MEDI-CLINIC

Private hospital group

ANNUAL REPORT 07

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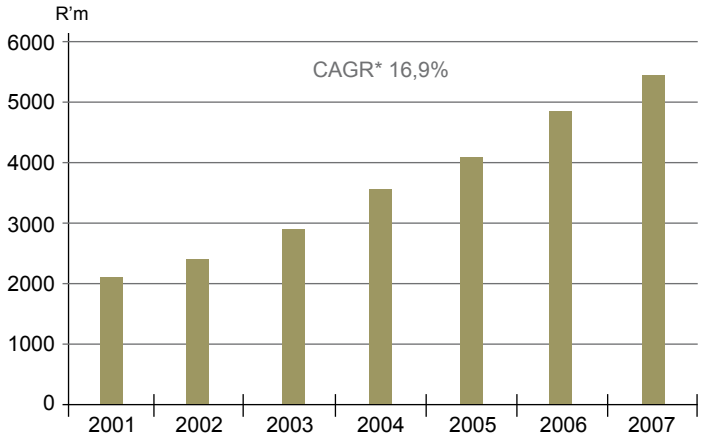
SCOPE OF REPORT The 2007 annual report of Medi-Clinic Corporation Limited presents the operating and financial results of the group for the financial year ended 31 March 2007 and covers all our operations in South Africa, Namibia and the United Arab Emirates. The report has been prepared in accordance with International Financial Reporting Standards, the Companies Act No. 61 of 1973, the Listings Requirements of the JSE Limited and the guidelines of the King II Report on Corporate Governance.

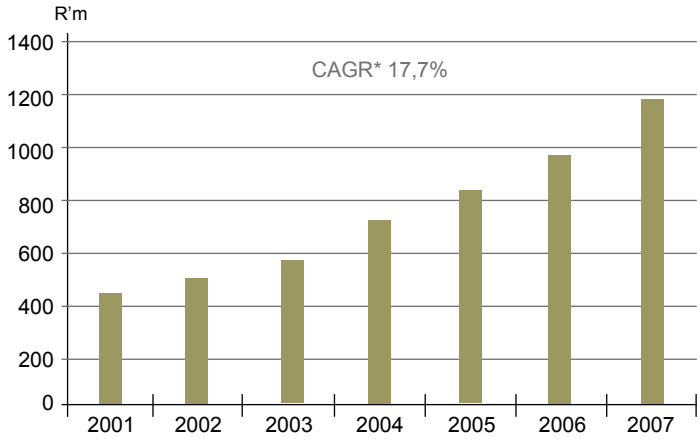
FINANCIAL HIGHLIGHTS

GROUP SUMMARY	2007	2006	Increase
	R'm	R'm	
REVENUE	5,364	4,723	13.6%
Operating profit before depreciation, taxation and amortisation (EBITDA)	1,151	987	16.6%
Core earnings attributable to ordinary shares	581	553	5.0%
Total assets	5,489	3,597	52.6%
Shareholders' equity	2,068	1,641	26.0%
Return (core earnings) on shareholders' equity	28.1%	33.7%	
	cents	cents	
Core earnings per ordinary share - basic	162.2	159.3	1.8%
Core earnings per ordinary share - diluted	147.2	140.9	4.5%
Total distribution per ordinary share	54.1	53.1	1.9%
Net asset value per ordinary share - diluted	575.5	460.7	24.9%

REVENUE



EBITDA



** Compounded Annual Growth Rate*

CORE EARNINGS AND DISTRIBUTION PER ORDINARY SHARE (BASIC)#

 # Excluding the special dividend of R4,02 per share on 27 December 2005

FROM THE SKILLS OF THE DOCTOR TO GENERAL PATIENT CARE, FROM FACILITIES TO EQUIPMENT, OUR PHILOSOPHY IS THAT THERE IS A STANDARD TO UPHOLD AT THE FAIREST POSSIBLE TARIFF. THIS LEADS TO OUR SPECIAL KIND OF QUALITY CARE.

IN OUR HOSPITALS THIS QUALITY CARE STARTS WITH OUR SKILLED AND MOTIVATED PERSONNEL WHO ARE DEDICATED TO THEIR PATIENTS' WELL-BEING. IT IS CONFIRMED BY TECHNOLOGICALLY ADVANCED EQUIPMENT COVERING THE ENTIRE SPECTRUM OF SPECIALISED MEDICAL SERVICES. IT CULMINATES IN A WARM AND FRIENDLY ATMOSPHERE – AN ENVIRONMENT THAT IS TRANQUIL AND CONDUCIVE TO SWIFT HEALING. MEDI-CLINIC SETS A PARTICULAR STANDARD IN HOSPITAL CARE.





OUR COMMITMENT TO QUALITY CARE AND OUR VISION

VISION

OUR CORE IDEOLOGY AND VALUES

- Client Orientation
- Team Approach
- Mutual Trust and Respect
- Performance Driven

OUR CORE PURPOSE

To enhance the quality of life of patients by providing comprehensive, high quality hospital services.

OUR ENVISIONED FUTURE AND ASPIRATIONS

To be regarded as the most respected and trusted provider of hospital services.

- We will focus relentlessly on the needs of our clients.
- Every hospital will be the preferred service provider in the community it serves.
- We will provide the most cost-effective quality care possible.
- We will maintain a contented workforce.

We, the members of Medi-Clinic, support the following core values. In our behaviour we:

CLIENT ORIENTATION

- reflect the image of the company
- deliver the right service in the right place on 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

- 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

- 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

- 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 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

SEVEN YEAR REVIEW

	2001 R'm	2002 R'm	2003 R'm	2004 R'm	2005 R'm	2006 R'm	2007 R'm	CAGR*
INCOME STATEMENTS								
REVENUE	2,098	2,438	2,924	3,643	4,040	4,723	**5,364**	16.9%
Operating profit before depreciation and amortisation (EBITDA)	434	506	571	722	819	987	**1,151**	17.7%
Profit on sale of property, plant and equipment	-	-	-	1	1	1	**1**	
BEE share-based payment	-	-	-	-	-	(85)	**-**	
Depreciation	(76)	(71)	(75)	(101)	(97)	(124)	**(146)**	
Amortisation/impairment of goodwill	(1)	(1)	(2)	(3)	(3)	-	**-**	
Operating profit	357	434	494	619	720	779	**1,006**	18.8%
Dividends	8	5	-	-	-	-	**-**	
Income from associates	16	18	19	18	25	13	**1**	
Abnormal items	-	-	-	-	50	43	**-**	
Finance income	15	20	43	46	58	70	**44**	
Finance cost	(24)	(17)	(16)	(32)	(29)	(45)	**(88)**	
Profit before taxation	372	460	540	651	824	860	**963**	
Taxation	(96)	(126)	(145)	(174)	(214)	(428)	**(270)**	
Profit for the year	276	334	395	477	610	432	**693**	
Attributable to:								
Equity holders of the Company	246	308	364	439	543	338	**582**	15.4%
Minority interest	30	26	31	38	67	94	**111**	
	276	334	395	477	610	432	**693**	
Headline earnings attributable to holders of ordinary shares	247	309	366	441	503	300	**581**	15.3%
Core earnings attributable to holders of ordinary shares	247	309	366	441	503	553	**581**	15.3%
Earnings per ordinary share - cents								
Basic	70.5	88.5	106.5	128.8	158.7	97.1	**162.5**	14.9%
Diluted	69.9	87.2	105.2	127.0	156.7	85.9	**147.5**	13.3%
Headline earnings per ordinary share - cents								
Basic	70.6	88.7	107.0	129.5	146.9	86.3	**162.2**	14.9%
Diluted	70.0	87.4	105.7	127.7	145.0	76.3	**147.2**	13.2%
Core earnings per ordinary share - cents								
Basic	70.6	88.7	107.0	129.5	146.9	159.3	**162.2**	14.9%
Diluted	70.0	87.4	105.7	127.7	145.0	140.9	**147.2**	13.2%
Distribution per ordinary share - cents	21.7	27.3	33.0	40.0	45.0	53.1	**54.1**	16.4%

** Compounded Annual Growth Rate*

	2001 R'm	2002 R'm	2003 R'm	2004 R'm	2005 R'm	2006 R'm	2007 R'm	CAGR*
BALANCE SHEETS								
ASSETS								
Property, plant and equipment	1,294	1,347	1,611	1,846	1,997	2,327	**3,124**	
Intangible assets	10	18	36	48	48	48	**419**	
Investments and loans	91	18	92	103	114	119	**46**	
Deferred income tax assets	48	52	69	89	92	123	**120**	
Current assets	546	715	891	1,134	1,510	980	**1,780**	
Total assets	1,989	2,150	2,699	3,220	3,761	3,597	**5,489**	
EQUITY								
Capital and reserves attributable to equity holders of the Company	1,488	1,660	1,917	2,246	2,693	1,641	**2,068**	
Minority interest	80	75	172	200	235	290	**752**	
LIABILITIES								
Long-term interest-bearing borrowings	134	58	112	168	159	848	**996**	
Deferred income tax liabilities	2	2	3	3	4	5	**5**	
Long-term interest-free liability	33	40	48	58	73	102	**129**	
Current liabilities	252	315	447	545	597	711	**1,539**	
Total equity and liabilities	1,989	2,150	2,699	3,220	3,761	3,597	**5,489**	
Net asset value per ordinary share - cents (diluted)	426.0	486.2	562.7	657.2	783.7	460.7	**575.5**	5.1%
CASH FLOW STATEMENTS								
Cash generated from operating activites	407	541	520	819	923	994	**1,187**	19.5%
Net finance income/(cost)	(9)	3	27	14	29	25	**(44)**	
Dividends	-	28	-	-	-	-	**-**	
Abnormal item	-	-	-	-	50	-	**-**	
Taxation paid	(99)	(123)	(143)	(196)	(243)	(448)	**(306)**	
Cash flow from operating activities	299	449	404	637	759	571	**837**	
Cash flow from investment activities	(151)	(96)	(276)	(325)	(178)	(388)	**(672)**	
Cash flow from financing activites	(117)	(224)	(142)	(106)	(185)	(830)	**43**	
Cash distributions to minorities	(11)	(15)	(19)	(32)	(34)	(39)	**(40)**	
Distributions to shareholders	(68)	(80)	(100)	(120)	(142)	(166)	**(178)**	
Special dividend to shareholders	-	-	-	-	-	(1,327)	**-**	
Movement in borrowings	(39)	(73)	(16)	40	(21)	689	**248**	
Other	1	(56)	(7)	6	12	13	**13**	
Net movement in cash and bank overdrafts	31	129	(14)	206	396	(647)	**208**	
Opening balance of cash and bank overdrafts	48	79	208	194	400	796	**149**	
Closing balance of cash and bank overdrafts	79	208	194	400	796	149	**357**	

** Compounded Annual Growth Rate*

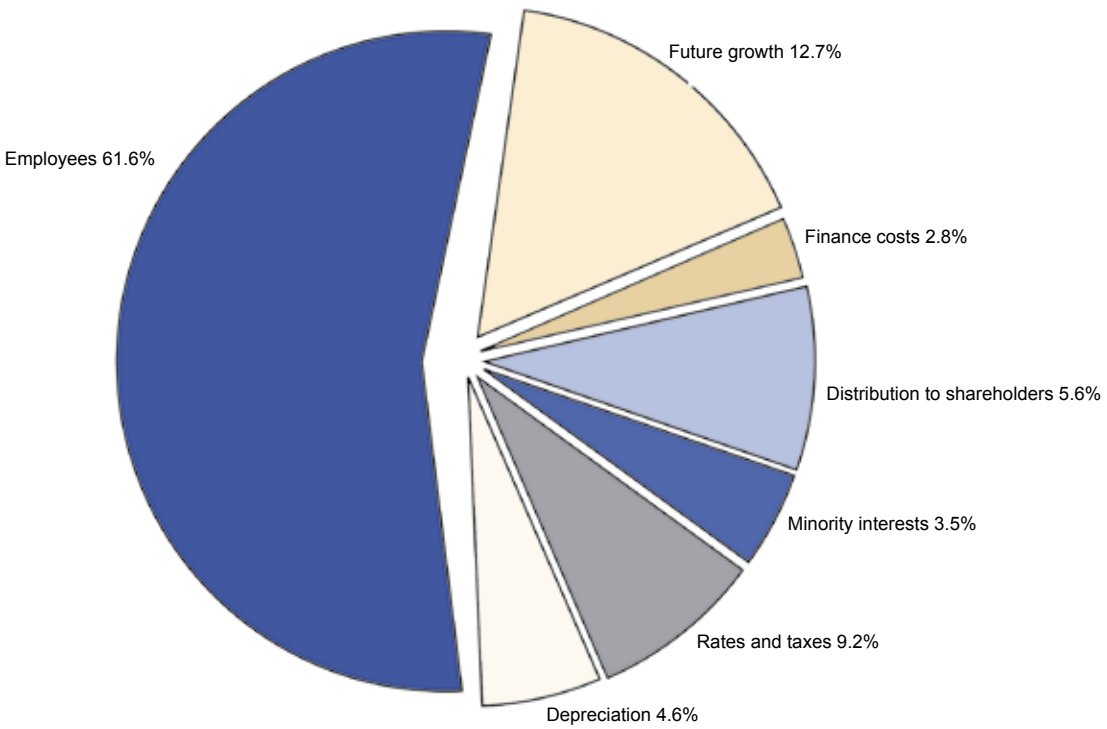
VALUE ADDED STATEMENT

FOR THE YEAR ENDED 31 MARCH 2007

	2007 R'm	%	2006 R'm	%
VALUE CREATED				
Revenue	5,364		4,723	
Cost of materials and services	(2,239)		(1,892)	
Interest received	44		68	
	3,169	100.0	2,899	100.0
DISTRIBUTION OF VALUE				
To employees as remuneration and other benefits	1,951	61.6	1,750	60.4
Taxation and other state and local authority levies (excluding VAT and STC on the special dividend)	291	9.2	287	9.9
To suppliers of capital:				
Minority interests	111	3.5	94	3.2
Finance cost on borrowed funds	88	2.8	45	1.6
Distributions to shareholders (excluding special dividend)	178	5.6	166	5.7
	2,619	82.7	2,342	80.8
VALUE RETAINED				
To maintain and replace assets	146	4.6	123	4.2
Income retained for future growth	404	12.7	434	15.0
	550	17.3	557	19.2

DISTRIBUTION OF VALUE

2007



ADMINISTRATION

COMPANY SECRETARY
G C Hattingh (42) B.Acc (Hons), CA (SA)

BUSINESS ADDRESS AND REGISTERED OFFICE
Medi-Clinic Offices, Strand Road, Stellenbosch, 7600
Postal address: P O Box 456, Stellenbosch, 7599
Tel: +27 21 809 6500 Fax: +27 21 886 4037

E-MAIL AND WEBSITE
medimail@mediclinic.co.za
http://www.mediclinic.co.za

COMPANY REGISTRATION NUMBER
1983/010725/06

TRANSFER SECRETARIES
Computershare Investor Services 2004 (Proprietary) Limited
70 Marshall Street, Johannesburg, 2001
Postal address: P O Box 61051, Marshalltown, 2107
Tel: +27 11 370 7700 Fax: +27 11 688 7716

AUDITORS
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

DATES OF IMPORTANCE TO SHAREHOLDERS

ANNUAL GENERAL MEETING
26 July 2007

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 19 (16.5 cents per share):

Declaration date	8 November 2006
Last date to trade *cum* dividend	1 December 2006
First date of trading *ex* dividend	4 December 2006
Record date	8 December 2006
Payment date	11 December 2006

Final Payment: Dividend number 20 (37.6 cents per share):

Declaration date	9 May 2007
Last date to trade *cum* dividend	15 June 2007
First date of trading *ex* dividend	18 June 2007
Record date	22 June 2007
Payment date	25 June 2007

BOARD OF DIRECTORS

AT 31 MARCH 2007

CHAIRMAN

E de la H Hertzog (57)
M.B.Ch.B., M.Med., F.F.A. (SA)

Appointed in 1983 as managing director, in 1990 as executive vice-chairman and in 1992 as chairman of the company. Other directorships include Distell, Remgro, Total (SA) and Trans Hex Group.

EXECUTIVE DIRECTOR

L J Alberts (59)
B.Comm, CA (SA)
(Managing Director)

Appointed in 1988 as director of the company and in 1990 as managing director.

EXECUTIVE DIRECTOR

J du T Marais (56)
H.N.T.D. (Mec)
(Technical Director)

Appointed in 1985 as director of the company.

EXECUTIVE DIRECTOR

D P Meintjes (50)
B.PI (Hons)
(Executive Director: United Arab Emirates)

Joined the company in 1985 and appointed in 1996 as director of the company. Seconded to Dubai in 2006 to oversee company's expansion into the United Arab Emirates.

EXECUTIVE DIRECTOR

K H S Pretorius (44)
B.Compt, MBL
(Group Operations Director)

Joined the group in 1998 and appointed in November 2006 as director of the company.

EXECUTIVE DIRECTOR

J G Swiegers (52)
B.Acc (Hons), B.Comm (Hons) (Taxation), CA (SA)
(Financial Director)

Appointed in 1994 as non-executive director of the company and in 1999 as financial director.

NON-EXECUTIVE DIRECTOR

V E Msibi (51)
M.B.Ch.B.

Group Executive Chairman of Phodiso Holdings. Appointed in November 2005 as director of the company.

NON-EXECUTIVE DIRECTOR

M H Visser (53)
B.Comm (Hons), CA (SA)

Chief Executive Officer of Remgro. Appointed in November 2005 as director of the company. Other directorships include Distell and Nampak. Chairman of Rainbow Chicken.

NON-EXECUTIVE DIRECTOR

M A Ramphele (59)
M.B.Ch.B., Diploma in Tropical Health and Hygiene, B.Comm, Diploma in Public Health, Ph.D.

Chairperson of Circle Capital Ventures. Appointed in March 2005 as director of the company. Other directorships include Anglo American and MTN Group.

INDEPENDENT NON-EXECUTIVE DIRECTOR

W L van der Merwe (55)
M.B.Ch.B., M.Med., F.F.A. (SA), MD

Dean of the Faculty Health Sciences of Stellenbosch University. Appointed in 2001 as director of the company.

INDEPENDENT NON-EXECUTIVE DIRECTOR

A A Raath (51)
B.Comm, CA (SA)

Chief Executive Officer of Innofin, a subsidiary of Sanlam. Appointed in 1996 as director of the company.

INDEPENDENT NON-EXECUTIVE DIRECTOR

S Dakile-Hlongwane (56)
BA, MA

Acting Chairperson and Chief Executive Director of Nozala Investments. Appointed in 2000 as director of the company.

INDEPENDENT NON-EXECUTIVE DIRECTOR

A R Martin (68)
B.Comm, CA (SA)

Appointed in 2002 as director of the company. Other directorships include Trans Hex Group, Santam and Credit Guarantee Insurance of Africa.

REPORT TO OUR SHAREHOLDERS

WE ARE PLEASED TO REPORT THAT THE GROUP HAS MAINTAINED ITS CONSISTENT GROWTH PATTERN. IT STRENGTHENED ITS OPERATIONAL PERFORMANCE AND CONTINUED TO IMPLEMENT STRATEGIC INITIATIVES AND INVESTMENTS AIMED AT EXPANDING THE GROUP'S OPERATIONS IN SOUTH AFRICA AND OTHER COUNTRIES.

FINANCIAL PERFORMANCE AND CORPORATE ACTIVITY

The black ownership initiative and the capital restructuring ("the transactions") implemented by Medi-Clinic in December 2005, continue to have an effect on the interpretation of the group's earnings, headline earnings per share ("HEPS") and earnings per share ("EPS").

The non-recurring effect of the transactions manifested in the following two charges to the group's income statement:

- a net STC charge of R168 million ("the STC charge") resulting from the special dividend declared as part of the capital restructuring; and
- a charge of R85 million being the IFRS charge on the share-based portion of the black ownership initiative ("the BEE share-based payment").

These charges were fully reflected in the financial results for the year to 31 March 2006. The resulting low base of the group's earnings, HEPS and EPS in the previous financial year was the main reason for the substantial increases this year in these denominators of 94%, 88% and 67% respectively.

The ongoing effect of the transactions is mainly reflected in:

- higher interest charges ("the higher interest charges") resulting from the capital restructuring implemented in December 2005. The higher interest charges consist of the aggregate of the interest income foregone on the cash balance on hand prior to the capital restructuring and the interest paid on the newly introduced debt of R700 million. Compared with the previous financial year the higher interest charges for the year under review amount to about R122 million (2006: R32 million) before taxation (therefore, representing a net amount of R90 million in higher interest charges before taxation for the year under review); and

- treasury stock: the 28,5 million new shares issued to the strategic black partners in terms of the black ownership initiative are treated as treasury stock and are being released in line with payments made to Medi-Clinic by the strategic black partners relative to the original market value of these shares, being R525 million. To date 10,9 million of these shares have been released from treasury stock (1,3 million during the period under review). This leaves a balance of 17,6 million treasury shares at 31 March 2007 in addition to the existing treasury shares held by the group and the 15,8 million shares issued to the Mpilo Trust. The release of such shares from treasury stock has had and will continue to have a commensurate dilutive effect on the EPS and HEPS of the group.

In the context of the above, the core earnings of the group are emphasised in this report. The core earnings include the headline earnings of the group and the ongoing effect of the transactions, but exclude the non-recurring effect of the STC charge and the BEE share-based payment.

The transactions did not have a significant financial effect on the operational performance of the group.

With the above transactions as background, revenue, which consists mainly of hospital fees, increased by 14% to R5 364 million (2006: R4 723 million) for the year under review. Operating profit before interest, taxation, depreciation and amortisation (EBITDA) was 17% higher at R1 151 million (2006: R987 million). After incurring the higher net interest charges of about R90 million before taxation, core earnings (which exclude the STC charge and the BEE share-based payment) rose by 5% to R581 million (2006: R553 million) resulting in an increase of 2% in core earnings per share ("CEPS") to 162.2 cents (2006: 159.3 cents). The total dividend per share at 54.1 cents for the year (2006: 53.1 cents) is 2% higher.

The group acquired a 49.9% interest in the Wits Donald Gordon Medical Centre ("WDGMC") (190 beds), a 100% interest in the Legae Private Hospital ("Legae") (137 beds) and a 51% interest in the 200-bed Protector Group effective from 1 July 2005, 1 December 2005 and 8 November 2006, respectively. (The acquisition of a controlling stake in Emirates Healthcare Holdings Limited ("Emirates Healthcare") became effective on 27 March 2007 just before year-end. Hence, no operational results for Emirates Healthcare are included in the


income statement for the period under review.) The current period's results are therefore, due to the above transactions, not directly comparable with those of the previous period. Excluding the increase in capacity due to these transactions, the group's revenue growth amounted to 11%.

On a comparable basis, the revenue growth of 11% was achieved through a 5% increase in in-patient bed-days, a 5% increase in the average income per bed-day and a 1% change in the case profile of patients treated. The increase in utilisation was evident in both surgical and medical cases. The number of patients admitted to our hospitals increased by 5% while the average length of stay remained fairly stable.

The group's EBITDA margin increased from 20.9% to 21.5%, mainly due to a maintained focus on operational efficiencies, as well as releases from the provision for doubtful debts as a result of improved collections from medical schemes.

The acquisition of a 49.9% interest in Emirates Healthcare, which was announced on 28 April 2006, became unconditional on 27 March 2007. This was communicated to the market in a SENS announcement on 19 April 2007. Ultimately, the group obtained a controlling equity interest of 50% plus one share, with board and management control. Emirates Healthcare owns and operates one of the two biggest private hospitals in Dubai in the United Arab Emirates, the 120-bed Welcare Hospital, along with one ambulatory surgery centre and two clinics which are in close proximity. It has also commenced with the construction of the first hospital in Dubai Health Care City ("DHCC"), the City Hospital with 210 beds, which is scheduled for commissioning towards the end of 2007 or the beginning of 2008. In addition, Emirates Healthcare has the right to develop a further hospital in DHCC and plans to develop a further three related clinics of which two will open during this year. This will make Emirates Healthcare the largest private healthcare provider in Dubai.

In terms of the transaction Medi-Clinic Middle East, a group subsidiary, subscribed for an equity interest of 50% plus one share in Emirates Healthcare for an amount of US$53,1 million (R384,2 million), while General Electric Company ("GE") a member of the General Electric Group subscribed for a 6,59% equity interest for an amount of US$7 million. Mr Sunny Varkey (the founder and chairman of Emirates Healthcare) will retain an equity interest of 43,41%. The parties will endeavour to secure a further strategic equity investor in the subsidiary of Emirates Healthcare which owns the Dubai based operating companies. To facilitate this, Medi-Clinic Middle East also subscribed for cumulative variable rate participating redeemable convertible preference shares in Emirates Healthcare for an amount of US$21,5 million (R155,2 million) to fund a portion of the equity contribution reserved for the strategic equity investor.

The total equity capital referred to above together with debt funding from local financial institutions in the amount of US$102 million are adequate to fund all the projects mentioned above. The debt funding is in the process of being finalised.

As mentioned in the SENS announcement of 19 April 2007 the short-term financial effect of the transaction on the group's EPS and HEPS is negligible, mainly due to the green field's nature of the investment. The group is very positive about the market outlook of Dubai and is confident about the long-term prospects of the investment.

This investment in Dubai is an ideal platform to enter health care markets in the rest of the Gulf Coalition Countries and the Middle East.

Due to the fact that the transaction only came into effect on 27 March 2007, only the balance sheet of Emirates Healthcare on 31 March 2007, but no financial results were consolidated into the group's accounts. However, if the acquisition had occurred on 1 April 2006, the group's revenue would have increased by R409 million, EBITDA by R48 million, operating profit by R28 million and profit for the year by R24 million, of which R12 million would have been attributable to the shareholders of the group.

From an operational perspective, two senior managers of the group who were or still are members of the Board hold the positions of Human Resource Director and Chief Financial Officer of Emirates Healthcare. The hospital managers of both the Welcare Hospital and the City Hospital were seconded by the group to Emirates Healthcare in addition to about 16 nurses. Medi-Clinic was also accredited by the DHCC as Emirates Healthcare's international affiliated partner.

Cash flow continued to be strong during the period under review, mainly due to more efficient working capital management. The group converted 103% (2006: 101%) of EBITDA into cash generated from operating activities. The group's strong cash flow continues to underline the quality of its earnings. Cash and cash equivalents increased from R160 million to R716 million (of which R505 million is held by Emirates Healthcare) at 31 March 2007. Interest-bearing debt increased from R922 million to R1 624 million (R307 million at Emirates Healthcare) after financing capital

expenditure and acquisitions, mainly the Protector Group and Emirates Healthcare. This resulted in an increase in the debt: equity ratio from 48% to 58%.

The group did not repurchase any of its own shares. Commencing the financial year with a balance of 3 467 185 treasury shares excluding the balance of shares held by the strategic black partners which are regarded as treasury shares and the shares held by the Mpilo Trust referred to above, 1 305 273 of the treasury shares were utilised for the group's share option scheme and 347 960 for the group's long term management incentive scheme. At year end the group therefore held 1 813 952 treasury shares.

The long-term growth trend of your group is gratifying. The compounded annual growth rate (CAGR) of the group's revenue and EBITDA over the past seven years is 16.9% and 17.7% respectively, while the corresponding CAGR of its distribution per ordinary share amounts to 16.4%.

REVIEW OF OPERATIONS

Virtually all the group's hospitals have been designed and equipped as multi-disciplinary units which provide, as far as possible, a one-stop service to doctors and patients. Effective operational management is a process which requires, and receives, meticulous ongoing attention. To ensure efficiency, operational management is decentralised into five regions each with its own limited support base. Head Office functions are mainly to plan, co-ordinate, control and provide certain specialised services.

Your group remains focused on its core business and at present operates 47 hospitals throughout South Africa, 3 in Namibia and 1 hospital, 1 ambulatory surgery centre and two clinics in Dubai, United Arab Emirates.

OPERATIONAL ISSUES AND HIGHLIGHTS

THE TRADING ENVIRONMENT IN SOUTH AFRICA

The trading environment improved compared with previous years. The country as a whole experienced good growth and the medical scheme membership also grew by 2.6% in terms of the annual report of the Council for Medical Schemes for the 2005 financial year. No significant growth in cash paying patients was experienced.

Revenue growth of 11% was achieved, on a comparable basis, through a 5% increase in in-patient bed-days, a 5% increase in the average income per bed-day and a 1% change in the case profile of patients treated. The increase in utilisation was evident in both surgical and medical cases. The number of patients admitted to our hospitals increased by 5% while the average length of stay remained fairly stable.

The group's EBITDA margin increased from 20.9% to 21.5%, mainly due to a maintained focus on operational efficiencies, as well as releases from the provision for doubtful debts as a result of improved collections from medical schemes.

The staff of the group deserve special mention for their dedicated and energetic efforts which enabled the group to achieve the published results. These results would also not have been possible without the loyal and competent support of the doctors utilizing the group's facilities.

INTEGRATION OF THE PROTECTOR HOSPITALS

The integration of the Protector Group consisting of the 155 bed Medivaal MediCentre in Vanderbijlpark, the 25 bed Kathu Private Hospital and the 12 bed Marapong Private Hospital went very smoothly. The staff at the various hospitals were very co-operative and supportive of the new ownership. We welcome them into the Medi-Clinic fold.

SHORTAGE OF NURSES

The acute skills shortage experienced in South Africa has been evident in the nursing profession for some time and the public and private sectors will have to find ways to work together to address this problem as a matter of urgency for the country as a whole. The Medi-Clinic nursing leadership has participated in the drafting of the country's national nursing strategy, and has committed to working with the Department of Health in the operationalisation of the strategy which forms an integral part of the strategic framework for the Human Resources for Health Plan for South Africa.

Training of nurses will remain a priority for both the private and public sectors in order to meet the needs of doctors and patients. The group has maintained an amount of nearly 4% of its payroll cost for training and development in the current budget. Results in SA Nursing Council registered examinations continue to be excellent which is a true reflection of the quality of students selected and the professionalism of the group's


nursing educators. A total of 676 students in all categories of nursing registered on learnerships during the year under review while 501 acquired new qualifications in the same period. A further 105 students were engaged in courses that will lead to a qualification.

The group firmly believes that its training investment contributes to empowering talented people in our country to participate in growing the economy and to attain sustainable socio-economic freedom.

As an interim strategy aimed at complementing our training initiatives in an endeavour to address the nursing shortage, Medi-Clinic has embarked on a foreign recruitment project where nurses are being recruited from Southern India. India was selected as the appropriate country following an extensive investigation. This included visiting hospitals and training facilities in three Asian countries. The pilot group of twenty-three specialist nurses, are awaiting the results of their South African Nursing Council examinations prior to arriving in South Africa in September. They will be followed by two further larger groups towards the end of the year and early in 2008.

The group's unique retention bonus scheme for nursing staff continues to have a positive effect on the stability of nursing staff. Together with the measured staff satisfaction ratings of the recent Markinor Survey, this translates well into quality care for patients as well as peace of mind for doctors.

Most of the group's nurses are members of the Mpilo Trust created as part of the BEE initiative. The group believes that employee participation in the BEE initiative is an imperative (just as BEE is a business imperative) to also economically empower its staff. It is believed that the loyalty it creates converts directly into quality care as is the case with the nursing retention bonus.

DOCTOR RELATIONSHIPS

Sound long-term doctor relationships built on ethical and fair business practices will always be one of the cornerstones of the strategic approach of the group.

The group has invested in infrastructure to strengthen and enhance its doctors' network in which free association and as much clinical independence as possible for the doctors, are key elements. It is strongly believed that these values, together with factors such as improving their working environment, providing them with the right address and peace of mind through the necessary support systems, are critical in gaining and maintaining enthusiastic doctors' support for the provision of cost effective quality healthcare. The associate specialists network and referring general practitioners network amount to approximately 1 600 and 3 900 respectively.

On the whole the group has fortunately never experienced any significant shortage of doctors' availability regarding the use of its facilities, especially consulting rooms. Currently it is more a question of striving to be fair and effective when attempting to satisfy the demand.

EMERGENCY MEDICINE

The group's national emergency service network, ER24, has experienced an increase in the number of emergency cases. ER24 continues to streamline its processes in order to optimise service delivery to hospitals.

The group has embraced the discipline of emergency medicine and complies with national regulations with regards to design, function, equipment and staff training.

The group continued to see a steady increase in patient volumes through the emergency units and it is anticipated that emergency medicine will continue to be a growth area. Medi-Clinic is the first hospital group to implement the triage system. The triage system, which prioritises emergency cases based on the patients' clinical condition, enables the emergency units to significantly improve service levels.

There is a financial risk involved in providing these services to patients who are not in a position to pay, but this is closely monitored and at this stage regarded as part of the corporate social investment of the group.

GROWING THE COMPANY LOCALLY

The group is continuously focusing on developing and growing its business to meet the needs of the market.

Phodiclinics (Proprietary) Limited, a company owned 51% by Medi-Clinic and 49% by Phodiso, one of the group's black economic empowerment partners, has been awarded a license to build a 140 bed hospital in the northern suburbs of the Cape Town Metropole. The building of this hospital will commence during this calendar year. The group will also, as a 49% shareholder, develop a 70 bed hospital in Scottburgh, KwaZulu-Natal.

An extensive upgrade of Panorama Medi-Clinic has commenced as well as the total reconstruction of the Plettenberg Bay Medi-Clinic. The establishment of a new cardiac unit at Windhoek Medi-Clinic has been approved and construction will commence later this year. Major upgrades at Morningside Medi-Clinic and Sandton Medi-Clinic, each involving over R100 million, are nearing completion. Expansions at Durbanville Medi-Clinic and Pietermaritzburg Medi-Clinic as well as a project at Nelspruit Medi-Clinic consisting of additional consulting rooms and the upgrade of the original hospital, are in their final stages. Routine upgrades continue at various other hospitals.

It is projected that the number of beds in the group will increase by about 500 over the next two years resulting from the building of new hospitals and extensions to existing hospitals.

GROWING THE COMPANY INTERNATIONALLY

The group took a strategic decision to continue to focus on its core business of acute, specialist orientated hospital care. This implies that in addition to growing the business locally, attractive international opportunities will continue to be pursued.

The group has confidence in the international growth potential of its core business due to inter alia the aging population, new medical technology, the increased burden of disease and consumerism by patients who demand cost-effective, quality healthcare. Furthermore, right across the world, governments find it increasingly difficult to manage the public healthcare burden. They are looking more and more to the private sector to assist them and in certain cases they are also beginning to acknowledge that the private sector can provide healthcare more cost-effectively. Germany is an example where public authorities have begun to offer management contracts to private operators to run large, public hospitals. In the Middle East the group's experience has been the same where it is the stated objective of most of the Gulf Coalition Countries to encourage the private sector to assist them in managing their healthcare burden.

The South African private hospital industry is one of the most advanced and mature markets in the world and the group believes that it has a lot to offer other countries especially since South African private hospital operators are used to managing their businesses within tight financial constraints. The group's venture into the United Arab Emirates bears testimony to this. During 2006 Medi-Clinic received the prestigious Markinor Sunday Times Top Brands Award for Healthcare Facilities which furthermore assists the group in pursuing growth opportunities.

DUBAI, UNITED ARAB EMIRATES

The current priority in Dubai is the commissioning of the City Hospital, which is aimed at the more sophisticated end of the market. This hospital is due to be completed towards the end of the current calendar year or the beginning of next year. The recruiting of doctors and nurses is a challenge since they are not freely available locally and need to be attracted from other countries. The commissioning period will impact on the financial risk since the amount of start up losses is largely dependent on a smooth commissioning process. The business model is different to that in South Africa due to the fact that all the doctors are employed by the hospital. The management team is confident that commissioning will be successful.

In the meantime, the 120 bed Welcare hospital is very busy and exceeding budget.

The three other clinics currently in operation namely, the Emirates Diagnostic Clinic, the Welcare Ambulatory Clinic and the Welcare Eye Clinic, are performing satisfactorily and two further clinics, respectively in Qusais and Mirdiff, will be commissioned during the year.

Another priority in this area is to create a solid and sustainable platform for managing future growth opportunities. Once the group is confident about this platform, these opportunities will be explored, including the management of public facilities.

INDUSTRY MATTERS

AFFORDABILITY OF HEALTHCARE

Affordability will always remain a critical issue in the healthcare industry internationally, but especially in developing countries.

Throughout the world increased healthcare costs are driven by increased utilisation resulting from factors such as the ageing population, new technology, patient expectations and the increased burden of disease. Locally the position is exacerbated by a shortage of skilled nursing staff, in line with the international shortage. This leads to and will for the foreseeable future continue to lead to sustained pressure for higher nursing salaries. Your group is fortunate to experience good staff retention due to proper retention strategies and also our drive to be the employer of choice. It further mitigates the risk by training nurses at all levels for its needs and by its foreign recruitment project.


The replacement cost of hospitals, being the cost of land as well as building costs, has risen dramatically in the recent past in line with local and international property trends. Current hospital tariffs do not reflect this trend.

The private hospital industry recognised the need to place private hospital costs in proper perspective and to explain the fundamental cost drivers in a typical private hospital in South Africa. To this end, the Hospital Association of South Africa ("HASA"), of which Medi-Clinic has always been an active member, commissioned independent research into the cost drivers and other variable factors influencing private hospital expenditure.

- Some of the most significant findings of the first phase of the research were that private healthcare cost inflation reduced significantly in the recent past; that private hospitals did absorb costs and did not pass all their cost increases on to consumers; and that South African private hospital inflation was the third lowest of the nine countries selected for the research.

- The second phase of the research was released during the HASA conference of June 2007. It showed, inter alia, that:

    - The private hospital industry's 2006 inflation rate of 5.6% was measurably lower than the overall medical inflation of 6.1% and the average increase granted to medical schemes by the Council for Medical Schemes of 7.9% at the beginning of 2007. Compared with several countries, including the United States of America, Australia and New Zealand, only the European Union at 4% had a lower medical inflation rate than South Africa. Australia's inflation rate was similar to South Africa. Turkey, the only other emerging market country included in the study recorded hospital inflation of 9%. The research found that nearly all countries experience a higher rate of medical inflation than overall inflation most of the time.
    - The cost per admission of private hospitals was lower than that of all categories of public hospitals, mainly due to a shorter length of stay attained in the private sector.
    - Visits to public hospitals declined by 3.2% from 2002 to 2005 while visits to private hospitals increased by 24.3% during the same period.

The research criticized a report released by the Council of Medical Schemes ("CMS"), edited by Alex van den Heever, which found that private hospital costs increased by more than 45% over a five year period. The CMS's findings were erroneously based on only the increased hospital costs per beneficiary, failing to take into account the increased use of hospital services by beneficiaries.

To compare the true public healthcare costs in South Africa with private healthcare costs is almost a futile exercise as the real, all inclusive public healthcare costs are just not known. The group is convinced that even medical scheme members in private wings of public hospitals receive substantial subsidisation by taxpayers: just to a lesser extent than the poor who should be receiving all the subsidisation.

The affordability of healthcare should be analysed through the total healthcare supply chain. The group's increase in average income per bedday of 5% compares favourably with premium increases of medical schemes. It also compares positively with inflation targets set by the South African Reserve Bank. On the whole, private hospital costs in South Africa compare very favourably when benchmarked internationally.

In order to find a solution to the issue of improved access to private hospitals, the group recently commissioned international consultants with the brief to assist the group in trying to develop an alternative healthcare delivery model suitable for South African circumstances.

HOSPITAL RATING INDICES

The focus on quality and patient safety in healthcare has become an international trend in recent years, and has been a stimulus for numerous important new initiatives aimed at improving quality. One such initiative is the measuring of and reporting on clinical quality. The group supports these initiatives since it not only promote quality, but also transparency and consumerism.

When these initiatives are however carefully dissected, it becomes clear that measuring and reporting quality of care is a complex undertaking that requires high levels of technical skills and responsibility. According to international literature, aspects that must be considered include the accuracy and reliability of the information, the integrity of the methodology used, deployment of indicators that really represent quality, and defining the ultimate value it offers the consumer. In South Africa, the first and only rating attempt thus far has been by Discovery Health.

According to its website the Discovery Health Hospital Rating Index measures clinical outcomes (quality) and hospital resources (cost) in order to calculate an overall value for each admission type. Administrative data are used as the source and indicators measured include mortality, complication rates (including infection rates) and re-admissions. Various studies in the United States have shown that for various reasons administrative data allow only limited insight into the effectiveness, efficiency and appropriateness of care. Unfortunately, the initiative was furthermore implemented in a unilateral fashion and healthcare providers were given literally no chance to evaluate the integrity of the Index.

Not surprisingly the Index was met with serious resistance from the outset by the different provider groups. In the months that followed, numerous gross errors were uncovered and pointed out by these provider groups. It became clear that the Index was in no way an accurate reflection of reality, but requests to remove it from the Internet were consistently ignored.

The refusal by Discovery Health to remove the Index from the public domain can only be interpreted as a total disregard for the reputational risk the providers (hospitals and doctors) undeservedly have to carry. The group hopes that this sad state of affairs will not be repeated.

HEALTH CHARTER

Medi-Clinic supports and is actively involved in the formulation and drafting of a Health Charter through the Hospital Association of South Africa ("HASA"). The group expects the Health Charter to be finalised in the foreseeable future.

Healthcare delivery by the private sector has been placed under the spotlight and has been subjected to many policy and regulatory changes during recent years. Against this background, a closer working relationship between the private healthcare sector and government is considered to be of the utmost importance. In this regard, the group will continue to take part in the many activities of the Hospital Association of South Africa (HASA) and the Private Healthcare Forum (PHF).

THE GOVERNMENT EMPLOYEE MEDICAL SCHEME ("GEMS")

GEMS was registered with effect from 1 January 2005 to address the challenges in respect of the current provision of healthcare services to public sector employees by government. Government employees were able to join the scheme from 1 January 2006. GEMS seeks to improve access to healthcare by increasing the number of insured people from those who are employed in Government. It is estimated that GEMS currently has about 130 000 members and that about 350 000 employees are still uninsured.

Medi-Clinic supports government in this initiative and the scheme is already among the group's Top 50 insurance clients based on turnover.

PROSPECTS FOR NEXT YEAR

The group expects to continue its track record of consistent growth in operating profit based on meeting the needs of the market.

The group has taken the strategic decision to diversify geographically within its core business of acute, specialist orientated hospital care. The Emirates Healthcare opportunity will require time and operational resources, but the group is very confident that it will provide an excellent platform for further growth. Other opportunities are also explored on an ongoing basis.

It is projected that the number of beds in the South African operations will increase by about 500 over the next two years resulting from the building of new hospitals and extensions to existing hospitals.

The group remains optimistic about its operational prospects for the next year.

DIRECTORATE AND PERSONNEL MATTERS

Prof WP Esterhuyse reached retirement age and consequently stood down at the group's recent annual general meeting on 27 July 2006, after 14 years of diligent service on the Board. His calm, wise and well informed contributions not only at Board level but also at other forums within the group will be sincerely missed. Our good wishes accompany him during his retirement.

Mr KHS Pretorius, the Chief Operating Officer of the group, was appointed to the Board with effect from 8 November 2006. We welcome him and wish him every success with his future career.

THANKS

We sincerely wish to express our thanks to:

- all patients and doctors for their continued support of our hospitals
- all nurses for their quality care of the patients in our hospitals
- all directors and employees for the dedication towards their work
- all shareholders for the confidence bestowed in our group.

E DE LA H HERTZOG
Chairman

LJ ALBERTS
Managing Director

OPERATIONAL PROFILE



MEDI-CLINIC WAS FOUNDED IN 1983 WHEN OUR CHAIRMAN, DR EDWIN HERTZOG, WAS COMMISSIONED BY THE THEN REMBRANDT GROUP TO UNDERTAKE A FEASIBILITY STUDY ON PRIVATE HOSPITALS. MEDI-CLINIC, BOASTING 7 HOSPITALS WITH 1 500 BEDS, SUBSEQUENTLY LISTED ON THE JSE LIMITED IN 1986. THE GROUP HAS STEADILY EXPANDED AND TODAY OPERATES 47 HOSPITALS THROUGHOUT SOUTH AFRICA AND 3 HOSPITALS IN NAMIBIA WITH MORE THAN 6 900 BEDS. OUR INTERNATIONAL HOSPITAL OPERATIONS EXPANDED FURTHER TO DUBAI IN THE UNITED ARAB EMIRATES WITH EFFECT FROM 27 MARCH 2007 WITH THE 120-BED WELCARE HOSPITAL, ALONG WITH ONE AMBULATORY SURGERY CENTRE AND TWO CLINICS. CONSTRUCTION OF THE FIRST HOSPITAL IN DUBAI HEALTH CARE CITY, THE CITY HOSPITAL WITH 210 BEDS, HAS ALSO COMMENCED AND THE COMMISSIONING THEREOF IS PLANNED FOR THE END OF 2007.

HOSPITAL SERVICES

Medi-Clinic's core purpose is 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 patients, doctors and funders of healthcare.

We provide patients with cost-effective healthcare by offering a wide range of specialised services, ensuring that medical practitioners are provided with the best possible infrastructure in the form of custom-designed facilities and state-of-the-art equipment, delivering excellent nursing care focusing on the needs and satisfaction levels of our patients and by employing motivated, dedicated and loyal staff.

Through a continuous process of expansion, upgrading and training, we are constantly improving our standards and equipping our personnel with the skills and facilities to support our doctors and to ensure the peace of mind of our patients.

Medi-Clinic currently operates 47 hospitals throughout South Africa, three hospitals in Namibia and one hospital, one ambulatory surgery centre and two clinics in Dubai, United Arab Emirates. Opposite is a map of the geographical spread of the group's South African and Namibian hospitals in operation. A complete list of our hospitals appears on pages 44 to 45.

Medi-Clinic's management approach is to run our hospitals on a decentralised basis. Our Head Office is situated in Stellenbosch and is responsible for co-ordination, planning and providing specialised services, such as information technology, data warehousing, marketing, purchasing, technical services and financial services to our hospitals.

Our management team consists of the following:

1. EXECUTIVE COMMITTEE:

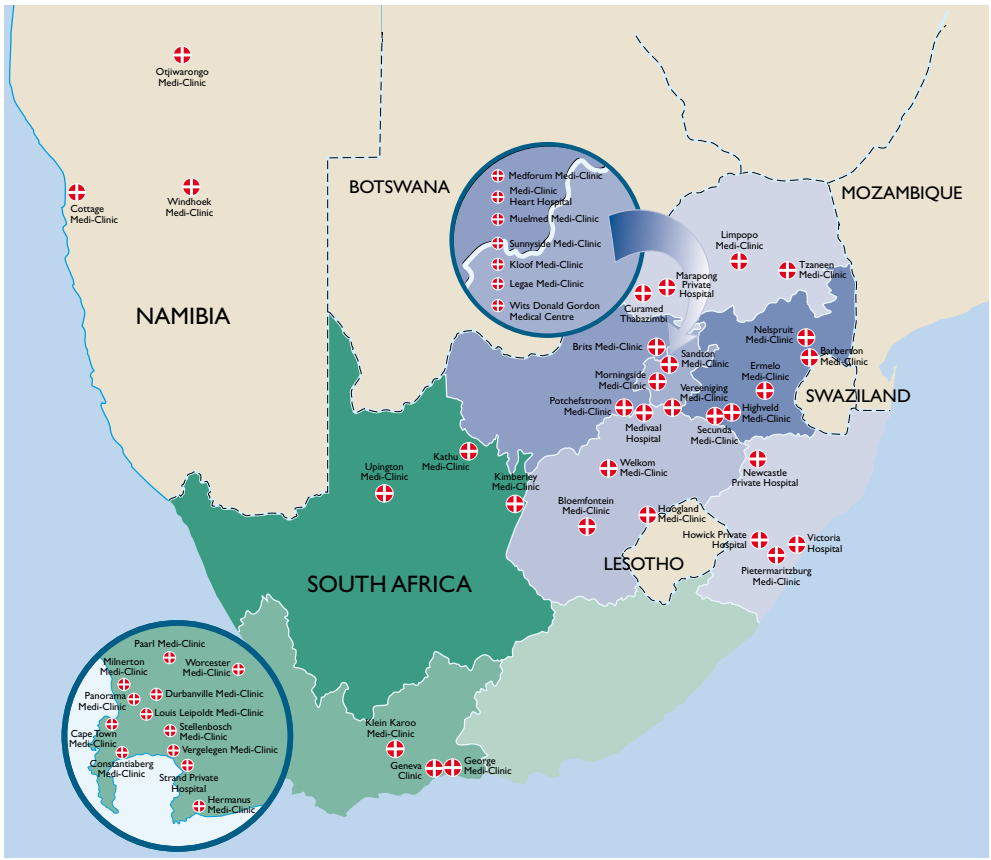
Dr Edwin Hertzog	Chairman
Mr Louis Alberts	Managing Director
Mr James Marais	Technical
Dr Nkaki Matlala	Clinical Relations
Mr Danie Meintjes	Executive Director: United Arab Emirates
Mr Koert Pretorius	Group Operations
Mr Gerhard Swiegers	Financial
Dr Ronnie van der Merwe	Clinical Services

2. OPERATIONAL:

Mr Wimpie Aucamp	Operations (Northern Region)
Mr Frikkie Burger	Operations (Central Region)
Mr Johann Geertsema	Operations (Tswhane Region)
Mr Edmund van Wyk	Operations (Western Cape Region)
Mr André Viljoen	Operations (Peninsula Region)

3. DEPARTMENTAL HEADS:

Mr Roly Buys	Funder Relations and Contracting
Mr Douglas Defty	Pharmacy Services
Mr Steve Drinkrow	Engineering Services
Ms Clara Findlay	Legal Services
Mr Gert Hattingh	Company Secretary and Related Business
Mr Braam Joubert	Financial
Ms Estelle Jordaan	Nursing
Mr Koos Veldsman	Projects
Dr Deon Moulder	Medical Affairs
Mr Theo Pauw	Information Technology
Mr Biren Valodia	Marketing and Corporate Liaison
Mr Linus van Onselen	Property Management and Purchasing
Mr Kobus Verster	Human Resources and Training & Development



EMERGENCY RESPONSE AND MEDICAL CARE

ER24, a wholly owned subsidiary, is a national private emergency medical care network committed to rendering affordable, fast and efficient 24 hour emergency response and medical care in line with international standards and quality. ER24 owns and operates in excess of 110 response vehicles and ambulances for the treatment and transportation of patients involved in emergency and life-threatening situations.

MANUFACTURING OF HOSPITAL EQUIPMENT

Medical Innovations, a wholly owned subsidiary, has since 1988 been designing and manufacturing quality hospital equipment and providing innovative engineering solutions. Our operating tables and products are used in more than 100 hospitals throughout South Africa and exported to countries such as Mauritius, Mozambique, Zimbabwe, Malawi, Namibia, Angola, Sierra Leone, Senegal, Kenya, Zambia and Botswana. Medical Innovations received ISO 9001:2000 certification for establishing and applying a quality management system, which certification is recognised worldwide as an international standard for product design, manufacturing and servicing.

STAFF PLACEMENTS

Medical Human Resources, a wholly owned subsidiary, provides temporary and permanent staff over the entire spectrum of the healthcare industry to more than 241 private hospitals throughout South Africa. The company consists of two divisions, namely Medi-Nurse for temporary placement of nursing staff and Medi-Staff for permanent and temporary placement of administration staff. Over the past three years we successfully accommodated 93% of requests for placements of temporary nursing and administrative position. We currently have over 15 800 employees available on a part-time basis and a growing database of qualified personnel for permanent positions.

SUSTAINABLE DEVELOPMENT REPORT

MEDI-CLINIC BELIEVES IN PROVIDING COST-EFFECTIVE QUALITY HEALTHCARE ON A SUSTAINABLE BASIS. THE GROUP CONTINUALLY STRIVES TO BE A RESPONSIBLE CORPORATE CITIZEN BY, INTER ALIA, SUPPORTING BROAD-BASED BLACK ECONOMIC TRANSFORMATION, MANAGING THE ENVIRONMENTAL IMPACT OF OPERATIONS AND CONTRIBUTING TO THE GENERAL WELL-BEING OF THE COMMUNITY. THE GROUP IS COMMITTED TO ETHICAL BUSINESS PRACTICES AND EFFICIENT RISK MANAGEMENT.

MEDI-CLINIC HAS QUALIFIED FOR INCLUSION IN THE JSE SOCIALLY RESPONSIBLE INVESTMENT ("SRI") INDEXES CONDUCTED TO DATE, AND WAS RANKED AS ONE OF THE TOP FOUR PARTICIPATING MEDIUM ENVIRONMENTAL IMPACT COMPANIES IN SOUTH AFRICA IN THE MOST RECENT INDEX. THE JSE SRI INDEX SHOWCASES THOSE LISTED COMPANIES WHO ACHIEVE THE REQUISITE SCORE IN RELATION TO A SET OF CRITERIA THAT MEASURE TRIPLE BOTTOM LINE (ECONOMIC, SOCIAL AND ENVIRONMENTAL) COMMITMENT AND PERFORMANCE.

COMMITMENT TO QUALITY

QUALITY IN HEALTHCARE

Medi-Clinic 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. Our focus on quality healthcare stretches from the skills of our supporting doctors to the care of the patients, from the empathy of our nursing staff to the high standards of our facilities, from the meticulous maintenance of our world-class technology to upholding the fairest possible tariff. By focusing on a patient centred team approach to improve quality and safety of care, we have established a culture of quality that permeates every aspect of our business and have ensured that our employees and associated doctors continuously strive to improve patient care and patient safety. Our dedication to excellence in healthcare is evidenced by the quality of our facilities.

We approach 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 standards and care processes that are sophisticated, reliable and free of errors.

Medi-Clinic has enjoyed a number of "firsts" in terms of ensuring quality healthcare. We were the first private hospital company in South Africa to implement a facility accreditation program based on a set of strict international accreditation standards. The accreditation process involves external audits of more than 350 standards and 3 500 criteria and a pass rate of 90% and higher is required to achieve accreditation. External audits are repeated every two to three years to ensure that accreditation standards are maintained. A total of 28 Medi-Clinic hospitals have been accredited by the Council for Health Service Accreditation of Southern Africa ("COHSASA") since 1995. This provides the group with a sound foundation to enhance our quality improvement systems that will sustain and continuously improve our high standard of patient care. The group plans to have a further 11 hospitals accredited by COHSASA during the next three years.

The Medi-Clinic Quality Assurance Team ("MQAT") system is a unique and first of its kind approach to ensure continuous training, adherence to quality protocols and international accreditation criteria and ensuring compliance with key operational risk management procedures.

From a process and outcomes perspective Medi-Clinic was the first private hospital company in Africa to implement the internationally acknowledged Vermont Oxford clinical outcomes database in the neonatal intensive care units of two of our hospitals in 2001. Participation has now been expanded to nine Medi-Clinic hospitals. The program has over 780 international participants and measures certain clinical process and outcomes parameters in the neonatal intensive care setting. Each participant's results are compared with international benchmarks and reported upon quarterly. All of our participating hospitals have benefited substantially from their membership and their respective performances compare favourably with international benchmarks.

Medi-Clinic was also the first hospital group in South Africa to implement the Apache III mortality prediction scoring system in the adult intensive care units of three of its hospitals. The system identifies high risk cases in intensive care, predicts mortality based on internationally developed algorithms and compares it with the actual mortality of each unit. This enabled the hospitals to benchmark themselves against internationally derived mortality norms.

Another first was the implementation of the American Society of Thoracic Surgeons database at one of our hospitals. This initiative measures numerous process and outcome


parameters in cardiac surgery and enhances the ability of the cardiac team to manage their complex environment. The participating hospital has been doing exceedingly well when compared internationally by achieving a very low complication and mortality rate on high risk patients. The roll-out of this database to other cardiac units at our hospitals is anticipated.

The latest addition to our clinical outcomes measurement initiative is that of a Stroke Database that was developed in conjunction with leading neurologists and neurosurgeons. The database will be implemented at three of our hospitals during 2007.

To further entrench our proud record in quality care, all quality initiatives are coordinated by a central Clinical Governance Committee. The Medi-Clinic clinical governance framework focuses on professional qualifications and standards, accreditation of facilities, professional performance evaluation, clinical risk management, clinical outcomes measurement, education and communication. A wide range of unique abilities and skills are represented on the Clinical Governance Committee, including expertise in areas of clinical patient care, medico-legal matters, ethical practice and skills in areas of clinical database management, clinical audit and change management.

We believe that Medi-Clinic, through all these initiatives and based on our proud track record, will continue to take the lead as the quality hospital provider of choice.

QUALITY IN TECHNOLOGY

The group strives to provide the best healthcare facilities and technology available in the developed world within budgets generated in a developing country. In doing this, Medi-Clinic has to design, build or improve facilities to meet the needs of our clients and to maintain our commitment to quality care. The life of the group's buildings, plant and equipment has to be maximised through reliable technical support in order to ensure a safe and user-friendly environment for staff and clients.

Medi-Clinic's planned maintenance system is risk-orientated aimed at patient safety and ensures the provision of service excellence that is respected and relied upon. The group's policy applies to three categories of equipment. The first category is all equipment where a failure would create a risk to the patient's life, whether directly or indirectly. The agent or an authorised representative or a person appointed by Medi-Clinic maintains this category of equipment according to the manufacturers' recommendation. The second category of equipment is where a failure would cause gross inconvenience to clients, have a substantial financial impact or hamper service significantly. The third category of equipment is general, including all equipment not falling in the preceding categories, but which will still have an overall effect on the service provided. The second and third categories of equipment are maintained according to Medi-Clinic's in-house policy by our technical staff, the agent or a contractor appointed by Medi-Clinic.

The planned maintenance system was developed over the last ten years and we have embarked on a project to review and update all documentation and policies. The aim is to evaluate the relevance of all procedures and service intervals to optimise maintenance cost and safety.

The group's hospitals are subjected to a comprehensive maintenance audit on an annual basis that covers all three categories of plant and equipment. The audit is performed in-house by trained staff. Although the standard of the audit is continuously being raised, the results of the maintenance audit show a steady improvement year on year. The average overall score achieved by all hospitals has increased from 73% to 79% during 2006. The upward trend was maintained by all regions and most hospitals bettered on the score achieved during the previous year.

RESULTS OF MAINTENANCE AUDIT

Region	2004	2005	2006	Improvement for year
Central Region	70%	87%	92%	5%
Peninsula Region	69%	78%	81%	3%
Northern Region	65%	69%	81%	11%
Western Cape Region	53%	69%	78%	9%
Tshwane Region	58%	61%	65%	4%
Average	**64%**	**73%**	**79%**	**6%**

The computerised maintenance management system enables the group to provide quality service and care to our patients and clients. We have accumulated eight years of data for 80% of the beds within the group, covering 28 of our hospitals. Through a designated project, this system is currently being expanded to all Medi-Clinic hospitals, making it the total asset management system for the group. This will ensure a living asset register with accurate life cycle data available for future capital budgets and forecasts.

BROAD-BASED BLACK ECONOMIC EMPOWERMENT

The Board of Medi-Clinic views the company as an integral part of the South African political, social and economic community. The Board endorses the process of democratisation and strives to support this process through a policy of business practices that enhances broad-based black economic empowerment ("BBBEE"), which is regarded as a strategic opportunity to strengthen the economic base of our country. A key success factor is the rapid capital accumulation at all levels of society involving human, social, intellectual and physical capital.

Enhancing the group's current BBBEE initiatives is a priority for Medi-Clinic and the group has therefore embarked on an initiative to develop a comprehensive BBBEE strategy that will address all seven pillars of the BBBEE scorecard. The current BBBEE status of Medi-Clinic, in terms of the final DTI scorecard, will be determined during the initial phases of this initiative. Professional consultants have been appointed to assist the company with this initiative and once a final strategy has been developed, it will be presented to the Board for approval.

BLACK OWNERSHIP INITIATIVE

Medi-Clinic implemented a R1.1 billion Black Ownership Initiative in 2005, which had the effect of introducing 15% black shareholding in Medi-Clinic. The Black Ownership Initiative introduced Phodiso Holdings Limited ("Phodiso") and Circle Capital Ventures (Proprietary) Limited ("Circle Capital") as our strategic partners and shareholders in Medi-Clinic. Our strategic black partners jointly hold approximately 11% (with Phodiso holding approximately 6.9% and Circle Capital holding approximately 4.1%) of the issued shares. All employees up to and including first line management level ("Participating Employees") were also introduced as shareholders of the company through the issue of Medi-Clinic shares to The Mpilo Trust, an employee share trust formed specifically for that purpose. The Participating Employees hold approximately 4% of Medi-Clinic's issued shares.

Phodiso

Phodiso is a focused healthcare group which owns and operates a number of successful businesses centred on the provision of quality healthcare services. Phodiso is owned and operated by a group of 64 healthcare practitioners and business people, and has a black ownership component of 94.4%.

In the last few years Phodiso has expanded its presence in the hospital services industry through a series of joint initiatives with Medi-Clinic, which include a 30.9% interest in Curamed and a 49% interest in Phodiclinics. Phodiso's involvement in Medi-Clinic's Black Ownership Initiative is a natural progression from their existing working relationship with the company and is a key strategic imperative for Phodiso.

Two of Phodiso's directors, Dr Nkaki Matlala and Dr Vincent Msibi are involved in key positions within the group. Dr Matlala is a member of the Executive Committee and Dr Msibi serves on the Board of Medi-Clinic, both since 2005.

Phodiso is well positioned to be Medi-Clinic's long-term value adding strategic black partner given its focus, in-depth experience and successful track record in the healthcare sector.

Circle Capital

Circle Capital, a new order, blue chip investment holding company, aims to add value to and grow established companies, assisting them in systematically navigating the challenges of transformation to increase shareholder value. Circle Capital participates in investments in companies of various sizes with varying needs such as black economic empowerment, strategic leadership, operational management and access to capital.

Circle Capital's sustainable partnership philosophy is cemented in its commitment to help create opportunities for black South Africans by making strategic investments in companies where Circle Capital will be able to exert influence in human capital and transformation. The investment philosophy of Circle Capital is based on investing in businesses that will deliver sound business returns while enhancing transformation in the South African business landscape. Circle Capital has identified the healthcare sector as one of the fastest growing and most important sectors in the new South African economy.

Circle Capital's chairperson, Dr Mamphela Ramphele serves on the Board of Medi-Clinic Board since 2005 and her vast experience both locally and globally in the fields of human development makes for a mutually beneficial partnership between Circle Capital and Medi-Clinic.

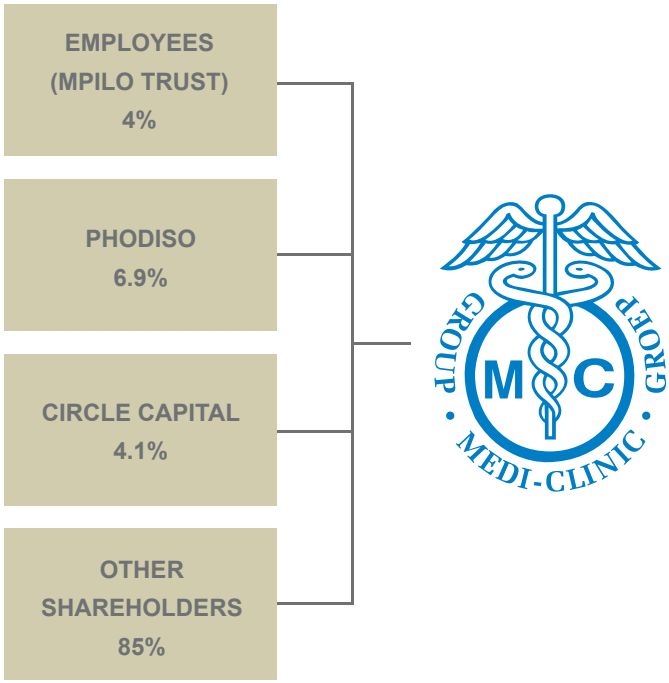
The Mpilo Trust

The Mpilo Trust was established in 2005 as an employee share ownership scheme as part of the group's Black Ownership Initiative. The trust subscribed for approximately 4% of Medi-Clinic's issued shares, which shares are held for the benefit


of almost 11 000 Participating Employees (of which 52% are black and 89% are women), which include, inter alia, nursing staff, support staff and administrative staff. All employees of the company up to, and including, first line management level participate in the Black Ownership Initiative through The Mpilo Trust. A minimum of 1 000 Medi-Clinic shares per employee were allocated to Participating Employees, with a further allocation of approximately 80 Medi-Clinic shares for every completed year of service. In offering participation to employees, Medi-Clinic aims to reward the contribution, loyalty and dedication of its employees. Therefore, the level of participation is linked to length of service in the group. In addition, employee participation is aimed at encouraging greater transparency and aligning the interests of Participating Employees with that of Medi-Clinic shareholders.

Group structure

The diagram below illustrates Medi-Clinic's group structure subsequent to the implementation of the initiative.



HEALTH CHARTER

Medi-Clinic, as a member of the HASA, has been actively involved in the negotiations to establish a Charter for the Healthcare Industry and supports the goals and objectives of the Charter. The process to develop a Charter for the Healthcare Industry was initiated by the Honourable Minister of Health during August 2004. After a lengthy negotiation process of approximately two years, when most stakeholder groupings were ready to finalise and sign the Charter, organised labour decided to refer the matter to Nedlac. After numerous meetings at Nedlac, it was decided that the original stakeholder groupings will be allowed to complete the Charter, as agreed initially.

The latest version of the Charter (Draft 11 dated 7 February 2007) incorporates the most recent input from the Department of Labour and will be the subject of further negotiations, scheduled to resume on 9 May 2007.

CURAMED

Tshwane Private Hospitals (Pty) Ltd, a joint venture company owned 50,95% by Medi-Clinic and 49,05% by Phodiso Clinics (Pty) Ltd, holds a 63% interest in Curamed Holdings Limited. We previously reported that Medi-Clinic and a black empowerment consortium, consisting of Phodiso Clinics and Nozala Investments (Pty) Ltd, jointly held a 63% interest in Curamed. During the period under review, Phodiso acquired the interest of Nozala and Phodiso now holds a 49,05% interest in Tshwane Private Hospitals (Pty) Ltd. Medi-Clinic facilitated the initial transaction in 2002 and provided the consortium with interim finance of about R49 million to enable them to finance their part of the transaction.

Curamed is a group of five Pretoria-based specialist hospitals comprising of approximately 700 beds, namely the Medi-Clinic Heart Hospital, Medforum Medi-Clinic, Sunnyside Medi-Clinic, Muelmed Medi-Clinic and Kloof Medi-Clinic. Medi-Clinic is responsible for the management of the hospitals in terms of a management agreement.

Phodiso has already added notable value to this venture, in particular in relationship building, transformation and on an operational level. At the same time their capital accumulation also increased rapidly. Medi-Clinic's successful relationship with Phodiso has naturally progressed to it being selected as one of our partners in the Black Ownership Initiative referred to earlier. Drs Vincent Msibi and Nkaki Matlala represent Phodiso on the Board of Curamed.

PHODICLINICS

The Competition Tribunal unconditionally approved the acquisition by Phodiclinics (Pty) Ltd ("Phodiclinics"), a joint venture company owned 51% by Medi-Clinic and 49% by Phodiso Clinics, of the four hospitals of the Protector group (in liquidation) with effect from 8 November 2006. Phodiclinics currently owns and operates three of the four hospitals acquired from Protector, namely Medivaal Hospital (Vanderbijlpark), Kathu Medi-Clinic (Kathu) and Marapong Private Hospital (Lepalale). Due to financial inefficiencies, Kingsley Medicentre (Pretoria) was closed.

HOSPITAL LICENSE - CAPE TOWN METROPOLE

As previously reported, Phodiclinics has been awarded a license to build a 140 bed hospital in the northern suburbs of the Cape Town Metropole which can be regarded as tangible evidence of the value created by the group's BBBEE initiatives. Commencement of construction is planned for the end of 2007.

TRAINING AND SKILLS DEVELOPMENT

Medi-Clinic invests about 4% of payroll annually in support of our commitment to training and skills development. To facilitate improvement of the representation of designated groups in management levels, we have expanded our management development program to include six positions. See pages 30 to 31 for more detail on the group's training and skills development initiatives.

PREFERENTIAL PROCUREMENT

Medi-Clinic remains committed to the government's BBBEE Preferred Procurement Strategy and supports the Health Charter Targets for Preferential Procurement. To this end, the group pro-actively uses the BBBEE status of a supplier in the awarding of contracts. Medi-Clinic has also invested in an electronic software procurement solution in order to implement a systems orientated approach ensuring policy enforcement as well as assurance that all sourcing activities comply with our rules, regulations and policies. This software is currently being implemented for use with effect from 1 September 2007.

FUTURE OPPORTUNITIES

The Board of Medi-Clinic has decided to adopt a phased approach in respect of BBBEE, aimed at transferring an initial 15% to black partners in terms of our Black Ownership Initiative, with a view to increasing such stake.

Medi-Clinic's commitment to sustainable growth and prosperity in a democratic South Africa and the location of its hospitals across the country implies that BBBEE strategies can be supported and encouraged across a broad spectrum of opportunities.

ECONOMIC PERFORMANCE

PUBLIC PRIVATE PARTNERSHIPS AND INTERACTIONS

Medi-Clinic believes that Public Private Partnerships ("PPP's") and the more informal Public Private Interactions ("PPI's") opportunities may provide a way of contributing to efficiencies of delivery by government and have the potential of being win-win situations to participants. We are continuously looking for meaningful opportunities for PPP and PPI participation. Medi-Clinic and the PPP Unit of National Treasury has met to share perspectives on PPP's and to express our interest in interaction with the National Treasury and the Department of Health to accelerate the delivery of public healthcare initiatives and the evaluation of PPP's and PPI's as mechanisms for co-operation.

Wits Donald Gordon Medical Centre ("WDGMC")

Medi-Clinic's firm commitment to the future of healthcare in South Africa was illustrated by investing R60 million in WDGMC during 2005 and a further R5 million during the period under review. In return, Medi-Clinic obtained a 49,9% share in the hospital located in Johannesburg, resulting in greater representation of the Medi-Clinic network in Johannesburg. Medi-Clinic also manages the hospital in terms of a management agreement and has added significant value to the hospital, specifically on an operational level, which has improved the sustainability of the hospital.

This investment has enhanced the ability of the University of Witwatersrand in Johannesburg ("Wits") to support the public sector health services without requiring any government subsidy. The significant partnership with the public sector is designed to support the training of specialists and super specialists for both public and private sectors and to make the best clinical staff available to the Johannesburg academic hospitals. Medi-Clinic and Wits will also explore the accreditation of certain units at Medi-Clinic's other Johannesburg hospitals as teaching units affiliated to Wits.

Stellenbosch Biokinetics Centre

Medi-Clinic and Stellenbosch University established a successful partnership during 2004 in respect of the management of the Stellenbosch Biokinetics Centre. Medi-Clinic provided the initial funding required to upgrade the equipment and is also providing marketing and administrative support to the centre. Students and interns associated with the centre are given the opportunity to obtain practical experience at the other biokinetics centres at the group's hospitals.

The capacity to enrol students in 2007 for the honours degree in Biokinetics increased by 39% during the period under review, which is directly attributable to the successes attained by the partnership.


Hermanus

We reported last year that the group submitted a bid to the Western Cape Department of Health early in 2006 in response to its request for proposal for the improvement and maintenance of facilities and the provision of non-core support services at the Hermanus Provincial Hospital and that the submitted bids were in the process of being evaluated. Since then, the Western Cape Department of Health requested clarity on certain aspects of the bid to enable it to proceed with the completion of the evaluation process. We are still optimistic that the outcome will be positive, yielding benefits for both parties.

ADEQUATE RETURNS TO CAPITAL PROVIDERS

Providing proper access to healthcare is a challenge facing all governments, even more so in developing countries.

Apart from resources, the progressively ageing population, new technology, patient expectations and the increased burden of disease all have the effect that public hospital systems suffer from considerable capacity and investment constraints. This typically translates into longer waiting lists, poor service and poorly maintained facilities. As a result, the private healthcare industry experiences an increase in business worldwide.

In South Africa, the private healthcare sector serves a large segment of the population. The industry has become a national asset and one of the important pillars on which the country's future economic growth is based. There are only a few countries in the world where the public health service provides more or less a total healthcare service to all its citizens. As a developing nation, South Africa is one of the many nations where the public sector is not in such a position. The private hospital industry plays a pivotal role in working away the healthcare burden by providing a service of high enough quality to those who can afford to pay for their own healthcare. It thereby increases the overall ability of the nation to deliver healthcare to all its citizens.

In research commissioned by Discovery Health, The Monitor Group found that the South African private healthcare sector compares favourably with quality levels of the best systems in the world.

There are still industry commentators who believe that the private hospital industry is only profitable at the cost of the consumer. However, independent analytical studies have conclusively shown that the return on capital in the private hospital industry in South Africa compares quite averagely with companies in other industries. Medi-Clinic's current return on capital, based on the market value of the shares at 31 March 2007, is between 5% and 6%.

Medi-Clinic believes that doing business in a sustainable manner and to sustain a consistent return on capital equal to or higher than its weighted average cost of capital over the long-term are the keys to meeting the demands of our stakeholders.

AFFORDABILITY OF HEALTHCARE

Affordability will always remain a critical issue in the healthcare industry, especially in developing countries. The group will therefore continue its efforts to improve the affordability of healthcare in South Africa. The group's Funder Relations and Contracting Department, as well as our Clinical Services Department provide a strong base for constructive deliberations on affordability with roleplayers in the funding industry. Transparency and constructive engagement with doctors remain key focus areas to ensure enduring solutions.

The South African private hospital industry recognised the need to place private hospital costs in a sound and proper perspective, explaining the fundamental cost drivers in a typical private hospital. To this end, HASA, of which Medi-Clinic has always been a member, commissioned independent research into the cost drivers and other variable factors influencing expenditure on private hospitals. The results of the first phase of the research was released in 2006 and showed a 5,2% inflation rate in the private hospital industry for the 2005 fiscal year, within the SA Reserve Bank's target of 3% to 6%. The results were benchmarked internationally against eight other countries which ranked South Africa's private hospital industry's inflation rate as the third lowest. The results of the second phase of the research will be published at the annual HASA conference during June 2007.

The successful implementation of the fully transparent net acquisition price model ("NAP model") promotes transparency in the pricing of medicines and scheduled drugs as well as surgical consumables and resulted in a significant slowdown in pharmaceutical price inflation to substantially lower levels. This trend is expected to continue. About 82% of Medi-Clinic's clients purchase pharmaceutical products at net acquisition price.

The group supports the Department of Health in their efforts to create transparency in the pricing of medicines and scheduled drugs. Since our previous report, the group has continued its

move to a fully transparent pricing system. The first transparent pricing system with a funder has been in place since 2003 and has subsequently been expanded to include various other funders. The scope of this model goes beyond ethical drugs and includes surgical consumables, which are the larger part of the total pharmaceutical portion of a typical private hospital account. This enables the group to focus on pharmaceutical items as cost items and not income contributors with major savings to medical schemes in the long-term and should be regarded as beneficial to the group since it improves the affordability of healthcare.

To ensure sustainable affordability of healthcare, we actively strive to drive down the costs of products procured. This benefit is passed on to the patient or funder. We are also actively promoting the increased utilisation of affordable generic medicines without compromising on patient safety or quality. Although it is an emotional issue at times, we believe there are substantial financial savings to patients and funders. In private hospitals, only 30% of the monetary value of ethical products used can be substituted with generic medicines; whilst 40% of the total quantity of ethical products used can be substituted. Medi-Clinic has set a target to achieve 62% usage in respect of the value and 72% usage in respect of the quantity of generic substitutable medicines. Although some resistance were experienced from specialists on the use of antibiotics, the group has already achieved 64% usage in respect of the value and 76% in respect of the quantity of generic substitutable medicines.

The standardisation of pricing for surgicals, also known as CEPS ("Cost Effective Pricing for Surgicals"), is an initiative whereby surgical products are classified into therapeutic and clinical classes. CEPS products are selected in classes on cost effectiveness with high standardisation potential and there are currently 600 CEPS products. The total annual spend on CEPS products is R75,5 million. Currently CEPS amounts to 12% of the total surgical products and we are hoping to expand it to 20% of the surgical basket. Of the 12%, the group has achieved 93% compliance with some hospitals already reaching 100% compliance.

Medi-Clinic fully supports the SASES (SA Society of Endoscopic Surgeons) initiative to drive down costs through replacing single-use surgical products with efficient re-usable instruments. Substantial savings can be achieved through this initiative.

Medi-Clinic is continuously focusing on initiatives to increase the accessibility and affordability of the private hospital market to include, amongst others, low income earners. This aim is important for growing and diversifying our market.

PROUDLY SOUTH AFRICAN

Medi-Clinic is the first Proudly South African private hospital group. Our membership confirms that Medi-Clinic is a truly South African company, that we maintain a high standard of quality care, adhere to fair labour practices and that we are committed to being environmentally responsible. The Proudly South African logo appears on all our corporate stationery, advertising and information leaflets. The group is in its third year of membership.

OUR PEOPLE

COMMUNICATION WITH EMPLOYEES

At Medi-Clinic we believe that effective communication is the backbone of an organisation and we strive to constantly encourage and enhance interactive communication within the group. Our Communications Department is continuously monitoring the effectiveness of its internal communication methods, ensuring that group messages are shared with each and every member of staff.

Ensuring effective two-way communication in the group has always been a challenge as our hospitals are widely distributed throughout South Africa and Namibia. To address the growing demand for innovative communication methods, a network of satellite and video conferencing facilities was set up to further streamline communication directly to and from our hospitals.

Utilising the satellite facilities, regular Leadership Conferences are held during which company and industry developments are shared with the group. These messages are then cascaded to all personnel using a structured line briefing system.

Our Communications Department invests substantial energy in creating and maintaining a range of communication tools such as our intranet-based *HaemoHighway* e-magazine for staff, our bi-annual *Nursing* magazine dedicated to nursing personnel, our quarterly staff magazine, the *Milieu*, and the bi-monthly staff newsletter, the *People's Interest*. These communication methods aim to share group and individual success stories and to keep employees informed on various issues, ranging from company and industry developments, company values and human resources related matters.

A dedicated nurses satellite broadcast service was also implemented, together with a successful SMS-based questions & answers session between nursing staff and the group's Nursing Director.


During the period under review, a special audiovisual production was created in TV soap-opera style to communicate the Mpilo Trust employee share ownership scheme. This innovative way of communicating intricate company messages proved to be very successful and was well received by staff.

EMPLOYEE REMUNERATION

Our remuneration policy is built on three pillars, namely internal equity, external equity and affordability. To ensure external equity balanced with affordability we participate in one of the largest ongoing salary surveys in South Africa. This ensures that our salaries and related benefits remain competitive, thus enabling us to retain and attract good quality staff.

The retention of good quality staff, especially in nursing and pharmacy services, remains a constant challenge in our competitive market. Our retention bonus scheme compensates loyal nursing staff and has contributed favourably towards the reduction of our nursing staff turnover.

As referred to earlier in this report, all employees of the company up to, and including, first line management level participate in an employee share ownership scheme through The Mpilo Trust.

A management incentive scheme for senior managers was implemented in 2006. The scheme aims to bring the total remuneration level of senior management closer to the benchmark level in the market and to introduce a risk component to the remuneration packages of senior management. The scheme includes appropriate mechanisms to ensure the retention of participating senior management. In terms of this cash bonus scheme a portion of the after tax value of the annual bonus is compulsorily invested in Medi-Clinic shares.

LABOUR RELATIONS

Medi-Clinic believes in creating and maintaining sound labour relations which supports our goal of being the employer of choice in our industry. Our policies and procedures are continuously evaluated to ensure that our employees are treated fairly and that they work in a safe environment. Our goal of being the employer of choice in the industry also necessitates continuous assessment of our employment conditions to ensure that we retain a competitive edge.

We continuously strive to ensure that all our employees are informed of their benefits. This information is supplied on our intranet and is regularly communicated through our *People's Interest* newsletter. Our standard disciplinary and grievance procedures are also available to all staff via the intranet to ensure that employees are aware of the avenues to put grievances forward, should they have the need to.

RECRUITMENT OF SKILLED STAFF

Together with our retention and training strategies, the placement of the right calibre of personnel is vital to our commitment to quality. This remains a challenge due to the decreasing number of suitably qualified staff in South Africa, specifically technical staff with the average age of technical managers in South Africa being 52.

Medi-Clinic has successfully implemented a digital recruitment management system that has built up an extensive talent bank from which appointments are made across the board of required skills.

The group has also embarked on an international nursing recruitment program to address the nursing shortage in South Africa. The selected nurses will have to complete the South African Nursing Council Foreign Registration Examination prior to their arrival in South Africa. The pilot program was launched in February 2006 with the recruitment of 60 operating theatre and intensive care unit nurses from India. To date, 23 nurses have written the examination and should be able to commence work in August 2007 and a further 21 candidates are expected to be eligible to write the examination in July 2007. Medi-Clinic also obtained a corporate work permit for an additional 150 nurses as a second phase. These nurses have been recruited and will arrive in South Africa in 2008.

EMPLOYMENT EQUITY

Medi-Clinic recognises employment equity as a crucial pillar of BBBEE and is committed to make the company structures representative of the country's economically active population. Our aim is to create a workplace in which individuals of ability and application can develop rewarding careers at all levels, regardless of their background, race or gender. The ultimate objective remains the growth and development of our company to the benefit of all our clients, employees and shareholders.

We have attained most of our goals but the representation of designated groups in the management levels remain a challenge. To facilitate improvement in this area we have expanded our management development program. Our Employment Equity Policy and procedures has been reviewed to ensure that we are strategically placed to improve our representation.

The race and gender representation of the group is set out as follows:

OVERALL RACE SPLIT	
African, Coloured, Asian	White
53%	47%

MANAGEMENT LEVEL RACE SPLIT	
African, Coloured, Asian	White
12%	88%

OVERALL GENDER SPLIT	
Female	Male
87%	13%

OTHER LEVELS RACE SPLIT	
African, Coloured, Asian	White
55%	45%

A summary of our employment equity report (EEA12) as at 31 March 2007, as required in terms of section 22 of the Employment Equity Act is set out below:

	DESIGNATED							NON-DESIGNATED			TOTAL
	Male			Female				White Male	Foreign Nationals		
OCCUPATIONAL LEVELS	A	C	I	A	C	I	W	W	Male	Female	
Top management								6			6
Senior management	1		1				2	19			23
Professionally qualified and experienced specialists and mid-management	7	23	5	10	9	4	230	168		3	459
Skilled technical and academically qualified workers, junior management, supervisors, foremen, and superintendents	74	85	12	784	694	88	2 779	178	3	50	4747
Semi-skilled and discretionary decision making	298	277	9	1 542	1 392	81	1 930	149	1	9	5 688
Unskilled and defined decision making	148	83		484	281	3	46	36			1081
TOTAL PERMANENT	**528**	**468**	**27**	**2 820**	**2 376**	**176**	**4 987**	**556**	**4**	**62**	**12 004**
Non – permanent employees	8	2		7	6	1	33	11			68
GRAND TOTAL	**536**	**470**	**27**	**2 827**	**2 382**	**177**	**5 020**	**567**	**4**	**62**	**12 072**

Note: A=Africans, C=Coloureds, I=Indians and W=Whites


HEALTH AND SAFETY AT WORK

Special attention is given to health and safety aspects in the workplace to ensure a safe environment for our employees and patients.

During our annual planned maintenance audits the function of the Health and Safety Committees are checked and the competency of the responsible staff members is verified. A legal register is maintained to ensure that all legislation is adhered to. Regular training is given to safety representatives and other members of the team.

The health of the group's employees is important so as to ensure the sustainability of quality care to our patients. Medi-Clinic's Corporate Health Program, which was implemented during 2002, provides a framework for primary care and occupational health services to employees that include primary medical care, chronic disease monitoring and support, as well as social and personal problem solving and counselling provided by an Employment Assistance Program (EAP). In addition, the EAP offers a 24-hour emergency helpline service for employees.

Comprehensive health services are delivered to employees free of charge at the health clinics that have been established at various hospitals. More clinics are being established in order to provide our employees with in-house health services. The management of these clinics have been outsourced to INCON, an independent occupational health and safety provider with considerable experience in this field.

Regular health education programs are presented to employees throughout the year to create a better understanding of their ailments and to ensure a healthy workforce.

HIV/AIDS

Medi-Clinic's commitment to quality healthcare also applies to our employees, ensuring the improvement of our human capital. The Medi-Clinic HIV/Aids Program was implemented in support of this commitment and consists of the following elements:

- education on HIV/Aids combined with awareness programs;
- 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.

Since the implementation of the program approximately 3 992 (33%) of our employees attended the ongoing awareness sessions, of which 1 172 (29%) have voluntarily participated in the counselling and testing for HIV/Aids. We aim to reach all our employees with the program, with at least the majority participating in the voluntary counselling and testing.

After workplace surveys were conducted, statistical analyses indicated a low level of incidence and expected prevalence of HIV/Aids in the group.

The group's HIV/Aids and Corporate Health Programs dictate absolute confidentiality, compassion and fairness as well as no discrimination on the grounds of illness. Every effort is made to accommodate HIV positive employees in a risk-free work environment.

ETHICS

Ethical behaviour remains a fundamental guiding principle in our business and management continually focuses on establishing a culture of responsibility, fairness, honesty and efficiency in the group.

Our Ethics Line, established in 2001, is managed by an established and respected service provider, which assures that each call will be treated with the utmost of confidentiality and is available on a 24-hour basis to all staff and outside contractors. Regular feedback is received via the system and all complaints are investigated according to a set protocol. Since 2001 the Ethics Line has received only 51 calls, of which the majority were of a grievance nature. To date we have not received any information that has led to the discovery of fraudulent behaviour – a clear indication of an overall commitment to ethical behaviour throughout all levels of our group.

Medi-Clinic follows a strict policy relating to any invitations, gifts or donations received from suppliers or any other party, in terms whereof personnel are compelled to declare these to management. All such invitations, gifts or donations are reviewed by departmental heads for recommendation to the Company Secretary, who may refer such recommendation to the Executive Committee. Our staff members involved in the purchasing of equipment or consumables are also bound to a strict code of ethics ensuring that an impeccable standard of integrity is maintained in our business relationships.

The group joined the Ethics Institute of South Africa as a full member in 2005 to further support its commitment to ethical behaviour as an organisation.

TRAINING AND SKILLS DEVELOPMENT

Medi-Clinic's training programs are focused on maintaining and promoting quality service delivery in all aspects of the business, ensuring that the group's values are reflected in every activity of our business. The group's training goals are directly related to the overall business plan and to improve its human capital.

Our training activities concentrate on core business processes and the enhancement of our service culture. The main focus remains on risk management, an integral part of which is the standardising of processes based on best practices. The changing nature of this environment has necessitated the use of technology in training delivery, particularly regarding performance support and on-line help systems.

INFRASTRUCTURE

Medi-Clinic has an established training and skills development infrastructure that serves the formal nursing education and operational training and development needs of the company, individuals and teams.

Medi-Clinic's commitment to training and skills development is illustrated by its training investment of about 4% of payroll. We firmly believe that our training investment contributes to empowering the talented people of our country to participate in growing the economy and to attain sustainable socio-economic freedom.

The company considers our professional tutors, mentors and training personnel as strategic assets that consistently ensure competent, caring service delivery. The geographically spread six learning centres are equipped with modern teaching equipment and current learning material to cover all aspects of the learning experience. The larger learning centres are equipped with networked computer workstations and an infrastructure was created for delivery via satellite and video conferencing.

CREATING OPPORTUNITIES

A total of 541 employees received new qualifications during the period under review, while 485 commenced their training in courses ranging from basic to post-basic specialist nursing qualifications. This brings the total number of learners currently on formal courses to 741. These new qualifications create opportunities for advancement and provide a guaranteed career opportunity for the 134 externally recruited Pupil Enrolled Nurses on successful completion of their course.

Medi-Clinic has developed a range of specialist short courses which will be presented in collaboration with the University of Pretoria during the year ahead. We are confident that these courses will continue to ensure competent service delivery to patients and doctors.

CONTINUING PROFESSIONAL DEVELOPMENT

Maintaining competence in the changing healthcare environment remains a challenge that requires an individual commitment to learning and performance. Medi-Clinic has an established continuing professional development system in place that requires all personnel engaged in core business processes to consistently prove that they possess the required knowledge and skills. This structured approach has encouraged continuous learning and has resulted in career enhancement opportunities for participants.

This process is supported by the company's performance management system which serves to align all employees with corporate goals and objectives and with the company's risk management initiative.

ENSURING QUALITY SERVICE DELIVERY

During the period under review an independent employee relationship assessment was conducted with the main objective to measure employee loyalty as this has a direct impact on service quality and ultimately business success. The results of the survey showed a marked improvement on the loyalty index compared to our 2002 survey and also fared better than the international norm for companies in the services sector. This has been a positive and gratifying experience that has provided managers with focused opportunities to improve employee relations in our quest to maintain a contented workforce and to be the employer of choice in the healthcare industry.

The results of daily telephonic patient satisfaction surveys and our Facility Red Flag system, in terms whereof regular inspections of our facilities are conducted, serve as added indicators to hospital managers of areas of service delivery that require immediate attention to ensure that we meet the expectations of our patients and doctors.

SUPPORTING ACADEMIC INSTITUTIONS

Medi-Clinic believes in the upliftment and educational development of the communities of South Africa and therefore supports various academic institutions around the country. We are proud to report that we are continuing our financial support to these academic institutions.

☐ Stellenbosch University

Medi-Clinic has renewed its cooperation agreement with Stellenbosch University to support research and training of medical specialists and has made a financial contribution of R1,26 million to the Health Sciences Faculty of the university for this purpose.

According to the university, this support is invaluable, particularly in strengthening the faculty's postgraduate training platform. At the same time it benefits the private health sector by ensuring a flow of excellent medical personnel. Among the departments and disciplines that benefited from the partnership are:

Neurosurgery: Two clinical assistants were exposed to neurosurgery in the private sector.

Obstetrics and gynaecology: Medi-Clinic awarded a bursary for the appointment of a specialist to complete a fellowship in gynaecological oncology.

Haematology: A specialist physician completed a fellowship in clinical haematology and contributed to training, research and service at Tygerberg Hospital and to the broader community.

Physiotherapy: The Masters studies of four students were subsidised. Three of the physiotherapists, who work in private practice in the Medi-Clinic group, are now accredited as lecturers and are involved with undergraduate training.

In terms of our partnership, Medi-Clinic also contributes to the facilitation of a multidisciplinary unit for infectious diseases which focuses on the training, research and service delivery in this vital area.

The Medi-Clinic funds also contribute to the remuneration of the director of the Ukwanda Project. This project aims to provide training opportunities in community healthcare for students across all disciplines. This model is currently regarded as the ideal training method for medical students in rural areas.

☐ University of Witwatersrand, Johannesburg

The group supports the training of specialists at the Wits Donald Gordon Medical Centre and contributes financially to the academic activities of the centre.

☐ University of Pretoria

The group has again provided support to the Health Sciences Faculty of the university during the period under review by donating R270 000 towards equipment for the vascular unit and providing administrative support to the value of approximately R80 000 to this unit of the academic hospital.

☐ University of Limpopo (Medunsa)

During the previous financial year Medi-Clinic awarded 21 bursaries of R10 000 each to medical students at the university. Most of these students are well under way to complete their Master studies in a number of disciplines such as orthopaedics, paediatrics and diagnostic radiology. This arrangement between Medi-Clinic and the University of Limpopo has been renewed once again.

☐ Paul Roos Academy

Medi-Clinic reaffirmed its commitment to the Paul Roos Academy in Stellenbosch with the sponsorship of R100 000 during the period under review. This sponsorship provides learning opportunities to 247 indigent children from Khayelitsha, Nyanga and Langa and farm schools surrounding Stellenbosch.

OUR COMMUNITY INVOLVEMENT

Medi-Clinic embraces its responsibility to serve the communities in which it operates. Apart from the substantial investment in the training of personnel, Medi-Clinic is committed to a wide variety of national and community-based projects and organisations.

CORPORATE EVENTS – "ENJOY OR DARE, WE CARE!"

The Corporate Events team is a specialised division within our Marketing and Corporate Liaison Department and provides

medical expertise and support at major national and regional sports and cultural events.

The aim of this team is to extend the Medi-Clinic experience beyond the walls of its hospitals and to provide quality care and services to South Africa's sporting and spectator communities.

Through the years Medi-Clinic has become synonymous with major annual sporting events such as the Cape Argus Pick 'n Pay Cycle Tour, the Cape Times Big Walk, the Women's World Cup of Golf and the ABSA Cape Epic Mountain Bike Challenge. We also provide invaluable medical support and services at arts festivals, such as the annual Klein Karoo Nasionale Kunstefees, Aardklop and Innibos.

EDUCATION AND TRAINING

Please refer to the report on training and skills development on pages 30 to 31.

ENSURING HEALTHY COMMUNITIES

Medi-Clinic takes pride in its role as community health and wellness provider. Our core purpose is to enhance the quality of life of our patients and our community activities are therefore centred around this essential service that we provide. We are involved in a vast range of community-based activities which are aimed at extending our quality service offering through direct involvement with the members of our communities.

Through these various ongoing sustainable development projects the Medi-Clinic group wishes to entrench itself as a social leader, committed to its end goal of enriching the lives of South Africans at all levels.

We are particularly excited about our involvement with the Phelopepa Healthcare Train. This initiative was launched in 1994, taking quality healthcare to communities where health services and infrastructure are not yet fully in place. This year 16 of Medi-Clinic's bridging learners from the Sandton and Curamed Medi-Clinic Learning Centres took part in this initiative as part of their practical and community experience. We are proud to be servicing and enriching the lives of destitute people along the South African railway line through this initiative.

We are proud to have been involved in a number of life-changing medical interventions such as breakthrough operating procedures, transplants and medical treatments that have been performed completely free of charge at our facilities. A number of needy patients have benefited from these procedures in the period under review.

All our Medi-Clinic hospitals engage in ongoing community activities such as offering in-hospital support groups as part of their disease management initiatives, antenatal sessions and mother and baby wellness clinics, and other specialised services such as pain clinics and weekly clinic sessions for the elderly.

Medi-Clinic also support the official national health calendar by offering free blood glucose, cholesterol and blood pressure tests to coincide with dedicated awareness weeks and months.

First aid bags and medical gear are regularly donated to schools and community organisations, as is hospital linen and medical items such as wheelchairs to needy institutions. Our hospitals also provide first-aid services at local events such as schools' sports days and local sporting and community events.

ENVIRONMENTAL PERFORMANCE

Medi-Clinic is committed to protecting the environment, conserving our natural resources and ensuring the health and safety of our employees and clients by employing sound health, safety and environmental practices in all our business activities.

ENVIRONMENTAL POLICY

The Medi-Clinic Environmental Policy is aimed at minimising our environmental impacts and contains the following objectives:

- COMPLY with relevant environmental legislation and regulations.
- DEFINE environmental management programmes to achieve continual improvement in our Environmental Management System.
- CREATE an environmental awareness among all employees.
- PREVENT pollution and minimise the impact of our activities on the environment.
- IDENTIFY all aspects of our business that could have a significant impact on the environment and set objectives and targets with a review process to eliminate or reduce the impact of these on the environment.
- ENCOURAGE reduction, re-use and re-cycling of general waste.


- MANAGE hazardous waste including medical waste according to legal and other requirements and where possible apply international best practices.
- INFLUENCE all our suppliers and service providers to adopt similar programmes, in order to limit our overall impact on the environment.
- NURSE the use of resources, specifically electricity and water.

In support of the above policy, the group has implemented an environmental management system based on the ISO 14001:2004 Specification for Environmental Systems.

The group has assessed its performance against the above objectives and has stipulated specific action plans to achieve its goals:

CRITERIA	SPECIFIC ASSESSMENT CRITERIA	PERFORMANCE	REVISION & PLANNING
Compliance with environmental and other legislation	28 applicable legislation, excluding tax, business & finance legislation	Legal Register established.	Priority to confirm legal compliance at all hospitals. Auditing to check.
Environmental Management Systems	ISO 14001:2004 JSE SRI rating	8 hospitals ISO certified. ISO certification of additional 10 hospitals for 2007 in progress. Rated in top four in results of JSE SRI for medium impact companies.	36 hospitals planned for ISO certification by the end of 2011. Maintain current JSE SRI rating.
Environmental awareness	ISO 14001:2004	Road show to all hospital managers during 2007 to reiterate environmental awareness.	Environmental awareness entrenched in all business activities.
Prevention and minimise of impacts	ISO 14001:2004	8 ISO certified hospitals with programmes.	Implementation of additional 10 ISO certified hospitals during 2007. Remaining hospitals to start phasing in of ISO-principles.
Aspect Identification	Aspect Register	8 ISO certified hospitals with aspect registers.	Principles of aspect registers to be rolled out to all hospitals to start phasing in of ISO-principles.
Re-cycling of general waste	ISO 14001:2004 Local by-laws	8 ISO certified hospitals with processes.	Introduction of re-cycling at all hospitals.
Management of hazardous waste	ISO 14001:2004 Local by-laws	8 ISO certified hospitals with confirmed processes. Various other processes in place.	ISO 14001:2004 processes to be implemented at all hospitals with the aim of future accreditation.
Influencing suppliers and service providers	ISO 14001:2004	8 ISO certified hospitals with programmes.	Introduction of green approach to suppliers and providers.
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. Monitoring via ISO 14001:2004 system.

ENVIRONMENTAL MANAGEMENT AND RISK ASSESSMENT

Medi-Clinic is committed to ensuring that its environmental management systems and practices are aligned with international best practice, such as the ISO 14001:2004 standard. Eight Medi-Clinic hospitals have obtained ISO 14001:2004 certification. The hospitals in the group which are not ISO 14001 certified follow the same environmental management practices and are also subject to annual internal audits.

The main environmental impacts that are being managed at the group's hospitals are the utilisation of resources and waste management, details of which appear below.

WATER CONSUMPTION AND RECYCLING

We have continued with the implementation of water saving projects at the group's hospitals, resulting in significant reduction of water consumption per month. Uncontaminated water from autoclaves and laundry is recycled and used for irrigation of our hospitals' gardens. Awareness training and the commitment of our staff to save water have also contributed to the reduction in water wastage, examples of which are cited below:

HOSPITAL	WATER RECYCLED PER DAY	SAVING PER DAY
Panorama Medi-Clinic	Recycled water from autoclave used. 10,000 litres to irrigate the garden. The balance is pumped to the cooling towers and depending on the season the remaining water is recycled back to the autoclaves.	33,000 litres
Constantiaberg Medi-Clinic	Recycled water from autoclave used to irrigate the garden.	21,000 litres
Milnerton Medi-Clinic	Recycled water from autoclave used to irrigate the garden.	11,000 litres
Cape Town Medi-Clinic	Recycled water from autoclave used to irrigate the garden.	3,600 litres
Durbanville Medi-Clinic	Recycled water from autoclave used to irrigate the garden.	14,400 litres
Worcester Medi-Clinic	Recycled water from autoclave cooled down and pumped back to the autoclave. Excess used to irrigate the garden.	22,000 litres
Bloemfontein Medi-Clinic	Recycled water from autoclave used to irrigate the garden.	5,000 litres
Welkom Medi-Clinic	Recycled water from autoclave cooled down and pumped back to the autoclave. Excess used to irrigate the garden.	11,200 litres
Hoogland Medi-Clinic	Recycled water from autoclave used to irrigate the garden.	1,000 litres

ENERGY CONSERVATION

All our hospitals continued with the energy management initiatives aimed to reduce energy consumption, involving the redistribution of the electrical load, changing to energy saving lamps, optimising the effectiveness of existing equipment and staff awareness training.

The implementation of ISO 14001 standards and principles at our hospitals has a positive effect on our energy consumption. Vergelegen Medi-Clinic, our first hospital to receive certification, is on average using 40,000 kWh less energy per month.

Recent problems with the power supply in the Western Cape area resulted in the installation of 16 additional generators at a cost of R12 million rand. During this problem period our hospitals were assessed by ESCOM with regards to energy saving possibilities.

We started a pilot project at Hoogland Medi-Clinic with involvement from ESCOM and a team from the North West University. The aim is to look at a cost effective model for future hospitals and possible upgrades to existing hospitals. It is envisaged that a saving of 10% of the electricity bill could be achieved.

WASTE MANAGEMENT AND RECYCLING

Stringent protocols are followed to ensure that refuse removal within the group complies with all legislation, regulations and bylaws. The implementation of ISO 14001 standards and principles at the group's certified hospitals contributes to waste management with sustainable processes in place to ensure continuous improvement. Year on year statistics show a downward trend in paper usage and medical waste costs of up to 50%. The principles of waste management and recycling are being rolled out to all the hospitals within the group. This contributes to Medi-Clinic's drive to limit the effect of our activities on the environment, to conserve available resources and to utilise resources in an effective and responsible manner.

STAKEHOLDER ENGAGEMENT

Medi-Clinic strives to engage in regular interaction with our wide range of stakeholders, including, inter alia, our patients, supporting doctors, employees, shareholders, suppliers, the communities where our hospitals are situated, healthcare funders and various government bodies through a variety of communication activities.

PATIENTS

Our ongoing patient satisfaction survey is conducted by an independent research organisation regarding their experience with Medi-Clinic. The 2006 results of this survey indicated that 96% of our patients would recommend Medi-Clinic to their families and friends.

Our quarterly hospital magazine *Gesundheit*, with a print-run of 65 000, is aimed at patients and contains informative articles promoting healthy lifestyle and general health related information.

The group launched our Medi-Twinkle maternity programme during the period under review, which programme provides expectant mothers with tailor-made antenatal programmes, as well as various value-add products.

Medi-Clinic will launch our program for older adults during October 2007 aimed at people 60 years and older, which will involve information sessions, health screening clinics and other hospitalisation value-adds. The program is aimed at empowering this target group to take charge of their own healthcare.

DOCTORS

Our supporting doctors are a key stakeholder of the group and play a vital role in Medi-Clinic's commitment to quality care. We continue to enhance and encourage regular two-way communication between Medi-Clinic and our referring doctors and other general practitioners.

Medi-Clinic continues to present regular Continuous Professional Development programs to supporting doctors throughout the year. The group has launched a doctors recruitment initiative through which Medi-Clinic endeavours to attract and retain professional association with highly skilled medical practitioners across all disciplines to address patient demand for specialised medical services.

Valuable information pertaining to the group's development is shared with doctors via our dedicated quarterly *Medi-Clinic Doctors Bulletin* leaflets. Medi-Clinic's *Perspectives* magazine provides profession related information as well as leisure content to doctors.

EMPLOYEES AND TRADE UNIONS

Interactive communication with all employees remains a priority for the group and their active participation in the day-to-day running of the company makes an important contribution to our success. Aside from various mechanisms such as workers forums, collective bargaining agreements, various committees and other formal engagement structures, Medi-Clinic also strives to act on staff opinions and perceptions.

During the period under review an independent research organisation conducted a follow-up employee relationship assessment. The results of the survey indicated that 83% of our staff is proud to work for Medi-Clinic and 84% believes that it is the best brand in the private healthcare industry.

Medi-Clinic annually embarks on a brand roll-out initiative during which key brand messages and group successes are communicated to staff. During the 2006 roadshow, feedback was given on the group's independent patient and staff surveys. Underscoring the group's commitment to the ongoing communication process, every effort was made to ensure that every staff member attend these sessions.

Following the implementation of the employee share ownership scheme via The Mpilo Trust in 2005, staff actively participated in the trustee election process, the trust's annual general meeting and will also be entitled to participate at the company's annual general meeting in July 2007.

Effective human resources management, good communication and sound labour relations have contributed to the group's low trade union membership. Good working relationships are maintained with trade unions where we do have recognition agreements. Our staff members are treated fairly, remunerated competitively and involved in the day to day running of the organisation.

Employee committees are encouraged at hospital level as a means to engage staff in the operation of the business. The Equity and Training committees at hospital level act as a conduit for input from shop floor level on issues that involve staff members.

SHAREHOLDERS

Communication to the public and shareholders are based on the principles of balanced reporting, clarity and transparency. Positive and negative aspects of both financial and non-financial information are provided.

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 most recent and historical financial and other information is published on the company's website at www.mediclinic.co.za.

SUPPLIERS

Medi-Clinic believes that the choice of supplier is extremely important to assist us in offering quality service to our clients. We therefore make use of strict selection criteria in selecting suppliers, which include proven national service and support, the compliance of products with applicable local or international standards and a responsible, affordable pricing structure.

Medi-Clinic annually hosts a Supplier of the Year Award ceremony, awarding a supplier who has provided the most exceptional service to the group. The ten short-listed suppliers, compiled from nominations received from the group's hospitals, are rated based on a set of weighted criteria. These criteria include response time, quality of product, service and support, as well as a responsible pricing structure.

The Medi-Clinic Ethics Line, as referred to earlier in this report, is also available on a 24-hour basis to our suppliers.

COMMUNITY

For more information regarding our engagement with the community, please refer to pages 31 to 32.

HEALTHCARE FUNDERS

Our Funder Relations and Contracting Department, which negotiates tariffs and contracts on behalf of all the hospitals within our group, deals directly with the healthcare funders in South Africa and abroad. The Funder Relations client base is segmented into a number of different payor groups, of which medical schemes are the most significant as they contribute largely to Medi-Clinic's revenue. The medical scheme environment is undergoing a significant process of legislative change, with the result that we are currently seeing and expecting further consolidation of medical schemes. In 2006 the medical schemes market consisted of approximately 140 medical schemes - at present there are approximately 125 schemes. To this end, our Funder Relations and Contracting Department endeavours to understand the healthcare funders' specific needs with a view to building long-term sustainable relationships. A number of product development initiatives have been investigated with various schemes in order to enhance the Medi-Clinic service offering.

Ongoing efforts to enhance our vision to be the most trusted and respected provider of hospital services is focused on developing a range of collaborative initiatives to increase access and interface effectiveness and to improve transparent data sharing through business to business (B2B) interactions. These actions are aimed at improving the quality of case management interventions and reducing the operational costs for the schemes and the hospital to sustain affordability for the member.

GOVERNMENT AND AUTHORITIES

- ☐ **Department of Health**

  Medi-Clinic is involved in ongoing communication and interaction with the National and Provincial Departments of Health. Issues pertaining to, inter alia, license applications, inspection of facilities, approval of building plans and comment on draft legislation and regulations are dealt with on a continuous basis.

  The group is however of the opinion that closer relationships between private hospitals and the various Departments of Health will be beneficial for both parties and has therefore taken the initiative to work more closely with the Department of Health. High level discussions between the National Director General of Health and various senior executives of Medi-Clinic were held to focus on certain issues of mutual concern, for example, access to private healthcare services, affordability of healthcare, cost increase, human resources and training of healthcare professionals.

- ☐ **South African Nursing Council**

  Medi-Clinic engages with the South African Nursing Council on all issues relevant to the profession and the private healthcare sector in particular. At times this is done under the umbrella of HASA, and at other times directly. The State President has proclaimed certain sections of the Nursing Act, No 33 of 2005, with effect from 15 December 2006. Certain sections of this Act are dependent on the publication of new regulations, which are still awaited. Medi-Clinic recently delivered a submission to the Department of Health concerning the regulations regarding the implementation of community service for nursing practitioners.

- ☐ **South African Pharmacy Council**

  Medi-Clinic provides input as and when requested to the Pharmacy Council regarding legislative changes to the


Pharmacy Act, the most recent issue being provisions relating to good pharmacy practice. We strive to ensure that our pharmacies comply with all the required standards and this is measured by regular inspections internally as well as by the inspectorate of the Pharmacy Council.

- Engineering Council of South Africa

  The group participates in the work groups with the Engineering Council of South Africa to develop the registration criteria in respect of the compulsory registration of hospital engineering professionals regarding the proposed amendments to the Health Technology Regulations.

HOSPITAL ASSOCIATION OF SOUTH AFRICA ("HASA")

HASA is an industry association which represents the collective interests of the majority of private hospital groups and independently-owned private hospitals in South Africa. Three of Medi-Clinic's executive management members are represented on the board of HASA and continually engage in constructive debate regarding issues pertaining to the private healthcare industry, such as proposed legislation and the Health Charter.

HEALTH PROFESSIONS COUNCIL OF SOUTH AFRICA ("HPCSA")

The HPCSA has very specific ethical rules that guide the relationship between medical practitioners and private hospitals. Although it is the responsibility of the individual health professionals to adhere to the ethical rules governing their profession, Medi-Clinic endeavours to structure its relationships with medical practitioners according to these guidelines. Interaction between Medi-Clinic and the HPCSA takes place from time to time in order to discuss issues of interpretation and application of the ethical guidelines.

ENGINEERING ASSOCIATIONS

The group's Director: Engineering Services has served terms as the President of SAFHE (South African Federation of Hospital Engineering) and is currently the President of IFHE (International Federation of Hospital Engineering). Several of the group's regional engineers and technical managers are members of their local SAFHE branch committees.

The group's Clinical Engineering Specialist recently completed a term as President of CEASA (Clinical Engineering Association of South Africa) and is the current Vice President and Chairman for the Western Cape Branch of CAESA.

PROMOTION OF RIGHT TO ACCESS TO INFORMATION

Medi-Clinic complies with the regulations of the Act on the Promotion of Access to Information, No 2 of 2002, which ensures the constitutional right of access to information needed for the exercising or protection of any right.

CORPORATE GOVERNANCE REPORT

MEDI-CLINIC HAS SINCE ITS INCORPORATION IN 1983, ALWAYS UPHELD STRICT PRINCIPLES OF CORPORATE GOVERNANCE AND THE HIGHEST STANDARD OF INTEGRITY AND ETHICS, AS EMBODIED IN THE KING II REPORT ON CORPORATE GOVERNANCE ("THE KING REPORT").

THE BOARD OF DIRECTORS ACCEPTS FULL RESPONSIBILITY FOR CORPORATE GOVERNANCE AND IS COMMITTED TO ENSURING A HIGH STANDARD OF DISCIPLINE, INDEPENDENCE, ETHICS, EQUITY, SOCIAL RESPONSIBILITY, ACCOUNTABILITY, COOPERATION AND TRANSPARENCY.

THE BOARD BELIEVES THAT THE GROUP HAS MATERIALLY COMPLIED WITH THE PRINCIPLES OF THE KING REPORT AND HAS MET THE LISTINGS REQUIREMENTS OF THE JSE LIMITED ("THE JSE").

BOARD OF DIRECTORS

COMPOSITION

The composition of the board reflects the required balance between executive and non-executive directors to ensure that 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 managing director are segregated.

The chairman of the board, Dr Edwin Hertzog, is also an executive director and is regarded as a semi-executive chairman. He was involved in a chief executive capacity from the incorporation of the company until his appointment as chairman in 1992. The board considers it in the company and the group's best interest to have him as chairman. He also serves on the boards of Remgro and three other Remgro associated companies, of which two are listed on the JSE. In addition, he is also the chairman of the Stellenbosch University Council.

Every year, at the first board meeting after the annual general meeting, both the chairman and the managing director are formally elected for a further term of one year by way of a closed ballot.

The managing director, Mr Louis Alberts, is responsible for the day-to-day management of the company 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. The appointment of directors is a function of the entire board, based on recommendations made by the Human Resources Committee.

Non-executive directors do not receive any benefits or share options from the company apart from directors' fees, which fees are submitted for approval by our shareholders at the company's annual general meeting. None of the directors have service contracts with longer than a one month notice period.

BOARD CHARTER AND RESPONSIBILITIES

The board has accepted a formal code of conduct ('the board charter") in which the responsibilities of the board, individual directors and the company secretary are set out. Key responsibilities in terms of the board charter include the following:

- 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 material or strategic nature or that may impact the group's reputation;
- monitoring compliance with all laws and regulations and our 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 company's remuneration policy;
- empowering management to execute along delegated authorities;
- ensuring that the board's composition possesses the necessary skills and experience;
- the appointment of new directors;
- compliance with the group's core values (as set out on page 3); and
- ensuring the group's financial performance and maintenance of its going concern status.

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 every two months and measures exist to accommodate any resolutions that may have to be approved between meetings. Members of the board and sub-committees receive an agenda containing comprehensive and accurate information well ahead of time. This enables them to meet their commitments and to determine whether or not prescribed functions have been executed according to set standards, within the margins of cautious and predetermined risk levels and according to international best practices.

Every director has free access to senior management and the company secretary.

BOARD EVALUATION & INDUCTION OF NEW DIRECTORS

The board conducts an objective and confidential evaluation in respect of the board's performance and the effectiveness of its procedures bi-annually.

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.

Directors are continuously informed of any new relevant legislation, as well as any changes in business risks that may have an impact on the group.

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

COMPANY SECRETARY'S ROLE AND RESPONSIBILITIES

The board has unlimited access to the company secretary, who advises the board and the sub-committees on relevant matters, including compliance with the group's policies and procedures, the JSE Listings Requirements, relevant legislation, statutory regulations and the King Report.

The company secretary is responsible to ensure the proper administration of the proceedings and matters of the board, the company and the shareholders of the company in accordance with applicable legislation and procedures.

The name and address of the company secretary appear on page 7.

EXECUTIVE MANAGEMENT

The executive directors meet regularly to consider, inter alia, investment opportunities, operational matters and other aspects of strategic importance to the company. They are continuously in contact with department heads and hospital managers to ensure effective communication and decision-making.

SUB-COMMITTEES OF THE BOARD

Specific responsibilities are delegated to the board's sub-committees, with defined tasks in terms of approved mandates. Reports on the committees' activities are also submitted to the board. The main sub-committees are:

- ### Human Resources Committee

  The Human Resources Committee (the composition of which appears on page 41) meets periodically to discuss matters such as remuneration policy, executive management and staff remuneration, directors' remuneration and incentive schemes. The committee ensures that adequate succession planning measures are in place.

  The committee has an independent non-executive director as chairman. The Managing Director and Human Resources Director also attend meetings.

  Independent consultancy studies are used by the committee to ensure remuneration remains competitive and market-related. The group's remuneration strategies are aimed at ensuring that:

  - the appropriate skills are attracted and retained;
  - employees earn market-related salaries;
  - remuneration is fair and just;
  - no discrimination exists;
  - good performance is acknowledged and encouraged;
  - no conflict exists between individual wealth and long-term sustainability; and
  - remuneration is cost effective and affordable.

☐ Audit and Risk Committee

The Audit and Risk Committee (the composition of which appears on page 41) meets with the internal and external auditors and the executive management at least three times per year to discuss matters pertaining to risk management and internal control. These include internal and external auditing, accounting policy and financial reporting within the mandate provided by the board. The Audit and Risk Committee is responsible for the ongoing identification and evaluation of the group's exposure to strategic, opportunity, asset, legal, regulatory, statutory, operational, financial, currency, technological and business risks and to evaluate the adequacy and appropriateness of the internal control systems used to manage such risks to levels within the risk tolerance parameters set for the group.

The committee is also responsible for appointing the external and internal auditors. Non-audit services by the external auditors are limited to tax advice, the remuneration of which is disclosed in the financial statements. The services of the internal and external auditors are adequately integrated.

The committee is chaired by Mr Thys Visser, a non-executive director. Although Mr Visser is not an independent director, as recommended in terms of the King Report, the board and committee deemed it in the best interest of the group to have him as chairman of the committee considering his knowledge and experience. Due to the promulgation of the Corporate Laws Amendment Act, No 24 of 2006, the appointment of an independent chairman will be considered. The chairman of the board also attends the meetings. The internal and external auditors have unlimited access to the chairman of the Audit and Risk Committee.

ATTENDANCE OF BOARD AND SUB-COMMITTEE MEETINGS

BOARD MEETINGS:

DIRECTORS	10/05/06	27/07/06	29/09/06	08/11/06	16/02/07	30/03/07
E de la H Hertzog (Chairman) (Executive)	√	√	√	√	√	√
L J Alberts (Executive)	√	√	√	√	√	√
S Dakile-Hlongwane (Independent non-executive)	√	√	√	√	x	√
W P Esterhuyse (Independent non-executive) (resigned 27/07/06)	x	√	n/a	n/a	n/a	n/a
J du T Marais (Executive)	√	√	√	√	√	√
A R Martin (Independent non-executive)	√	√	√	√	√	√
D P Meintjes* (Executive)	x	√	x	√	x	√
V E Msibi (Non-executive)	√	√	√	√	√	√
K H S Pretorius (Executive) (appointed 8 November 2006)	n/a	n/a	n/a	n/a	√	√
A A Raath (Independent non-executive)	x	√	x	√	√	√
M A Ramphele (Non-executive)	x	√	√	x	√	x
J G Swiegers (Executive)	√	√	√	√	√	√
W L van der Merwe (Independent non-executive)	√	√	√	√	√	√
M H Visser(Non-executive)	√	√	√	√	√	√

* Due to his secondment to Dubai as Executive Director: United Arab Emirates, Mr Meintjes is only required to attend every second board meeting.

AUDIT AND RISK COMMITTEE MEETINGS:

DIRECTORS	09/05/06	07/11/06	15/03/07
M H Visser (Chairman) (Non-executive)	√	√	√
L J Alberts (Executive)	√	√	√
A R Martin (Independent non-executive)	√	√	√
A A Raath (Independent non-executive)	√	√	√
M A Ramphele (Non-executive)	√	x	√
J G Swiegers (Executive)	√	√	√

HUMAN RESOURCES COMMITTEE MEETINGS:

DIRECTORS	15/06/06	26/07/06	17/10/06	15/02/07
W P Esterhuyse* (Chairman) (Independent non-executive) (Resigned 27/07/06)	√	√	n/a	n/a
W L van der Merwe* (Chairman) (Independent non-executive) (Appointed as Chairman from 17/10/06)	√	√	√	√
E de la H Hertzog (Executive)	√	√	√	√
V E Msibi (Non-executive)	√	x	x	√
M H Visser (Non-executive)	x	x	√	√

* Following Prof W P Esterhuyse's resignation as director and chairman of the Human Resources Committee in July 2006, Prof W L van der Merwe was appointed as chairman of the committee with effect from 17 October 2006.

DEALINGS IN SECURITIES

Procedures have been put in place to ensure that directors and senior management of the company do not trade in the company's shares during price sensitive or closed periods. In terms of the group's policy closed periods commences 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.

CONFLICT OF INTERESTS

All board members are required to disclose their shareholding in the company, other directorships and any potential conflict of interests, which is monitored annually by the company secretary. Where a potential conflict of interests exists, directors are expected to recuse themselves from relevant discussions and decisions.

In terms of the company's conditions of employment personnel are obliged to disclose any potential conflict of interests.

INTERNAL CONTROL AND RISK MANAGEMENT

INTERNAL CONTROL

The directors are responsible for the company and its subsidiaries' system of internal control, which is designed to provide reasonable, but not absolute, assurance against misrepresentation and loss. Internal control is broadly defined as a process, instituted by a company's board of directors, management and other personnel, to ensure the effectiveness of operations, sound financial controls, safeguarding of assets and compliance with applicable laws and regulations.

The system contains self-monitoring mechanisms and actions are also taken to correct deficiencies where they are identified.

The internal audit function of the group has been outsourced. The effectiveness of operational procedures is audited internally by the Medi-Clinic Quality Assurance Team ("MQAT") under direction of the Director: Training and Skills Development. The audits performed by MQAT monitor the self assessment process of risk management and compliance with COHSASA's internationally accredited structure standards. The company secretary is responsible for guidance in respect of the compliance with applicable laws and regulations. The assurance that the system of internal control is effective and that it is timeously adjusted to changing conditions is enhanced by the performance of these duties as well as the duties of the central Risk Management Committee.

The Audit and Risk Committee has reviewed the internal control systems of the company and its subsidiaries for the financial year up to 31 March 2007. Based on inquiries and the reports of the internal and external auditors and MQAT, the directors are satisfied that the internal control measures for the period under review were effective.

RISK MANAGEMENT

Effective risk management is integral to the group's objective of continuously adding value to the business whilst ensuring its sustainability.

The objectives of the risk management process, which is benchmarked against COSO (Committee of Sponsoring Organisations of the Treadway Commission) and complies with the recommendations of the King Report, are to optimise the group's residual risk profile and exploiting all viable opportunities within the risk appetite set by the board, whilst minimising exposure to potential losses.

The group's risk management process comprises the following:

- Group Risk Assessment
  Formalisation of the group's risk register based on risk assessment taking cognisance of all identified risks assessed in terms of probability of occurrence and potential impact.

- Activity Risk Analysis
  Detailed analyses of all risks inherent to the group's core activities. Monitors risk management activities and reports progress against targeted deadlines by responsible manager.

- Induction of Risk Management Practices
  The group has implemented an automated and integrated control self assessment process which monitors compliance with key procedures by discipline by site. This system caters for exception reporting of non-compliance, incident reporting and dissemination of policies and procedures. It furthermore renders full transparency of risk management activities per group, region, hospital and discipline.

- Integrated Assurance
  Due care is taken to ensure that the following assurance functions are optimally integrated:

  - MQAT is tasked with continuous training, adherence to quality protocols and operational risk review;
  - internal audit;
  - external audit; and
  - COHSASA accreditation.

- Risk Funding
  The funding of risks with material potential impact is hedged with risk funding strategies aimed at maximising the group's ability to retain risk.

The board, which is ultimately responsible for risk management, pays continuous attention to fundamental risks and addresses these in annual business plans. The board, via the Audit and Risk Committee, also regularly receives and considers risk management reports from the central Risk Management Committee. Based on the aforementioned, the board is of the opinion that the residual risk profile of the group is within the risk tolerances appropriate for Medi-Clinic.

It is furthermore responsible for the prevailing ethics and values systems along with the appointment of executive management tasked with the implementation and maintenance of effective policies, procedures and practices.

The central Risk Management Committee comprising of management, representing all disciplines considered core to the business, is responsible for drawing up policies and procedures on risk management as well as the financing of residual risks, including self insurance. The board believes that the group's risk funding strategy and existing cover are appropriate and adequate.

MOST SIGNIFICANT RISKS

The following risks are central to the group's risk register activities and assurance processes:

- availability of trained personnel;
- medical practitioner selection and support;
- medico-legal accountability and patient safety;
- quality medical care;
- technology;
- operational efficiency and effectiveness;
- fee structuring; and
- legislative requirements.

EXTERNAL AUDIT

The Audit and Risk Committee is responsible for appointing the external auditors. The external auditors, whose report appears on page 49, are 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.

As referred to earlier in the report, the non-audit services provided by the external auditors are limited to tax advice. The remuneration payable in respect of these services is disclosed in the financial statements. The Audit and Risk Committee meet at least three times per year with the external auditors, internal auditors and executive management to ensure that their efforts pertaining to risk management and internal control are properly co-ordinated.

ETHICS

Conducting business in an honest, fair and legal manner is a fundamental guiding principle in Medi-Clinic, which is actively endorsed by the board and management, ensuring that the highest ethical standard is maintained in all our dealings with stakeholders.

To this end the group maintaines an independent Ethics Line, established in 2001, which enables all staff and outside stakeholders to report any possible incidences of fraud, corruption or any other unethical behaviour on an anonymous basis. All gifts or invitations by suppliers are also monitored and are subject to a strict approval procedure.

Our sound long-term relationships with our supporting doctors are built on ethical and fair business practices which also ensure their free association and clinical independence, and will always be one of the cornerstones of the strategic approach of the group.

INVESTOR RELATIONS AND SHAREHOLDER COMMUNICATION

The board is committed to keeping shareholders informed of developments in the group's business. Communication with our shareholders is based on the principles of balanced reporting, clarity and transparency. Both positive and negative aspects of financial and non-financial information are provided.

For further information regarding the group's initiatives on shareholder communication, please refer to pages 35 to 36 under Stakeholder Engagement.

HOSPITALS IN OPERATION

	HOSPITAL MANAGER	LOCATION	LICENCED BEDS	LICENCED THEATRES
WESTERN CAPE				
Cape Town Medi-Clinic	Mr K Seaman	Cape Town	150	5
Constantiaberg Medi-Clinic	Mr C K W Lake	Cape Town	238	8
Durbanville Medi-Clinic	Mr H Calitz	Durbanville	180	8
Geneva Clinic	Mr G T Schutte	George	60	4
George Medi-Clinic	Mr G T Schutte	George	160	4
Hermanus Medi-Clinic	Mr J P Lotz	Hermanus	45	2
Klein Karoo Medi-Clinic	Mrs A Nortjé	Oudtshoorn	38	2
Louis Leipoldt Medi-Clinic	Mr J Hofmeÿr	Bellville	235	7
Milnerton Medi-Clinic	Mrs C Defty	Milnerton	112	4
Paarl Medi-Clinic	Mr O A Dippenaar	Paarl	139	5
Panorama Medi-Clinic	Mr G M Harris	Parow	386	12
Plettenberg Bay Private Health Centre	Mr G T Schutte	Plettenberg Bay	25	-
Stellenbosch Medi-Clinic	Mrs C D van Zyl	Stellenbosch	90	4
Strand Private Hospital	Mr E G Fismer	Strand	24	2
Vergelegen Medi-Clinic	Mr E G Fismer	Somerset West	237	8
Worcester Medi-Clinic	Mr M S Crotz	Worcester	207	5
GAUTENG				
Kloof Medi-Clinic	Mrs R Swart	Pretoria	169	10
Marapong Private Hospital	Mrs C Swart	Lephalale	12	1
Medforum Medi-Clinic	Mrs J le Roux	Pretoria	204	14
Medi-Clinic Heart Hospital	Mr J Scheepers	Pretoria	90	3
Medivaal Hospital	Mrs C Savva	Vanderbijlpark	155	4
Morningside Medi-Clinic	Mrs A Rayray (acting)	Sandton	230	9
Muelmed Medi-Clinic	Dr B M Duminy	Pretoria	222	8
Sandton Medi-Clinic	Mrs L Sole	Sandton	379	10
Sunnyside Medi-Clinic	Mrs J le Roux	Pretoria	53	2
Vereeniging Medi-Clinic	Mr L Lambrechts	Vereeniging	165	7
Wits Donald Gordon Medical Centre *	Mr S J van der Walt	Johannesburg	95	5
MPUMALANGA				
Barberton Medi-Clinic	Mr W Kruger	Barberton	30	1
Ermelo Medi-Clinic	Mr W Schoonbee	Ermelo	40	2
Highveld Medi-Clinic	Mr R A van Zyl	Trichardt	202	4
Nelspruit Medi-Clinic	Mr W Kruger	Nelspruit	260	7
Secunda Medi-Clinic	Mr R A van Zyl	Secunda	43	3

HOSPITALS IN OPERATION

	HOSPITAL MANAGER	LOCATION	LICENCED BEDS	LICENCED THEATRES
KWAZULU-NATAL				
Howick Private Hospital	Mr M J R Vorster	Howick	26	2
Newcastle Private Hospital	Mr F G Meiring	Newcastle	130	4
Pietermaritzburg Medi-Clinic	Mr M J R Vorster	Pietermaritzburg	127	5
Victoria Hospital	Mrs J Meer	Tongaat	120	4
FREE STATE				
Bloemfontein Medi-Clinic	Mr F C Bührmann	Bloemfontein	377	10
Hoogland Medi-Clinic	Mrs E Swanepoel (acting)	Bethlehem	107	3
Welkom Medi-Clinic	Mr F X van Niekerk	Welkom	191	8
NORTHWEST PROVINCE				
Brits Medi-Clinic	Mrs R Janse van Rensburg	Brits	80	3
Legae Medi-Clinic	Mr J Verwey	Mabopane	137	4
Potchefstroom Medi-Clinic	Mr D du Plooy	Potchefstroom	114	4
NORTHERN CAPE				
Kathu Medi-Clinic	Mr H R Hendricks	Kathu	25	1
Kimberley Medi-Clinic	Mr H R Hendricks	Kimberley	234	8
Upington Medi-Clinic	Mrs J D van Niekerk	Upington	40	2
LIMPOPO PROVINCE				
Limpopo Medi-Clinic	Mr A Spek	Polokwane	186	6
Tzaneen Medi-Clinic	Mr Z Fanie	Tzaneen	64	2
NAMIBIA				
Cottage Medi-Clinic	Mr P J Sander	Swakopmund	72	2
Otjiwarongo Medi-Clinic	Mr J von Solms	Otjiwarongo	20	1
Windhoek Medi-Clinic	Mrs E Vink	Windhoek	120	4
			6 845	243
UNITED ARAB EMIRATES				
Welcare Hospital	Mr S van der Vyver	Dubai	120	4
			6 965	247

* Proportionally consolidated
(100% = 190 beds and 11 theatres)

MEDI-CLINIC CORPORATION LTD

ANNUAL FINANCIAL STATEMENTS

07

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DIRECTORS' RESPONSIBILITY STATEMENT

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

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

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

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

The annual financial statements and Group annual financial statements as set out on pages 50 to 85, have been approved by the Board of Directors and are signed on their behalf by:

E DE LA H HERTZOG
Chairman
Stellenbosch
9 May 2007

LJ ALBERTS
Managing director

CERTIFICATE BY THE COMPANY SECRETARY

In terms of section 268G(d) of the Companies Act No 61 of 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
Secretary
Stellenbosch
9 May 2007

INDEPENDENT AUDITOR'S REPORT TO THE MEMBERS OF MEDI-CLINIC CORPORATION LIMITED

We have audited the annual financial statements and group annual financial statements of Medi-Clinic Corporation Limited, which comprise the directors' report, the balance sheet and the consolidated balance sheet as at 31 March 2007, the income statement and the consolidated income statement, the statement of changes in equity and the consolidated statement of changes in equity, the cash flow statement and the consolidated cash flow statement for the year then ended, and a summary of significant accounting policies and other explanatory notes, as set out on pages 50 to 85.

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. This responsibility includes: designing, implementing and maintaining internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error; selecting and applying appropriate accounting policies; and making accounting estimates that are reasonable in the circumstances.

Auditor's Responsibility

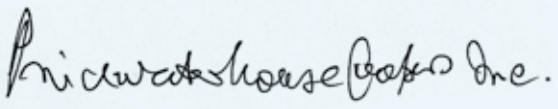
Our responsibility is to express an opinion on these financial statements based on our audit. We conducted our audit in accordance with International Standards on Auditing. Those standards require that we comply with ethical requirements and plan and perform the audit to obtain reasonable assurance whether 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 financial position of the Company and of the Group as of 31 March 2007, and their financial performance and their 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: JH Loubser
Registered Auditor
Stellenbosch
9 May 2007

NATURE OF ACTIVITIES

The main business of your 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

Your Group currently operates fifty hospitals in Southern Africa and one hospital in Dubai. Sixteen of the hospitals in Southern Africa are located in the Western Cape, eleven in Gauteng, five in Mpumalanga, four in KwaZulu-Natal, three in the Northwest Province, three in the Free State, three in the Northern Cape, two in the Limpopo Province and three in Namibia.

The Group acquired the hospitals of the Protector Group (200 beds) through a 51% subsidiary (Phodiclinics (Proprietary) Limited) with effect from 7 November 2006.

The Group also acquired a 50% plus one share controlling interest in Emirates Healthcare Holdings Limited BVI effective 27 March 2007.

A complete list of hospitals appear on pages 44 and 45.

The financial results are fully disclosed in the income statement and discussed in the report to shareholders.

SHARE CAPITAL

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

There was no movement in the number of issued ordinary shares during the year, which remains at 394 338 449 shares of 10 cents each.

The Group's treasury shares comprise new shares issued to the BEE shareholders (Phodiso Holdings Limited and Circle Capital Ventures (Proprietary) Limited) to the extent that the amount to be repaid in terms of the Group's black ownership initiative has not been received; the shares issued to the employee share trust (the Mpilo Trust) as well as shares held through a wholly-owned subsidiary to employees in terms of the executive share option scheme and the long-term management incentive scheme.

During the year under review 1 251 810 shares (2006: 9 631 867) have been released from the original 28 498 919 treasury shares issued to the BEE shareholders. Furthermore the Mpilo Trust released 233 780 shares to employees.

The Group also released 1 653 233 (2006: 2 980 325) treasury shares held through a wholly-owned subsidiary.

DISTRIBUTION TO SHAREHOLDERS

The Board of Directors has declared a dividend of 37.6 cents (2006: 36.6) per ordinary share. This, together with the interim dividend of 16.5 cents (2006: 16.5) per share, brings the total normal dividend for the year to 54.1 cents (2006: 53.1) per share.

	2007 R'000	2006 R'000
Interim distribution of 16.5 cents (2006: 16.5 cents)	**65,066**	57,761
Final distribution of 37.6 cents (2006: 36.6 cents)	**148,271**	144,328
Special distribution in prior year of R4.02	**-**	1,585,241
	213,337	1,787,330

MANAGEMENT

M & I Group Services Limited, a wholly-owned subsidiary of Remgro Limited, is a service company which provides limited specialised management services on request to your Group. Your 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% (2006: 43.4%) of the issued ordinary shares. Details of subsidiaries, joint ventures and associates appear in the annexure on pages 82 and 83.

DIRECTORS AND SECRETARY

The names of the directors and secretary of the Company, as well as the latter's postal address, appears on pages 7 to 9. Prof W P Esterhuyse retired as director with effect from 27 July 2006.

Mr K H S Pretorius was appointed as a director with effect from 8 November 2006.

Your Board recommends that directors' fees for services rendered during the past financial year be fixed at R1 153 000 (2006: R1 524 500).

DIRECTORS' INTERESTS

Details of the direct and indirect interest in the issued permanent capital structure of your Company by directors are set out on pages 84 and 85. 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 BALANCE SHEET DATE

Other than the facts and developments reported in the annual report, there have been no material changes in the affairs or financial position of the Company and the Group from the date of signature of the audit report and the date of such report.

BALANCE SHEETS

AT 31 MARCH 2007

COMPANY 2006 R'm	COMPANY 2007 R'm		Notes	GROUP 2007 R'm	GROUP 2006 R'm
		ASSETS			
441	468	**Non-current assets**		3,709	2,617
-	-	Property, plant and equipment	5	3,124	2,327
-	-	Intangible assets	6	419	48
419	451	Interest in subsidiary	7	-	-
-	-	Investments in associates	8	5	3
-	-	Other investments and loans	9	41	116
22	17	Deferred income tax assets	10	120	123
-	-	**Current assets**		1,780	980
-	-	Inventories	11	190	153
-	-	Trade and other receivables	12	874	667
-	-	Cash and cash equivalents		716	160
441	468	**Total assets**		5,489	3,597
		EQUITY			
		Capital and reserves attributable to equity holders of the Company			
39	39	Ordinary shares		39	39
289	289	Share premium		289	289
-	-	Treasury shares		(297)	(310)
328	328	Share capital	13	31	18
93	101	Share-based payment reserve	14	101	93
-	-	Foreign currency translation reserve	14	2	-
20	39	Retained earnings	14	1,934	1,530
441	468			2,068	1,641
-	-	**Minority interest**	15	752	290
441	468	**Total equity**		2,820	1,931
		LIABILITIES			
-	-	**Non-current liabilities**		1,130	955
-	-	Borrowings	16	996	848
-	-	Deferred income tax liabilities	10	5	5
-	-	Retirement benefit obligations	17	129	102
-	-	**Current liabilities**		1,539	711
-	-	Trade and other payables	18	903	590
-	-	Borrowings	16	628	74
-	-	Current income tax liabilities		8	47
-	-	**Total liabilities**		2,669	1,666
441	468	**Total equity and liabilities**		5,489	3,597

COMPANY				GROUP	
2006 R'm	2007 R'm		Notes	2007 R'm	2006 R'm
-	-	**Revenue**		5,364	4,723
-	-	Cost of sales		(2,928)	(2,571)
-	-	Administration and other operating expenses	19	(1,430)	(1,288)
-	-	**Trading profit**		1,006	864
974	240	Dividends received		-	-
-	-	BEE share-based payment		-	(85)
974	240	**Operating profit**		1,006	779
-	-	Income from associates	21	1	13
-	-	Profit on sale of associate		-	43
-	-	Finance income		44	70
-	-	Finance cost		(88)	(45)
974	240	**Profit before taxation**		963	860
(191)	(12)	Taxation	22	(270)	(428)
783	228	**Profit for the year**		693	432
		Attributable to:			
		Equity holders of the Company		582	338
		Minority interest		111	94
				693	432
		Earnings per ordinary share attributable to the equity holders of the Company - cents			
		Basic	23	162.5	97.1
		Diluted	23	147.5	85.9

STATEMENTS OF CHANGES IN OWNERS' EQUITY

FOR THE YEAR ENDED 31 MARCH 2007

COMPANY 2006 R'm	COMPANY 2007 R'm		Notes	GROUP 2007 R'm	GROUP 2006 R'm
39	39	Ordinary shares	13	39	39
35	39	Opening balance		39	35
4	-	Shares issued		-	4
289	289	Share premium	13	289	289
45	289	Opening balance		289	45
289	-	Shares issued		-	289
(45)	-	Capital distribution paid to shareholders		-	(45)
		Treasury shares	13	(297)	(310)
		Opening balance		(310)	(38)
		Shares acquired by the Mpilo Trust		-	(290)
		Capital distribution received		-	1
		Utilised by the Mpilo Trust		4	-
		Utilised for share option scheme		9	17
93	101	Share-based payment reserve	14	101	93
3	93	Opening balance		93	3
5	8	Employees: value of services		8	5
85	-	Strategic Black Partners: value of services		-	85
		Foreign currency translation reserve			
		Movement for the year		2	-
20	39	Retained earnings	14	1,934	1,530
953	20	Opening balance		1,530	2,648
(7)	-	Share issue costs		-	(7)
783	228	Profit for the year		582	338
(1,709)	(209)	Dividends paid		(178)	(1,449)
441	468	**Attributable to equity holders of the Company**		2,068	1,641
		Minority interest	15	752	290
		Opening balance		290	235
		Distributions to minorities		(40)	(39)
		Profit for the year		111	94
		Minority interest acquired		391	-
		Currency translation differences		2	-
		Decrease in minority interest		(2)	-
441	468	**Total equity at the end of the year**		2,820	1,931

COMPANY inflow/(outflow)				GROUP inflow/(outflow)	
2006 R'm	2007 R'm		Notes	2007 R'm	2006 R'm
		CASH FLOW FROM OPERATING ACTIVITIES			
-	-	Cash received from customers		5,456	4,637
-	-	Cash paid to suppliers and employees		(4,269)	(3,643)
-	-	Cash generated from operations	24.1	1,187	994
974	240	Dividends received		-	-
-	-	Finance income		44	70
-	-	Finance cost		(88)	(45)
(207)	(7)	Taxation paid	24.2	(306)	(448)
767	233	**NET CASH FLOW FROM OPERATIONS**		837	571
701	(24)	**CASH FLOW FROM INVESTMENT ACTIVITIES**		(672)	(388)
701	(24)	Investment to maintain operations	24.3	(139)	(118)
-	-	Investment to expand operations	24.4	(542)	(357)
-	-	Proceeds on sale of property, plant and equipment	24.5	9	3
-	-	Proceeds on sale of associate	24.6	-	84
1,468	209			165	183
(1,468)	(209)	**CASH FLOW FROM FINANCING ACTIVITIES**		43	(830)
293	-	Proceeds of shares issued		-	3
-	-	Cash distributions to minorities	15	(40)	(39)
(1,754)	(209)	Distributions to shareholders	24.7	(178)	(1,493)
(7)	-	Share issue costs		-	(7)
-	-	Proceeds from borrowings		298	717
-	-	Repayments of borrowings		(50)	(28)
-	-	Treasury shares utilised		13	17
-	-	Net movement in cash, cash equivalents and bank overdrafts		208	(647)
-	-	Opening balance of cash, cash equivalents and bank overdrafts		149	796
-	-	Closing balance of cash, cash equivalents and bank overdrafts	24.8	357	149

1. GENERAL INFORMATION

Medi-Clinic Corporation Limited (the Company) and its subsidiaries ("the Group") operates 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 consolidated financial statements have been approved for issue by the Board of Directors on 9 May 2007.

2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

The principal accounting policies applied in the preparation of these annual consolidated 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 consolidated financial statements of the Medi-Clinic Group have been prepared in accordance with International Financial Reporting Standards (IFRS). The annual consolidated financial statements have been prepared on the historical cost convention, as modified by the available-for-sale financial assets, in accordance with the requirements of the South African Companies Act and the Listing Requirements of the JSE Limited.

The preparation of 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 Group's accounting policies. The areas involving a higher degree of judgement or complexity, or areas where assumptions and estimates are significant to the annual consolidated financial statements, are disclosed in Note 4.

Standards, amendments and interpretations to published standards that are not yet effective

In the prior year the Group early adopted IFRIC 8 - Scope of IFRS 2 which was issued in January 2006, which requires that BEE transactions involving equity linked instruments be accounted for under IFRS 2 (Share-based payments).

The following new accounting standards, amendments and interpretations have been published that are mandatory for accounting periods beginning on or after 1 April 2007 or later periods but which the entity has not early adopted and which would not have a material effect if implemented:

a) *Standards, amendments and interpretations not affecting the Group*

- IFRIC 9 (AC 442) - Reassessment of Embedded Derivatives (effective from 1 June 2006).
- IFRIC 11 (AC 444) - IFRS 2 - Group and Treasury Share Transactions (effective from 1 March 2007).
- IFRIC 12 (AC 445) - Service Concession Arrangements (effective from 1 January 2008).
- AC 503 - Accounting for Black Economic Empowerment ("BEE") transactions (effective from 1 May 2006).

b) *Standards, amendments and interpretations affecting the Group*

- IAS 1 (AC 101) - Presentation of Financial Statements (effective from 1 January 2007). New and additional disclosures with regard to Capital Disclosures. The Group will adhere to the new requirements.
- IFRS 7 (AC 144) - Financial Instruments: Disclosures, and IFRS 4 (AC 141) - Revised Implementation Guidance (effective from 1 January 2007). New and additional disclosures with regard to financial instruments. The Group will adhere to the new requirements.
- IFRS 8 (AC 145) - Operating Segments (effective from 1 January 2009). The standard sets requirements for disclosure about an entity's operating segments. The Group will adhere to the new requirements.
- IFRIC 10 (AC 443) - Interim Financial Reporting and Impairment (effective from 1 November 2006). The intrepretation addresses the interaction between the requirements of IAS 34 and recognition of impairment losses on goodwill in IAS 36 and certain financial assets in IAS 39, and the effect of that interaction on subsequent interim and annual financial statements. The amendment will not have a significant impact on the Group's interim results.

2.2 Consolidation and equity accounting

a) Subsidiaries

Hospital operations that operate as partnerships or trusts, over which the Group has the power to govern the financial and operating policies are treated as subsidiaries. This includes all companies defined as subsidiary companies in terms of the Companies Act. Subsidiaries are fully consolidated from the date on which control is transferred to the Group. They are de-consolidated from the date on which control ceases.

The purchase method of accounting is used to account for the acquisition of subsidiaries by the Group. The cost of an acquisition is measured as the fair value of the assets given, equity instruments issued and liabilities incurred or assumed at the date of exchange, plus costs directly attributable to the acquisition. Identifiable assets acquired and liabilities and contingent liabilities assumed in a business combination are measured initially at their fair values at the acquisition date, irrespective of the extent of any minority interest. The excess of the cost of acquisition over the fair value of the Group's share of the identifiable net assets acquired is recorded as goodwill. If the cost of acquisition is less than the fair value of the Group's share of the net assets of the subsidiary acquired, the difference is recognised directly in the income statement.

Intercompany transactions, balances and unrealised gains on transactions between group companies are eliminated. Unrealised losses are also eliminated unless the transaction provides evidence of an impairment of the asset transferred. Subsidiaries' accounting policies have been changed where necessary to ensure consistency with the policies adopted by the Group.

The Group applies a policy of treating transactions with minority interests as transactions with parties external to the Group. Disposals to minority interests result in gains and losses for the Group that are recorded in the income statement. Purchases from minority interests result in goodwill, being the difference between any consideration paid and the relevant share acquired of the carrying value of net assets of the subsidiary.

b) Joint Ventures

The Group's interests in jointly controlled entities are accounted for by proportionate consolidation. The Group combines its share of the joint ventures' 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.

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

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

2.3 Segment reporting

The Group operates in the private hospital industry and is not significantly involved in other industries. The primary segments of the Group have been identified on a geographic basis.

2.4 Property, plant and equipment

Land and buildings comprise mainly hospitals and offices. All property, plant and equipment is 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
- Equipment:	5-10 years
- Furniture and vehicles:	5-7 years

The assets' residual values and useful lives are reviewed, and adjusted if appropriate, at each balance sheet date.
Due to the system of licensing of private hospitals and the fact that licenses are linked to a specific site, it is fundamentally important that the earnings potential of a hospital building is placed on a permanent basis. The Group therefore follows a structured maintenance program 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.

Gains and losses on disposals are determined by comparing proceeds with carrying amounts. These are included in the income statement.

2.5 Intangible assets

a) Trade names

Trade names are capitalised at the cost to the Group and amortised on the straight-line basis over its estimated useful lifetime.

In general trade names are amortised over 20 years. 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, joint venture or associate at the date of acquisition. Goodwill on acquisitions of subsidiaries and joint ventures are included in intangible assets. Goodwill on acquisitions 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 (CGU's) for the purpose of impairment testing. The allocation is made to those CGU's or groups of CGU's that are expected to benefit from business combinations in which goodwill arose. CGU's has been defined as each individual hospital of the Group.

c) Computer software

Acquired computer software licences 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 developing or maintaining computer software programs are recognised as an expense as incurred.

2.6 Impairment of non-financial assets

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

2.7 Investments

The Group classifies its investments in the following categories: loans and receivables, and available-for-sale financial assets. The classification depends on the purpose for which the investments were acquired. Management determines the classification of its investments at initial recognition and re-evaluates this designation at every reporting date.

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 balance sheet date, which are classified as non-current assets. Loans and receivables are carried at amortised cost using the effective interest 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 balance sheet 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.

Impairment

The Group assesses at each balance sheet date whether there is objective evidence that a financial asset or a group of financial assets is impaired. In the case of equity investments classified as available-for-sale, a significant or prolonged decline in the fair value of the security below its cost is considered an indicator that the investments are impaired. If any such evidence exists for available-for-sale financial assets, the cumulative loss – measured as the difference between the acquisition cost and the current fair value, less any impairment loss on that financial asset previously recognised in profit or loss – is removed from equity and recognised in the income statement.

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

2.8 Inventories

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

2.9 Trade receivables

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

2.10 Cash and cash equivalents

Cash and cash equivalents consist of balances with banks and cash on hand. Bank overdrafts are disclosed as part of borrowings in current liabilities on the balance sheet.

2.11 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.

2.12 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 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 balance sheet date.

2.13 Deferred income tax

Deferred income tax is provided at current rates, using the liability method, for all temporary differences arising between the tax bases of assets and liabilities and their carrying values for financial reporting purposes. Deferred income tax is determined using tax rates (and laws) that have been enacted or substantially enacted by the balance sheet 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 not raised in respect of deferred income tax on assessed losses, unless it is probable that future taxable profits will be available against which the deferred tax asset can be realised in the future.

2.14 Employee benefits

a) Retirement benefit costs

The Group provides for retirement fund benefits to employees by contributing to defined contribution funds. These contributions are accounted for against income when the employees render the related services.

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.

b) Post-employment medical benefits

The Group provides 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 spread forward over the average remaining service lives of employees.

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 balance sheet 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) Profit-sharing 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.

2.15 Revenue recognition

Revenue comprises hospital fees, net of value added taxes (VAT) and discounts and is recognised when the significant risks and rewards of ownership have been transferred or services have been rendered.

Other revenues earned are recognised on the following basis:

a) Interest income

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

b) Dividend income

When the shareholders' right to receive payment is established.

2.16 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.

2.17 Leased assets

Leases of property, plant and equipment where the Company 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, plant and equipment 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.

2.18 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 shareholders.

2.19 Foreign currency transactions

The assets and liabilities of foreign operations, including goodwill and fair value adjustments arising on consolidation, are translated at foreign exchange rates ruling at the balance sheet date. The revenues and expenses of foreign operations are translated at the monthly weighted average rate of exchange for the year. Profits and losses arising on the translation of assets and liabilities of foreign entities are taken directly to equity and shown separately in a foreign currency translation reserve.

Transactions denominated in foreign currencies are accounted for at the rates of exchange ruling on the dates of the transactions. Gains and losses arising from the settlement of such transactions are recognised in the income statement.

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 and price risk), credit risk, liquidity risk and cash flow interest rate risk. The Group's overall risk management programme seeks to minimise potential adverse effects on the Group's financial performance.

a) *Market risk*

Foreign currency risk

i) Investment in foreign operation

The Group has foreign exchange risk arising from assets in its foreign operation which are exposed to the US dollar. This risk is managed primarily through borrowing in US dollars.

ii) Transactions in foreign currency

Exposure regarding foreign currency transactions are insignificant, but a prudent approach towards foreign cover is followed if applicable. Currently there is limited exposure and consequently no forward cover contracts.

Price risk

The Group is not 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 and trade and other receivables. The Group's cash equivalents and short-term deposits 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 aid funders. The financial condition of these clients in relation to their credit standing is evaluated on an ongoing basis. After the provision for doubtful receivables has been brought into account, the Group does not have any significant exposure to any individual customer or counter party.

The carrying amounts of financial assets included in the balance sheet represents the Group's exposure to credit risk in relation to these assets. At 31 March 2007 and 31 March 2006, 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 forecast cash flows.The borrowing powers of the Group can only be limited by the Company's holding company. No such limitation currently exists.

	2007 R'm	2006 R'm
Shareholders' funds and minority interests	2,820	1,931
Interest-bearing debt	1,624	922
% interest-bearing debt to shareholders' funds	58%	48%
The Group's overdraft facilities are	1,700	1,701

d) *Cash flow and fair value interest rate risk*

As the Group has no significant interest-bearing assets, the Group's income and operating cash flows are substantially independent of changes in market interest rates. The Group's interest rate risk arises from long-term borrowings. Borrowings issued at variable rates expose the Group to cash flow interest rate risk. Borrowings issued at fixed rates 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.

3.2 Fair value estimation

The fair value of investments that are not traded in an active market is determined by using valuation techniques. The Group uses a variety of methods and makes assumptions that are based on market conditions existing at each balance sheet date. The fair values of investments are represented in notes 8 and 9.

The nominal value less impairment provision of trade receivables and payables are assumed to approximate their fair values.

The fair value of long-term borrowings for disclosure purposes is estimated by discounting the future contractual cash flows at the current market interest rate that is available to the Group for similar financial instruments.

	Floating interest rate R'm	Fixed interest rate maturing < 1 year R'm	Fixed interest rate maturing 1-5 years R'm	Fixed interest rate maturing > 5 years R'm	Non interest-bearing R'm	Total R'm	Weighted average rate %
31 March 2007							
ASSETS							
Cash resources	716	-	-	-	-	716	8.5
Trade and other receivables	-	-	-	-	874	874	-
Investments and loans	39	-	-	-	7	46	12.1
Total financial assets	755	-	-	-	881	1,636	
LIABILITIES							
Trade and other payables	-	-	-	-	903	903	-
Interest-bearing debt	840	72	163	549	-	1,624	8.6
Total financial liabilities	840	72	163	549	903	2,527	
Financial liabilities	(85)	(72)	(163)	(549)	(22)	(891)	
31 March 2006							
Total financial assets	261	-	-	-	685	946	
Total financial liabilities	88	50	200	584	590	1,512	
Net financial assets/(liabilities)	173	(50)	(200)	(584)	95	(566)	

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*

The Group tests annually whether goodwill has suffered any impairment, in accordance with the accounting policy stated in Note 2.5. The recoverable amounts of cash-generating units have been determined based on value-in-use calculations. These calculations require the use of estimates.

b) *Income taxes*

The Group is subject to income taxes in both South Africa and Namibia. 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) *BEE transaction*

The Group calculates 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 in accordance with the accounting policy stated in Note 2.11. These calculations require the use of estimates.

d) *Share-based compensation to employees*

The Group use 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.

	GROUP	
	2007	2006
	R'm	R'm
5. PROPERTY, PLANT AND EQUIPMENT		
Land - cost	**130**	110
Buildings	**1,560**	1,457
Cost	**1,606**	1,478
Accumulated depreciation	**(46)**	(21)
Land and buildings	**1,690**	1,567
Equipment	**593**	485
Cost	**1,491**	1,179
Accumulated depreciation	**(898)**	(694)
Furniture and vehicles	**121**	98
Cost	**329**	264
Accumulated depreciation	**(208)**	(166)
Subtotal	**2,404**	2,150
Capital expenditure in progress	**720**	177
	3,124	2,327

Property, plant and equipment with a book value of R264m (2006 : R234m) are encumbered as security for borrowings (see note 16).

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 materially exceeds their book value.

5. PROPERTY, PLANT AND EQUIPMENT (continued)

	GROUP			
	Land and buildings R'm	Equipment R'm	Furniture and vehicles R'm	Total R'm
At 1 April 2005				
Cost	1,381	1,006	210	2,597
Accumulated depreciation	(16)	(607)	(132)	(755)
Net book value	1,365	399	78	1,842
Year ended 31 March 2006				
Net opening book value	1,365	399	78	1,842
Capital expenditure	92	149	33	274
Business acquisitions	125	29	18	172
Disposals	-	(1)	(1)	(2)
Impairments	(12)	-	-	(12)
Depreciation per income statement	(3)	(91)	(30)	(124)
Net closing book value	1,567	485	98	2,150
At 31 March 2006				
Cost	1,588	1,179	264	3,031
Accumulated depreciation	(21)	(694)	(166)	(881)
Net book value	1,567	485	98	2,150
Year ended 31 March 2007				
Net opening book value	**1,567**	**485**	**98**	**2,150**
Capital expenditure	**15**	**142**	**43**	**200**
Business acquisitions	**117**	**78**	**12**	**207**
Currency translation differences	**-**	**1**	**-**	**1**
Disposals	**(5)**	**(1)**	**(2)**	**(8)**
Depreciation per income statement	**(4)**	**(112)**	**(30)**	**(146)**
Net closing book value	**1,690**	**593**	**121**	**2,404**
At 31 March 2007				
Cost	**1,736**	**1,491**	**329**	**3,556**
Accumulated depreciation	**(46)**	**(898)**	**(208)**	**(1,152)**
Net book value	**1,690**	**593**	**121**	**2,404**

Capital expenditure	2007 R'm	2006 R'm
Capital expenditure excluding expenditure in progress	**200**	274
Capital expenditure in progress	**125**	22
Total additions	**325**	296
To maintain operations	**139**	120
To expand operations	**186**	176

	GROUP		
	Trade names R'm	Goodwill R'm	Total R'm
6. INTANGIBLE ASSETS			
At 1 April 2005			
Cost	15	47	62
Accumulated amortisation and impairment	(11)	(3)	(14)
Net book value	4	44	48
Year ended 31 March 2006			
Net opening book value	4	44	48
Business acquisitions	-	1	1
Amortisation charge	(1)	-	(1)
	3	45	48
At 31 March 2006			
Cost	15	48	63
Accumulated amortisation and impairment	(12)	(3)	(15)
Net book value	3	45	48
Year ended 31 March 2007			
Net opening book value	3	**45**	48
Additions	-	**3**	3
Business acquisitions	-	**366**	366
Currency translation differences	-	**2**	2
	3	**416**	419
At 31 March 2007			
Cost	15	**419**	434
Accumulated amortisation and impairment	(12)	**(3)**	(15)
Net book value	3	**416**	419

Trade names with a cost price of R2,5m (2006: R2,5m) have been fully impaired.

The impairment tests for goodwill is 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 relating to the hospital industry.

A segment-level summary of the goodwill is presented below:	**2007 R'm**	2006 R'm
Southern Africa	**48**	45
Middle East	**368**	-
	416	45

COMPANY 2006 R'm	COMPANY 2007 R'm		GROUP 2007 R'm	GROUP 2006 R'm
		7. INTEREST IN SUBSIDIARY		
		Unlisted		
1	1	Shares at cost less amounts written off		
418	450	Due by subsidiary		
419	451			
		Details appear on pages 82 and 83.		
		8. INVESTMENTS IN ASSOCIATES		
		Unlisted		
		Carrying value of investments in associates' equity	1	-
		Opening balance	-	8
		Business acquisition	1	-
		Investment sold	-	(8)
			1	-
		Amounts owing	4	3
			5	3
		Directors' valuation	5	3
		The total profit of associates are R2m (2006: R35m) of which the Group's share is R1m (2006: R13m). Total revenue for the associates are R8m.		
		The aggregate balance sheets of associates are summarised as follows:		
		Non-current assets	17	3
		Current assets	7	9
		Total assets	24	12
		Current liabilities	(10)	(5)
		Shareholders' funds	14	7
		Outside interests	(9)	(4)
		Group's share in net assets of associates	5	3
		Details appear on page 83.		
		9. OTHER INVESTMENTS AND LOANS		
		Unlisted - no active market		
		Loans and receivables	41	102
		Available-for-sale: Shares	-	14
			41	116
		Directors' valuation	41	116

COMPANY			GROUP	
2006 R'm	2007 R'm		2007 R'm	2006 R'm
		10. DEFERRED INCOME TAX		
		Deferred taxation is calculated on all temporary differences according to the liability method using a principal tax rate of 29% (2006: 29%).		
		The movement on the deferred income tax account is as follows:		
14	22	Opening balance	118	88
		Taxation rate change	-	(3)
8	(5)	Income statement charge for the year	(3)	32
		Acquired during the year	-	1
22	17	Balance at the end of the year	115	118
		The balance consists of:		
		Accelerated wear and tear for tax purposes on property, plant and equipment	(27)	(24)
22	17	STC credits	18	34
		Accruals and other temporary differences	124	108
22	17		115	118
22	17	Deferred income tax assets	120	123
		Deferred income tax liabilities	(5)	(5)
22	17		115	118
		11. INVENTORIES		
		Inventories consist of:		
		Pharmaceutical products	173	139
		Consumables	10	8
		Finished goods and work in progress	7	6
			190	153
		The cost of inventories recognised as an expense and included in cost of sales amounted to R1 568m (2006: R1 440m).		
		There are no inventories that are valued at net realisable value.		
		12. TRADE AND OTHER RECEIVABLES		
		Trade receivables	726	663
		Less provision for impairment of receivables	(91)	(82)
		Trade receivables - net	635	581
		Other receivables	239	86
			874	667
		Net trade receivables to the value of R70m (2006: R72m) have been ceded as security for banking facilities.		

COMPANY 2006 R'm	COMPANY 2007 R'm		GROUP 2007 R'm	GROUP 2006 R'm
		13. SHARE CAPITAL		
		Share capital consists of ordinary shares and share premium.		
		Ordinary shares		
		Authorised :		
45	45	450 000 000 ordinary shares of 10 cents each (2006 : 450 000 000)	45	45
		Issued :		
39	39	394 338 449 ordinary shares of 10 cents each (2006 : 394 338 449)	39	39
		The unissued shares 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.		
289	289	**Share premium**	289	289
45	289	Opening balance	289	45
289	-	Premium on shares issued	-	289
(45)	-	Distributed to shareholders	-	(45)
		Treasury shares		
		34 968 952 (2006 : 38 107 775) ordinary shares of 10 cents each	(297)	(310)
		Opening balance	(310)	(38)
		Shares acquired by the Mpilo Trust	-	(290)
		Distribution received	-	1
		Utilised by the Mpilo Trust	4	-
		Utilised for share option scheme	9	17
		During the year the Mpilo Trust, an employee share trust, released 233 780 of its 15 539 758 shares to employees.		
		To date, no value was received for an equivalent of 17 615 242 (2006:18 867 052) shares issued to the strategic black partners.		
		The Company, through a wholly-owned subsidiary, holds 1 813 952 (2006: 3 467 185) shares in treasury. During the year 1 305 273 (2006: 2 385 072) of these shares were utilised in terms of the executive share option scheme.		
328	328		31	18

COMPANY			GROUP	
2006 R'm	2007 R'm		2007 R'm	2006 R'm

13. SHARE CAPITAL (continued)

Share options

In terms of the executive share option scheme, 34 472 230 (2006: 34 472 230) ordinary shares are kept in reserve. To date 23 880 000 share options have been granted, 4 930 800 (2006: 4 275 000) share options have been forfeited and 14 187 435 (2006: 12 882 162) 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	R8,38	6,722,038	9,445,110
Options granted		-	70,000
Options forfeited		(655,000)	(408,000)
Options exercised - treasury shares utilised	R5,71	(1,305,273)	(2,385,072)
Outstanding at the end of the year	R9,29	4,761,765	6,722,038

14. RESERVES

			R'm	R'm
		Share-based payment reserve		
6	9	Executive share option scheme	9	6
2	7	Employee share trust	7	2
85	85	Strategic black partners	85	85
93	101		101	93
		Foreign currency translation reserve	2	-
		Distributable reserve		
20	39	Company	39	20
		Subsidiaries and joint ventures	1,895	1,510
20	39		1,934	1,530

15. MINORITY INTEREST

Opening balance	290	235
Distributions to minorities	(40)	(39)
Share of profit	111	94
Minority interest acquired	391	-
Currency translation differences	2	-
Decrease in minority interest	(2)	-
Minority interest in hospital activities	752	290

	GROUP	
	2007 R'm	2006 R'm
16. BORROWINGS		
Unsecured long-term bank loans	**694**	716
Long-term portion	**655**	694
Short-term portion	**39**	22
These loans bear interest at an average fixed rate of 9.3% per annum and are repayable in seven years.		
Unsecured foreign bank loan	**302**	-
Long-term portion	**156**	-
Short-term portion	**146**	-
The loan is US dollar denominated, bears interest at a variable rate of 1.4% above LIBOR per annum and has no fixed terms of repayment.		
Secured long-term bank loans	**90**	118
Long-term portion	**57**	90
Short-term portion	**33**	28
These loans bear interest at an average fixed rate of 12.8% per annum and are repayable in four years. Property, plant and equipment with a book value of R135m (2006: R134m) are encumbered as security for these loans.		
Secured long-term bank loans	**87**	77
Long-term portion	**75**	64
Short-term portion	**12**	13
These loans bear interest at variable rates linked to the prime overdraft rate and are repayable in periods ranging between one and 14 years. Property, plant and equipment with a book value of R100m (2006: R100m) are encumbered as security for these loans.		
Bank overdrafts	**143**	11
Borrowings in Southern African operations	**1,316**	922
Borrowings in Middle East operations	**308**	-
Secured long-term bank loans		
Long-term portion	**41**	-
Short-term portion	**39**	-
	80	-
These loans bear interest at variable rates linked to EIBOR and are repayable in periods ranging between one and three years. Property, plant and equipment with a book value of R29m are encumbered as security for these loans.		
Unsecured long-term loan	**12**	-
The loan is unsecured, interest free and repayable within 12 to 24 months.		
Bank overdrafts	**216**	-
Total borrowings	**1,624**	922
Short-term portion transferred to current liabilities	**(628)**	(74)
	996	848

	GROUP	
	2007 R'm	2006 R'm

17. RETIREMENT BENEFIT OBLIGATIONS

Post-employment medical benefits

The Group accounts for actuarially determined future medical benefits and provide for the expected liability in the balance sheet.

During the last valuation on 31 March 2007 a 6.5% (2006: 5.5%) medical inflation cost and a 8.5% (2006: 7.5%) interest rate were assumed. The average retirement age was set at 63 years (2006: 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 balance sheet are as follows:		
Opening balance	**102**	73
Acquired during the year	**-**	3
Amounts recognised in the income statement	**27**	26
Current service cost	**18**	13
Interest cost	**9**	7
Actuarial loss	**1**	7
Contributions	**(1)**	(1)
Closing balance	**129**	102
Present value of unfunded obligations	**129**	102

	Increase	Decrease
The effects of a 1% movement in the assumed discount rate trend are as follows:		
Defined benefit obligation	**18.1%**	(14.5%)
Defined benefit obligation plus current service cost and interest cost	**17.3%**	(13.9%)
The effects of a 1% movement in the assumed subsidy increase rate are as follows:		
Defined benefit obligation	**18.0%**	(14.6%)
Defined benefit obligation plus current service cost and interest cost	**18.3%**	(14.9%)

Expected post-employment medical benefits payable for the year ended 31 March 2008 are R1,34m.

18. TRADE AND OTHER PAYABLES

	R'm	R'm
Trade payables	**539**	311
Other payables and accrued expenses	**364**	279
	903	590

		GROUP	
		2007 R'm	2006 R'm
19.	**EXPENSES BY NATURE**		
Auditors' remuneration	- external audit	**3**	2
	- other services	**	*
	- total value of other services provided	**-**	1
	- share issue costs	**-**	(1)
Cost of inventories		**1,568**	1,440
Depreciation	- buildings	**4**	3
	- equipment	**112**	91
	- furniture and vehicles	**30**	30
Employee benefit expenses		**1,951**	1,750
Wages and salaries		**1,841**	1,661
Post-employment medical benefits (note 17)		**27**	26
Retirement benefit costs		**75**	58
Share-based payment expense		**8**	5
Impairment of property, plant and equipment		**-**	12
Maintenance costs		**172**	154
Managerial and administration fees		**3**	3
Operating leases	- buildings	**39**	27
	- equipment	**25**	19
Trade names amortised		**	1
Other expenses		**451**	327
General expenses		**519**	385
Profit on sale of equipment		**1**	1
Other income		**67**	57
		4,358	3,859
Classified as:			
Cost of sales		**2,928**	2,571
Administration and other operating expenses		**1,430**	1,288
		4,358	3,859

** Amounts less than R0,5m.*

20. DIRECTORS' REMUNERATION

	GROUP 2007 R'000	GROUP 2006 R'000
Executive		
E de la H Hertzog *	5,060	4,790
L J Alberts	4,424	3,895
J du T Marais	2,736	2,579
D P Meintjes	1,014	2,625
K H S Pretorius	1,118	-
J G Swiegers	3,584	3,052
Total	17,936	16,941
Non-executive fees	1,153	1,525
W E Bührmann	-	213
W P Esterhuyse	56	183
S Dakile-Hlongwane	99	120
A R Martin	194	247
V E Msibi	130	69
A A Raath	176	225
M A Ramphele	117	132
C I Tingle	-	119
W L van der Merwe	158	147
M H Visser	223	70
	19,089	18,466
Paid by:		
Subsidiaries	16,499	16,038
Management company *	2,590	2,428
	19,089	18,466

Detail for 2007: (R'000)	Salaries	Retirement fund	Other benefits (****)	Bonus	Share options	Total
Executive						
E de la H Hertzog *	2,069	200	146	2,645	-	5,060
L J Alberts	2,242	202	17	1,963	-	4,424
J du T Marais	1,536	138	17	1,045	-	2,736
D P Meintjes **	-	140	239	635	-	1,014
K H S Pretorius ***	574	54	29	461	-	1,118
J G Swiegers	1,405	145	232	1,086	716	3,584
	7,826	879	680	7,835	716	17,936

Detail for 2006: (R'000)	Salaries	Retirement fund	Other benefits (****)	Bonus	Share options	Total
Executive						
E de la H Hertzog *	2,096	186	146	2,362	-	4,790
L J Alberts	1,888	168	25	1,814	-	3,895
J du T Marais	1,408	123	9	1,039	-	2,579
D P Meintjes	1,301	121	143	1,060	-	2,625
J G Swiegers	1,237	128	229	958	500	3,052
	7,930	726	552	7,233	500	16,941

* Dr E de la H Hertzog also earned a further R1,3m (2006: R1,2m) from M & I Group Services Limited relating to other duties. Also refer to note 28.
** Mr D P Meintjes also earned R1,5m from a subsidiary of Emirates Healthcare Holdings Limited BVI relating to other duties.
*** Mr K H S Pretorius was appointed as a director on 8 November 2006. His director's remuneration is from this date.
**** Other benefits include medical aid and vehicle benefits.

COMPANY			GROUP	
2006	2007		2007	2006

20. DIRECTORS' REMUNERATION (continued)

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 2007.

	Offer price	Number	Number
The number of outstanding share options are:			
K H S Pretorius	R4.90	30,000	-
K H S Pretorius	R9.80	10,000	-
J G Swiegers	R2.80	-	40,000
		40,000	40,000

R'm	R'm		R'm	R'm

21. INCOME FROM ASSOCIATES

		Unlisted associates	
		Share of income before taxation	1	13
		Share of taxation		
		Provided by the Group	-	(4)
			1	9

22. TAXATION

		Taxation on income excluding income from associates	(270)	(424)
		Taxation on income from associates		
		Provided by the Group	-	(4)
		Taxation per income statement	(270)	(428)
		Current taxation		
-	(1)	RSA taxation	(252)	(251)
		Foreign taxation (Namibia)	(8)	(6)
(199)	(6)	Secondary taxation on companies ("STC")	(7)	(200)
		Deferred income tax		
		Rate change	-	(3)
		Current year	13	13
8	(5)	STC credits	(16)	19
(191)	(12)		(270)	(428)
		Reconciliation of rate of taxation:		
		Standard rate for companies (RSA)	29.0 %	29.0 %
		Adjusted for:		
		Capital gains taxation	0.4 %	1.4 %
		Non-taxable income	(3.0)%	(4.2)%
		Non-deductible expenses	0.6 %	3.6 %
		Minorities share of profit before taxation	(1.5)%	(1.4)%
		Rate differences	0.2 %	0.4 %
		STC	2.3 %	21.0 %
		Effective tax rate	28.0 %	49.8 %

	GROUP	
	2007 R'm	2006 R'm
23. EARNINGS PER ORDINARY SHARE		
Earnings reconciliation		
Profit attributable to shareholders	**582**	338
After tax profit on sale of associate	**-**	(37)
Profit on sale of property, plant and equipment	**(1)**	(1)
Headline earnings	**581**	300
Net STC on special dividend	**-**	168
BEE share-based payment	**-**	85
Core earnings	**581**	553
Weighted number of issued ordinary shares		
Number of issued ordinary shares at the beginning of the year	**394,338,449**	350,065,992
Weighted number of ordinary shares issued during the year	**-**	12,372,394
Weighted number of treasury shares	**(36,732,391)**	(15,297,978)
	357,606,058	347,140,408
Diluted number of issued ordinary shares		
Weighted number of issued ordinary shares	**357,606,058**	347,140,408
Weighted number of treasury shares held in terms of the BEE initiative not yet released from treasury stock	**33,778,457**	41,580,447
Adjustment for outstanding share options granted	**2,722,055**	3,696,405
	394,106,570	392,417,260
Earnings per ordinary share (cents)		
Basic	**162.5**	97.1
Diluted	**147.5**	85.9
Headline earnings per ordinary share (cents)		
Basic	**162.2**	86.3
Diluted	**147.2**	76.3
Core earnings per ordinary share (cents)		
Basic	**162.2**	159.3
Diluted	**147.2**	140.9

COMPANY 2006 R'm	COMPANY 2007 R'm		GROUP 2007 R'm	GROUP 2006 R'm
		24. CASH FLOW INFORMATION		
		24.1 Reconciliation of profit before taxation to cash generated from operations		
		Operating profit before interest and taxation	1,006	779
		Non-cash items		
		Trade names amortised	-	1
		Movement in share-based payment reserve	8	90
		Depreciation	146	124
		Impairment of property, plant and equipment	-	12
		Movement in retirement benefit obligations	27	26
		Profit on sale of property, plant and equipment	(1)	(1)
		Operating income before changes in working capital	1,186	1,031
		Working capital changes	1	(37)
		Increase in inventories	(18)	(13)
		Increase in trade and other receivables	(60)	(105)
		Increase in trade and other payables	79	81
			1,187	994
		24.2 Taxation paid		
(8)	-	Liability at the beginning of the year	(47)	(33)
		Business acquisitions	-	(5)
(199)	(7)	Provision for the year	(267)	(457)
			(314)	(495)
		Liability at the end of the year	8	47
(207)	(7)		(306)	(448)
		24.3 Investment to maintain operations		
		Property, plant and equipment purchased	(139)	(120)
701	(24)	Loans from subsidiaries		
		Distributions from associates	-	4
		Other investments and loans	-	(2)
701	(24)		(139)	(118)
		24.4 Investment to expand operations		
		Property, plant and equipment purchased	(186)	(176)
		Loans granted/(repaid)	75	(50)
		Business acquisitions	(426)	(131)
		Acquisition of minority interests in hospital activities	(5)	-
			(542)	(357)

COMPANY 2006 R'm	COMPANY 2007 R'm		GROUP 2007 R'm	GROUP 2006 R'm
		24. CASH FLOW INFORMATION (continued)		
		24.5 Proceeds on sale of property, plant and equipment		
		Book value of property, plant and equipment sold	8	2
		Profit per income statement	1	1
			9	3
		24.6 Proceeds on sale of associate		
		Book value of associate	-	41
		Profit per income statement	-	43
			-	84
		24.7 Distributions paid to shareholders		
(45)	-	Capital distributions declared and paid during the year	-	(45)
		Capital distributions received on treasury shares held	-	1
(1,709)	(209)	Dividends declared and paid during the year	(178)	(1,449)
(1,754)	(209)		(178)	(1,493)
		24.8 Cash, cash equivalents and bank overdrafts		
		For the purposes of the cash flow statement, cash, cash equivalents and bank overdrafts include:		
		Cash and cash equivalents	716	160
		Bank overdrafts	(359)	(11)
		Southern Africa operations (see note 16)	(143)	-
		Middle East operations (see note 16)	(216)	-
			357	149
		25. COMMITMENTS		
		Capital commitments		
		Incomplete capital expenditure contracts - Southern Africa	214	251
		Incomplete capital expenditure contracts - Middle East	201	-
			415	251
		Capital expenses authorised by the Board of Directors but not yet contracted	274	133
			689	384
		These commitments will be financed from Group and borrowed funds.		
		Operating lease commitments		
		The Group has entered into various operating lease agreements on premises and equipment. At 31 March 2007 and 31 March 2006, future non-cancellable minimum lease rentals are payable during the following financial years:		
		Within 1 year	38	31
		1 to 5 years	87	76
		Over 5 years	-	1
			125	108

	GROUP		
	R'm	R'm	R'm

26. SEGMENTAL REPORT

The Group is organised into two geographic segments, which is the basis on which primary segment information is reported.

The segments are as follows:

- Southern Africa operations
- Middle East operations

Financial information pertaining to the geographic segments for 2007 is as follows:

	Southern Africa	Middle East	Total
Goodwill, included in total assets	55	364	419
Total assets	3,951	1,538	5,489
Total liabilities	2,212	457	2,669
Capital expenditure	325	-	325

The Group acquired the Middle East operations at the end of the 2007 financial year and therefore no comparative and income statement information are provided.

27. RETIREMENT BENEFITS

The Group provides retirement benefits to its permanent employees as determined by the rules of the retirement funds by contributing monthly to the funds.

The Group has a number of defined contribution funds which are controlled by the Pension Funds Act and administered by financial institutions.

COMPANY			GROUP	
2006 R'm	2007 R'm		2007 R'm	2006 R'm

28. RELATED PARTY TRANSACTIONS

The major shareholder of the Group is Industrial Partnership Investments Limited (Remgro Limited), which owns 43.4% (2006: 43.4%). The remaining shares are listed and widely held.

The following transactions were carried out with related third parties:

i) Transactions with shareholders

		M & I Group Services Limited (subsidiary of Remgro Limited)		
		Managerial and administration fees	3	3
		Balance owing to	-	2
		Remgro Finance Corporation Limited (subsidiary of Remgro Limited)		
		Interest received	-	31
		M & I Group Services Limited		
		Internal audit services	1	1

ii) Key management compensation: Directors

Information regarding the directors' remuneration appears in note 20.

iii) Transactions with subsidiaries

		Medi-Clinic Investments Limited		
800	217	Dividend received		
418	450	Balance owing from		

29. BUSINESS ACQUISITIONS

The Group has acquired the hospitals in the Protector group (R121m) with effect from 7 November 2006, as well as an equity interest (R387m) of 50% plus one share in Emirates Healthcare Holdings Limited BVI ("Emirates Healthcare") on 27 March 2007.

The acquired businesses of the Protector Group contributed R34m to the Group's revenue for the year.

During the previous year the Group has acquired the remaining 50% interest in ER24 Holdings (Pty) Ltd with effect from 1 April 2005, a 49.9% interest in the Wits University Donald Gordon Medical Centre (Pty) Ltd with effect from 1 July 2005, as well as a 100% interest in Phodiso Health Services (Pty) Ltd t/a Legae Private Hospital with effect from 1 December 2005. The acquired businesses contributed revenues of R127m for the year.

Details of net assets and goodwill acquired is:

	GROUP 2007 R'm	GROUP 2006 R'm
Property, plant and equipment	(623)	(172)
Goodwill	(362)	-
Investment in associates	(1)	15
Deferred income tax	-	(1)
Inventories	(19)	(4)
Trade and other receivables	(146)	(37)
Cash resources	-	(27)
Interest-bearing debt	104	35
Retirement benefit obligations	-	3
Trade and other payables	152	26
Taxation	-	5
Minority interest of existing shareholders	391	-
Value of interests acquired	(504)	(157)
Goodwill	(4)	(1)
Purchase consideration	(508)	(158)
Purchase consideration	(508)	(158)
Purchase consideration outstanding	82	-
Cash resources	-	27
Cash outflow on acquisition	(426)	(131)

The goodwill is attributable to the high profitability expected from the acquisition of Emirates Healthcare.

ANNEXURE - INVESTMENTS IN SUBSIDIARIES AND ASSOCIATES

AT 31 MARCH 2007

	Issued share capital		Interest in capital		Book value of shares	
	2007	2006	2007	2006	2007	2006
	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 R450m (2006 : R418m).						
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						
Aukland Medicine Distributors (Proprietary) Limited			100.0	100.0		
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 Middle East (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			75.6	70.0		
Phodiclinics (Proprietary) Limited			51.0	51.0		
Legae Medi-Clinic (Proprietary) Limited			100.0	100.0		
Plettenberg Bay Private Health Centre (Proprietary) Limited			100.0	100.0		
Practice Relief (Proprietary) Limited			100.0	100.0		
Reef-Med (Proprietary) Limited			55.9	53.9		
Tshwane Private Hospitals (Proprietary) Limited			51.0	51.0		
Tzaneen Private Hospital (Proprietary) Limited *			49.4	49.4		
Victoria Hospital Limited			33.3	33.3		
Indirectly held through Medi-Clinic Limited						
Kimberley Medi-Clinic (Proprietary) Limited $			89.7	89.7		
Ermelo Medi-Clinic (Proprietary) Limited $			50.1	50.8		
Barberton Medi-Clinic (Proprietary) Limited $			77.0	77.0		
Hermanus Medi-Clinic Limited * $			34.9	34.9		
Potchefstroom Medi-Clinic (Proprietary) Limited $			94.6	94.6		
Limpopo Medi-Clinic Limited $			50.0	50.0		
Upington Private Hospital (Proprietary) Limited * $			40.9	40.9		
Indirectly held through Medi-Clinic Middle East (Proprietary) Limited						
Emirates Healthcare Holdings Limited BVI			50.0	-		

ANNEXURE - INVESTMENTS IN SUBSIDIARIES AND ASSOCIATES

AT 31 MARCH 2007

	Issued share capital		Interest in capital		Book value of shares	
	2007	2006	2007	2006	2007	2006
	Rand	Rand	%	%	R'm	R'm
SUBSIDIARIES (continued)						
Indirectly held through Tshwane Private Hospitals (Proprietary) Limited						
Curamed Holdings Limited (Effective holding = 35% (2006: 34%))			63.0	63.0		
Indirectly held through Medipark Clinic (Proprietary) Limited						
ER24 Holdings (Proprietary) Limited			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						
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	
	2007	2006	2007	2006	2007	2006
	%	%	R'm	R'm	R'm	R'm
ASSOCIATES						
Group						
Unlisted:						
First Medical Centre L.L.C., Oman	20.0	-	1	-	-	-
Curamed Thabazimbi Trust	38.0	38.0	-	-	4	3
			1	-	4	3
The nature of the activities of the associates is similar to the major activities of the Group.						

	Number of shareholders	Number of shares	%
DISTRIBUTION OF ORDINARY SHAREHOLDERS			
Public shareholders	3,934	159,966,188	40.56%
Non-public shareholders	25	234,372,261	59.44%
Directors and associates	20	2,291,466	0.58%
Own holdings (treasury shares)	1	2,032,430	0.52%
Industrial Partnership Investments Limited (Remgro)	1	171,128,418	43.40%
Black Economic Empowerment shareholders	3	58,919,947	14.94%
	3,959	394,388,449	100.00%

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 an interest of more than 5% in the Company on 31 March 2007:

Industrial Partnership Investments Limited (Remgro)	171,128,418	43.40%
Black Economic Empowerment shareholders	58,919,947	14.94%
Mpilo Investment Holdings 2 (Pty) Ltd (Phodiso Holdings)	27,110,768	6.87%
Mpilo Investment Holdings 1 (Pty) Ltd (Circle Capital Ventures)	16,266,461	4.13%
The Mpilo Trust	15,542,718	3.94%

	2007				2006	
	Beneficial		Non-Beneficial		Beneficial	
	Direct	Indirect	Direct	Indirect	Direct	Indirect
DIRECTORS' INTERESTS*						
E de la H Hertzog	-	1,714,319	6,702	-	-	1,714,319
LJ Alberts	257,177	24,416	-	-	257,177	24,416
S Dakile-Hlongwane	-	-	-	-	-	-
J du T Marais	1,963	3,685	-	-	1,963	3,685
AR Martin	-	1,915	-	-	-	1,915
DP Meintjes	47,683	500	-	-	47,683	500
VE Msibi (see Note 1)	-	-	-	-	-	-
KHS Pretorius	7,066	-	-	-	n/a	n/a
AA Raath	-	-	-	-	-	-
MA Ramphele (see Note 2)	-	-	-	-	-	-
JG Swiegers	54,543	157,135	-	13,405	54,543	117,135
WL van der Merwe	957	-	-	-	957	-
MH Visser	-	-	-	-	-	-
	369,389	1,901,970	6,702	13,405	362,323	1,861,970

* The following directors acquired shares in terms of the Medi-Clinic Management Incentive Scheme between the end of the financial year and 9 May 2007, as published on SENS:

	Number of shares	
E de la H Hertzog	38,747	(indirect beneficial)
LJ Alberts	27,727	(direct beneficial)
J du T Marais	32,439	(direct beneficial)
DP Meintjes	14,503	(direct beneficial)
JG Swiegers	14,870	(indirect beneficial)
KHS Pretorius	7,240	(direct beneficial)

Note 1: Dr V E Msibi holds an effective interest of 24.8% in the issued ordinary shares of Mpilo Investment Holdings 2 (Pty) Ltd through his shareholding in Phodiso Holdings Limited.

Note 2: Dr M A Ramphele holds an effective interest of 23.71% in the issued ordinary shares of Mpilo Investment Holdings 1 (Pty) Ltd through her indirect interest in Circle Capital Ventures (Pty) Ltd through the Ramphele Family Trust.

	Number of shareholders	%	Number of shares	%
SHAREHOLDING ANALYSIS				
1 - 1 000 shares	2,226	56.23%	822,017	0.21%
1 001 - 10 000 shares	1,171	29.58%	4,124,322	1.05%
10 001 -100 000 shares	378	9.55%	12,958,386	3.29%
100 001 - 1 000 000 shares	152	3.84%	53,414,175	13.55%
Over 1 000 000 shares	32	0.81%	323,019,549	81.91%
	3,959	100.00%	394,338,449	100.00%

	2007	2006
JSE LIMITED		
Market capitalisation as at 31 March (R'000)	9,897,895	8,143,089
Price (cents per share)		
31 March	2,510	2,065
Highest	2,541	2,230
Lowest	2,510	1,420
Number of shares traded (000's)	200,096	112,967

SHARE CLOSING PRICE FROM 1987 - 2007

NOTICE OF ANNUAL GENERAL MEETING

MEDI-CLINIC CORPORATION LIMITED

Registration number: 1983/010725/06
Share Code: MDC
ISIN Code: ZAE000074142
("Medi-Clinic" or "the Company")

Notice is hereby given that the twenty-fourth annual general meeting of the Company will be held at Medi-Clinic Offices, Strand Road, Stellenbosch on Thursday, 26 July 2007 at 15:00 to consider, and if approved, pass the following resolutions with or without modification:

1. CONSIDERATION OF ANNUAL FINANCIAL STATEMENTS

Ordinary Resolution Number 1
Resolved that the audited annual financial statements of the Company and the group for the year ended 31 March 2007 be accepted.

2. APPROVAL OF DIRECTORS' REMUNERATION

Ordinary Resolution Number 2
Resolved that the joint remuneration of the non-executive directors in the amount of R1 153 800 for the year ended 31 March 2007 be approved.

3. RATIFICATION OF CO-OPTION OF DIRECTOR

Ordinary Resolution Number 3
Resolved that the co-option of Mr K H S Pretorius on 8 November 2006 as executive director of the Company is ratified.

A brief CV of Mr Pretorius appears on page 8 of the annual report.

4. ELECTION OF DIRECTORS

Ordinary Resolution Number 4

4.1 Resolved that Dr E de la Hertzog who retires in terms of clause 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;

4.2 Resolved that Mr A R Martin who retires in terms of clause 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;

4.3 Resolved that Mr D P Meintjes who retires in terms of clause 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;

4.4 Resolved that Dr M A Ramphele who retires in terms of clause 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; and

4.5 Resolved that Prof W L van der Merwe who retires in terms of clause 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;

A brief CV of each of the directors mentioned above appears from page 8 to 9 of the annual report.

5. AUTHORITY TO PLACE SHARES UNDER CONTROL OF THE DIRECTORS

Ordinary Resolution Number 5
Resolved that 39 433 845 of the unissued ordinary shares in the authorised share capital of the Company be hereby placed under the control of the directors as a general authority in terms of section 221(2) of the Companies Act (Act 61 of 1973), as amended ("the Companies Act"), who are hereby authorised to allot and issue any such shares upon such terms and conditions as the directors in their sole discretion may deem fit, subject to the provisions of the Companies Act, the Articles of Association of the Company and the JSE Limited ("JSE") Listings Requirements ("the Listings Requirements").

6. AUTHORITY TO ISSUE SHARES FOR CASH

Ordinary Resolution Number 6
Resolved that, subject to Ordinary Resolution Number 5, 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, when applicable, and the following limitations, namely that –

6.1 the securities which are the subject of the issue for cash must be of a class already in issue, or where this is not the case, must be limited to such securities or rights that are convertible into a class already in issue;

6.2 any such issue will only be made to public shareholders as defined in the Listings Requirements and not to related parties;

6.3 the number of shares issued for cash shall not in the aggregate in any one financial year exceed 10% of the Company's issued share capital of ordinary shares. The number of ordinary shares which may be issued shall be based on the number of ordinary shares in issue at the date of such application less any ordinary shares issued during the current financial year, provided that any ordinary shares to be issued pursuant to a rights issue (announced and irrevocable and underwritten) or acquisition (concluded up to date of application) may be included as though they were shares in issue at the date of application;

6.4 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;

6.5 a 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

6.6 in determining the price at which an issue of shares may be made in terms of this authority post the listing of the Company, 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 by the directors of the Company.

This Ordinary Resolution Number 6 is required, under the Listings Requirements, to be passed by achieving a 75% majority of the votes cast in favour of such resolution by all members present or represented by proxy and entitled to vote, at the annual general meeting.

7. AUTHORITY TO REPURCHASE SHARES

Special Resolution Number 1

Resolved that, as a general authority contemplated in sections 85(2) and 85(3) of the Companies Act, the acquisition/s by the Company and/or any subsidiary of the Company, from time to time of the issued ordinary shares of the Company, upon such terms and conditions and in such amounts as the directors of the Company may from time to time determine are hereby authorised, but subject to the Articles of Association of the Company, the provisions of the Companies Act and the Listings Requirements, when applicable, and provided that:

7.1 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;

7.2 any repurchase of securities will be effected through the order book operated by the JSE trading system and done without any prior understanding or arrangement between the Company and the counter party;

7.3 the Company will only appoint one agent to effect any repurchase(s) on its behalf;

7.4 any acquisitions by the Company and/or any subsidiary of the Company of ordinary shares in the aggregate in any one financial year shall be limited to a maximum of 20% 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 exceed 10% of the number of issued shares in the Company;

7.5 in determining the price at which the Company's ordinary shares are acquired by the Company and/or any subsidiary of the Company in terms of this authority, the maximum premium at which such ordinary shares may be acquired will be 10% of the weighted average of the market price at which such ordinary shares are traded on the JSE, as determined over the 5 trading days immediately preceding the date of the repurchase of such ordinary shares by the Company and/or any subsidiary of the Company;

7.6 the Company and/or any subsidiary of the Company may not repurchase securities during a prohibited period, as defined in the Listings Requirements;

7.7 after any repurchase of securities the Company will continue to comply with the Listings Requirements concerning shareholder spread requirements; and

7.8 a press announcement will be published giving such details as may be required in terms of the 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 this resolution, and for each 3% in aggregate of the initial number of shares in issue acquired thereafter.

The board has no immediate intention to use this authority to repurchase Company shares. However, 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. The board undertake that they will not implement the proposed authority to repurchase shares, unless the directors are of the opinion that:

7.9 the Company and the Group will be able in the ordinary course of business to pay its debts for a period of 12 months after the date of the notice of the annual general meeting;

7.10 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 for a period of 12 months after the date of the notice of the annual general meeting;

7.11 the share capital and reserves of the Company and the Group will be adequate for ordinary business purposes for a period of 12 months after the date of the notice of the annual general meeting; and

7.12 the working capital of the Company and the Group will be adequate for ordinary business purposes for a period of 12 months after the date of the notice of the annual general meeting.

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 Listings Requirements, prior to entering the market to proceed with a repurchase.

Please refer to the additional disclosure of information contained in this notice, which disclosure is required in terms of the Listings Requirements.

Reason for and Effect of Special Resolution Number 1
The reason for and the effect of the special resolution is to grant the Company's directors 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 of shares in its holding Company, or to permit a subsidiary of the Company to purchase shares in the Company.

8. To transact any other business that may be transacted at an annual general meeting.

ADDITIONAL DISCLOSURE OF INFORMATION

Further to Special Resolution Number 1, the Listings Requirements require the disclosure of the following information, some of which appears elsewhere in the annual report of which this notice forms part as set out below:

- Directors and management
  See pages 8 to 9 of the annual report.
- Major shareholders of the Company
  See page 84 of the annual report.
- Material changes
  There are no material changes to report on.
- Directors' interests in securities
  See pages 84 to 85 of the annual report.
- Share capital of the Company
  See page 69 of the annual report.
- Litigation statement
  In terms of section 11.26 of the Listings Requirements, the directors, whose names appear on pages 8 to 9 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 8 to 9 of the annual report, collectively and individually accept full responsibility for the accuracy of the information pertaining to Special Resolution Number 1 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 Number 1 contains all information required by law and the Listings Requirements.

VOTING AND ATTENDANCE AT THE ANNUAL GENERAL MEETING

Members 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 member is entitled to appoint a proxy or proxies to attend, speak and vote in their stead. The person so appointed need not be a member of the Company. Proxy forms must be forwarded to reach the Company's transfer secretaries, Computershare Investor Services 2004 (Proprietary) Limited, 70 Marshall Street, Johannesburg, 2001 or posted to the

transfer secretaries at P O Box 61051, Marshalltown, 2107, South Africa, so as to be received by them by not later than 15:00 on Tuesday, 24 July 2007. Proxy forms must only be completed by members who have not dematerialised their shares or who have dematerialised their shares and registered them in their own name.

On a show of hands, every member of the Company present in person or represented by proxy shall have one vote only. On a poll, every member of the Company shall have one vote for every share held in the Company by such member.

Members who have dematerialised their shares, other than those members 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.

By order of the Board of Directors.

GC HATTINGH
Company Secretary

STELLENBOSCH
29 June 2007

EXPLANATORY NOTES TO THE NOTICE OF ANNUAL GENERAL MEETING

Ordinary Resolutions

1. **Consideration of annual financial statements**
   In terms of the Companies Act (Act 61 of 1973), as amended ("the Companies Act"), the directors are obliged to present the annual financial statements and group annual financial statements to the members at the annual general meeting.

2. **Approval of directors' remuneration**
   In terms of the Company's Articles of Association, the remuneration payable to non-executive directors must be determined at the Company's annual general meeting.

   Full particulars of directors' emoluments are disclosed on pages 74 to 75 of the annual report of which this notice forms part.

3. **Ratification of co-option of director**
   The board has approved the appointment of Mr K H S Pretorius with effect from 8 November 2006 as an executive director of the Company. The Company's members are requested to ratify the co-option of Mr Pretorius.

4. **Election of directors**
   In terms of the Company's Articles of Association, one third of the directors are required to retire at each annual general meeting and may offer themselves and are eligible for re-election.

5. **Authority to place shares under control of the directors**
   In terms of the Companies Act, the members of the Company must approve the placement of the unissued shares under the control of the directors. This authority is due to expire at the forthcoming annual general meeting, unless renewed.

6. **Authority to issue shares for cash**
   In terms of the JSE Limited ("JSE") Listings Requirements ("the Listings Requirements"), the members of the Company must approve the issue of shares for cash. The existing authority is due to expire at the forthcoming annual general meeting, unless renewed.

   The directors consider it advantageous for the Company to obtain the authority to issue shares for cash to enable the Company to take advantage of business opportunities that may arise in the future.

Special Resolution

7. **Authority to repurchase shares**
   The annual renewal of the authority is required in terms of the Companies Act and the Listings Requirements. The existing authority to the directors is due to expire at the forthcoming annual general meeting, unless renewed.

MEDI-CLINIC
Private hospital group

PROXY FORM

MEDI-CLINIC CORPORATION LIMITED

Registration number: 1983/010725/06
Share Code: MDC
ISIN Code: ZAE000074142
("Medi-Clinic" or "the Company")

THIS PROXY FORM IS ONLY FOR USE BY:

1. REGISTERED MEMBERS WHO HAVE NOT YET DEMATERIALISED THEIR SHARES IN THE COMPANY, AND
2. REGISTERED MEMBERS WHO HAVE ALREADY DEMATERIALISED SHARES IN THE COMPANY AND ARE REGISTERED IN THEIR OWN NAMES IN THE COMPANY'S SUB-REGISTER*

For use by registered members of the Company at the twenty-fourth annual general meeting of the Company to be held on Thursday, 26 July 2007 at 15h00 at Medi-Clinic Offices, Strand Road, Stellenbosch ("the annual general meeting").

I/We (please print) _____(name)

of _____(address)

being the holder of _____ ordinary shares in the Company, hereby appoint (see instruction 1 overleaf):

1._____or failing him/her,

2._____or failing him/her,

3. the chairman of the annual general meeting,

as my/our proxy to attend, speak and vote for me/us and on my/our behalf or to abstain from voting at the annual general meeting of the Company to be held on the 26th day of July 2007 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.	Approval of directors' remuneration			
3.	Ratification of co-option of Mr K H S Pretorius			
4.	Election of directors:			
	4.1 E de la H Hertzog			
	4.2 A R Martin			
	4.3 D P Meintjes			
	4.4 M A Ramphele			
	4.5 W L van der Merwe			
5.	Authority to place shares under control of the directors			
6.	Authority to issue shares for cash			
SPECIAL RESOLUTION				
7.	Authority to repurchase shares			

Signed at _____ on _____2007.

Signature/s _____

Assisted by me (where applicable) _____

Please read the notes and instructions overleaf.
* See explanatory note 3 overleaf.

Notes:

1. A member 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 member of the Company.

2. Every member 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 member holds, but in the event of a poll, every ordinary share in the Company shall have one vote.

3. Members who have dematerialised their shares in the Company and are registered in their own names are members 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 members in their own names.

Instructions on signing and lodging the proxy form:

1. A member may insert the name of a proxy or the names of two alternative proxies of the member'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 member. 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 member's voting instructions to the proxy must be indicated by the insertion of the number of votes exercisable by that member 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 member's exercisable votes. A member 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 member 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 2004 (Proprietary) Limited, 70 Marshall Street, Johannesburg, 2001, South Africa or posted to the transfer secretaries at P O Box 61051, Marshalltown, 2107, South Africa, to be received by them not later than Tuesday, 24 July 2007 at 15h00 (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 member 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 member 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 member wishes to vote.