of subsidiaries is available at the registered office of the Company.						
GROUP						
Indirectly held through Medi-Clinic Investments Limited						
Medi-Clinic Southern Africa Limited			**100.0**	100.0		
Medi-Clinic Europe (Proprietary) Limited			**100.0**	100.0		
Medi-Clinic Middle East (Proprietary) Limited			**100.0**	100.0		
Mecli Properties Limited			**100.0**	100.0		
Medi-Clinic CHF Finco Limited			**100.0**	–		
Medi-Clinic Group Services (Proprietary) Limited			**100.0**	100.0		
Indirectly held through Medi-Clinic Southern Africa Limited						
Aukland Medicine Distributors (Proprietary) Limited			**100.0**	100.0		
Curamed Holdings Limited			**70.1**	63.0		
Howick Private Hospital Holdings Limited*			**49.1**	49.1		
Medical Human Resources (Proprietary) Limited			**100.0**	100.0		
Medical Innovations (Proprietary) Limited			**100.0**	100.0		
Medi-Clinic Limited			**100.0**	100.0		
Medi-Clinic Holdings (Namibia) (Proprietary) Limited			**100.0**	100.0		
Medi-Clinic Properties (Proprietary) Limited			**100.0**	100.0		
Medi-Clinic Properties (Windhoek) (Proprietary) Limited			**100.0**	100.0		
Medi-Clinic Operations (Namibia) (Proprietary) Limited			**100.0**	100.0		
Medi-Clinic Properties (Swakopmund) (Proprietary) Limited			**100.0**	100.0		
Medi-Clinic Finance Corporation (Proprietary) Limited			**100.0**	100.0		
Medi-Clinic Investments (Namibia) (Proprietary) Limited			**100.0**	100.0		
Medipark Clinic (Proprietary) Limited			**100.0**	100.0		
Newcastle Private Hospital Limited*			**15.1**	15.1		
Paarl Medi-Clinic (Proprietary) Limited			**78.9**	78.9		
Phodiclinics (Proprietary) Limited			**100.0**	100.0		
Legae Medi-Clinic (Proprietary) Limited			**100.0**	100.0		
Practice Relief (Proprietary) Limited			**100.0**	100.0		
Reef-Med (Proprietary) Limited			**60.9**	60.9		
Tshwane Private Hospitals (Proprietary) Limited			**100.0**	100.0		
Tzaneen Private Hospital (Proprietary) Limited *			**49.4**	49.4		
Victoria Hospital Limited*			**33.3**	33.3		

	Interest in capital	
	2011	2010
	%	%
SUBSIDIARIES (continued)		
Indirectly held through Medi-Clinic Southern Africa Limited (continued)		
Barberton Medi-Clinic (Proprietary) Limited[$]	**77.0**	77.0
Ermelo Medi-Clinic (Proprietary) Limited[$]	**50.1**	50.1
Hermanus Medi-Clinic Limited*	**34.9**	34.9
Kimberley Medi-Clinic (Proprietary) Limited[$]	**89.7**	89.7
Limpopo Medi-Clinic Limited[$]	**50.0**	50.0
Potchefstroom Medi-Clinic (Proprietary) Limited[$]	**94.6**	94.6
Upington Private Hospital (Proprietary) Limited*[$]	**40.9**	40.9
Indirectly held through Medi-Clinic Europe (Proprietary) Limited		
Medi-Clinic Holdings Netherlands B.V.	**100.0**	100.0
Medi-Clinic 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, Heiden	**99.1**	99.1
Klinik am Rosenberg Heiden, Heiden	**100.0**	100.0
Klinik Belair AG	**100.0**	100.0
Klinik Birshof AG	**100.0**	100.0
Klinik Hirslanden AG	**100.0**	100.0
Klinik Im Park AG	**100.0**	100.0
Klinik Stephanshorn AG	**100.0**	–
Klinik St. Anna AG	**100.0**	100.0
Salem-Spital AG	**100.0**	100.0
Indirectly held through Medi-Clinic Middle East (Proprietary) Limited		
Emirates Healthcare Holdings Limited BVI	**50.4**	50.4
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
The City Hospital FZ LLC	**100.0**	100.0
Welcare Ambulatory Care Centre	**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

	Interest in capital	
	2011	2010
	%	%
SUBSIDIARIES (continued)		
Indirectly held through Curamed Holdings Limited		
Thabazimbi Medi-Clinic Trust	**85.0**	85.0
Indirectly held through Medipark Clinic (Proprietary) Limited		
ER24 Holdings (Proprietary) Limited	**100.0**	100.0
JOINT VENTURES		
Wits University Donald Gordon Medical Centre (Proprietary) Limited	**49.9**	49.9

	Interest in capital		Book value of investment		Amount owing by associates	
	2011	2010	**2011**	2010	**2011**	2010
	%	%	**R'm**	R'm	**R'm**	R'm
ASSOCIATES						
GROUP						
Unlisted:						
First Medical Centre L.L.C., Oman	**–**	20.0	**–**	–	**–**	–
Zentrallabor Zürich, Zürich (ZLZ)*	**50.0**	56.6	**4**	11	**–**	–
			4	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 2011

	Number of shareholders	Number of shares	%
DISTRIBUTION OF ORDINARY SHAREHOLDERS			
Public shareholders	**4 668**	**220 531 344**	**33.81%**
Non-public shareholders	**21**	**431 783 997**	**66.19%**
Directors and their associates	**14**	**4 961 638**	**0.76%**
Own holdings (held by Medipark Clinic (Pty) Ltd as treasury shares)	**1**	**1 202 587**	**0.18%**
Industrial Partnership Investments Limited (Remgro)	**1**	**283 080 915**	**43.40%**
International Hospitals Network (Trilantic Capital Partners)	**1**	**65 231 535**	**10.00%**
Black economic empowerment shareholders	**4**	**77 307 322**	**11.85%**
	4 689	**652 315 341**	**100.00%**
Distribution of local and foreign beneficial shareholding:		**652 315 341**	**100.00%**
South African		**568 933 968**	**87.22%**
Foreign		**83 381 373**	**12.78%**

MAJOR SHAREHOLDERS

In terms of the principles of disclosure in accordance with section 140A(8)(a) of the Companies Act, 61 of 1973, as amended, the following shareholders held a beneficial interest of 5% or more in the Company on 25 March 2011:

Industrial Partnership Investments Limited (Remgro)	**283 080 915**	**43.40%**
Black economic empowerment shareholders	**77 307 322**	**11.85%**
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)	**14 597 098**	**2.24%**
International Hospitals Network (Trilantic Capital Partners)	**65 231 535**	**10.00%**
Government Employees Pension Fund	**53 428 547**	**8.19%**

SHAREHOLDING SPREAD

	Number of shareholders	%	Number of shares	%
1 – 1 000 shares	**2 389**	**50.95%**	**862 957**	**0.13%**
1 001 – 10 000 shares	**1 545**	**32.95%**	**4 942 282**	**0.76%**
10 001 – 100 000 shares	**490**	**10.45%**	**15 313 010**	**2.35%**
100 001 – 1 000 000 shares	**221**	**4.71%**	**69 835 883**	**10.71%**
Over 1 000 000 shares	**44**	**0.94%**	**561 361 209**	**86.06%**
	4 689	**100.00%**	**652 315 341**	**100.00%**

DIRECTORS' INTERESTS*

	2011				2010			
	Direct beneficial	**Indirect beneficial**	**Associates**	**%**	Direct beneficial	Indirect beneficial	Associates	%
E de la H Hertzog	**34 845**	**3 724 801**	**384 803**	**0.64%**	–	3 386 183	349 821	0.63%
JC Cohen	**–**	**–**	**–**	**0.00%**	–	–	–	0.00%
RE Leu[1]	**–**	**–**	**–**	**0.00%**	n/a	n/a	n/a	n/a
MK Makaba**	**–**	**–**	**–**	**0.00%**	–	–	–	0.00%
ZP Manase	**–**	**–**	**–**	**0.00%**	–	–	–	0.00%
AR Martin[2]	**–**	**3 168**	**–**	**0.00%**	–	2 880	–	0.00%
DP Meintjes	**138 622**	**–**	**–**	**0.02%**	107 022	–	–	0.02%
KHS Pretorius	**112 605**	**–**	**–**	**0.02%**	109 252	–	–	0.02%
AA Raath	**–**	**–**	**–**	**0.00%**	–	–	–	0.00%
MA Ramphele	**–**	**–**	**–**	**0.00%**	–	–	–	0.00%
DK Smith	**–**	**–**	**–**	**0.00%**	–	–	–	0.00%
JG Swiegers[3]	**90 225**	**339 962**	**22 175**	**0.07%**	82 023	284 720	20 159	0.07%
CI Tingle[4]	**98 823**	**–**	**–**	**0.02%**	n/a	n/a	n/a	n/a
CM van den Heever	**–**	**–**	**–**	**0.00%**	–	–	–	0.00%
CA van der Merwe[5]	**10 652**	**–**	**–**	**0.00%**	n/a	n/a	n/a	n/a
WL van der Merwe	**957**	**–**	**–**	**0.00%**	957	–	–	0.00%
MH Visser	**–**	**–**	**–**	**0.00%**	–	–	–	0.00%
TO Wiesinger	**–**	**–**	**–**	**0.00%**	–	–	–	0.00%
	486 729	**4 067 931**	**406 978**	**0.76%**	299 254	3 673 783	369 980	0.73%

[1] Appointed 26 July 2010

[2] Retired 26 July 2010

[3] Resigned 15 September 2010

[4] Appointed 1 September 2010

[5] Appointed 26 July 2010

* There has been no change in the directors' interests between 25 March 2011 and the approval of the annual financial statements on 24 May 2011.

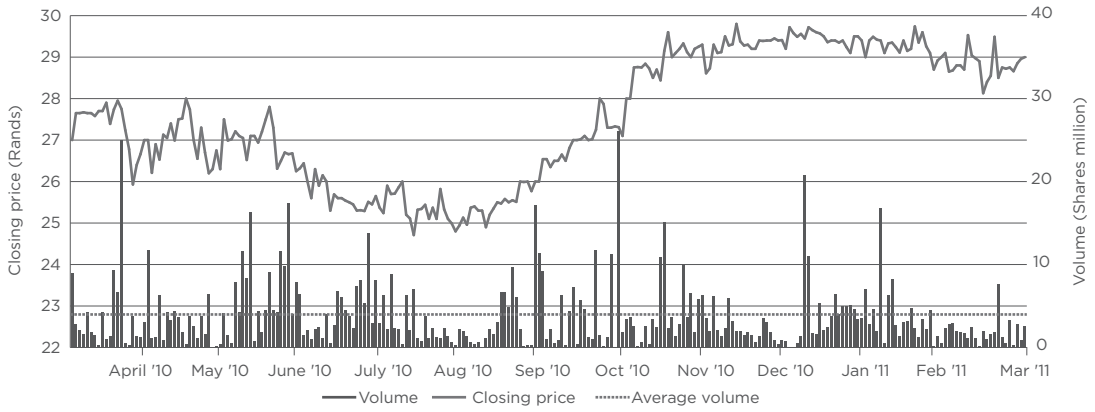
** Dr MK Makaba holds a 5.08% interest in Phodiso Holdings Limited, which company is the holder of all the issued ordinary shares in Mpilo Investment Holdings 2 (Pty) Ltd, which holds a 6.03% interest in Mediclinic.

JSE SHARE PERFORMANCE

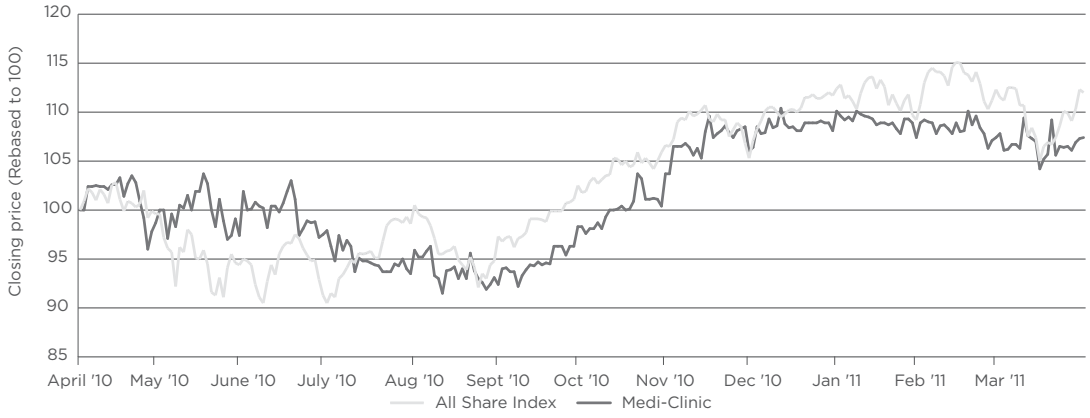
	2011	2010
Market capitalisation as at 31 March (R'000)	**18 917 145**	16 011 377
Price (cents per share)		
31 March	**2 900**	2 700
Highest	**3 150**	2 765
Lowest	**2 325**	1 864
Number of shares traded (000's)	**98 979**	101 801

JSE SHARE PERFORMANCE (continued)

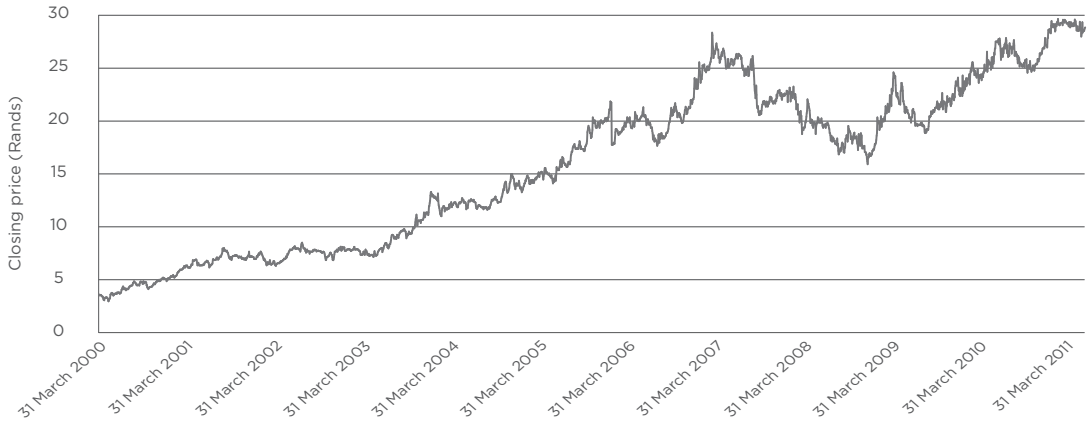
TRADING STATISTICS (SHARE CLOSING PRICE AND VOLUME)



SHARE PERFORMANCE COMPARED TO JSE ALL SHARE INDEX (REBASED TO 100)



SHARE CLOSING PRICE FROM 2000 – 2011



NOTICE OF ANNUAL GENERAL MEETING

MEDICLINIC
INTERNATIONAL

MEDI-CLINIC CORPORATION 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-eighth Annual General Meeting of the Company will be held at the Protea Hotel, Techno Avenue, Techno Park, Stellenbosch, on **Wednesday, 27 July 2011** 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, 17 June 2011, 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 2011 are 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 2011 are included in the annual report of which this notice forms part. Shareholders should note that the audit, approval and publishing of the Company's annual financial statements in respect of the period under review are in accordance with the requirements of the old Companies Act, 61 of 1973, as amended, as provided for in terms of the transitional arrangements of the new Companies Act, 71 of 2008, as amemded.

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 2012.

3. RE-ELECTION OF DIRECTORS

Ordinary Resolutions Number 3.1 to 3.8
Directors appointed during the year:

3.1 **Resolved that** Dr CA van der Merwe who was appointed by the Board as an executive director of the Company with effect from 26 July 2010 and retires in terms of article 30.10 of the Company's Articles of Association (defined in the Companies Act as the 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** Prof. Dr RE Leu who was appointed by the Board as an independent non-executive director of the Company with effect from 26 July 2010 and retires in terms of article 30.10 of the Company's Articles of Association and who, being eligible, offers himself for re-election be hereby re-elected as an independent non-executive director of the Company;

3.3 **Resolved that** Mr CI Tingle who was appointed by the Board as an executive director of the Company with effect from 1 September 2010 and retires in terms of article 30.10 of the Company's Articles of Association and who, being eligible, offers himself for re-election be hereby re-elected as an executive director of the Company;

Directors retiring by rotation:

3.4 **Resolved that** Dr MK Makaba who retires in terms of article 30.1 of the Company's Articles of Association and who, being eligible, offers himself for re-election be hereby re-elected as a director of the Company;

3.5 **Resolved that** Ms ZP Manase who retires in terms of article 30.1 of the Company's Articles of Association and who, being eligible, offers herself for re-election be hereby re-elected as a director of the Company;

3.6 **Resolved that** Mr KHS Pretorius who retires in terms of article 30.1 of the Company's Articles of Association and who, being eligible, offers himself for re-election be hereby re-elected as a director of the Company;

3.7 **Resolved that** Mr DK Smith who retires in terms of article 30.1 of the Company's Articles of Association and who, being eligible, offers himself for re-election be hereby re-elected as a director of the Company; and

3.8 **Resolved that** Dr TO Wiesinger who retires in terms of article 30.1 of the Company's Articles of Association and who, being eligible, offers himself for re-election be hereby re-elected as a director of the Company.

Additional information in respect of Ordinary Resolutions Number 3.1 to 3.8
Article 30.10 of the Company's Articles of Association provides that any person appointed as a director of the Company by the Board to fill a casual vacancy or as an additional director shall retire at the following annual general meeting in addition to the directors retiring by rotation in terms of article 30.1. Article 30.1 provides that one third of the Company's directors shall retire at every annual general meeting. A brief CV of each of the directors mentioned above appears on pages 6 to 7 of the annual report of which this notice forms part.

4. ELECTION OF INDEPENDENT AUDIT AND RISK COMMITTEE

Ordinary Resolution Number 4
Resolved that Prof. Dr RE Leu, Ms ZP Manase, Mr AA Raath and Mr DK Smith, who are independent non-executive directors of the Company, be hereby elected as the members of the Company's Audit and Risk Committee for the financial year ending 31 March 2012.

Additional information in respect of Ordinary Resolution Number 4
A brief CV of each of the independent non-executive directors mentioned above is included on pages 6 to 7 of the annual report of which this notice forms part. 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 125 to 126 of the annual report of which this notice forms part, 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 Articles of Association, 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 2011, and further subject to the provisions of the Companies Act, the Articles of Association of the Company and the JSE Limited ("**JSE**") Listings Requirements ("**the JSE Listings Requirements**"), 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 Articles of Association of the Company, 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 have 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 should be consulted for a ruling if the applicant'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 – 2010/2011

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 R2 396 298 for the financial year ended 31 March 2011 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 2011. The fees payable to the non-executive directors are calculated on a fee per meeting basis, with the exception of Prof. Dr RE Leu who receives an annual fee, which is pro rated based on the number of meetings attended during the year, 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 172 to 173 and in the Remuneration Report on page 126 of the annual report of which this notice forms part.

9. APPROVAL OF NON-EXECUTIVE DIRECTORS' REMUNERATION – 2011/2012

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 2012 with only 50% of the respective fee per meeting being payable in the case of non-attendance of a meeting:

Meeting	Fee per meeting for the year ended 31 March 2011	Proposed fee per meeting for the year ending 31 March 2012
Board	R25 800	R27 700
Chairperson: Audit and Risk Committee	R27 520	R32 000
Member: Audit and Risk Committee	R20 645	R22 200
Chairperson: Remuneration and Nominations Committee	R20 645	R24 450
Member: Remuneration and Nominations Committee	R15 480	R16 600
Chairperson: Investment Sub-committee	R27 520	R32 000
Member: Investment Sub-committee	R20 645	R22 200
Lead Independent Director (annual fee)	R20 645	R22 200
Prof. Dr RE Leu*	CHF100 000	CHF109 450

** annual fee, pro rated according to the 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 2012. 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 page 126 of the annual report of which this notice forms part.

10. APPROVAL OF CHANGE OF COMPANY NAME

Special Resolution Number 3

Resolved that the Company's Memorandum of Association be amended by changing the name of the Company from "Medi-Clinic Corporation Limited" to "Mediclinic International Limited".

Additional information in respect of Special Resolution Number 3

The reason for and the effect of the special resolution is to change the Company's name in line with the new Mediclinic brand and to reflect the international nature of its operations. Due to the minor change to the Company's name, the abbreviated name "Medclin", the JSE share code "MDC", as well as the ISIN number ZAE000074142 will remain unchanged. Share certificates issued by the Company to certificated shareholders prior to the registration of this resolution will remain valid and good for delivery and no action is required by certificated shareholders to surrender or replace their share certificates. Any documents of title issued by the Company after the registration of this resolution will, for a period of not less than one year thereafter, reflect the former name "Medi-Clinic Corporation Limited" in brackets beneath the new name "Mediclinic International Limited".

The salient dates and times in respect of the proposed name change are as follows:

Annual general meeting (at 15:00)	Wednesday, 27 July 2011
Results of annual general meeting and change of name announcement released on SENS	Thursday, 28 July 2011
Finalisation date: Date by which the change of the name to be registered with the Companies and Intellectual Property Commission and announcement on SENS	Friday, 26 August 2011
Last date to trade under old name (Medi-Clinic Corporation Limited)	Friday, 2 September 2011
Commencement of trading under the new name (Mediclinic International Limited)	Monday,5 September 2011
Record date	Friday, 9 September 2011

Share certificates may not be dematerialised or rematerialised between Monday, 5 September 2011 and Friday, 9 September 2011, both days inclusive.

11. GENERAL AUTHORITY TO REPURCHASE SHARES

Special Resolution Number 4

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 Articles of Association, 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 Articles of Association of the Company, the provisions of the Companies Act and the JSE Listings Requirements, when applicable, and provided that:

11.1 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;

11.2 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 counterparty (reported trades are prohibited);

11.3 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;

11.4 the Company will only appoint one agent to effect any repurchase(s) on its behalf;

11.5 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 five business days immediately preceding the date of the repurchase of such ordinary shares by the Company and/or any subsidiary of the Company;

11.6 any such general repurchases are subject to exchange control regulations and approvals at that point in time, where relevant;

11.7 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;

11.8 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

11.9 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.

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:

11.10 the Company and the Group will be able in the ordinary course of business to pay its debts;

11.11 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;

11.12 the share capital and reserves of the Company and the Group will be adequate for ordinary business purposes; and

11.13 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 4
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.

12. APPROVAL OF AMENDMENTS OF ARTICLES OF ASSOCIATION: ELECTRONIC PAYMENTS

Special Resolution Number 5
Resolved that the Company's Articles of Association is amended by substituting articles 38.9 – 38.14 in its entirety with the following:

"38.9 Dividends, interest or any other sum payable in cash to any holder of the company's shares shall be paid by way of an electronic funds transfer only, unless agreed to otherwise at the discretion of the company, into the selected bank account of:

38.9.1 the holder; or

38.9.2 in the case of joint holders, to the holder whose name stands first in the register in respect of the share(s); or

38.9.3 such person as the holder or joint holders may in writing direct.

38.10 The electronic funds transfer of the dividends, interest or other sum made into such account shall discharge the company of any further liability in respect of the amount concerned. The company shall not be responsible for a holder's loss arising from any fraudulent, diverted or incorrect electronic funds transfer of dividends, interest or other sum payable to a holder unless such loss was due to the company's gross negligence or wilful default.

38.11 For the purpose of this article, no notice of change of bank account or instructions as to payment being made at any other bank account which is received by the company after the date on which a member must be registered in order to qualify for a dividend or other payment and which would have the effect of changing the currency in which such payment would be made, shall be effective in respect of such payment.

38.12 A member who is a South African resident shall only be entitled to supply a Rand denominated bank account of a bank registered to operate such account in South Africa.

38.13 In the event that a member has failed to supply a valid bank account as envisaged herein, the dividends, interest or other moneys shall be deemed unclaimed dividends in terms of article 38.8.

38.14 Dividends, interest or any other sum may be paid in any other way determined by the directors, and if the directives of the directors in that regard are complied with, the company shall not be liable for any loss or damage which a member may suffer as a result thereof."

Additional information in respect of Special Resolution Number 5
The reason for and the effect of the special resolution is to amend the Company's Articles of Association to allow for the electronic payment of dividends, interest and other sum payable to a holder of shares in the Company. This resolution is proposed due to the increasing number of attempted fraud with cheque payments. The effect of the resolution is that payments will in future only be made by way of electronic funds transfer into the bank accounts supplied by shareholders to the Company's transfer secretaries, Computershare Investor Services (Pty) Ltd.

13. GENERAL AUTHORITY TO PROVIDE FINANCIAL ASSISTANCE TO RELATED AND INTER-RELATED COMPANIES AND CORPORATIONS

Special Resolution Number 6

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 6), 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:

13.1 it will not adopt a resolution to authorise such financial assistance, unless the directors are satisfied that –

13.1.1 immediately after providing the financial assistance, the Company would satisfy the solvency and liquidity test as contemplated in the Companies Act; and

13.1.2 the terms under which the financial assistance is proposed to be given are fair and reasonable to the Company; and

13.2 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 –

13.2.1 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

13.2.2 within 30 business days after the end of the financial year, in any other case.

Additional information in respect of Special Resolution Number 6

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. Prior to the commencement of the Companies Act on 1 May 2011, it was not a requirement to obtain shareholder approval for such financial assistance. The Board of the Company provided such inter-group financial assistance to a subsidiary, as disclosed in the annual financial statements in note 7 on page 156 and the annexure listing the Company's investments in subsidiaries and associates on page 191 of the annual report of which this notice forms part.

14. TO TRANSACT ANY OTHER BUSINESS THAT MAY BE TRANSACTED AT AN ANNUAL GENERAL MEETING.

Additional disclosure of information

Further to Special Resolution Numbers 3 and 4, 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 6 to 7 of the annual report.

- **Major shareholders of the Company**
  See page 194 of the annual report.

- **Material changes**
  The Company raised R1 331m by way of a rights offer of 59 301 395 ordinary shares ("rights offer shares") in the Company in August 2010, as referred to in the Chief Financial Officer's Report on page 26 of the annual report. There have been no other material changes in the financial or trading position of the Company and its subsidiaries since 31 March 2010.

- **Directors' interests in securities**
  See page 195 of the annual report.

- **Share capital of the Company**
  See page 194 of the annual report.

- **Litigation statement**
  In terms of section 11.26 of the JSE Listings Requirements, the directors, whose names appear on pages 6 to 7 of the 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 6 to 7 of the 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 Articles of Association of the Company and the JSE Listings Requirements.

Ordinary Resolution Number 7 (general authority to issue shares for cash) and Special Resolutions Number 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, and further subject to the provisions of the Companies Act, the Articles of Association of the Company and the JSE Listings Requirements.

ATTENDANCE AND VOTING BY SHAREHOLDERS OR PROXIES

Attendance by webcast-facilities:
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 Yolande Beck by email at yolande.beck@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 Company's 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, 22 July 2011.

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 (Proprietary) Limited, 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 **Monday, 25 July 2011**. 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.

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 and to obtain the necessary authority to do so, in the event that they wish to attend the Annual General Meeting.

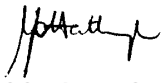
On a show of hands, every shareholder of the Company present in person or represented by proxy shall have one vote only. On a poll, every shareholder of the Company shall have one vote for every share held in the Company by such shareholder.

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
28 June 2011

PROXY FORM

MEDI-CLINIC CORPORATION LIMITED
Registration number: 1983/010725/06
Share Code: MDC
ISIN Code: ZAE000074142
("**the Company**")

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-eighth Annual General Meeting of the Company to be held at the Protea Hotel, Techno Avenue, Techno Park, Stellenbosch, on Wednesday, 27 July 2011 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 27th day of July 2011 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 CA van der Merwe			
	3.2 RE Leu			
	3.3 CI Tingle			
	3.4 MK Makaba			
	3.5 ZP Manase			
	3.6 KHS Pretorius			
	3.7 DK Smith			
	3.8 TO Wiesinger			
4.	Election of independent Audit and Risk Committee			
5.	Approval of Group 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 – 2010/2011			
2.	Approval of non-executive directors' remuneration – 2011/2012			
3.	Approval of change of Company name			
4.	General authority to repurchase shares			
5.	Approval of amendments to Articles of Association: electronic payments			
6.	General authority to provide financial assistance to related and inter-related companies and corporations			

Signed at _____ on _____ 2011.

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 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 (Proprietary) Limited, 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 **Monday, 25 July 2011** at 15:00 (South African time).

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 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.

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
Board	the board of directors of Mediclinic International
CAGR (%)	compounded annual growth rate
cash conversion (%)	cash generated from operations divided by core EBITDA
CDLI	Carbon Disclosure Leadership Index
CDP	Carbon Disclosure Project
COHSASA	Council for Health Services Accreditation in South Africa
Companies Act, 1973	the South African Companies Act, 61 of 1973, as amended, which Act was repealed and replaced by the Companies Act, 2008
Companies Act, 2008	the South African Companies Act, 71 of 2008, as amended which came into effect on 1 May 2011
the Company	Medi-Clinic Corporation Limited
core EBITDA	operating profit before depreciation and amortisation excluding one-off items
core 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
core headline earnings per share (HEPS) (cents)	core headline earnings divided by the weighted average number of ordinary shares in issue
core price-earnings ratio	closing share price on the JSE divided by the basic headline earnings per share excluding one-off items
CSI	Corporate Social Investment
DHCC	Dubai Healthcare City
DoH	Department of Health
DRG	diagnostic related groupings
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	Mediclinic 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
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

GLOSSARY
(CONTINUED)

TERM	MEANING
headline earnings per share (HEPS) (cents)	headline earnings divided by the weighted average number of ordinary shares in issue
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
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 II	King Report on Corporate Governance for South Africa 2002
King III	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	Medi-Clinic Corporation Limited or the Mediclinic Group, as the context may indicate
Mediclinic Group	Mediclinic and its three operating platforms in Southern Africa, Switzerland and the United Arab Emirates
Mediclinic Southern Africa	Medi-Clinic Southern Africa Limited, 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
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 2011 and ending on 31 March 2012
NHI	National Health Insurance of South Africa
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/year under review	the financial year which commenced on 1 April 2010 and ended on 31 March 2011
price-earnings ratio	closing share price on the JSE divided by the basic headline earnings per share
Swiss pension fund payout ratio	the percentage ratio of the retirement capital which will be paid as an annuity to a pensioner
UAE	United Arab Emirates
VON	Vermont Oxford Network

NOTES

NOTES

ADMINISTRATION

COMPANY SECRETARY
Gert Hattingh (46) B.Acc. (Hons), CA(SA)

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

E-MAIL AND WEBSITE
info@mediclinic.com
www.mediclinic.com

COMPANY REGISTRATION NUMBER
1983/010725/06

TRANSFER SECRETARIES
Computershare Investor Services Proprietary Limited
70 Marshall Street, Johannesburg, 2001
Postal address: PO Box 61051, Marshalltown, 2107
Tel: +27 11 370 5000 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	27 July 2011
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 27 (23 cents per share):	
Declaration date	Tuesday, 9 November 2010
Last date to trade cum dividend	Friday, 3 December 2010
First date of trading ex dividend	Monday, 6 December 2010
Record date	Friday, 10 December 2010
Payment date	Monday, 13 December 2010
Final payment: dividend number 28 (50 cents per share):	
Declaration date	Tuesday, 24 May 2011
Last date to trade cum dividend	Friday, 17 June 2011
First date of trading ex dividend	Monday, 20 June 2011
Record date	Friday, 24 June 2011
Payment date	Monday, 27 June 2011

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