# 2008

ANNUAL REPORT

MEDI-CLINIC

Private hospital group

*25 Years of Quality Care*

# contents



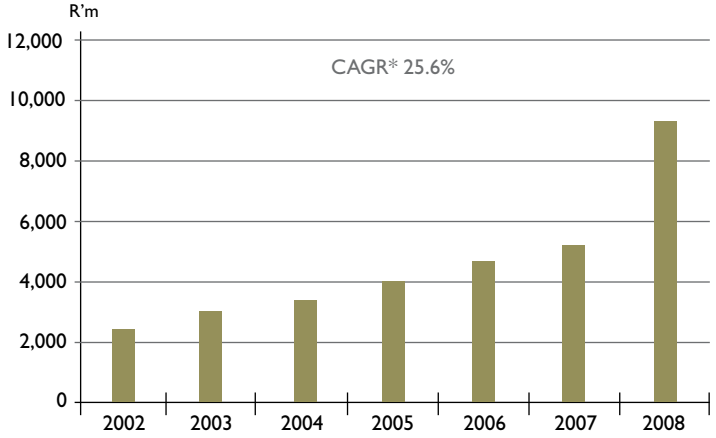


SCOPE OF REPORT: The 2008 annual report of Medi-Clinic Corporation Limited presents the operating and financial results of the Group for the financial year ended 31 March 2008 and covers all our operations in Southern Africa, Switzerland and the United Arab Emirates. The report has been prepared in accordance 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 Report on Corporate Governance for South Africa 2002.

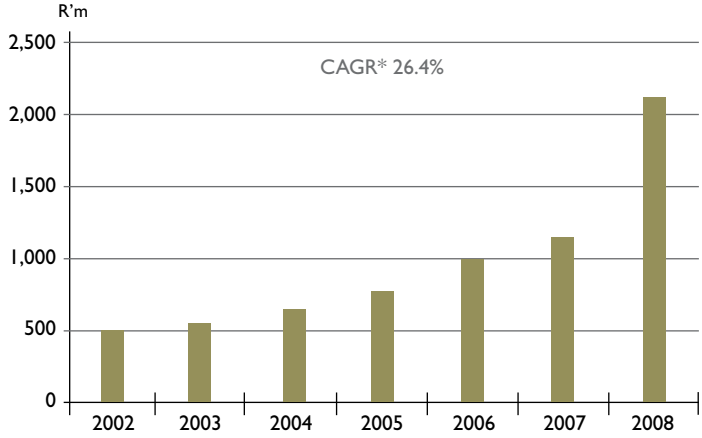
# financial highlights

| GROUP SUMMARY | 2008 R'm | 2007 R'm | Change % |
|---|---|---|---|
| Revenue | **9,579** | 5,364 | 79% |
| EBITDA | **2,060** | 1,151 | 79% |
| Total assets | **41,577** | 5,489 | 657% |
| Shareholders' equity | **8,880** | 2,068 | 329% |
| Return (headline earnings) on shareholders' equity | **6.8%** | 28.1% | (76)% |
| | **cents** | cents | |
| Headline earnings per ordinary share – basic | **144.5** | 162.2 | (11)% |
| Headline earnings per ordinary share – diluted | **133.6** | 147.2 | (9)% |
| Total distribution per ordinary share | **61.2** | 54.1 | 13% |
| Net asset value per ordinary share | **1,585.0** | 575.5 | 175% |

**REVENUE**

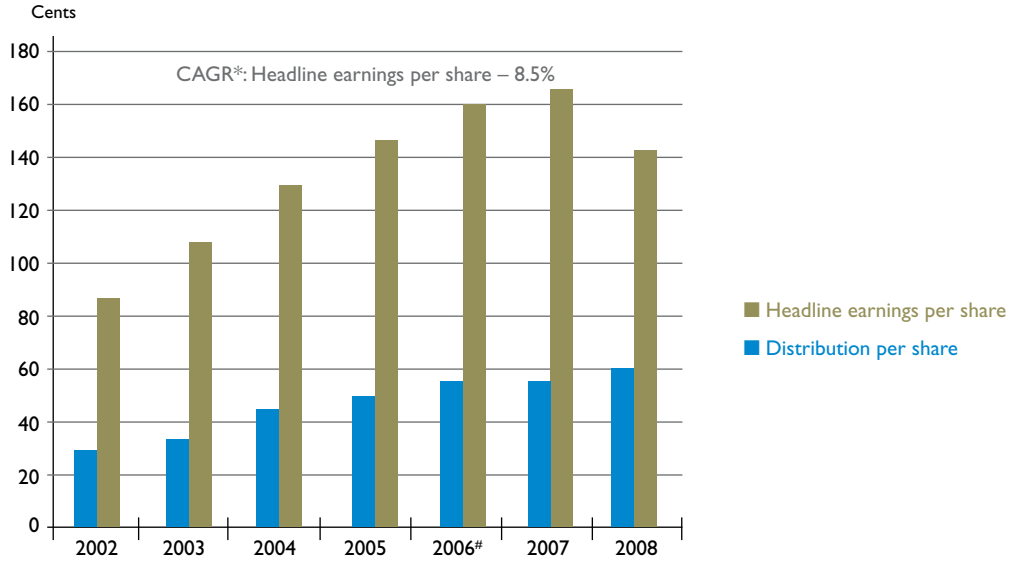



**EBITDA**




** Compounded Annual Growth Rate*

**HEADLINE EARNINGS AND DISTRIBUTION PER ORDINARY SHARE (BASIC)**




*# The 2006 headline earnings per share was adjusted to exclude the BEE share-based payment and the once-off STC charge of R168 million.*

## Commitment to Quality Care

From the skills of the doctor to general patient care, 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 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

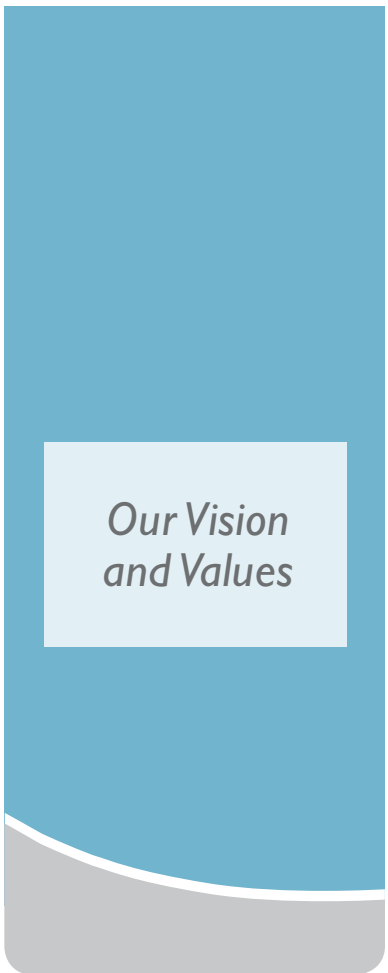
- promote positive team behaviour
- ensure the participation of all role players in problem solving
- set common goals
- exhibit responsible, fair, honest and effective leadership and followership

### 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

| | CAGR* | **2008 R'm** | 2007 R'm | 2006 R'm | 2005 R'm | 2004 R'm | 2003 R'm | 2002 R'm |
|---|---|---|---|---|---|---|---|---|
| **INCOME STATEMENTS** | | | | | | | | |
| **REVENUE** | 25.6% | **9,579** | 5,364 | 4,723 | 4,040 | 3,643 | 2,924 | 2,438 |
| Operating profit before depreciation and amortisation (EBITDA) | 26.4% | **2,060** | 1,151 | 987 | 819 | 722 | 571 | 506 |
| Profit on sale of property, equipment and vehicles | | **2** | 1 | 1 | 1 | 1 | – | – |
| BEE share-based payment | | **–** | – | (85) | – | – | – | – |
| Depreciation | | **(336)** | (146) | (124) | (97) | (101) | (75) | (71) |
| Amortisation/impairment of goodwill | | **(5)** | – | – | (3) | (3) | (2) | (1) |
| Operating profit | 25.8% | **1,721** | 1,006 | 779 | 720 | 619 | 494 | 434 |
| Dividends | | **–** | – | – | – | – | – | 5 |
| Income from associates | | **–** | 1 | 13 | 25 | 18 | 19 | 18 |
| Abnormal items | | **–** | – | 43 | 50 | – | – | – |
| Finance income | | **49** | 44 | 70 | 58 | 46 | 43 | 20 |
| Finance cost | | **(685)** | (88) | (45) | (29) | (32) | (16) | (17) |
| Profit before taxation | | **1,085** | 963 | 860 | 824 | 651 | 540 | 460 |
| Taxation | | **(364)** | (270) | (428) | (214) | (174) | (145) | (126) |
| Profit for the year | | **721** | 693 | 432 | 610 | 477 | 395 | 334 |
| Attributable to: | | | | | | | | |
| Equity holders of the Company | 12.1% | **610** | 582 | 338 | 543 | 439 | 364 | 308 |
| Minority interest | | **111** | 111 | 94 | 67 | 38 | 31 | 26 |
| | | **721** | 693 | 432 | 610 | 477 | 395 | 334 |
| Headline earnings attributable to holders of ordinary shares | 11.9% | **608** | 581 | 300 | 503 | 441 | 366 | 309 |
| Earnings per ordinary share – cents | | | | | | | | |
| Basic | 8.6% | **144.9** | 162.5 | 97.1 | 158.7 | 128.8 | 106.5 | 88.5 |
| Diluted | 7.4% | **134.0** | 147.5 | 85.9 | 156.7 | 127.0 | 105.2 | 87.2 |
| Headline earnings per ordinary share – cents | | | | | | | | |
| Basic | 8.5% | **144.5** | 162.2 | 86.3 | 146.9 | 129.5 | 107.0 | 88.7 |
| Diluted | 7.3% | **133.6** | 147.2 | 76.3 | 145.0 | 127.7 | 105.7 | 87.4 |
| Distribution per ordinary share – cents | 14.4% | **61.2** | 54.1 | 53.1 | 45.0 | 40.0 | 33.0 | 27.3 |

| | CAGR* | 2008 R'm | 2007 R'm | 2006 R'm | 2005 R'm | 2004 R'm | 2003 R'm | 2002 R'm |
|---|---|---|---|---|---|---|---|---|
| **BALANCE SHEETS** | | | | | | | | |
| **ASSETS** | | | | | | | | |
| Property, equipment and vehicles | | **30,972** | 3,124 | 2,327 | 1,997 | 1,846 | 1,611 | 1,347 |
| Intangible assets | | **6,079** | 419 | 48 | 48 | 48 | 36 | 18 |
| Investments and loans | | **34** | 46 | 119 | 114 | 103 | 92 | 18 |
| Deferred income tax assets | | **123** | 120 | 123 | 92 | 89 | 69 | 52 |
| Derivative financial instruments | | **43** | – | – | – | – | – | – |
| Current assets | | **4,326** | 1,780 | 980 | 1,510 | 1,134 | 891 | 715 |
| Total assets | | **41,577** | 5,489 | 3,597 | 3,761 | 3,220 | 2,699 | 2,150 |
| **EQUITY** | | | | | | | | |
| Capital and reserves attributable to equity holders of the Company | | **8,880** | 2,068 | 1,641 | 2,693 | 2,246 | 1,917 | 1,660 |
| Minority interest | | **807** | 752 | 290 | 235 | 200 | 172 | 75 |
| **LIABILITIES** | | | | | | | | |
| Long-term interest-bearing borrowings | | **23,266** | 996 | 848 | 159 | 168 | 112 | 58 |
| Deferred income tax liability | | **5,187** | 5 | 5 | 4 | 3 | 3 | 2 |
| Long-term interest-free liability | | **177** | 129 | 102 | 73 | 58 | 48 | 40 |
| Derivative financial instruments | | **595** | – | – | – | – | – | – |
| Provisions | | **190** | – | – | – | – | – | – |
| Current liabilities | | **2,475** | 1,539 | 711 | 597 | 545 | 447 | 315 |
| Total equity and liabilities | | **41,577** | 5,489 | 3,597 | 3,761 | 3,220 | 2,699 | 2,150 |
| Net asset value per ordinary share – cents | 21.8% | **1,585.0** | 575.5 | 460.7 | 783.7 | 657.2 | 562.7 | 486.2 |
| **CASH FLOW STATEMENTS** | | | | | | | | |
| Cash generated from operating activities | 18.7% | **1,517** | 1,187 | 994 | 923 | 819 | 520 | 541 |
| Net finance income/(cost) | | **(419)** | (44) | 25 | 29 | 14 | 27 | 3 |
| Dividends | | **–** | – | – | – | – | – | 28 |
| Abnormal item | | **–** | – | – | 50 | – | – | – |
| Taxation paid | | **(360)** | (306) | (448) | (243) | (196) | (143) | (123) |
| Cash flow from operating activities | | **738** | 837 | 571 | 759 | 637 | 404 | 449 |
| Cash flow from investment activities | | **(16,898)** | (672) | (388) | (178) | (325) | (276) | (96) |
| Cash flow from financing activities | | **16,461** | 43 | (830) | (185) | (106) | (142) | (224) |
| Cash distributions to minorities | | **(41)** | (40) | (39) | (34) | (32) | (19) | (15) |
| Distributions to shareholders | | **(189)** | (178) | (166) | (142) | (120) | (100) | (80) |
| Special dividend to shareholders | | **–** | – | (1,327) | – | – | – | – |
| Proceeds from issuance of ordinary shares | | **4,472** | – | – | – | – | – | – |
| Movement in borrowings | | **12,219** | 248 | 689 | (21) | 40 | (16) | (73) |
| Other | | **–** | 13 | 13 | 12 | 6 | (7) | (56) |
| Net movement in cash and bank overdrafts | | **301** | 208 | (647) | 396 | 206 | (14) | 129 |
| Opening balance of cash and bank overdrafts | | **357** | 149 | 796 | 400 | 194 | 208 | 79 |
| Exchange rate fluctuations on foreign cash | | **129** | – | – | – | – | – | – |
| Closing balance of cash and bank overdrafts | | **787** | 357 | 149 | 796 | 400 | 194 | 208 |

** Compounded annual growth rate*

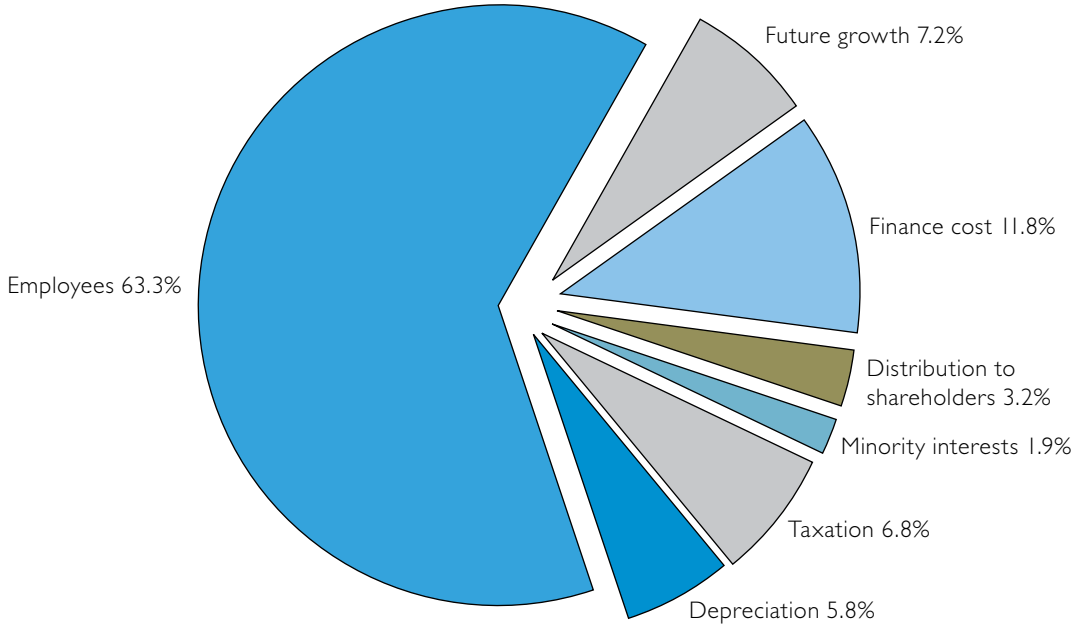
# value added statement

for the year ended 31 March 2008

| | 2008 R'm | % | 2007 R'm | % |
|---|---|---|---|---|
| **VALUE CREATED** | | | | |
| Revenue | **9,579** | | 5,364 | |
| Cost of materials and services | **(3,795)** | | (2,239) | |
| Interest received | **44** | | 44 | |
| | **5,828** | **100.0** | 3,169 | 100.0 |
| **DISTRIBUTION OF VALUE** | | | | |
| To employees as remuneration and other benefits | **3,688** | **63.3** | 1,951 | 61.6 |
| Taxation and other state and local authority levies (excluding VAT) | **394** | **6.8** | 291 | 9.2 |
| To suppliers of capital: | | | | |
| Minority interest | **111** | **1.9** | 111 | 3.5 |
| Finance cost on borrowed funds | **685** | **11.8** | 88 | 2.8 |
| Distributions to shareholders | **189** | **3.2** | 178 | 5.6 |
| | **5,067** | **87.0** | 2,619 | 82.7 |
| **VALUE RETAINED** | | | | |
| To maintain and replace assets | **340** | **5.8** | 146 | 4.6 |
| Income retained for future growth | **421** | **7.2** | 404 | 12.7 |
| | **761** | **13.0** | 550 | 17.3 |

# distribution of value

2008



# administration and dates of importance to shareholders

## ADMINISTRATION

### COMPANY SECRETARY

G C Hattingh (43) B.Acc. (Hons), CA(SA)

### BUSINESS ADDRESS AND REGISTERED OFFICE

Medi-Clinic Offices, Strand Road, Stellenbosch, 7600
Postal address: PO Box 456, Stellenbosch, 7599
Tel: +27 21 809 6500 Fax: +27 21 886 4037

### E-MAIL AND WEBSITE

medimail@mediclinic.co.za
http://www.mediclinic.co.za

### COMPANY REGISTRATION NUMBER

1983/010725/06

### TRANSFER SECRETARIES

Computershare Investor Services (Proprietary) Limited
70 Marshall Street, Johannesburg, 2001
Postal address: PO Box 61051, Marshalltown, 2107
Tel: +27 21 370 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

30 July 2008

### 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 21 (19.3 cents per share):

| | |
|---|---|
| Declaration date | 7 November 2007 |
| Last date to trade cum dividend | 23 November 2007 |
| First date of trading ex dividend | 26 November 2007 |
| Record date | 30 November 2007 |
| Payment date | 3 December 2007 |

Final payment: Dividend number 22 (41.9 cents per share):

| | |
|---|---|
| Declaration date | 14 May 2008 |
| Last date to trade cum dividend | 12 June 2008 |
| First date of trading ex dividend | 13 June 2008 |
| Record date | 20 June 2008 |
| Payment date | 23 June 2008 |

# Board of Directors

## Chairman

E de la H Hertzog (58)
M.B.Ch.B., M.Med., F.F.A. (SA)

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

* Please refer to the explanation in respect of the classification of Dr Hertzog as executive chairman on page 74 of the report.

## Executive Director

L J Alberts (60)
B.Comm., CA (SA)
(Chief Executive Officer)

Appointed in 1988 as director of the company and in 1990 as Chief Executive Officer.

## Executive Director

R H Bider (60) (*Swiss*)
Ph.D. Technical Science
(Chief Executive Officer: Medi-Clinic Switzerland)

Chief Executive Officer of the Hirslanden private hospital group in Switzerland since 1990. Appointed as director of the company in February 2008.

## Executive Director

J du T Marais (57)
H.N.T.D. (Mec) G.C.oC
(Technical Director)

Appointed in 1985 as director of the company.

## Executive Director

D P Meintjes (51)
B.PI (Hons) (Chief Executive Officer: Medi-Clinic Middle East)

Joined the Group in 1985 and appointed in 1996 as director of the company. Seconded to Dubai in 2006 and appointed as the Chief Executive Officer of Medi-Clinic Middle East in 2007.

## Executive Director

K H S Pretorius (45)
B.Compt, MBL
(Chief Executive Officer: Medi-Clinic Southern Africa)

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

## Executive Director

J G Swiegers (53)
B.Acc. (Hons), B.Comm. (Hons) (Taxation), CA (SA)
(Chief Financial Officer)

Appointed in 1994 as non-executive director of the company and in 1999 as Chief Financial Officer.

# board of directors

as at 31 March 2008

## Independent Non-Executive Director

S Dakile-Hlongwane (57)
BA, MA

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

## Independent Non-Executive Director

A R Martin (69)
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.

## Independent Non-Executive Director

A A Raath (52)
B.Comm., CA (SA)

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

## Independent Non-Executive Director

D K Smith (60)
B.Sc., FASSA, FIA

Chairman of Santam and the RGA Reinsurance Company of South Africa. Appointed in March 2008 as director of the company.

## Independent Non-Executive Director

W L van der Merwe (56)
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.

## Non-Executive Director

J C Cohen (41) (*British*)
B.Sc. in Economics

A managing director of Lehman Brothers and co-head of Lehman Brothers Merchant Banking, Europe. Appointed as director of the company in February 2008.

## Non-Executive Director

V E Msibi (52)
M.B.Ch.B.

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

## Non-Executive Director

M A Ramphele (60)
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.

## Non-Executive Director

M H Visser (54)
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.

# Chairman's Report

It was in 1983, 25 years ago, that the Board of the then Rembrandt Group under the leadership of Dr Anton Rupert (Chairman) decided to approve and financially support the establishment of one private hospital in the northern suburbs of Cape Town. Today, the Board of Medi-Clinic Corporation would like to pay tribute to the courage, insight and confidence of the Rembrandt Group Board of those days. Over the 25 years Medi-Clinic Corporation has grown to become a company with 48 hospitals in South Africa; 13 in Switzerland; 3 in Namibia; 1 hospital, 5 clinics and 1 hospital under construction in the United Arab Emirates. Although the Group made no profits in the first two years after its listing on the JSE in 1986, the Group's financial track record since then has been one of solid and consistent growth. The numbers of the last seven years are given on pages 4 to 5.

The past financial year was a watershed year for the group with the acquisition of the Hirslanden group of hospitals in Switzerland. This was the proverbial quantum leap into the international area which the Group had been contemplating for many years. It required a large amount of capital, but a jewel of a company in a very attractive country became the platform from where the Group can hopefully expand further in the future.

With the changes that this brought to the Group, it was decided to also change the format of the report to our shareholders as it used to appear in previous annual reports. In this report and henceforth, you will find a Chairman's Report, a Chief Executive Officer's Report and a Chief Financial Officer's Report.

The operational profile of your Group is given on pages 41 to 45. It is important to note that the Group is now structured in three distinct operational platforms, one each for Southern Africa, Switzerland and the Middle East. Each platform has its own executive committee and board of directors, all reporting to the executive committee and Board of Medi-Clinic Corporation based in Stellenbosch, South Africa. This structure ties up with our business approach of decentralised management, with individual hospitals being regarded primarily as neighbourhood businesses. However, through the years the Group has been very successful with its acquisitions in Southern Africa and has always been able to unlock value by enlarging the Group. This was mainly achieved by increasing operational efficiencies through benchmarking exercises. Positive results are then reflected in areas such as staff utilisation, operating capital, procurement, information systems, quality measurement, tariff negotiations, business development and the improvement and maintenance of facilities. It is the intention of the Group to adhere to this approach also with its international expansions. The Group wants to be an international group of cost-effective, high-quality, Medi-Clinic associated hospitals. It does not want to be just a holding group for hospitals in different places in different countries.

To achieve this goal requires a reasonable amount of time which varies for different situations. In South Africa, the last 120-bed hospital that became a Medi-Clinic hospital (Medivaal which became Emfuleni Medi-Clinic) only needed one week to be integrated, but doing business across international boundaries is of course much more complex. To unlock value and ensure efficient management at the Hirslanden group is a top priority for the Group. In Dubai the successful launch of the City hospital is of critical importance for the Group's activities in the Middle East. South Africa is of course the home base of the Group and we shall continue to investigate and invest in sound opportunities.

On the whole the Group had a very busy, but also a very satisfactory, year. The detailed results are given in the financial reports for the Group as well as for the 3 individual operating platforms. These are found on pages 81 to 130. My and the Board's as well as all shareholders' sincere thanks must go to the CEOs and their management teams as well as all the nurses and other staff in the different hospitals for achieving this performance. In the hospital industry we also have to and like to express our gratitude and appreciation to all the doctors and patients who supported our facilities throughout the year. Some special thanks should go to the Group's two senior executives (and their families), Messrs Danie Meintjes and Craig Tingle, who relocated to Dubai for a two to three year period which comes to a close next year. In Switzerland the co-operation and support of the Hirslanden management team have been most valuable and heart warming. In South Africa it has been a pleasure to see the enthusiasm and competency with which the new local executive committee and their colleagues have gone about their jobs.

Challenges remain and will always remain in each of the operational regions: be it the regulatory environment or skills shortage in South Africa, unlocking further value in Switzerland, the opening of the new City Hospital in Dubai or issues that we currently may not even be aware of. Last year we could state that we remained optimistic about the prospects for the year ahead. Despite the draft tariff regulation proposals by the Minister of Health in South Africa for prescribed minimum benefits, we at this stage again remain optimistic about the prospects for the year ahead. Cost-effective, high-quality hospital services that improve quality of life are much sought after by everybody. Those people that can afford to receive these services in the private sector are getting more and are also getting older. They are better informed and they have higher expectations. If one adds to this all the new medical technological developments and its rapid internationalisation, a realistic conclusion reached for the sector is that volume growth can be expected. The big challenge for your Group remains, as phrased in its Vision statement, "to be regarded as the most respected and trusted provider of hospital services by patients, doctors and funders of healthcare" in the areas where the hospitals of the Group are located. We are confident that the Group will continue to achieve this.

## DIRECTORATE MATTERS

During the year the following directors were appointed to the Board:

- Mr Joseph Cohen from Lehman Brothers, as a non-executive director with effect from 1 February 2008.
- Dr Robert Bider, the Chief Executive Officer of Medi-Clinic Switzerland, as an executive director with effect from 1 February 2008.
- Mr Desmond Smith, chairman of Santam, as an independent non-executive director with effect from 31 March 2008.

We welcome them and look forward to their positive contribution to the Group.

Mr James Marais, who served as an executive director of Medi-Clinic since 1985, and Ms Salu Dakile-Hlongwane, who served as a non-executive director for more than eight years, have decided not to offer themselves for re-election at the forthcoming annual general meeting of the company on 30 July 2008. Their valuable input as members of the Board is greatly appreciated. A special word of thanks must go to Mr James Marais for his outstanding service and loyal dedication to the Group for the past 23 years. Under his leadership the Technical Department of the Group has developed to one that we have good reason to be proud of. We wish both of them everything of the best.

**E DE LA H HERTZOG**
Chairman

# Chief Executive Officer's Report

## BUSINESS HIGHLIGHTS

The acquisition of the Hirslanden group of 13 hospitals in Switzerland on 26 October 2007 transformed Medi-Clinic into an international private hospital company. This transformational growth is a quantum leap in the Group's core business. Rather than growing the company through business diversification it was decided to stay within the Group's core competencies where our skills and expertise lie and where we believe there is growth potential internationally.

The Hirslanden transaction was preceded in March 2007 by the acquisition of a controlling interest in the Dubai-based Emirates Healthcare Holdings consisting of one hospital and three clinics at the time. Although the private hospital market in Dubai and the United Arab Emirates ("UAE") is relatively small and underdeveloped, it is a growing market with a specific focus on uplifting the standards of healthcare to support the development of the region. We expect to see many opportunities as the region develops.

With internationalisation come changes, new responsibilities and new challenges. What remains unchanged is the focus of management on delivering the most cost-effective quality care possible and the aspiration to be regarded as the most respected and trusted provider of hospital services by patients, doctors and funders of healthcare.

As an international group the company is exposed to exchange rate fluctuations. Depending on the volatility of the Rand as the reporting currency against the Swiss Franc and the US Dollar (against which the UAE Dirham is currently pegged at AED3.675 to the US Dollar) the difference between the spot rate and the average exchange rate could lead to distortions when ratios between the balance sheet and income statement are calculated in Rand. This is the result of accounting conventions to translate foreign balance sheets at the spot rate and trading results at the average rate. Refer to the comments in this regard in the Chief Financial Officer's Report on pages 17 to 24.

The financial integration of Hirslanden has been completed successfully. Teams from both Medi-Clinic Southern Africa and Hirslanden are focusing on projects to extract value from immediate synergies. These synergies should have a positive effect on the EBITDA of the Group. Some of these synergies will also have a positive effect on both the Southern African and UAE operations. Over the longer term further benchmarking of Southern Africa, Switzerland and the UAE will be done so as to create an integrated international platform running according to best practices across borders.

## FINANCIAL HIGHLIGHTS

From a Group perspective revenue for the year increased to R9 579 million with Southern Africa contributing 63%, Hirslanden 32% (for five months) and Emirates Healthcare 5%. EBITDA increased to R2 060 million with a 64% contribution by Southern Africa, 34% by Hirslanden and 2% by Emirates Healthcare. The increased debt resulted in finance costs of R685 million leaving a profit for the year of R721 million. For a more detailed review of the financial performance turn to the Chief Financial Officer's Report on pages 17 to 24.

The Hirslanden and Emirates Healthcare transactions have had a material impact on the results of this year. To put the results for the year in perspective I will discuss the performance of each region separately.

The Group has managed to transform itself into a truly international acute-care hospital company. During the next financial year more than half of its revenue and EBITDA will be derived from sources outside South Africa. Three platforms for growth have been established. The South African private hospital market is a developed and mature market from which the international market can learn in terms of cost-effectiveness. The Hirslanden group should act as a solid platform for future Swiss and European expansion. Emirates Healthcare, which is more greenfields by nature, offers a platform for incremental growth in the UAE.

## SOUTHERN AFRICA OPERATIONS

### Business highlights

South Africa is and will for the foreseeable future remain the Group's home base and an important component of the Group.

On a comparable basis revenue growth of 12% was recorded through a 3% increase in patients admitted to the hospitals. Admissions in the second half of the year were negatively influenced by school and Easter holidays during the last two weeks of March. The increase in utilisation was evident in both surgical and medical cases. Although the average length of stay in hospital remained virtually the same, in-patient bed-days also increased by 3%. The change in the profile of patients resulted in increased utilisation of specialised facilities. The increase of 6% in the average price of in-patient admissions ended at a lower level than the average CPIX of 7.6% for the year.

The continuous focus on cost containment and productivity enabled the group to maintain its operating margin in spite of double-digit salary increases implemented on 1 July 2007 for nurses and certain other vocational categories where major shortages are experienced.

The transparency of the net acquisition price model ("NAP"), implemented in 2003, enabled the procurement department to increase competition amongst suppliers resulting in savings for medical schemes and private paying patients. Notable savings in surgical product prices were also achieved with the "cost-effective pricing for surgicals" programme.

### Financial highlights

In line with international best practices the business activities were reorganised during the year into operational and hospital property groups. The property group raised R2 750 million to finance the acquisition of the hospital properties.

The focus on working capital management continued to yield strong cash flows despite lower cash receipts from medical schemes during the Easter and school holidays in March.

Including the increase in the effective equity interests of Curamed and Protector, the operations recorded a 13% increase in both revenue and EBITDA. On a comparable basis both revenue and EBITDA increased by 12%.

### Business environment

The South African private hospital industry is one of the most advanced and mature markets in the world. It has developed over time to its current status as a national asset and an important pillar on which the country's future economic growth is based. It plays a pivotal role in addressing the healthcare burden of the country's population.

Affordability remains a critical issue in healthcare internationally and especially so in developing countries. Throughout the world, increased healthcare costs are driven by various factors of which increased utilisation is by far the most important driver.

In South Africa the increased utilisation of the insured population is mainly driven by an increase in the burden of chronic diseases, gradual ageing of the insured population with a concomitant change in case-mix, increase in level of care, the progression of the HIV pandemic and changes in usage patterns as a result of changes in the benefit design of medical schemes. The situation is exacerbated by a shortage of skilled nursing staff in line with the international shortage.

When reference is made to the need for access to hospital services it is important to distinguish between the needs of the economically active portion of the population and the non-active portion. Ultimately, the Government is responsible for the healthcare needs of all the citizens of the country. However, the private sector is available and does relieve the burden of the public sector for the employed

and insured portion of the population. The insured portion of the population is estimated at around 7 million people, who mostly depend on the services provided by the private sector. It is estimated that a further 5 million people are economically active but uninsured. For the private hospital industry to be available to them the capacity in the industry should be increased. This will only happen when the environment is conducive to further investments. At the current cost to establish a private hospital of R1.5 million per bed and with existing tariffs the development of new hospitals is already under pressure. Lower tariffs will stop any further developments.

## Regulatory environment

The proposed intervention in the pricing of private hospitals by the Department of Health ("DoH") as contained in the Draft Bill to amend the National Health Act is a step backwards in trying to solve the problem of access and affordability. The intention of Government to provide a solution to the problem is unfortunately based on a misunderstanding and incorrect diagnosis of the real issues in the delivery of private healthcare services. It is also unfortunate that a proper and constructive consultation process with the DoH could not be achieved.

The proposed amendments to the National Health Act are extremely vague and lack substantive detail. In essence it boils down to price regulation by a third party which is fundamentally unfair and unreasonable and lacks objectivity. It is also ironic that the legislation wants to address the so-called collusive behaviour in the private sector and perverse incentives to professionals for which the Competition Act and the Health Professions Council are already in existence.

Along with the private healthcare sector, Medi-Clinic has provided its comments on the Draft Bill and will continue its endeavours to engage with the DoH to develop a process of real consultation and engagement to find joint solutions to the challenges facing the entire healthcare sector in South Africa.

## Skilled manpower

The acute shortage of skilled and experienced manpower in South Africa is not limited to nursing but is also prevalent in other disciplines like pharmacists, engineers and artisans.

The negative effect of the closing of nursing schools by the DoH and the moratorium on training introduced by the South African Nursing Council ("SANC") is being felt across the country but especially in the Western Cape region. Unfortunately very little happened to the implementation of the National Nursing Strategy drafted in early 2007.

Training of nurses will remain a priority for both the private and public sector 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. It is also well positioned for training in terms of the new nursing qualification framework and has extended its partnering with higher education institutions for an exchange of nursing students to meet the clinical requirements of the new curricula. The group is also finalising an agreement with a higher educational institution which will provide for Medi-Clinic Southern Africa to be a campus of this institution. The intake of students has been increased in the second half of 2007 and will also be increased in 2008.

The interim strategy to recruit nurses from India to complement the training initiatives in an attempt to address the current nursing shortage was partly derailed by a dysfunctional SANC. Of the original 62 nurses recruited in February 2006, 18 nurses arrived in South Africa towards the end of 2007, of whom two were lost due to family reasons. A second group of 30 nurses were recruited in 2007 and are in the process of completing the required SANC formalities. A further recruitment campaign will be launched in June 2008.

## Projects

A number of projects are in progress for revitalising existing hospitals in line with the group's policy to follow a structured maintenance programme with regard to hospital buildings with the specific goal to prolong the useful lives of the hospitals.

Projects are in progress to increase the capacity at Hermanus Medi-Clinic (31 beds) and Newcastle Private Hospital (40 beds). Investigations into increasing the capacity of Windhoek Medi-Clinic (40 beds) and Brits Medi-Clinic (20 beds) are well advanced and final decisions will be made shortly. The construction of a new 140-bed hospital in the northern suburbs of Cape Town will commence shortly, with the expected date of commissioning in the first quarter of 2010.

## SWITZERLAND OPERATIONS

### Business highlights

With the change in ownership from a financial investor to an industry player, Hirslanden became part of an international private hospital group sharing in a business model and corporate culture very similar to what both parties were accustomed to. This change in ownership is regarded by both Hirslanden and Medi-Clinic as an important milestone in putting together a group to take advantage of further international opportunities.

Based on a full financial year Hirslanden recorded a 4% growth in in-patient admissions, with a slight increase in the severity of cases while the average length of stay remained fairly constant. The group strengthened its position in the in-patient market and made good progress in attracting international patients to its state-of-the-art high technology hospitals. Day surgery admissions increased over the same period by 7%.

The opening of new wings at Klinik Hirslanden, Klinik St. Anna and Klinik Birshof were successfully commissioned during the year. The new wings are doing better than expected and the Group is set to recover and increase the operating margin lost through start-up losses associated with these projects.

Hirslanden's association with highly specialised doctors and well trained staff enables it to maintain its position as the leading provider of complex elective surgery.

### Financial highlights

Hirslanden's results are included from 26 October 2007, being the effective date of the transaction. For this period Hirslanden's contribution to Group revenue amounted to R3 041 million (CHF461 million) or 32% of total Group turnover. The contribution to group EBITDA amounts to R708 million (CHF107 million) or 34% of Group EBITDA. Hirslanden experienced a slight drop in the EBITDA margin as a result of start-up costs associated with the new wings mentioned above. All indications are that the EBITDA margin will recover over the coming financial year.

### Business environment

Hirslanden is the only private hospital provider in Switzerland with a near national coverage of acute-care facilities and is increasingly becoming an attractive partner for health insurance companies. The group has developed a number of innovative products with insurance companies to strengthen its position in the complementary insurance market and continues to explore further opportunities.

With an already high percentage of elderly citizens, major demographic changes are not expected.

The financial integration of Hirslanden has been completed successfully. The accounting systems have been configured to accommodate the new group structure following the capital and financial restructuring. An integration structure and process have been put into place to manage the short and long-term strategy.

### Projects

Stereotactic radiotherapy, with state-of-the-art CyberKnife technology, for the treatment of tumours and metastases has gained importance over the last few years as an alternative method to invasive interventions. A CyberKnife will be commissioned at Klinik Hirslanden to complement a new centre for neurology, neurosurgery and neuroradiology to be established during the year.

In addition to the CyberKnife a second LINAC oncology unit and a centre for laparoscopic neurofunctional pelvic surgery will also be established during the third quarter of 2008.

# UNITED ARAB EMIRATES OPERATIONS

## Business highlights

All the units in full operation, namely the Welcare Hospital and three clinics, experienced a successful year in terms of patient visits, reduction in staff turnover and increasing the operating margin. The Welcare Hospital managed to increase patient visits in all areas of the business with an all-time record for in-patients in March 2008.

The Welcare Qusais Clinic was opened in July 2007 and is showing encouraging monthly growth in patient visits. The Welcare Mirdiff Clinic situated in a premium residential area will open in June 2008. With the growth in the population of Dubai and demand for medical services these two clinics are well positioned to meet the increased demand.

Emirates Healthcare, through a subsidiary, Welcare World Health Systems ("WWHS") is making a significant investment in infrastructure, mainly in systems and human capital, to ensure a solid platform from which advantage of the many opportunities to grow the group can confidently be taken.

The construction of the new 210-bed City Hospital in the Dubai Health Care City ("DHCC") is substantially complete and will be commissioned by the end of July 2008. Most of the key management positions have already been filled. Start-up losses will have an effect on the results of the first six months of the coming financial year.

## Financial highlights

The group's revenue for the year amounted to R482 million (AED249 million) of which the Welcare Hospital contributed R401 million (AED207 million). The Welcare Hospital contributed R64 million (AED33 million) to EBITDA and after taking into account start-up losses of the newly established units and contribution by the other established units, the group's EBITDA for the year amounted to R50 million (AED26 million).

A strong focus on working capital management resulted in an EBITDA conversion rate of more than 100%.

## Business environment

It is the stated objective of the DHCC authorities to establish international standards of healthcare in the DHCC. The City Hospital will be the first multidisciplinary hospital in the DHCC and Dubai to have to comply with these standards. The standards include amongst others a clinical affiliation with an internationally recognised institution, accreditation within two years by the Joint Commission International and practising doctors with qualifications received in only 16 countries worldwide. Medi-Clinic has been approved as the internationally accepted clinical affiliate for The City Hospital. The City Hospital will set a new standard in private healthcare with a significant first-mover advantage over other developments.

The medical insurance market is experiencing strong growth on the back of unprecedented economical growth in Dubai. There has been a steady growth in the number of insured patients over the past year with insured patients now outnumbering self-pay patients. The UAE is moving towards a National Insurance Scheme with the Emirate of Abu Dhabi taking the lead. It is expected that Dubai will announce a similar initiative towards the end of 2008. Although the overall benefits of the insurance product are relatively low, it creates a new layer of patients with access to private medical services.

Emirates Healthcare with its network of two hospitals and five clinics ensures a large footprint in Dubai with referral clinics in the residential areas. It is uniquely positioned as the only group in the UAE with a truly international ownership.

**L J ALBERTS**
Chief Executive Officer

# Chief Financial Officer's Report

## CORPORATE ACTIVITY THAT HAD A MATERIAL IMPACT ON THE GROUP RESULTS

### United Arab Emirates ("UAE")

The Group obtained a controlling equity interest of 50% plus one share (with board and management control) in Emirates Healthcare for an amount of US$53.1 million (R384.2 million), effective 27 March 2007. General Electric Company, a member of the General Electric Group, subscribed for a 6.59% equity interest. Mr Sunny Varkey, the founder and chairman of Emirates Healthcare, retained an equity interest of 43.41%. The Group 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).

Emirates Healthcare owns and operates the 120-bed Welcare Hospital, one of the largest private hospitals in Dubai, along with one ambulatory surgery centre, three clinics and one specialist eye clinic with a further clinic under construction. It has also commenced with the construction of the first multidisciplinary hospital in Dubai Health Care City ("DHCC"), The City Hospital with 210 beds, which is scheduled for commissioning towards the third quarter of 2008. In addition, Emirates Healthcare has the right to develop an additional 150-bed hospital in DHCC. This will make Emirates Healthcare the largest private healthcare provider in Dubai.

### Switzerland

The Group acquired 100% of Hirslanden, the holding company of the largest private hospital group in Switzerland, with effect from 26 October 2007.

Hirslanden is the leading private hospital group in Switzerland, comprising 13 private acute-care facilities located in nine cantons. It currently operates 1 301 beds, provides admitting rights to some 1 400 specialists and employs over 3 800 staff (full-time equivalents).

The purchase consideration for the total issued share capital of Hirslanden was CHF2 556 million, which represented an enterprise value of CHF3 364 million.

CHF2 450 million of new debt was arranged by Barclays Capital, the investment banking division of Barclays Bank plc. This is fully underwritten by Barclays Bank plc on a non-recourse basis to Medi-Clinic's Southern African operations. The debt was used to repay Hirslanden's existing debt and to pay part of the purchase consideration. The interest rates in respect of these facilities have been fixed. The interest payable on debt of CHF1 610 million, raised to finance the purchase consideration, will not be tax deductible for a period of five years.

The remainder of the purchase consideration, together with expenses, interest accrued on the purchase price and other costs, amounted to CHF1 114 million and was funded by Medi-Clinic by way of a rights offer of R4 500 million (see below) and existing debt facilities within the Group.

The acquisition of Hirslanden was unanimously approved in a general meeting held on 10 September 2007 by shareholders representing 91.2% of all the company's ordinary shares in issue.

For more information about the transaction, see the company's announcement of 2 August 2007, the detailed acquisition circular by Medi-Clinic to shareholders dated 17 August 2007 ("the Circular"), the company's announcements of 10 September 2007 and 26 October 2007 as well as the company's announcement relating to the rights offer of 26 October 2007. All these documents are available on the company's website, www.mediclinic.co.za.

## The rights offer

The company raised approximately R4 500 million through a rights offer that closed on 7 December 2007. Approximately R4 000 million of the proceeds was applied towards the equity contribution for the acquisition of Hirslanden and the balance will be used to fund expansion opportunities in Medi-Clinic's Southern African operations.

The rights offer was for a total of 198 675 497 Medi-Clinic shares ("rights offer shares") at a subscription price of 2 265 cents per rights offer share in the ratio of 50.38197 rights offer shares for every 100 Medi-Clinic shares held at the close of trade on Friday, 16 November 2007.

The rights offer was oversubscribed and no allocation was made to the underwriters.

The company now has 593 013 946 ordinary shares in issue and had a market capitalisation of R11.7 billion at year-end. On a pro forma basis, the number of shares in issue net of treasury shares would have been 560.3 million shares.

## Southern Africa

The Southern African operations acquired a 51% interest in the 200-bed Protector hospitals effective from 8 November 2006. It also acquired from Phodiso Holdings ("Phodiso") its 49% interest in Tshwane Private Hospitals ("Tshwane"), which in turn holds a 63% interest in Curamed Holdings, as well as its 49% interest in Phodiclinics effective from 1 April 2007. Curamed Holdings owns all the group's hospitals in Pretoria with 738 beds while Phodiclinics owns the 200-bed Protector hospitals as well as the licence to the 140-bed Cape Gate Medi-Clinic in the northern suburbs of the Cape Metropole. The acquisition of Phodiso's interests in Tshwane and Phodiclinics decreases the amount attributable to minorities in the Group's income statement.

In line with international best practices, the Southern African business activities were reorganised during the year into operational and hospital property groups. The property group raised R2 750 million to finance the acquisition of the hospital properties.

## Group financial performance

### Trading results

Due to the above transactions, the Group results are not directly comparable with those of the previous period.

Group revenue increased by 79% to R9 579 million (2007: R5 364 million) for the year under review. Operating income before interest, taxation, depreciation and amortisation ("EBITDA") was 79% higher at R2 060 million (2007: R1 151 million). Headline earnings rose by 5% to R608 million (2007: R581 million) after incurring higher finance charges, mainly resulting from the Hirslanden transaction and the financing of the Southern African property group. Basic headline earnings per ordinary share declined by 11% to 144.5 cents (2007: 162.2 cents) due to the higher finance charges and the increased weighted number of ordinary shares resulting from the rights offer. The total dividend per ordinary share at 61.2 cents (2007: 54.1 cents) is 13% higher, in line with the Southern African performance as indicated in the Circular and in the commentary to the interim results.

The decline in the Group's headline earnings per share was mainly as a result of the Hirslanden transaction, as anticipated at the time. This decline was adequately compensated for by the fact that the Group's blended weighted average cost of capital ("WACC") decreased from about 12% to about 8% at the time of the transaction, due to the lower cost of capital in Switzerland.

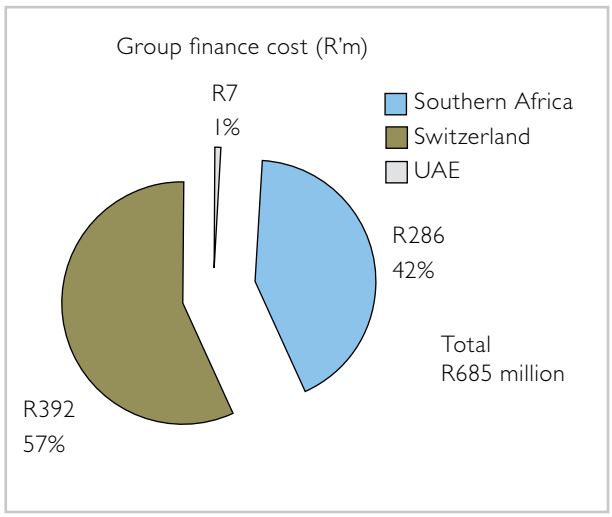
Comparing the Group financial results with the underlying assumptions used in the Circular, depreciation amounting to R54.8 million (CHF8.3 million) provided for in the Group financial results was not provided for in the Circular. This depreciation relates to installations in the hospitals, as opposed to equipment, which was assumed to be part of hospital buildings at the time of preparing the Circular.

## Finance cost

Included in the finance cost of R685 million is an amount of R53.7 million that represents interest paid on the bridge finance from the closing of the Hirslanden transaction at 26 October 2007 until the proceeds of the rights issue were received on 10 December 2007. This interest is not tax deductible and will not recur in the future.

Also included in the finance cost is an amount of R15.9 million, being the current year's amortisation in respect of raising fees paid on the local and offshore debt. These amounts are amortised over the terms of the relevant loans in line with future cash payments as prescribed in IAS39.

The geographical composition of the Group finance cost for the 12 months ended 31 March 2008 is as follows:




Had the Hirslanden debt and the debt relating to the Southern African property group been in place for the full financial year, the Group interest cost, on a pro forma basis, would have been R1 263 million.

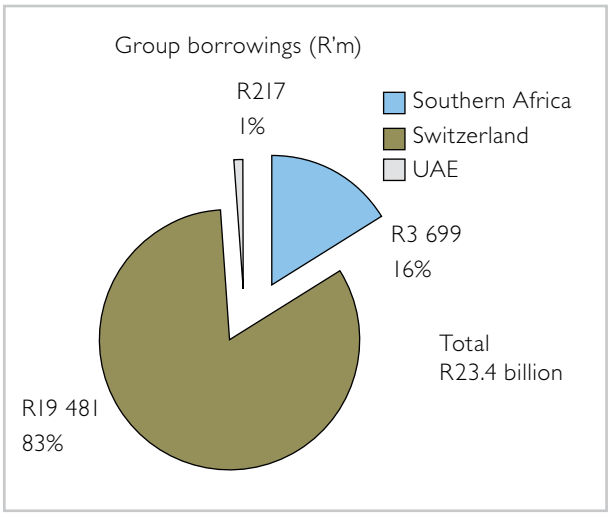
## Foreign exchange rates

The Rand proved to be quite volatile against the Swiss Franc and the US Dollar (against which the UAE Dirham is pegged at AED3.675 to the US Dollar) during the year under review. The spot rate of the Swiss Franc moved from R6.11, being the exchange rate at which the Group acquired Hirslanden, to R8.14 at year-end, with an average rate of R6.60 for the reporting period from 26 October 2007. The spot rate of the UAE Dirham moved from R1.98 at 31 March 2007 to R2.20 at year-end, with an average rate of R1.94 for the year. In terms of accounting convention, the offshore balance sheets are converted at spot rate, while the trading results in the offshore income statements are converted at the average rate. The large difference between the spot rate and the average foreign exchange rate results in a distortion when financial ratios between the balance sheet and the income statement are calculated in Rand. Therefore, the spot rate should also be used for translating EBITDA to achieve the actual financial ratio.

The resulting currency translation difference, being the amount by which the Group's interest in the equity of the two foreign platforms increased merely as a result of the movement in the spot rate, amounted to R2 186 million and was credited to the statement of recognised income and expense.

Interest-bearing borrowings increased from R1 624 million at 31 March 2007 to R23 397 million, mainly as a result of the Hirslanden transaction and the financing of the Southern African property group. It is important to note that the offshore debt amounting to R19 698 million is matched with foreign assets in the same currency. The foreign debt also has no recourse to South African assets, as stipulated by the South African Reserve Bank as well as applicable financing arrangements.

The geographical composition of the Group interest-bearing borrowings at 31 March 2008 is as follows:



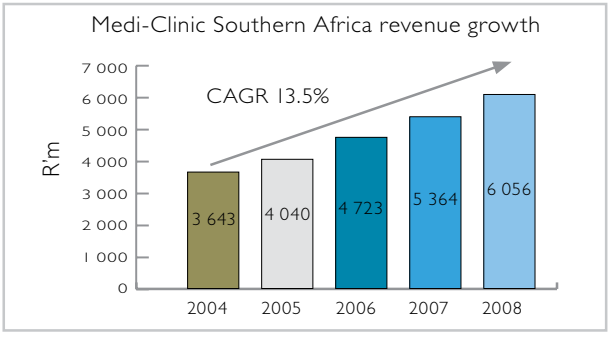
## SOUTHERN AFRICA

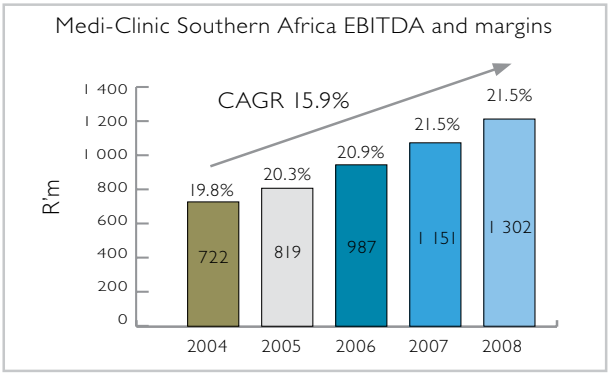
The Southern African revenue increased by 13% to R6 056 million (2007: R5 364 million) for the year under review. EBITDA was 13% higher at R1 302 million (2007: R1 151 million).

Excluding the increase in capacity due to the acquisition of the Protector hospitals, the Southern African operations' revenue growth amounted to 12%. This revenue growth was achieved through a 3% increase in bed-days sold, a 6% increase in the average income per bed-day and a 3% change in the profile of patients treated. The increase in utilisation was evident in both surgical and medical cases. The number of patients admitted increased by 3% while the average length of stay remained the same. Volumes in the second half of the year were negatively influenced by the Easter holidays during the last two weeks of March 2008.

The Southern African operations managed to maintain its EBITDA margin at 21.5%.

The historic Southern African performance from a revenue and EBITDA perspective is set out in the two graphs below.




The Southern African operations' cash flow continued to be strong during the period under review. It converted 96% (2007: 103%) of EBITDA into cash generated from operations, despite lower cash receipts from medical schemes at year-end due to the Easter holidays during the last two weeks in March 2008. Cash and cash equivalents increased to R361 million from R211 million at 31 March 2007 after financing capital expenditure and investments.

Interest-bearing debt increased from R1 316 million at 31 March 2007 to R3 699 million at year-end mainly as a result of the increased debt due to the formation of the hospital property group referred to above.

## SWITZERLAND

The Group consolidated Hirslanden's results from the effective date of its acquisition, 26 October 2007. During this period, Hirslanden's revenue was R3 041 million (CHF461 million) and EBITDA was R708 million (CHF107 million).

Although not included in the Group's results, the figures below are provided to give shareholders a better understanding of the results for a full year as well as the seasonal flow of revenue and EBITDA at Hirslanden. It should be noted that the winter period over November until January has a stronger patient flow than in summer.

Hirslanden's revenue for the six months ended 31 March 2008 amounted to CHF532 million, which was 9% higher than the same period last year. EBITDA for the same period was CHF124 million which was 5.7% higher than the same period last year. Revenue for the 12 months ended 31 March 2008 amounted to CHF1 001 million, which was respectively 3.4% and 8.3% higher than budgeted revenue and the same period last year. EBITDA for the same period was CHF222 million, which was respectively 2.1% and 6% higher than budgeted EBITDA and the same period last year.

Based on a full financial year, Hirslanden's in-patient admissions increased by 4% while day surgery admissions improved by 7.3%. The average length of stay remained fairly constant.

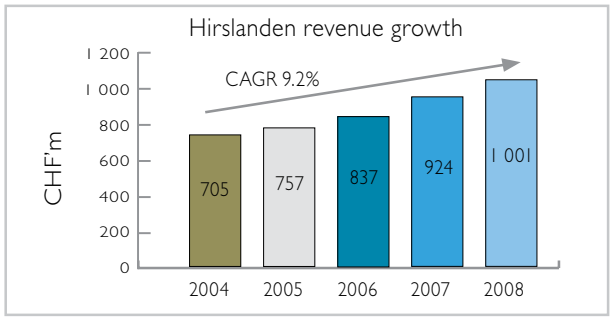
The EBITDA margin declined slightly on a full-year basis from 22.7% to 22.2%, mainly as a result of the start-up costs

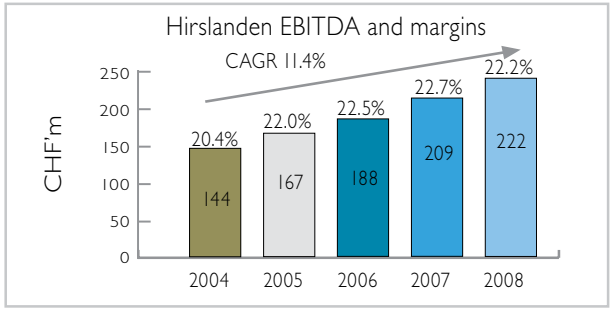
associated with the opening of new wings at Klinik Hirslanden, Klinik St. Anna and Klinik Birshof. The new wings are doing better than expected and the results should be evident in the following financial year.

The number of fully operational beds are budgeted to increase to about 1 341 beds (based on the average number of beds for the year), with the addition of 35 at Klinik Hirslanden, 7 at Klinik Im Park and 13 at Klinik St. Anna.

In addition, a second LINAC oncology machine as well as a CyberKnife will be commissioned at Klinik Hirslanden during the middle of the year. The CyberKnife is a state-of-the-art non-invasive stereotactic radiation device for the treatment of tumours and metastases. It is the first of its kind in Switzerland and it ensures that, in comparison with conventional radiotherapy, fewer treatment sessions are required. A state-of-the-art centre for neurology, neurosurgery and neuroradiology will also be opened at Klinik Hirslanden during May 2008. An international centre for laparoscopic neurofunctional pelvic surgery with two renowned surgeons will furthermore open at Klinik Hirslanden during October 2008.

Hirslanden's historic revenue and EBITDA growth are set out in the graphs below.




The Hirslanden group converted only 18% of EBITDA into cash generated from operations. The reasons are twofold. The cash inflows in respect of trade and other receivables are cyclical in nature with October (the time of the opening balance sheet), normally lower while it peaks in March. The negative effect of this seasonal movement was approximately R231 million (CHF35 million). Secondly, certain transaction costs of about R350 million (CHF53 million) were accrued in trade and other payables in the opening balance sheet of which most were paid subsequently. If these two amounts are excluded the conversion rate would have been above 90%. At year-end cash and cash equivalents amounted to R400 million (CHF49 million) while interest bearing debt was R19 481 million (CHF 2 393 million) net of capitalised debt transaction fees.

The solid macro-economic qualities of Switzerland with its benign inflation, low unemployment, low cost of capital and solid growth rate, have recently been proved again when the Swiss economy remained virtually unscathed by the international credit crisis and economic uncertainty that impacted on most of the other Western economies. The reality is that Switzerland, as has become the custom, benefited from the flight to a high-quality and stable environment, which resulted in its macro-economic indicators and property prices remaining intact.

## Integration of the Hirslanden group

The financial integration of Hirslanden has been completed successfully. The opening balance sheet and the IFRS purchase price allocation is complete and the accounting systems have been configured to accommodate the new group structure following the capital and financial restructuring. This proved to be an immense task.

Between the effective date and year-end, management, together with members of the Hirslanden Board, where appropriate, undertook a strategy review which included an analysis of measures to extract value from synergies between Medi-Clinic and Hirslanden. The result was an eight-point plan which will be implemented in the new financial year to extract value from immediate synergies. Over the longer term, further detailed benchmarking will be done between the two groups so as to create an integrated international platform running according to best practices and defined by common definitions (as far as it is possible) across borders. Activities in the UAE form part of this process.

## UNITED ARAB EMIRATES

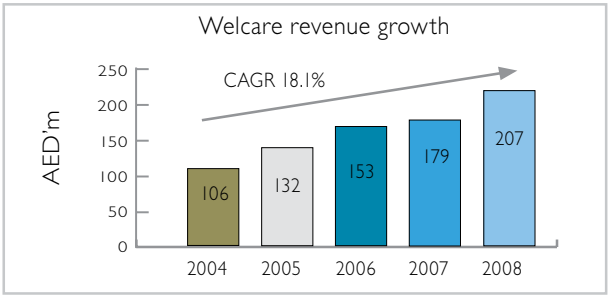
The UAE revenue amounted to R482 million (AED249 million) for the year under review. EBITDA was R50 million (AED26 million). After incurring depreciation charges of R28 million (AED14 million) and net finance costs of R2 million (AED1 million), Emirates Healthcare contributed R18 million (AED9 million) to the Group after deducting for minority interests.

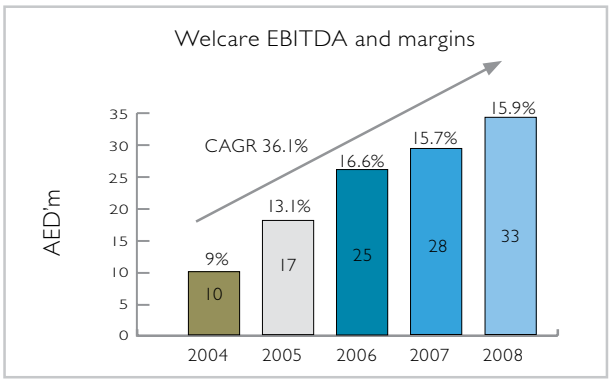
The units in full operation, being the Welcare Hospital, the Emirates Diagnostic Clinic ("EDC"), the Welcare Ambulatory Care Centre ("WACC") and the Welcare Eye Clinic ("WEC"), produced revenue of R478 million (AED246 million) and EBITDA of R82 million (AED42 million). The Welcare Clinic Al Qusais, which opened for business on 7 July 2007, and Welcare World Health Systems ("WWHS") had a turnover of R4 million (AED2 million), but generated start-up operating losses at EBITDA level of R18 million (AED9 million). The City Hospital and the Welcare Clinic Mirdiff, both still to be commissioned, incurred start-up losses of R14 million (AED7 million).

The Welcare Hospital increased its revenue (R401 million: AED207 million) and EBITDA (R64 million: AED33 million) by 15.5% and 17.2%, respectively, against the same period last year. It increased its EBITDA margin from 15.7% to 15.9%.

The three clinics in full operation, namely EDC, WACC and WEC, maintained an EBITDA margin of 23.4%.

The historic performance of the Welcare Hospital, the group's only hospital in the UAE with an established track record, is set out below.




Due to extensions of the project scope such as the creation of a maternity unit, the fitting out of shell floors, and the addition of an operating theatre, together with certain other functional improvements, the commissioning of The City Hospital has been postponed to the third quarter of 2008. The recruitment of staff, specifically also doctors and nurses, is progressing satisfactorily. Careful planning is required regarding the timing of the commissioning and staffing of the hospital. The timing of all the aspects of the commissioning and opening of the hospital holds a substantial financial risk which may impact on the earnings of the group, particularly in the first six months.

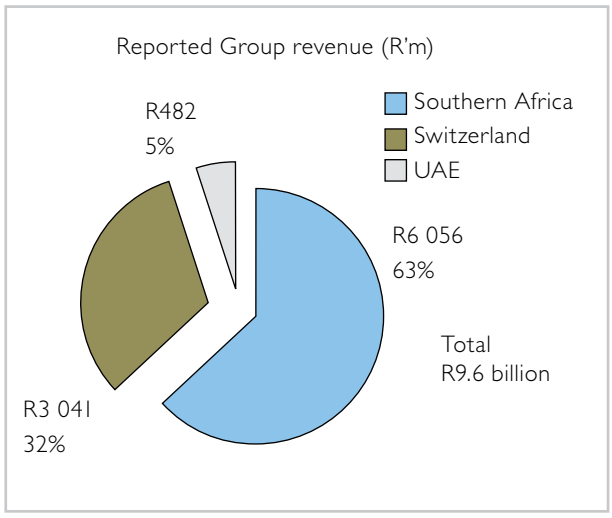
Emirates Healthcare, through a subsidiary, WWHS, is currently making a significant investment in infrastructure, mainly in systems and human capital, to ensure a solid platform from which to take advantage of the many growth opportunities in the region.

Emirates Healthcare converted 331% of EBITDA into cash generated from operations. This figure is distorted due to high creditors at year-end mainly due to retentions on The City Hospital project. If this effect is excluded, the conversion rate would be about 108%. Cash and cash equivalents decreased to R40 million (AED18 million) from R505 million (AED255 million) at 31 March 2007, while interest-bearing debt decreased from R307 million (AED155 million) at 31 March 2007 to R217 million (AED98 million). The cash flow from a net cash position of R198 million (AED100 million) at 31 March 2007 to a net debt position at year-end of R177 million (AED80 million) was utilised to finance capital expenditure, mainly the construction of The City Hospital.

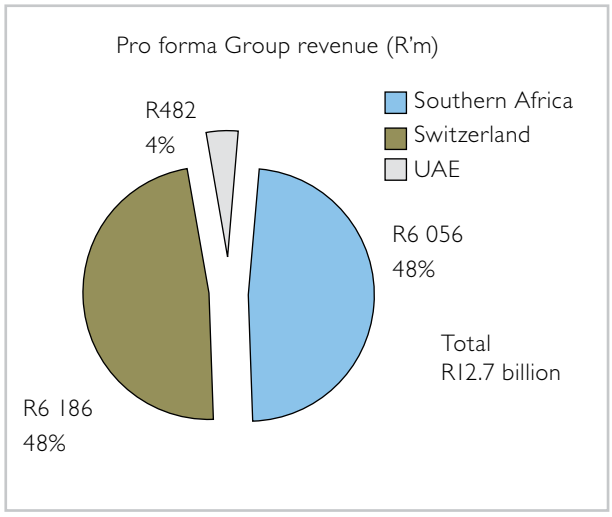
## ANALYSIS OF THE GROUP RESULTS

### Group revenue analysis

The geographical composition of the reported Group revenue for the year ended 31 March 2008 of R9.6 billion is as follows:

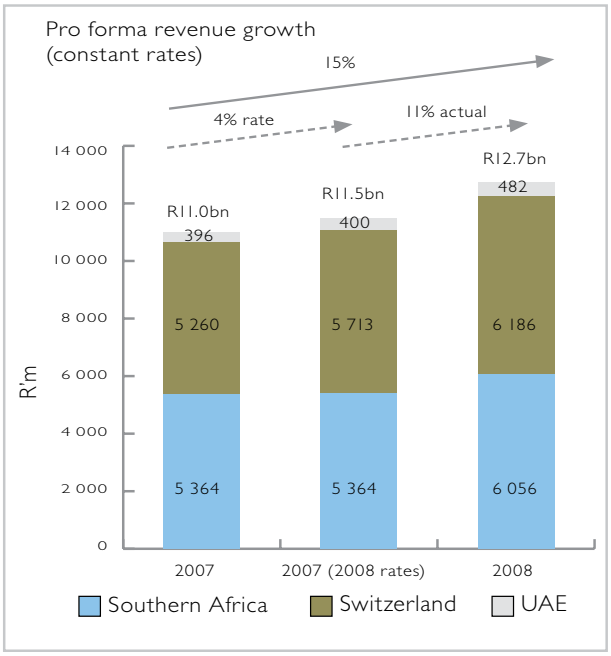



The pro forma revenue for the Group, if Switzerland had been consolidated for a full year, would have been R12.7 billion.




The average Rand/CHF exchange rate for the full 2008 financial year was R6.18.

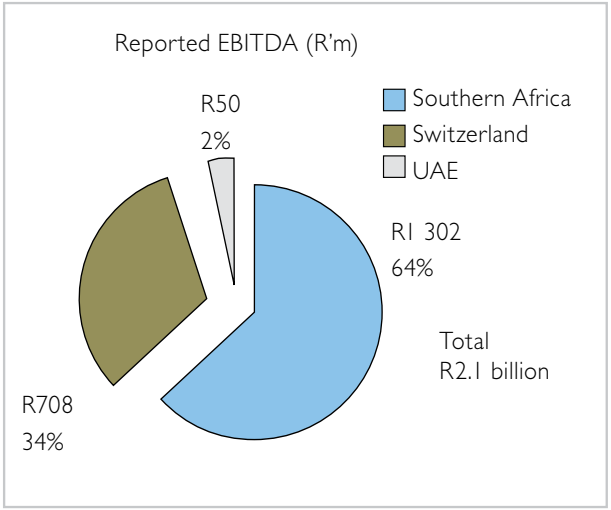
As illustrated in the graph below, revenue would have increased on a pro forma basis by 15% from R11.0 billion for the 2007 financial year to the pro forma revenue for the current financial year of R12.7 billion. Four percent of the increase would have related to exchange rate movements, while the revenue growth at constant exchange rates would have been 11%.



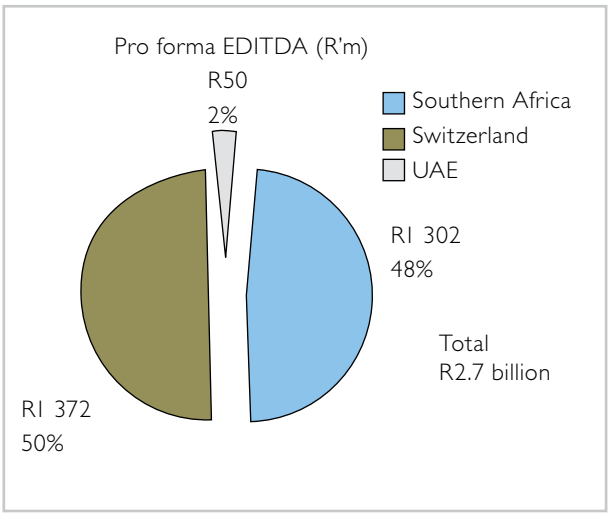

The average Rand/CHF and Rand/AED exchange rates for the 2007 financial year were R5.69 and R1.92, respectively.

### Group EBITDA analysis

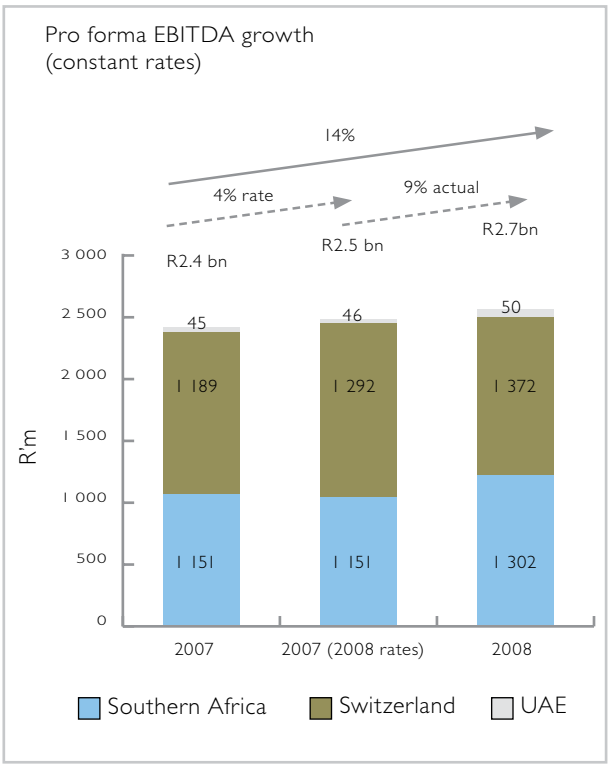
The geographical composition of the reported Group EBITDA for the year ended 31 March 2008 of R2.1 billion is as follows:



The pro forma EBITDA for the Group, if Switzerland had been consolidated for a full year, would have been R2.7 billion.




As illustrated in the graph below, EBITDA would have increased on a pro forma basis by 14% from R2.4 billion for the 2007 financial year to the pro forma revenue for the current financial year of R2.7 billion. EBITDA growth at constant exchange rates would have been 9%.




On a pro forma basis the group EBITDA margins would have declined slightly due to the start-up costs associated with the opening of new wings at Klinik Hirslanden, Klinik St. Anna and Klinik Birshof in Switzerland as well as the general start-up costs incurred in the UAE.

## RISK MANAGEMENT

Risk management receives top priority throughout the Group. The risk management policy is benchmarked against the international COSO (Committee of Sponsoring Organisations of the Treadway Commission) framework and complies with the recommendations of the King II Report. The Group's risk management process is summarised in the Corporate Governance Report on pages 73 to 80, the Sustainable Development Report on pages 48 to 72 and notes 3.1 and 3.3 to the Annual Financial Statements on pages 97 to 98.

## ACCOUNTING POLICIES

The annual financial statements have been prepared in accordance with International Financial Reporting Standards ("IFRS"). During the year, the Group adopted IFRS 7 Financial Instruments: Disclosures. This new standard has not changed the recognition of financial instruments but has resulted in additional risk management and risk exposure disclosures. The Group also adopted the amendment to IAS 19 Employee Benefits – Actuarial Gains and Losses, Group Plans and Disclosures. All actuarial gains and losses are now recognised outside profit and loss in the period in which they occur and are presented in the statement of recognised income and expense (SoRIE).

**J G SWIEGERS**
Chief Financial Officer

# Clinical Governance Report

The tables referred to in this report appear on pages 36 to 40.

## INTRODUCTION

Medi-Clinic celebrates its twenty-fifth birthday this year, and has developed a proud reputation for its commitment to quality of care by investing a significant amount of time and resources in measuring and improving clinical quality.

The purpose of this report is to give an overview of clinical activities within the company and its approach to quality of care, to report on some important quality indicators and quality improvement efforts, and to highlight notable trends in this field.

## CLINICAL GOVERNANCE

Achieving internationally comparable quality of care is an ambitious goal that not only requires a talented workforce, working with superior technological equipment, but also a set of clear objectives and a multidisciplinary team approach. Over the years Medi-Clinic has formalised a unified approach to clinical quality in all its dimensions. This approach has led to the implementation of structures and processes to ensure and promote quality. This systemic approach, called clinical governance, is all about quality monitoring and management that covers every aspect of clinical care.

### Definition and characteristics

At Medi-Clinic Southern Africa clinical governance is aimed at ensuring and improving clinical quality and safety of patient care. It adheres to certain important characteristics, namely; self-governance at hospital level, being non-punitive, focused on measurable improvement targets, and involving the entire clinical team.

### Components

Clinical governance has clear objectives and responsibilities for each of the following components:

1. Professional qualifications and standards
2. Professional performance
3. Facility accreditation and certification
4. Clinical risk management
    - Infection prevention and control
    - Hospital events management
    - Drug adverse event management
5. Clinical performance management
    - Clinical indicators
    - Clinical outcomes
6. Functional programmes
    - Emergency services
    - Critical care
7. Clinical standards
8. Health technology assessment
9. Clinical Information Systems

### Co-ordination

A central multidisciplinary clinical governance committee (CGC) co-ordinates and oversees this initiative, and each hospital has a clinical hospital committee (CHC) that is responsible for the quality of clinical care and patient safety in its respective hospital. A critical success factor is the commitment and participation of nursing staff and doctors.

### Information

The clinical governance initiative is supported by a clinical information department with unique data collection and analytical abilities. The department generates strategic, clinical and management information in order to support decision-making, and is an important enabler in quality management.

## CLINICAL ACTIVITIES

In the year under review Medi-Clinic Southern Africa experienced a steady growth in volumes across hospital admissions as well as emergency centre and out-patient cases. Both length of stay and theatre time per surgical case remained unchanged, as summarised in Table 1.

Table 2 reports the top 10 surgical disciplines (in terms of volumes) at Medi-Clinic SA during 2007 and 2008. Obstetric and gynaecological surgery, gastrointestinal surgery and orthopaedics continue to be the major volume contributors.

Table 3 reports the top 10 medical disciplines (in terms of volumes) at Medi-Clinic during 2007 and 2008. Respiratory disorders, specifically chest infections, dominate medical admissions. The significant growth in the infectious and parasitic diseases category can be attributed almost entirely to an increase in gastro-enteritis cases.

## CLINICAL INDICATORS

Clinical indicators are the "vital signs" of clinical care, and give an idea of the performance and integrity of this very important core element of operating hospitals.

This section deals with four of the most prominent indicators that are frequently used around the world, namely; Mortality, Extended Stay, Re-admission and Adverse Events / Near Misses.

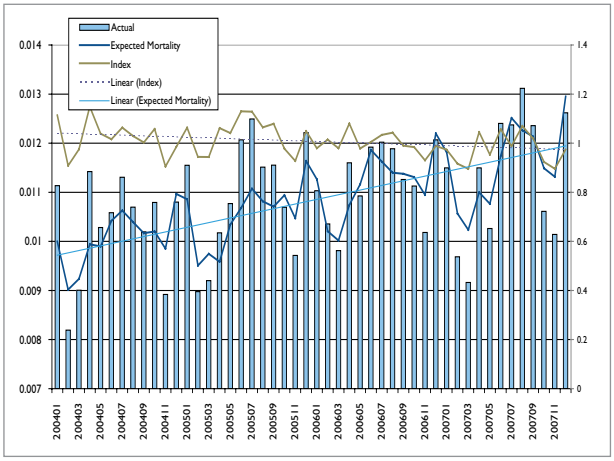
### Mortality

Mortality is one of the most important indicators for determining quality of care, but needs to be interpreted with caution due to the influence of patient risk factors. Medi-Clinic uses a statistical methodology to adjust hospital mortality rates for these factors in order to make justifiable comparisons between hospitals and time periods. This methodology is also used to measure trends over time.

Table 4 reports an increase in actual as well as expected mortality due to the factors described below, but the index (actual versus expected) has been decreasing. This means that the effective management of mortality outcome improved from 4% higher than expected to 2% lower than expected over the three years.

Figure 1 illustrates actual and expected mortality rates for Medi-Clinic from 2004 to 2007 and the increase of both indicators over time. The increase in the expected mortality rate is indicative of an increase in the population mortality risk.

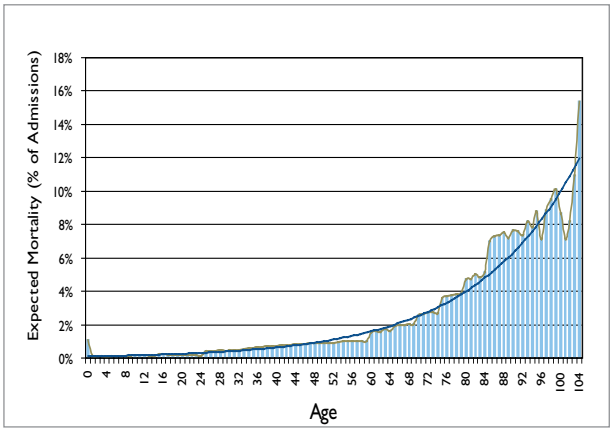
***Figure 1: Mortality Risk History***




The reasons for this increase are due to changes in various risk factors, but the principal contributing factors are:

1. Ageing of the population: Figure 2 shows that there is an exponential relation between mortality risk and age, apart from neonatal cases.

***Figure 2: Age vs Expected Mortality***



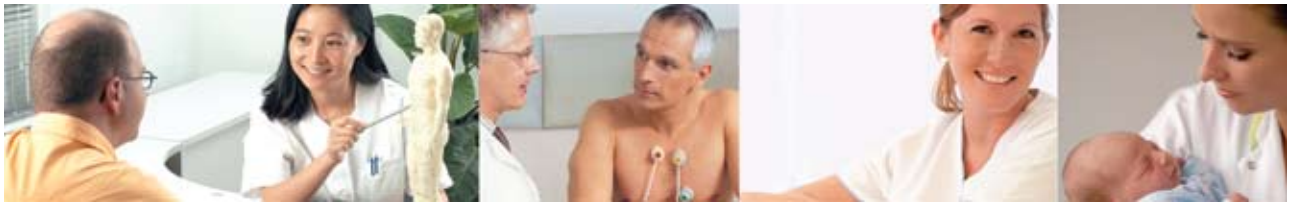
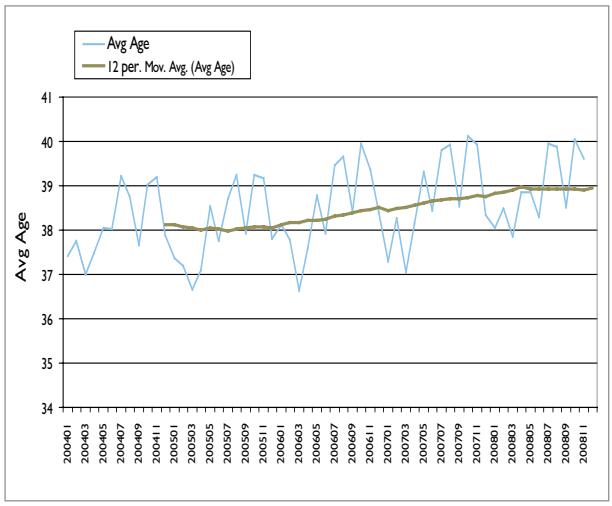


Figure 3 shows an increase in the age of patients admitted to Medi-Clinic, hence the conclusion that our mortality risk is increasing due to an increase in the age of the population.

***Figure 3: Medi-Clinic In-patient Population Ageing***




2. Medical-Surgical Split: An Increase in the proportion of medical cases relative to surgical cases, as illustrated in Figure 4.

***Figure 4: Medical vs Surgical***

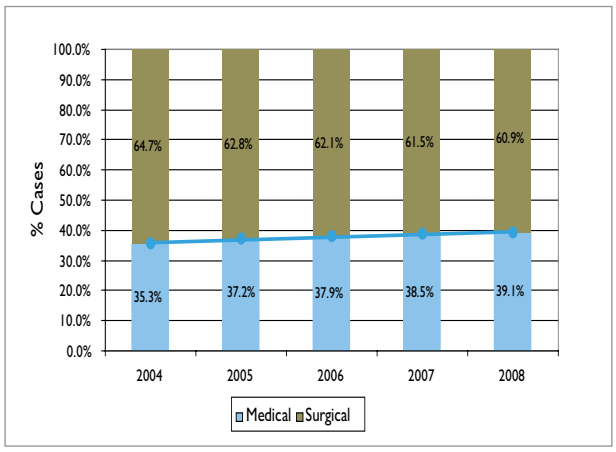
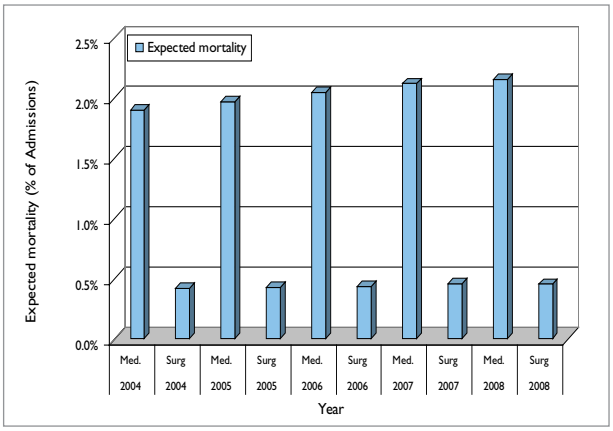


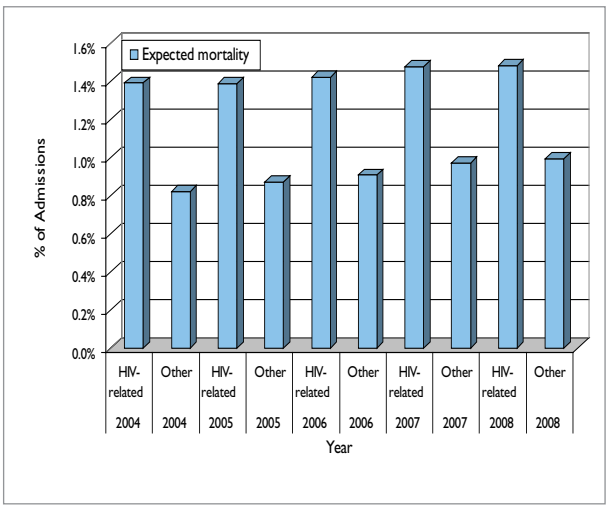

Figure 5 shows that mortality risk for medical cases is higher than for surgical cases, hence the conclusion that this is another reason for the increase.

***Figure 5: Mortality (Medical vs Surgical)***




3. HIV Influence: Figure 6 shows that patients with HIV-related conditions have a higher mortality risk than other cases.

***Figure 6: Mortality (HIV-related vs Rest)***




Medi-Clinic has experienced an upward trend in patients with HIV-related conditions being admitted to hospital, in comparison with other admissions over the last four years.

## Extended Stay Indicator (LOS)

Table 5 indicates the extended stay rates for a number of prominent admission types commonly used in the literature. It is the proportion of cases per admission type of which the hospital stay exceeded the ***extended stay point*** (second column in the table). The indicator is regarded as a proxy

measure for quality of care in certain medical and elective surgical admissions.

The ***extended stay point*** was calculated as the 90th percentile of hospital stays (admission type) during the 2005 financial year. Note that the figures are unadjusted, and may, in addition to complications, reflect changes in severity of cases, patient demographics (age, gender), and comorbidity profiles. There is ongoing research in this area, and further improvements to the methodology can be expected in the future.

A number of trends can be noticed: in the medical section, the acute myocardial infarction, asthma, and cardiac failure groups seem to be on an upward trend, with a larger proportion of cases experiencing extended stays in 2008 than during the previous two years. The extended stay rate of the pneumonia group was slightly lower than the previous two financial years.

On the surgical side, the extended stay rates of the CABG, large bowel resection surgery, and spinal fusion groups have been steadily growing over the past three years. There are downward trends in the cardiac catheterisation and cholecystectomy groups, with big improvements in the abdominal hysterectomy, primary hip replacement, and primary knee replacement groups. (Note that the cholecystectomy group includes cases of both laparoscopic and open cholecystectomies.)

Both the obstetric groupings show a downward trend, with progressively fewer patients experiencing extended hospital stays.

## Re-admission

The re-admission indicator is calculated by counting the number of patients re-admitted to hospital for reasons related to, or complications of, the initial admission within a 30-day period. Although still an incomplete science, it is generally accepted as one of the proxy measures for quality of care in certain types of procedures.

Procedures selected for this report include prominent high volume or long stay elective procedures, which include cardiac, orthopaedic-, gastrointestinal-, and ear-, nose- and throat-surgery, as well as obstetric and gynaecological surgery.

Table 6 shows the re-admission rate for 2008, as compared with benchmarks. These benchmarks were derived from the results of studies done in the US, UK and Canada. As expected, complex surgery shows a larger re-admission rate.

It is also quite clear that results can only be compared within a procedure type. Comparing a cardiac procedure with a tonsillectomy would not be sensible given the difference in risk, skills and resource intensity between the two.

Unfortunately data and methodological constraints do not allow for the calculation of re-admission rates for previous years. These reported rates will therefore be used as a base for comparison in future years.

The performance of a number of procedure categories was poorer than the benchmark, and as with the extended stay indicator, the re-admission indicator highlights areas for the clinical governance teams to focus on.

## Adverse Events and Near Misses

An adverse event is defined as any event which causes harm to a patient, staff member, visitor, doctor or contractor while he or she is under our care or on our premises. A near miss is any event which could have caused harm, damage or loss but which was prevented from happening by design or luck.

It is commonly quoted by various healthcare institutions which focus on quality in healthcare that approximately 10% of patients admitted to hospital experience an adverse event or near miss. Published studies suggest that at least half of these events can be prevented.

A cornerstone of quality and safety in clinical care is a functional adverse event or near miss management system. Medi-Clinic developed and implemented its own unique system consisting of the following key components:

- Identification
- Grading
- Notification (Reporting)
- Prioritisation
- Investigation
- Action and feedback

The system includes both adverse events and near misses. The latter is important since we believe that lessons learned from near misses can minimise the occurrence of adverse events.

Accurate reporting of all events is compulsory. This is a rather ambitious programme and is reliant on the participation of all hospital staff to realise its benefits. Table 7 provides a breakdown of the most prominent adverse event indicators together with incidence rates and benchmarks. The benchmarks were derived from results of studies done in the US, UK, Canada, Australia and New Zealand. As the electronic reporting system was recently implemented, comprehensive results for 2007 are not available. It is also acknowledged that the quality of reporting will improve over time.

The grading of an adverse event/near miss is based on the relationship between the likelihood and the consequence of the event. The system assigns a level of severity based on the above information, and designated people receive notification of all high and extreme graded events for investigation and further action.

The high and extreme graded events respectively constituted 14.8% and 2.2% of all reported events, as illustrated in Figure 7.

***Figure 7: Event Grading Levels***

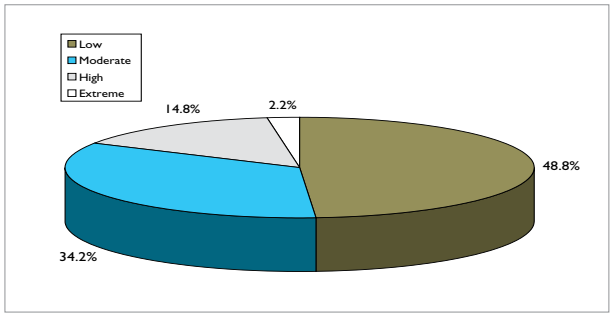



Table 8 provides a detailed breakdown of each of the most prominent adverse event indicators.

## Medication-related Events

The Medi-Clinic events management system reports on both clinical and non-clinical medication-related events. Clinical events are events that have an impact, or potential impact, on the patient.

Most of the medication-related events occurred in the administration of medication. These include incorrect dosages, drugs, patients, rates, routes, strength or concentration and techniques. Loss and breakages (non-clinical events) combined, comprised a fair portion of these medication events.

## Hospital Acquired Infections

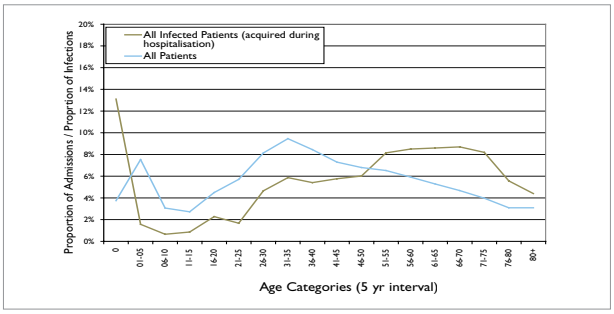
The incidence and prevalence of hospital acquired infections are of great concern to doctors, patients and hospital management alike. The impact can be devastating to patients and their families.

Medi-Clinic operates a robust and comprehensive infection surveillance programme using the Unit for Disease Control and Prevention (CDC) as a reference point. This is supported by a national electronic database of all hospital acquired infections as part of the hospital event management system. Surveillance is done by clinical risk managers through the gathering of both physical and laboratory data. Each hospital has an infection control committee that oversees infection prevention and control, and focuses on resistance patterns and antibiotic use.

The most common sites of hospital acquired infections are non-ventilated respiratory infections with an incidence rate of 0.3% of admissions to hospital.

The following graph compares the age distribution of infections with that of admissions to hospital. Infection rates are high in neonates and infants, as well as in adults over 50 years.

***Figure 8: Hospital Acquired Infections – Age Group Breakdown***




## Hospitalised Skin Related Events

Skin related events can occur quite frequently in the acute care setting, and can lead to substantial morbidity. It is essential that events be prevented from happening in the first instance, as having to deal with the resultant skin lesions can be very challenging.

Patients who acquired abrasions, blisters and skin lesions while in the care of the hospital represented 0.5% of all admissions to hospitals. Skin lesions caused by unrelieved pressure to any part of the body occurred in 0.1% of all admissions to hospitals and occurred more frequently in the elderly population, particularly in patients older than 80 years, with an incident rate of less than 0.02%.

### Falls

Falls and injuries sustained by patients while in hospital remain an enormous challenge to hospital management teams. There are many reasons why patients may fall, but in order to minimise the risk of falling many factors need to be considered. Medi-Clinic's hospital events management system gives the group the ability to record falls, and to purposefully analyse important trends.

The majority of reported inpatient falls occurred in the patient's room with an occurrence rate of 0.3% of admissions. In total, 31.3% of all reported falls resulted in injuries. Patients who underwent knee replacements and stroke patients, as well as patients in the 71 – 75 years age category, had the highest incidence rate.

The reporting system provides hospitals with essential information in order to formulate action plans to avoid adverse events, and to improve care processes in general.

## ACCREDITATION

Accreditation is a quality assurance process under which the structures and processes of a healthcare facility are examined by a third-party accrediting agency to determine if applicable quality standards are met, and in which case the facility will receive accredited status. Patients receiving treatment in an accredited facility can have the peace of mind that quality and safety standards are achieved and continuously monitored.

Healthcare facilities in South Africa are fortunate to have access to the Council for Health Services Accreditation of South Africa (COHSASA), a local accreditation agency that is one of eight agencies around the world which has been accredited as a competent healthcare facility accreditation agency by the International Society for Quality in Healthcare (ISQua).

The process of accreditation of healthcare facilities in the South African health sector is entirely voluntary, and Medi-Clinic was the first private hospital group to enrol its hospitals. Over the years COHSASA has accredited 33 Medi-Clinic hospitals in South Africa, some of them three times over.

In late 2007 Medi-Clinic entered into a new arrangement with COHSASA, in which 35 of its facilities will participate in a renewable three-year rolling quality improvement and accreditation programme. As hospitals typically receive accreditation status for three years at a time, this arrangement will ensure that all participating hospitals maintain their status in the long term. The formal process is not suitable for small hospitals, which will work closely with selected large hospitals in order to comply with the accreditation standards.

### Programme

The COHSASA programme, which consists of standards, performance measures, a scoring system, and a web-based database to report performance, is designed not only to examine the services and operations of healthcare facilities, but also to assist in improving structures, processes and systems.

### Standards

A standard is a statement that defines the performance expectations, structures or processes that must be substantially in place in an organisation to enhance the quality of care. COHSASA's multidisciplinary standards are designed to guide staff in providing effective and efficient patient care, and cover 41 different service elements.

The patient is at the centre of the COHSASA quality improvement programme. The standards are organised in such a manner that the key functions of the different departments are integrated, thereby encouraging the function of a multidisciplinary team.

Accreditation is an important component of a comprehensive clinical governance system. Medi-Clinic is convinced that the rigour of the accreditation process adds value to its patients and associated doctors, and will continue to participate in the programme.

## CLINICAL OUTCOMES

### Vermont Oxford Network

The Vermont Oxford Network ("VON") is an initiative aimed at measuring and improving the quality of care in neonatal intensive care units ("NICU"). The project is based in Vermont, US with participating units all around the world.

During the year 2000 Medi-Clinic was approached by two prominent neonatologists working in its hospitals, suggesting that membership of the VON is sought. As a result, Medi-Clinic has been participating in the VON quality initiative since 2001, with the database being implemented on a pilot basis at a number of hospitals with NICUs. These hospitals were the first to become members of the VON in Africa. It has been introduced to an increasing number of Medi-Clinic hospitals over the years, and currently 15 hospitals are participating in the initiative.

Table 9 summarises the most prominent statistics and clinical indicators, and compares Medi-Clinic hospitals with the average figures of the entire network. Although all babies admitted to the neonatal intensive care units are included in the programme, there is a specific focus on the very low birth weight (< 1501 grams) infants because of the significant complexities involved in treating them. Table 11 deals with this subset of the neonatal intensive care population.

Table 10 is derived from the official VON Annual Report for the 2006 calendar year. The VON Annual Reports only become available six months after year-end, and the Report for 2007 was therefore not available in time to be included in this report.

During 2006, 45.3% of all infants had a birth weight of more than 2,500g, and over the last three years there has been a steady decline of very low birth weight babies. This trend corresponds with an improvement in antenatal care services.

In the very low birth weight category (infants with a birth weight of 501-1,500g), Medi-Clinic had 164 cases during 2006, compared to 46,377 for the total VON. Ninety percent of these babies were born in the participating Medi-Clinic hospitals, and the rest transferred from elsewhere.

For most of the respiratory support parameters, Medi-Clinic units were on par with or outperformed the VON averages. Pneumothorax and ventilator rates were significantly lower than the VON averages. However, the respiratory distress syndrome rate was significantly higher than the benchmark, as were the rates of nasal CPAP and nasal IMV/SIMV.

The Medi-Clinic units had below average rates of chronic lung disease during 2006, and the nosocomial infection rate was also lower than the VON average of 20% (though not statistically significant).

In a number of the other clinical outcomes, Medi-Clinic units performed better than the VON averages. Medi-Clinic had significantly lower rates of patent ductus arteriosus, necrotising enterocolitis, periventricular-intraventricular haemorrhages, and retinopathy of prematurity.

For the very low birth weight infants, our mortality rate (8%) was also lower than the VON average, though not statistically significant (p-value: 0.057).

The primary focus of the VON initiative is on very low birth weight infants. Within this group of patients, chronic lung disease, periventricular leukomalacia, and retinopathy of prematurity greatly determine survival and eventual quality of life. In all of these critical parameters and also with regards to mortality rate, Medi-Clinic performs above average, compared to the VON. These results can only be attributed to the professionalism, commitment, and enthusiasm of the staff and doctors working in the units.

Neonatal intensive care units deal with complex and very high risk patients, and require experienced teams that follow a sophisticated and rigorous approach to patient care. This is an enormous challenge for which the Vermont Oxford Network is an excellent support vehicle.

### Adult Cardio-thoracic Database

The Adult Cardio-thoracic Database (ACTD) is modelled on the database of the Society of Thoracic Surgeons (STS), and has been piloted at Panorama Medi-Clinic since August 2005. The primary aim of the ACTD initiative is to measure and improve the clinical outcomes of cardio-thoracic surgery.

Table 11 reports on some important general indicators, patient risk factors, and clinical outcomes. Comparative international figures are not freely available, hence the year-on-year comparisons.

The valve surgery rate is on the rise, increasing from 19.4% in 2006, to 20.6% and 24.6% in 2007 and 2008, respectively. During the 2008 financial year, about 82.7% of ACTD patients had coronary artery bypass procedures. This is slightly lower than the 2006 (85.1%) and 2007 (86.9%) figures.

About three quarters of all cases in the ACTD database were males, with a slight increase in the proportion of females during 2008.

High BMI and hypertension were the most predominant risk factors: of the surgeries performed during 2008, 76% of patients were overweight or obese, and 73% suffered from hypertension. There were also high proportions of patients with dyslipidemia and family history of coronary artery disease. Renal failure among patients in the ACTD database showed a steep increase in the last two financial years, growing from 1% in 2006 to 8% in 2008.

The proportions of patients classified as class III or IV, according to the New York Heart Association (NYHA), increased over the last three financial years, from 21.1% of patients treated during 2006, to 36.5% in 2008. Consequently there was also a proportionate decrease in patients grouped into the lower (classes I and II) categories.

The proportion of patients undergoing elective surgery remained around 60% during the last two financial years, up from the 2006 figure of 44.6%. Urgent surgery increased by 19.6% from 2007, but is still lower than during 2006. Emergent surgery is on the rise, but there was a proportionate decrease in emergent salvage procedures over the three years under consideration.

The average number of hours ventilated decreased from 29.8 hours in 2006, to under 20 hours during the last two years (2007: 19.2, 2008: 18.2). During all three years, the majority of patients were ventilated for less than 24 hours. In 2008, 7.5% of patients had assisted ventilation for 24 hours or more.

The mortality index (actual / expected) fluctuated between 0.45 and 0.82 during the last three years. This is significantly lower than the benchmark index of 1.

The re-admission rate decreased by 12.6% from 2007 to 2008: in 2008, 12.5% of all patients in the ACTD database were re-admitted to hospital within 30 days of the original procedure.

In summary, the database is a very valuable tool in support of quality improvement, and has been embraced by the team in the Cardiothoracic Unit at Panorama. As can be seen from the indicators, the Unit is performing very well.

## EMERGENCY MEDICINE

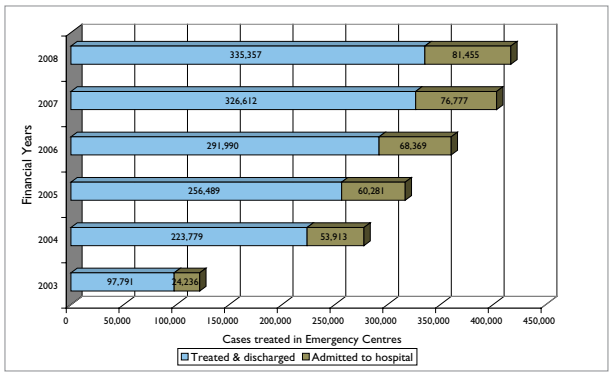
Currently Medi-Clinic has 43 emergency centres throughout South Africa and one in Windhoek, Namibia. The centres are graded into two groups based on the proposed national guidelines. There are 28 regional level emergency centres (doctor on site 24 hours per day) and sixteen district level emergency centres (doctor on call for the centre, but not on site 24 hours per day).

The discipline of emergency medicine has been regarded as a speciality in some first-world countries for some time. The USA for instance registered the speciality in 1979. In South Africa the speciality was registered by the Health Professional Council of South Africa (HPCSA) in March 2003 and the first specialist qualified in 2007. Medi-Clinic currently employs five emergency medicine physicians. A further 31 full-time emergency medicine doctors are employed by Medi-Clinic, all of whom adhere to a strict policy on credentialling, training and performance evaluation. All doctors working in regional emergency centres must be qualified in the three advanced life support courses, namely Advanced Cardiac Life Support ("ACLS"), Advanced Paediatric Life Support ("APLS") and Advanced Trauma Life Support ("ATLS"). Most of the doctors working in the Medi-Clinic emergency centres complete additional courses and attend regular clinical updates. All nursing staff working in Medi-Clinic's emergency centres are enrolled on a compulsory biannual internationally accredited Basic Life Support course.

## Volumes

Medi-Clinic's emergency centres treat on average 1,171 patients per day of whom 229 (19%) are admitted to hospital for further treatment. The number of patients treated in Medi-Clinic's emergency centres, the majority of whom arrive by means of private transport and not by emergency services, has increased significantly over the past six years (see Figure 9). On average the number of patients seen has increased by 9% per year over the past four years. The admission percentage has remained at 19%, indicating that the number of admissions to hospital has also grown significantly but has remained in proportion to the number of patients seen in total.

***Figure 9: Patients Seen vs Patients Admitted (Financial Years)***



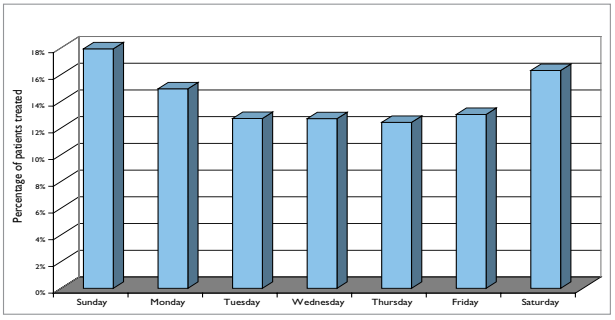

## Planning

Emergency medicine embraces an extremely large group of clinical presentations and pathological conditions. Patients of all ages present with urgent, often life threatening, problems without warning at any time, day or night. It is therefore imperative that the staff of an emergency unit plan for every eventuality with their main focus being the prevention of further harm, and effective resuscitation and stabilisation when required.

Although the nature of emergency medicine makes it near impossible to predict when additional staff will be needed we use data to predict busy days in a week and busy times in a day. This helps tremendously in the planning of our resources.

As indicated in Figure 10, weekends are the busiest times in our emergency centres, mostly due to the limited availability of general practitioners and specialists.

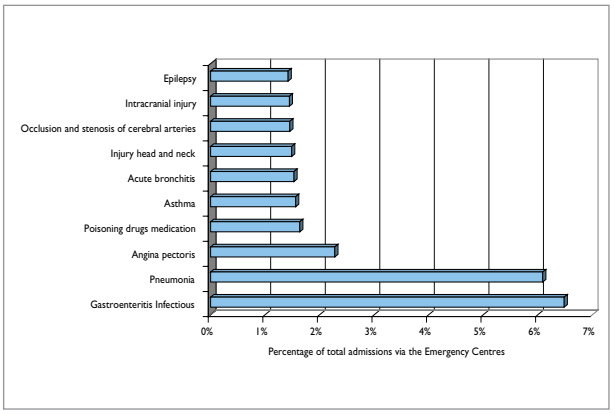
***Figure 10: Average Percentage of Patients Treated Per Day of the Week***




In order to equip and staff an emergency centre appropriately it is important to use data describing the profile of the patients who attend. Additionally, data related to the profile of patients admitted to the hospital helps in the creation of systems and structures to facilitate rapid and appropriate treatment within the hospital.

The top 10 reasons for admission to hospital (as a percentage of total admissions) are illustrated by Figure 11.

***Figure 11: Top 10 Admitting Diagnoses (Volumes) as % of Total Admissions to Hospital via Emergency Centres***




Of note is the high frequency of respiratory disease as a cause for admission (especially if Pneumonia, Asthma and Acute bronchitis are added together). Gastroenteritis is the most common cause for admission. Included in this group would be patients presenting with food poisoning, travel diarrhoea, enteritis and gastroenteritis. Most patients admitted required intravenous re-hydration and additional medication.

## Triage

In emergency medicine it is often difficult to consistently and accurately determine which patients have the most urgent need for emergency medical care. Clinical tools to assist emergency centre staff in making the correct decisions were developed in other countries but were often impractical in the South African setting. In order to address this problem Medi-Clinic was involved in the research and development of the South African Triage Score (previously known as the Cape Triage Score, http://www.triagesa.co.za).

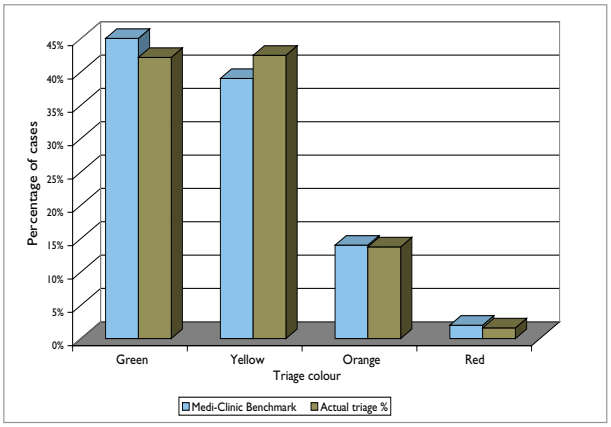
Four of Medi-Clinic's emergency centres took part in this triage research project in 2005. The original article, published in the January 2006, Vol.96, No.1 SAMJ, reflects some of the results obtained within Medi-Clinic's emergency centres confirming the validity of the clinical parameters used to prioritise patients.

After a clinical assessment colour codes are allocated according to the priority of the presenting patient. Red indicates that a patient needs immediate emergency care. Orange indicates that the patient should be seen urgently. The yellow category is allocated to patients that have a serious problem but compared to the red and orange cases are considered less urgent. The green triage category is allocated to the less urgent cases of the four categories.

In 2006 Medi-Clinic was the first private hospital group to implement the South African Triage Score in all its emergency centres as a way to ensure that the provision of emergency care is prioritised in the same scientifically proven way.

A Medi-Clinic Triage benchmark was derived from the data collected in the research in 2005. As illustrated by Figure 12 the Medi-Clinic benchmarks were reached with only a small margin of variation with regards to the green and yellow cases. This would indicate that a large portion of potential green cases wait until they can see their General Practitioner and that patients attending the emergency centres usually present with serious problems (57.8% of total cases treated consist of yellow, orange and red triage cases).

***Figure 12: Actual Triage Results Compared to the Medi-Clinic Triage Benchmark***

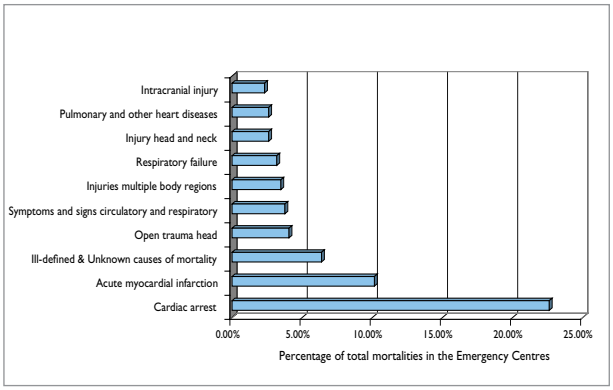



## Mortality in the Emergency Centres

The mortality rate – deaths in Medi-Clinic's emergency centres as a percentage of total patients seen – for the past financial period was 0.09%, with males comprising 72% of the total mortalities in emergency centres. This percentage is low compared to in-hospital mortality rates. This is due to the fact that most critically ill patients in the emergency centres are resuscitated, stabilised and then transferred to theatre or ICU for further definitive treatment.

The top 10 causes of mortality are in Figure 13.

***Figure 13: Top 10 reasons for mortality as % of total mortalities in the Emergency Centres***




It should be noted that most deaths are due to cardiovascular disease, as would be expected. The group with unknown or "ill-defined" causes of death represents cases where patients die of unknown causes and a post mortem is not conclusive

(or available). The group described as "symptoms and signs circulatory and respiratory" consist largely of patients presenting with respiratory arrest. Regular mortality and morbidity meetings ensure that the above mentioned cases are discussed in a clinical forum in order to continuously improve outcomes.

## Research and development

Apart from the mentioned Triage Research project in 2005, Medi-Clinic initiates a number of quality improvement projects yearly with the aim of continuously improving the quality of care. One project that aims to improve support systems needs special mention: The participating emergency centres have been involved in the further development and refinement of a computer software system that enables the clinician's immediate access to current and historic clinical information. Over the last year the program has proven its ability to facilitate the accurate capturing of important and relevant clinical information. With a wealth of clinical information available in the developed database it is now possible for the clinicians to research numerous aspects of emergency care with the aim of improving the quality of care through evidence based principles. As a result several best practices and policies have been developed and shared within the Medi-Clinic group.

## THE WAY FORWARD

Quality of care requires continued focus and relentless attention to detail, and whilst much has been achieved, there will always be room for improvement.

During the year ahead, Medi-Clinic will integrate and benchmark the quality initiatives of the three international platforms into a single framework, implement new developments in its existing clinical governance components, expand on its clinical performance measurement activities, and finalise its investigation into a new integrated clinical hospital information system.

### *Table 1: Summary Statistics*

| | % Diff. from 2007 - 2008 |
|---|---|
| Emergency Centre and Out-Patient Cases | **4.3%** |
| | |
| Hospital Admissions | |
| Day case admissions | **2.9%** |
| In-patient admissions | **4.9%** |
| | |
| Length of Stay (LOS) (Calendar days) | |
| All Admissions | **0.0%** |
| In-Patient Admissions | **0.0%** |
| | |
| Ave Theatre Time per Surgical Admission (Min) | **0.4%** |
| | |
| Medical / Surgical Split | **1.3%** |

### *Table 2: Top 10 Surgical Disciplines*

| Number of Hospital Admissions | | | |
|---|---|---|---|
| Discipline | **2008** | 2007 | **% Diff.** |
| Obstetric and gynaecological surgery | **61,858** | 58,135 | **6.4%** |
| Gastrointestinal surgery | **58,605** | 56,147 | **4.3%** |
| Orthopaedic surgery | **54,544** | 52,673 | **3.6%** |
| Ear, nose and throat surgery | **25,802** | 26,502 | **-2.6%** |
| Uro-genital surgery | **23,533** | 21,874 | **7.6%** |
| General surgery | **12,811** | 12,520 | **2.3%** |
| Ophthalmological surgery | **12,946** | 11,976 | **8.1%** |
| Cardiac Catheterisations and open heart surgery | **10,236** | 10,474 | **-2.3%** |
| Plastic and reconstructive surgery | **9,120** | 8,712 | **4.7%** |
| Neurosurgery | **8,945** | 8,596 | **4.1%** |

### *Table 3: Top 10 Medical Disciplines*

| Number of Hospital Admissions | | | |
|---|---|---|---|
| Discipline | **2008** | 2007 | **% Diff.** |
| Respiratory disorders | **40,651** | 37,998 | **7.0%** |
| Infectious and parasitic diseases | **20,444** | 18,522 | **10.4%** |
| Cardiac disorders | **15,962** | 15,374 | **3.8%** |
| Minor injuries and poisoning | **14,125** | 13,224 | **6.8%** |
| Gastro-intestinal tract disorders | **13,709** | 13,124 | **4.5%** |
| Diseases of the nervous system | **12,940** | 11,999 | **7.8%** |
| Obstetric disorders | **9,729** | 9,009 | **8.0%** |
| Urological disorders | **8,958** | 7,988 | **12.1%** |
| Endocrine and metabolic disorders | **7,927** | 7,955 | **-0.4%** |
| Musculoskeletal disorders | **7,778** | 7,736 | **0.5%** |

### Table 4: Clinical Indicators – Mortality

| Category | 2008 | 2007 | 2006 |
|---|---|---|---|
| Mortality : In-patients | | | |
| Actual | **1.13%** | 1.12% | 1.09% |
| Expected | **1.15%** | 1.12% | 1.05% |
| Index | **0.98** | 1.00 | 1.04 |

### Table 5: Clinical Indicators – Extended Stay

| Extended Stay | Extended stay point (days) | 2008 | 2007 | 2006 | |
|---|---|---|---|---|---|
| Medical | | | | | |
| Acute Myocardial Infarct | 7.0 | **11.9%** | 9.0% | 10.5% | ↑ |
| Asthma | 5.6 | **12.3%** | 11.9% | 9.9% | ↑ |
| Cardiac failure | 8.9 | **11.8%** | 11.0% | 11.7% | ↑ |
| Neonatal disorders | 27.7 | **9.4%** | 8.6% | 9.7% | ~ |
| Pneumonia | 7.9 | **10.2%** | 11.0% | 10.7% | ↓ |
| Surgical | | | | | |
| CABG | 15.6 | **13.0%** | 12.5% | 11.0% | ↑ |
| Cardiac catheterisation | 5.0 | **9.8%** | 10.0% | 9.9% | ↓ |
| Cholecystectomy | 5.9 | **10.3%** | 11.3% | 10.7% | ↓ |
| Hysterectomy (abdominal) | 4.3 | **8.5%** | 9.5% | 9.7% | ↓ |
| Hysterectomy (vaginal) | 3.8 | **8.3%** | 9.8% | 7.6% | ~ |
| Primary hip replacement | 12.9 | **8.3%** | 9.0% | 9.3% | ↓ |
| Primary knee replacement | 9.8 | **7.7%** | 9.3% | 10.2% | ↓ |
| Resection surgery large bowel | 20.9 | **12.8%** | 11.3% | 10.3% | ↑ |
| Spinal fusion | 9.2 | **11.7%** | 11.2% | 9.7% | ↑ |
| Obstetrics | | | | | |
| Normal vertex delivery | 2.7 | **8.4%** | 9.7% | 9.5% | ↓ |
| Caesarean section | 3.7 | **8.1%** | 8.7% | 9.4% | ↓ |

### Table 6: Clinical Indicators – Re-admission

| Category | 2008 | Benchmark |
|---|---|---|
| Re-admission | | |
| Surgical | | |
| Aorta valvuloplasty / replacement | **13.1%** | 19.3% |
| Mitral valvuloplasty / replacement | **7.0%** | 22.2% |
| Coronary artery bypass graft | **7.4%** | 16.7% |
| Hip replacement | **4.1%** | 8.5% |
| Knee replacement | **5.3%** | 7.2% |
| Cholecystectomy | **4.1%** | 3.2% |
| Resection surgery large bowel | **11.6%** | 11.1% |
| Laparoscopic fundoplasty (Nissen) | **3.4%** | |
| Spinal fusion | **4.0%** | 3.8% |
| Spinal laminectomy / decompression | **3.4%** | |
| Hysterectomy vaginal | **3.5%** | 2.3% |
| Hysterectomy abdominal | **3.7%** | 2.3% |
| Tonsil and adenoid surgery | **2.2%** | 3.9% |
| Obstetrics | | |
| Caesarean section | **1.8%** | 1.2% |
| Normal vertex delivery | **1.3%** | |

*Table 7: Clinical Indicators – Adverse Events / Near Misses*

| Category | 2008 | Benchmark |
|---|---|---|
| **Adverse Events / Near Misses** | | |
| Medication related events | **1.1%** | **1.2 – 2.2%** |
| Patient falls | **0.6%** | **0.6 – 1.2%** |
| Hospital acquired infections | **1.8%** | **1.9 – 3.5%** |
| Hospitalised skin related events | **0.9%** | **1.0 – 1.8%** |

*Table 8: Adverse Events and Near Misses*

| | % of admissions | Per 1000 bed-days | Internal benchmark (% of admissions) | Internal benchmark (expressed per 1000 bed-days) |
|---|---|---|---|---|
| **Medication Related Events** | **1.1%** | **3.4** | **1.2 – 2.2%** | **3.6 – 6.7** |
| Administration | 0.4% | 1.1 | | |
| Loss | 0.3% | 0.9 | | |
| Breakage | 0.2% | 0.6 | | |
| Dispensing / Delivery | 0.2% | 0.5 | | |
| Transcription | 0.0% | 0.1 | | |
| Adverse Drug Reaction | 0.0% | 0.1 | | |
| Clinician Ordering | 0.0% | 0.1 | | |
| Monitoring | 0.0% | 0.1 | | |
| | | | | |
| **Hospital Acquired Infections:** | **1.8%** | **5.5** | **1.9 – 3.5%** | **5.7 – 10.7** |
| Respiratory Infection: Non Ventilated | 0.3% | 1.0 | | |
| Surgical Site Infection | 0.3% | 0.9 | | |
| Vascular Catheter Infection | 0.3% | 0.9 | | |
| Other | 0.3% | 0.9 | | |
| Urinary Tract Infection | 0.2% | 0.7 | | |
| Ventilator Associated Pneumonia | 0.2% | 0.6 | | |
| Septicaemia | 0.2% | 0.5 | | |
| | | | | |
| **Hospitalised Skin Related Events:** | **0.9%** | **2.8** | **1.0 – 1.8%** | **3.0 – 5.5** |
| Abrasions, Blisters and Lesions | 0.5% | 1.4 | | |
| Discolouration | 0.3% | 0.9 | | |
| Haematoma | 0.1% | 0.3 | | |
| Pressure Sores | 0.1% | 0.2 | | |
| | | | | |
| **Patient Falls:** | **0.6%** | **1.5** | **0.6 – 1.2%** | **1.6 – 2.9** |
| In Patient's Room | 0.3% | 0.9 | | |
| In Bathroom | 0.2% | 0.5 | | |
| Outside Room | 0.0% | 0.1 | | |
| | | | | |
| **Other Reported Events:** | **2.4%** | **7.5** | **2.5 – 4.6%** | **7.8 – 14.6** |

*Table 9: Vermont Oxford Network Participating Hospitals*

| Hospital | 2007 | 2006 | 2005 | 2004 | 2003 | 2002 | 2001 | Total |
|---|---|---|---|---|---|---|---|---|
| Sandton Medi-Clinic | 304 | 271 | 250 | 293 | 325 | 386 | 149 | **1,978** |
| Panorama Medi-Clinic | 216 | 200 | 208 | 201 | 170 | 194 | 89 | **1,278** |
| Welkom Medi-Clinic | 160 | 147 | 129 | 59 | 0 | 0 | 0 | **495** |
| Kimberley Medi-Clinic | 198 | 211 | 184 | 0 | 0 | 0 | 0 | **593** |
| Kloof Medi-Clinic | 152 | 155 | 186 | 0 | 0 | 0 | 0 | **493** |
| George Medi-Clinic | 103 | 88 | 0 | 0 | 0 | 0 | 0 | **191** |
| Vereeniging Medi-Clinic | 202 | 0 | 0 | 0 | 0 | 0 | 0 | **202** |
| Constantiaberg Medi-Clinic | 197 | 0 | 0 | 0 | 0 | 0 | 0 | **197** |
| Bloemfontein Medi-Clinic | 94 | 0 | 0 | 0 | 0 | 0 | 0 | **94** |
| Medi-Clinic Total | 1,626 | 1,072 | 957 | 553 | 495 | 580 | 238 | **5,521** |
| **VON Network** | **N/A** | **75,603** | **56,274** | **44,240** | **33,421** | **26,407** | **13,119** | **N/A** |

*Table 10: Medi-Clinic Vermont Oxford Network Outcomes*

| Medi-Clinic Vermont Oxford Network Outcomes | 2006 | VON Average |
|---|---|---|
| **All Infants** | | |
| Average birth weight (g) | 2399 | |
| Average gestational age (weeks) | 35 | |
| Average discharge weight (g) | 2675 | |
| LOS (days) | 20 | |
| **Very Low Birth Weight Infants (< 1501g)** | | |
| Average birth weight (g) | 1141 | **1044** |
| Average gestational age (weeks) | 29 | **28** |
| Average discharge weight (g) | 2209 | **2177** |
| LOS (days) | 53 | **53** |
| | | |
| **Very Low Birth Weight Infants (n)** | 164 | **46,377** |
| **Location of Birth** | | |
| Inborn | 90% | **84%** |
| Outborn | 10% | **16%** |
| **Respiratory Support** | | |
| Respiratory distress syndrome | 82% | **73%** |
| Pneumothorax | 1% | **5%** |
| NCPAP | 76% | **67%** |
| Early CPAP | 33% | **35%** |
| Ventilation after early CPAP | 46% | **44%** |
| Ventilator | 52% | **65%** |
| Hifi Ventilator | 23% | **22%** |
| High Flow Nasal Cannula | 36% | **39%** |
| Nasal IMV or SIMV | 15% | **10%** |
| **Chronic Lung Disease** | | |
| CLD 36 weeks | 20% | **27%** |
| CLD 36 weeks (gestational age < 33 weeks) | 21% | **29%** |
| **Infections** | | |
| Early infections | 4% | **2%** |
| Nosocomial | 17% | **20%** |
| **Other Outcomes** | | |
| Patent Ductus Arteriosus | 24% | **38%** |
| Necrotising Enterocolitis | 2% | **7%** |
| Focal Gastrointestinal Perforation | 1% | **2%** |
| Periventricular-Intraventricular Haemorrhage | 18% | **26%** |
| Periventricular Leukomalacia | 1% | **3%** |
| Retinopathy of Prematurity | 24% | **37%** |
| **Mortality** | 8% | **13%** |

## *Table 11: Adult Cardio-thoracic Database Outcomes*

| INDICATOR | 2008 | 2007 | 2006 |
|---|---|---|---|
| **Total number of cases** | **480** | 601 | 242 |
| **Procedures** | | | |
| Coronary artery bypass graft | **397** | 522 | 206 |
| Valve surgery | **118** | 124 | 47 |
| Ventricular assist device | **0** | 0 | 2 |
| Other cardiac procedure | **24** | 28 | 15 |
| Other non-cardiac procedure | **17** | 6 | 3 |
| **Gender** | | | |
| Female | **24.4%** | 22.6% | 22.7% |
| Male | **75.6%** | 77.4% | 77.3% |
| **Age distribution (years)** | | | |
| <= 20 | **0.0%** | 0.3% | 0.8% |
| 21 – 30 | **0.6%** | 0.3% | 0.4% |
| 31 – 40 | **2.7%** | 3.2% | 4.5% |
| 41 – 50 | **15.2%** | 13.6% | 12.0% |
| 51 – 60 | **24.6%** | 25.8% | 27.7% |
| 61 – 70 | **34.4%** | 36.6% | 32.2% |
| 71 – 80 | **20.2%** | 18.6% | 20.7% |
| 81+ | **2.3%** | 1.5% | 1.7% |
| **Risk factors** | | | |
| Overweight or obese (BMI >25) | **76.3%** | 77.5% | 79.3% |
| Hypertension | **73.1%** | 74.0% | 68.6% |
| Dyslipidemia | **64.4%** | 58.4% | 53.3% |
| Family history of coronary artery disease | **52.7%** | 51.2% | 55.8% |
| Smoker | **50.4%** | 53.1% | 47.9% |
| Diabetes | **25.4%** | 24.8% | 24.4% |
| Renal failure | **7.9%** | 6.8% | 0.8% |
| **New York Heart Association (NYHA) classification** | | | |
| Class I | **30.2%** | 26.5% | 30.2% |
| Class II | **33.3%** | 38.1% | 48.3% |
| Class III | **17.9%** | 14.8% | 9.1% |
| Class IV | **18.5%** | 20.6% | 12.0% |
| **Angina** | | | |
| No | **26.0%** | 26.0% | 20.7% |
| Stable | **32.9%** | 36.9% | 38.8% |
| Unstable | **41.0%** | 37.1% | 40.1% |
| **Number of diseased vessels (CABG cases only)** | | | |
| One | **4.8%** | 2.5% | 2.9% |
| Two | **10.9%** | 9.4% | 8.3% |
| Three | **84.3%** | 88.1% | 88.8% |
| **Ejection fraction** | | | |
| <= 35 | **4.6%** | 5.2% | 7.4% |
| 36 – 45 | **7.5%** | 7.5% | 14.0% |
| 46 – 55 | **21.0%** | 19.8% | 26.4% |
| 56 – 65 | **45.2%** | 44.4% | 39.7% |
| 66 – 75 | **13.8%** | 14.8% | 8.7% |
| 76 – 85 | **2.9%** | 3.3% | 2.5% |
| 86+ | **0.2%** | 0.0% | 0.4% |
| **Status of procedure** | | | |
| Elective | **56.7%** | 63.9% | 44.6% |
| Urgent | **40.2%** | 33.6% | 52.1% |
| Emergent | **2.9%** | 2.2% | 2.1% |
| Emergent salvage | **0.2%** | 0.3% | 0.8% |
| **Intra aortic balloon pump (IABP)** | | | |
| Pre-operative | **13.1%** | 15.5% | 19.8% |
| Intra-operative | **1.7%** | 1.7% | 2.9% |
| Post-operative | **0.4%** | 0.7% | 0.4% |
| **Total hours ventilated post-operative** | | | |
| 0 – 6 | **30.2%** | 29.3% | 35.1% |
| 6 – 12 | **10.8%** | 10.5% | 9.1% |
| 12 – 24 | **51.5%** | 53.2% | 47.1% |
| 24 – 48 | **2.7%** | 2.5% | 1.7% |
| > 48 | **4.8%** | 4.3% | 6.6% |
| **Other post-operative outcomes** | | | |
| Infections | **2.3%** | 3.0% | 2.9% |
| Re-operation | **2.7%** | 4.2% | 6.2% |
| Renal failure | **2.3%** | 2.8% | 0.8% |
| Prolonged ventilation | **7.3%** | 3.7% | 4.5% |
| **Mortality** | | | |
| Expected Mortality (EuroSCORE) | **6.3%** | 5.6% | 7.3% |
| Actual Mortality | **5.2%** | 2.5% | 5.0% |
| Mortality Index | **0.82** | 0.45 | 0.68 |
| **Re-admit <=30 days from date of procedure** | **12.5%** | 14.3% | 12.4% |

# Operational Profile

Medi-Clinic was founded 25 years ago in 1983 when our Chairman, Dr Edwin Hertzog, was commissioned by the Rembrandt Group to undertake a feasibility study on private hospitals. Three years later Medi-Clinic, boasting four hospitals with 691 beds in commission and three hospitals with 688 beds under construction, listed on the JSE Limited. The Group has steadily expanded throughout Southern Africa and internationally. Today Medi-Clinic Southern Africa operates 48 hospitals throughout South Africa and three in Namibia with more than 6 900 beds in total. Medi-Clinic Switzerland operates 13 private acute care facilities in Switzerland with 1 301 beds and Medi-Clinic Middle East operates the 120-bed Welcare Hospital and five clinics in Dubai with the commissioning of the first hospital in the Dubai Health Care City, The City Hospital (a 210-bed multidisciplinary hospital), scheduled for mid-2008. A complete list of our hospitals appears on pages 46 to 47.

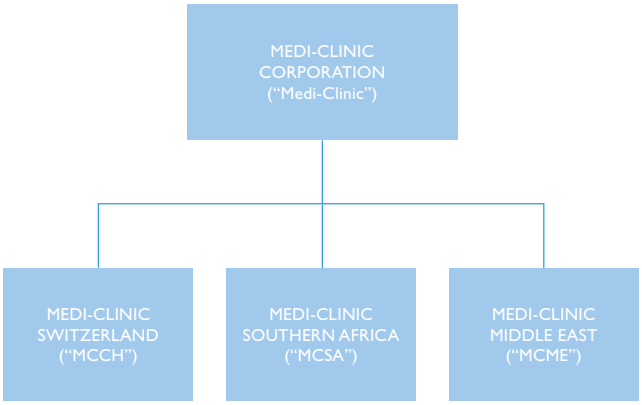
Our international hospital operations expanded to Dubai in the United Arab Emirates with effect from March 2007 and to Switzerland with the acquisition of Hirslanden, the leading private hospital group in Switzerland, in October 2007.

Subsequent to the Group's international expansion, the management and operational structure of the Group have been divided into three operating platforms, namely Medi-Clinic Southern Africa, Medi-Clinic Switzerland and Medi-Clinic Middle East. The new group structure is set out below.

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.

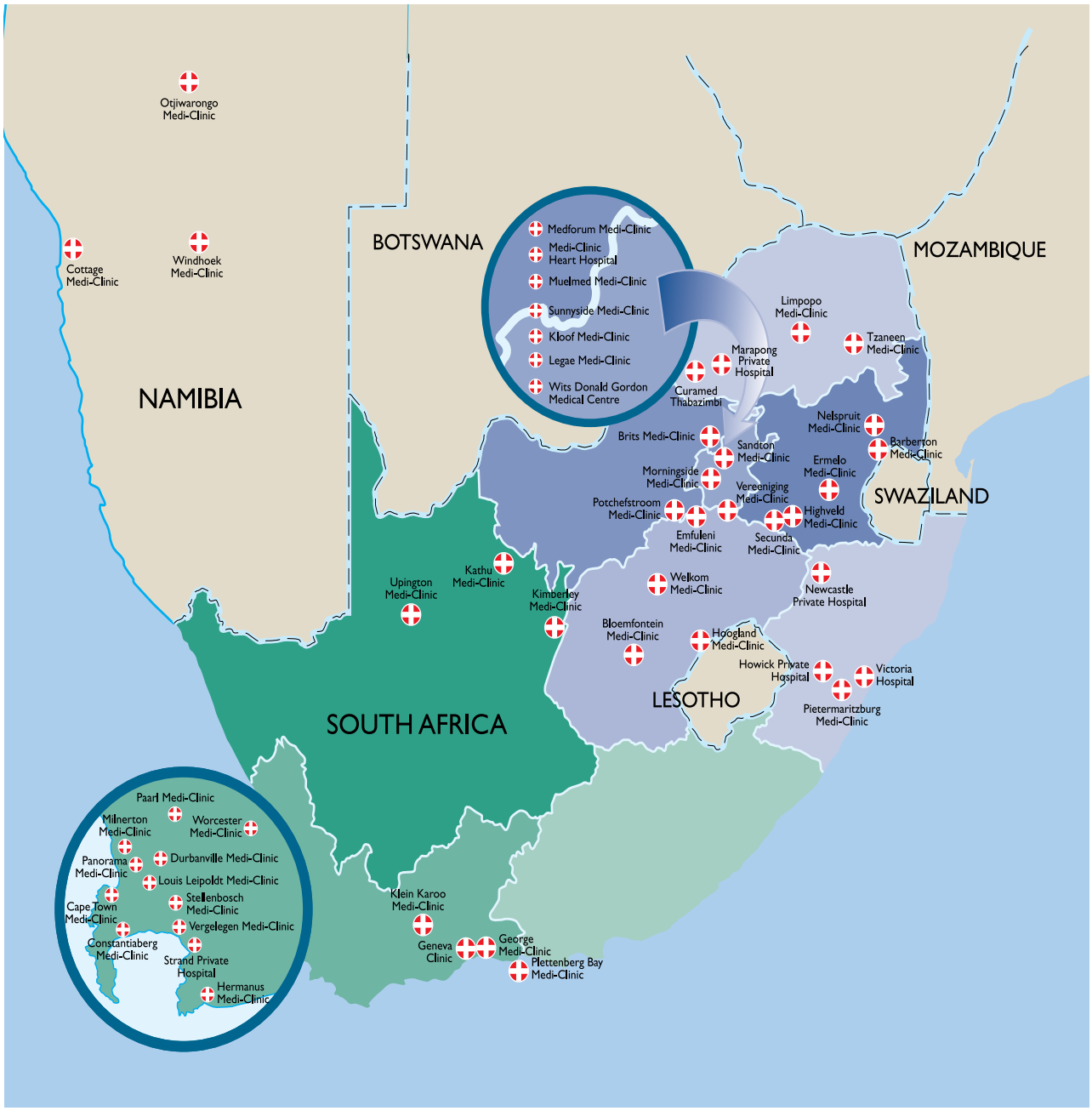
Through a continuous process of expansion, upgrading and training, we are constantly improving our standards and equipping our personnel with the skills and facilities to support our doctors and to ensure the peace of mind of our patients.

Medi-Clinic's management approach is to run our hospitals on a decentralised basis. The head office of each of the three operational platforms 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.



## MEDI-CLINIC SOUTHERN AFRICA

MCSA's head office is situated in Stellenbosch and currently operates 48 hospitals throughout South Africa and three hospitals in Namibia. The geographical spread of the Group's South African and Namibian hospitals in operation is illustrated in the map below.



At year-end the group had approximately 12 500 employees in Southern Africa. The management team consists of the following senior managers:

| | |
|---|---|
| Mr Koert Pretorius | Chief Executive Officer |
| Mr Wimpie Aucamp | Chief Operating Officer |
| Mr Braam Joubert | Chief Financial Officer |
| Dr Nkaki Matlala | Chief Clinical Officer |
| Mr Biren Valodia | Chief Marketing Officer |
| Mr Roly Buys | General Manager: Funder Relations & Contracting |
| Mr Steve Drinkrow | General Manager: Infrastructure |
| Ms Clara Findlay | General Manager: Legal Services |
| Ms Estelle Jordaan | General Manager: Nursing |
| Mr Theo Pauw | General Manager: Information Technology |
| Mr Kobus Verster | General Manager: Human Resources |
| Dr Mvula Yoyo | General Manager: Transformation |
| Ms Toni Lockyer | Company Secretary |

ER24, a wholly owned subsidiary, is an emergency assistance company committed to rendering affordable, fast and efficient assistance services in line with international norms and standards and provides a range of services to clients and the general public on a 24-hour basis. Services include emergency response and transportation, inter-facility transfers, emergency medical advice, general medical advice, incident management and co-ordination and other value-added services. ER24 owns and operates in excess of 120 response vehicles and ambulances co-ordinated by an Emergency Contact Centre that receives emergency and medical calls via the national short-dial number 084 124.

Medical Innovations, a wholly owned subsidiary, designs and manufactures quality hospital equipment and provides innovative engineering solutions. Our operating tables and other 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 and the first shipment to The City Hospital, Dubai. 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.

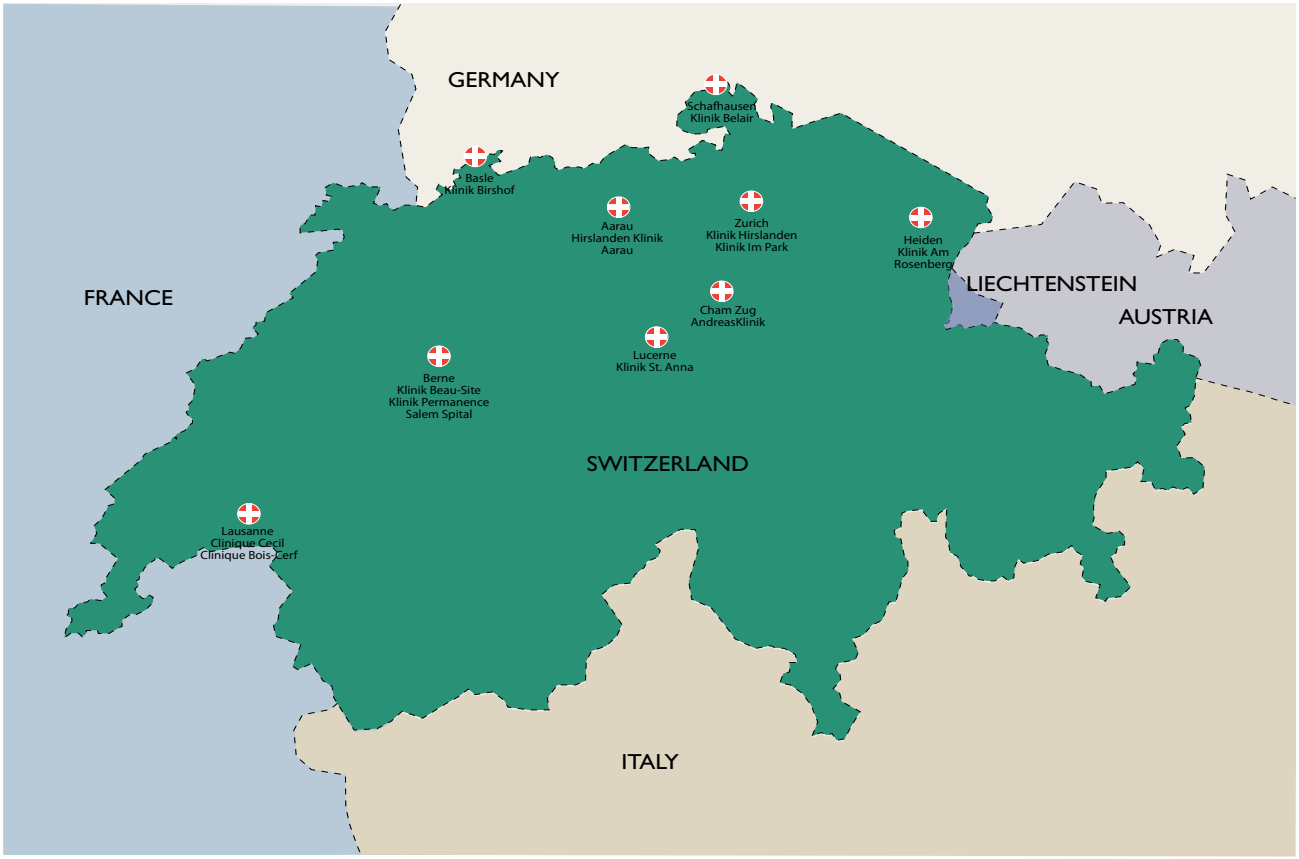
Medical Human Resources, a wholly owned subsidiary, provides temporary and permanent staff over the entire spectrum of the healthcare industry to more than 138 private hospitals throughout South Africa. The company consists of two divisions, namely Medi-Nurse for placement of nursing staff and Medi-Staff for placement of administration staff. Over the past three years we successfully accommodated more than 93% of requests for placements of temporary nursing and administrative positions. We currently have over 16 348 active employees available on a part-time basis and a growing database of qualified personnel for permanent positions.

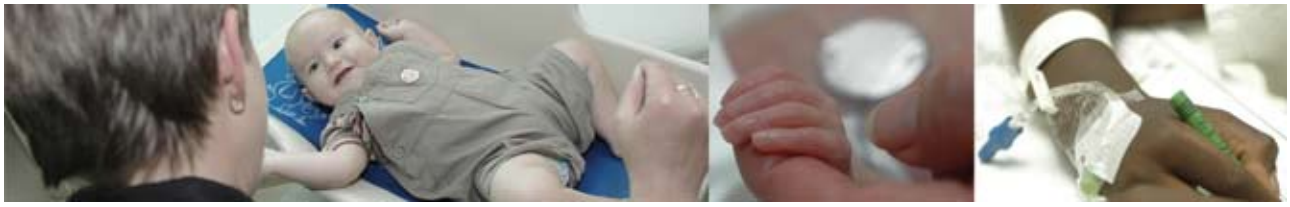
## MEDI-CLINIC SWITZERLAND

MCCH is the largest provider of acute healthcare in Switzerland and is renowned throughout the country and internationally for providing the highest level of clinical care and standard of facilities. MCCH's head office is situated in Zürich and operates a network of 13 private acute-care facilities located in nine cantons throughout Switzerland with 1 301 beds. The geographical spread of the group's hospitals in operation is illustrated in the map below.

At year-end the MCCH group employed over 3 600 staff. The management team consists of the following senior managers:

| | |
|---|---|
| Dr Robert Bider | Chief Executive Officer |
| Mr Reto Heierli | Chief Financial Officer |
| Mr Joseph Rohrer | Chief Operating Officer |
| Dr Teo Albarano | Head of Medical Department |
| Mr Zoran Alimpic | Head of Maintenance and Technical Infrastructure |
| Mr Urs Brogli | Head of Communication |
| Mr Julien Buro | Head of Marketing |
| Mr Patrik Gaignat | Head of Real Estate Management |
| Mr Andreas Kappeler | Head of Accounting |
| Mr Bruno Mäder | Head of Information Technology |
| Mr Magnus Oetiker | Head of Hospital Services |
| Ms Marta Betschard | Head of Human Resources Management |
| Mr Fritz Schiesser | Head of Logistics |
| Mr Sanjay Singh | Head of h-care & Strategy |
| Mr Christian Studer | Head of Projects (Hospital Services) |
| Mr Peter Obrist | Company Secretary |





## MEDI-CLINIC MIDDLE EAST

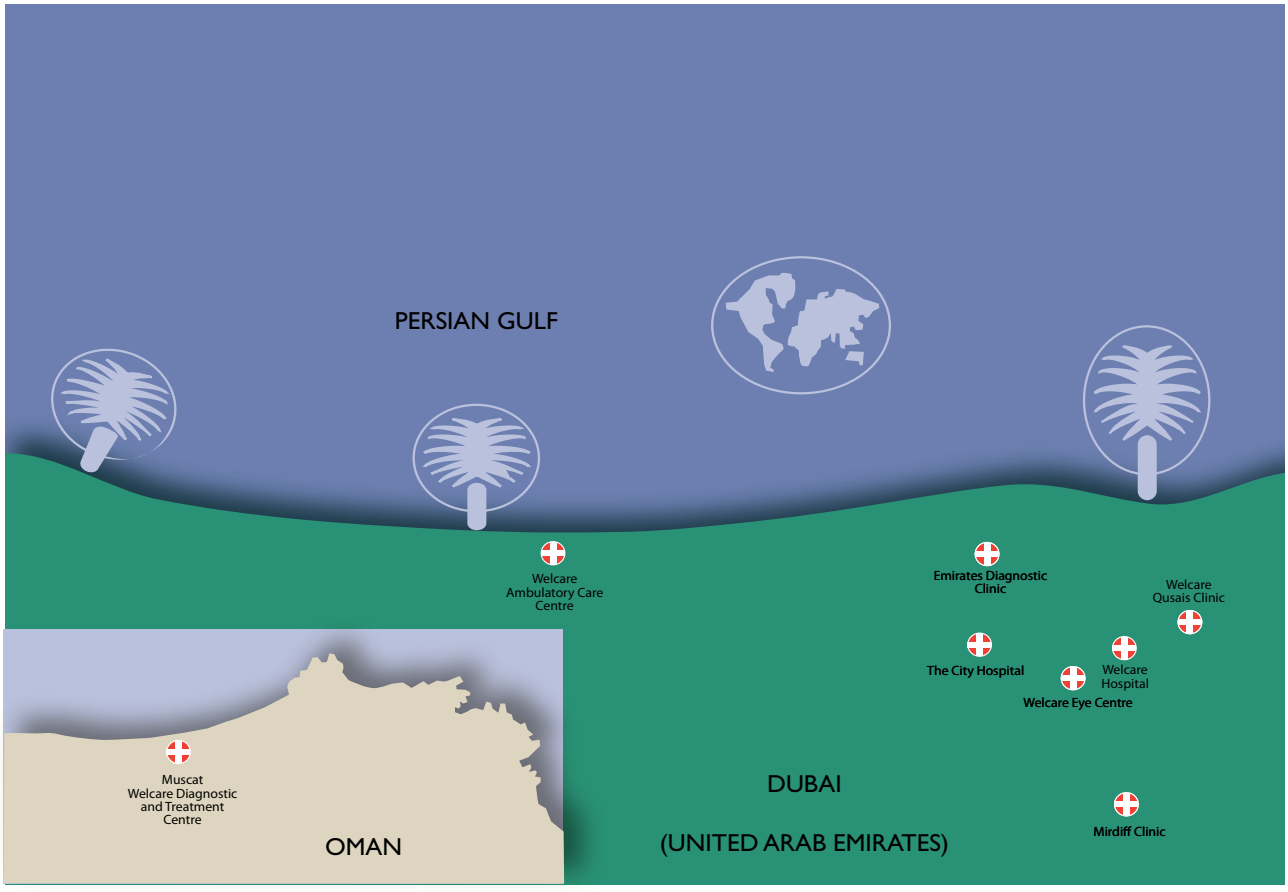
MCME holds 50% plus one of the ordinary shares in Emirates Healthcare Holdings Limited ("EHHL") since March 2007. EHHL's head office is situated in Dubai and it owns and manages the 120-bed Welcare Hospital as well as five clinics.

Construction of The City Hospital, a 210-bed multi disciplinary hospital in Dubai Health Care City, is progressing well and this prestigious up-market hospital is scheduled to open by mid-2008. The company also owns vacant land in Dubai Health Care City with the right to develop a further hospital.

The following map gives an overview of the geographical spread of the different operational units.

At year-end the MCME group had approximately 740 employees. The management team consists of the following senior managers:

| | |
|---|---|
| Mr Danie Meintjes | Chief Executive Officer |
| Mr Craig Tingle | Chief Financial Officer |
| Mr David Hadley | Hospital Manager (The City Hospital) |
| Mr Deon Myburgh (from 1 July 2008) | Director: Information Technology |
| Mr Mustafa Kantawala | Group Manager: Finance |
| Dr Shereen Milgan | Group Manager: Recruitment and Licensing |
| Mr Rajiv Pande | Group Manager: Procurement |
| Dr Lisa Pinto | Group Manager (Clinics) |
| Ms Malou Rojas | Group Manager: Human Resources |
| Dr Ottmar Schmidt | Director: Marketing and Public Relations |
| Mr Sakkie van der Vyver | Hospital Manager (Welcare Hospital) |
| Mr Darayus Baria | Company Secretary |



| | HOSPITAL / CLINIC MANAGER | LOCATION | LICENSED BEDS | LICENSED THEATRES |
|---|---|---|---|---|
| **SOUTH AFRICA** | | | | |
| **WESTERN CAPE** | | | | |
| Cape Town Medi-Clinic | Mr Kevin Seaman | Cape Town | 125 | 5 |
| Constantiaberg Medi-Clinic | Mr Clive Lake | Cape Town | 238 | 8 |
| Durbanville Medi-Clinic | Mr Hein Calitz | Durbanville | 210 | 8 |
| Geneva Clinic | Mr George Schutte | George | 60 | 4 |
| George Medi-Clinic | Mr George Schutte | George | 160 | 4 |
| Hermanus Medi-Clinic | vacant | Hermanus | 51 | 2 |
| Klein Karoo Medi-Clinic | Ms Anne-Marie Nortjé | Oudtshoorn | 38 | 2 |
| Louis Leipoldt Medi-Clinic | Ms Alosha Rayray | Bellville | 200 | 7 |
| Milnerton Medi-Clinic | Ms Carol Defty | Milnerton | 112 | 4 |
| Paarl Medi-Clinic | Mr Oelof Dippenaar | Paarl | 139 | 5 |
| Panorama Medi-Clinic | Mr George Harris | Parow | 386 | 12 |
| Plettenberg Bay Medi-Clinic | Mr George Schutte | Plettenberg Bay | 27 | 1 |
| Stellenbosch Medi-Clinic | Ms Carol van Zyl | Stellenbosch | 92 | 4 |
| Strand Private Hospital | Mr Pieter Lotz (from 1/07/08) | Strand | 24 | 2 |
| Vergelegen Medi-Clinic | Mr Pieter Lotz (from 1/07/08) | Somerset West | 237 | 8 |
| Worcester Medi-Clinic | Mr Marquin Crotz | Worcester | 187 | 5 |
| **GAUTENG** | | | | |
| Curamed Thabazimbi Hospital | Ms Charlene van der Walt | Thabazimbi | 21 | 1 |
| Emfuleni Medi-Clinic | Mr Joe Sandows | Vanderbijlpark | 155 | 4 |
| Kloof Medi-Clinic | Ms Riette Swart | Pretoria | 169 | 10 |
| Marapong Private Hospital | Ms Charlene van der Walt | Lephalale | 12 | 1 |
| Medforum Medi-Clinic | Ms Joey le Roux | Pretoria | 204 | 14 |
| Medi-Clinic Heart Hospital | Mr Jan Scheepers | Pretoria | 90 | 3 |
| Morningside Medi-Clinic | Mr Jaco Erasmus | Sandton | 230 | 9 |
| Muelmed Medi-Clinic | vacant | Pretoria | 222 | 8 |
| Sandton Medi-Clinic | Ms Louise Sole | Sandton | 379 | 10 |
| Sunnyside Medi-Clinic | Ms Joey le Roux | Pretoria | 53 | 2 |
| Vereeniging Medi-Clinic | Mr Leon Lambrechts | Vereeniging | 165 | 7 |
| Wits Donald Gordon Medical Centre * | Mr Sarel van der Walt | Johannesburg | 95 | 4 |
| **MPUMALANGA** | | | | |
| Barberton Medi-Clinic | Ms Carmen Savva | Barberton | 30 | 1 |
| Ermelo Medi-Clinic | Mr Willem Schoonbee | Ermelo | 40 | 2 |
| Highveld Medi-Clinic | Mr Willem Schoonbee | Trichardt | 204 | 4 |
| Nelspruit Medi-Clinic | Ms Carmen Savva | Nelspruit | 260 | 7 |
| Secunda Medi-Clinic | Mr Willem Schoonbee | Secunda | 43 | 3 |
| **KWAZULU-NATAL** | | | | |
| Howick Private Hospital | Mr Riaan Vorster | Howick | 26 | 3 |
| Newcastle Private Hospital | Mr Freddie Meiring | Newcastle | 90 | 4 |
| Pietermaritzburg Medi-Clinic | Mr Riaan Vorster | Pietermaritzburg | 127 | 6 |
| Victoria Hospital | Ms Jenny Meer | Tongaat | 120 | 4 |
| **FREE STATE** | | | | |
| Bloemfontein Medi-Clinic | Mr Carl Bührmann | Bloemfontein | 377 | 12 |
| Hoogland Medi-Clinic | Mr Henk Laskey | Bethlehem | 107 | 3 |
| Welkom Medi-Clinic | Mr Frans van Niekerk | Welkom | 191 | 8 |

# hospitals and clinics in operation

| | HOSPITAL / CLINIC MANAGER | LOCATION | LICENSED BEDS | LICENSED THEATRES |
|---|---|---|---|---|
| **NORTHWEST** | | | | |
| Brits Medi-Clinic | Ms Renee Janse van Rensburg | Brits | 60 | 3 |
| Legae Medi-Clinic | Mr Johan Verwey | Mabopane | 137 | 4 |
| Potchefstroom Medi-Clinic | Mr Dawid du Plooy | Potchefstroom | 114 | 4 |
| **NORTHERN CAPE** | | | | |
| Kathu Medi-Clinic | Mr Henry Hendricks | Kathu | 25 | 1 |
| Kimberley Medi-Clinic | Mr Henry Hendricks | Kimberley | 234 | 8 |
| Upington Medi-Clinic | Ms Johanna van Niekerk | Upington | 50 | 2 |
| **LIMPOPO** | | | | |
| Limpopo Medi-Clinic | Mr Antonius Spek | Polokwane | 186 | 6 |
| Tzaneen Medi-Clinic | Mr Zane Fanie | Tzaneen | 64 | 2 |
| **NAMIBIA** | | | | |
| Cottage Medi-Clinic | Mr Peter Sander | Swakopmund | 70 | 2 |
| Otjiwarongo Medi-Clinic | Mr Judith von Solms | Otjiwarongo | 20 | 1 |
| Windhoek Medi-Clinic | Ms Elmarie Vink | Windhoek | 120 | 4 |
| | | | 6 776 | 248 |
| **UNITED ARAB EMIRATES** | | | | |
| Welcare Hospital | Mr Sakkie van der Vyver | Dubai | 120 | 4 |
| Welcare Qusais Clinic | Dr Ravi Gupta | Qusais | n/a | n/a |
| Welcare Eye Centre | Dr Boughram Chidamber | DHCC | n/a | n/a |
| Emirates Diagnostic Clinic | Dr Nedungat Gangadharan | Satwa | n/a | n/a |
| Welcare Ambulatory Care Centre | Dr Lalith Uchil | Knowlegde Village | n/a | n/a |
| Welcare Diagnostic and Treatment Centre** | Dr Pavan Srivastava | Muscat, Oman | n/a | n/a |
| | | | 120 | 4 |
| **SWITZERLAND** | | | | |
| Hirslanden Klinik Aarau | Mr André Steiner | Aarau | 117 | 4 |
| Klinik Beau-Site | Mr Guy Jaquet | Berne | 93 | 4 |
| Klinik Permanence | Dr Andreas Kohli | Berne | 47 | 3 |
| Salem Spital | Dr Andreas Kohli | Berne | 169 | 7 |
| AndreasKlinik | Mr Martin Rauber | Cham | 56 | 4 |
| Klinik Am Rosenberg | Mr Alexander Rohner | Heiden | 62 | 4 |
| Clinique Bois-Cerf | Mr Thierry Siegrist | Lausanne | 66 | 5 |
| Clinique Cecil | Mr Pierre-Frédéric Guex | Lausanne | 89 | 5 |
| Klinik St. Anna | Dr Dominik Utiger | Luzern | 160 | 6 |
| Klinik Birshof | Ms Simone Schwinger | Münchenstein | 43 | 4 |
| Klinik Belair | Mr Urs Baumberger | Schaffhausen | 28 | 2 |
| Klinik Hirslanden | Dr Ole Wiesinger | Zürich | 232 | 10 |
| Klinik Im Park | Mr Nicolaus Fontana | Zürich | 139 | 6 |
| | | | 1 301 | 64 |
| | | | 8 197 | 316 |

* proportionally consolidated (100% = 190 beds and 9 theatres)

** only 20% financial interest

# Sustainable Development Report

## COMMITMENT TO TRANSPARENCY

This report is Medi-Clinic's sixth Sustainable Development Report published as part of our annual report. Our objective is to provide our stakeholders with information on Medi-Clinic's non-financial aspects of corporate practice that, in turn, create economic, social and environmental value. The recommendations on integrated sustainability reporting contained in the King Report on Corporate Governance for South Africa 2002 ("the King Report") forms the basis of this report, whilst also taking note of the G3 Sustainability Reporting Guidelines developed by the Global Reporting Initiative.

Medi-Clinic is focused on providing comprehensive high-quality hospital services on a sustainable basis. The Group is committed to ethical business practices and efficient risk management and 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.

Medi-Clinic has qualified for inclusion in the JSE Socially Responsible Investment ("SRI") Indexes conducted to date, which showcase those listed companies which achieve the requisite score in relation to a set of criteria that measures triple bottom line (economic, social and environmental) commitment and performance.

During March and October 2007 respectively, Medi-Clinic's business operations expanded from Southern Africa to the United Arab Emirates ("UAE") and Switzerland, as previously reported. Although similar best practices, policies and procedures of Medi-Clinic Southern Africa ("MCSA") have been implemented at our Medi-Clinic Switzerland ("MCCH") and Medi-Clinic Middle East ("MCME") operations, the integration and exchange of knowledge and expertise have and will receive ongoing attention. The extent of this report therefore covers mainly the Southern African operations. It is our objective to include more comprehensive reporting on our Swiss and UAE operations in our next annual report.

## COMMITMENT TO QUALITY 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 high standards and care processes that are sophisticated, reliable and free of errors. To demonstrate our commitment to quality in healthcare, our first Clinical Governance Report has been included in this annual report from page 25 to 40.

The Group strives to provide the best healthcare facilities and technology affordable and available in the different countries in which it operates. 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. With this in mind, MCSA has in the past year invested approximately R195 million on projects to ensure that our hospitals provide the technology required by supporting doctors and patients. Similarly, MCCH has invested approximately CHF19 million (R128 million) (including capital expenditure) in the maintenance and development of its asset base during the period under review since the acquisition date of 26 October 2007.

MCSA'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' specifications. 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.

Our proactive approach in creating additional power-generating capacity ensured that our hospitals in the Western Cape were able to function at full capacity in spite of the electricity outages experienced. Due to the instability of the national power supplier it was decided to increase the power-generating capacity of hospitals in other parts of the country as well. Increasing the group's power-generating capacity involves the purchase of an additional 29 generators at an estimated cost of R35,8 million. We anticipate that this project will be completed by the end of 2008, with the first units being installed during June of this year. On completion of this initiative the group would have invested R48 million over a two year period on additional power generating capacity to enable the South African hospitals to operate as normal during extended power outages.

The planned maintenance system and related procedures are constantly being evaluated to ensure that patient safety is paramount and that our staff delivers a value-adding service. A project to review and update all documentation and policies has been very successful in terms of streamlining workload. We constantly evaluate the relevance of all procedures and service intervals to optimise maintenance cost and safety.

The Group's MCSA hospitals are subjected to a comprehensive maintenance audit on an annual basis that covers all three categories of plant and equipment, as well as the aesthetics of our facilities. The audit is performed in-house by trained staff. The standard of the audit is continuously being raised and 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 the previous reporting period, and from 79% to 80% during the period under review. The upward trend was maintained by all regions, except in the Northern Region, where two additional hospitals were audited for the first time and three of the larger hospitals were in the process of major upgrades.

The computerised maintenance management system enables the MCSA group to provide quality service and complements the care of our patients and clients. We have accumulated nine years of data for 80% of the beds within the group, covering 28 of our hospitals. The EAMS (Electronic Asset Management System) project is being developed to ensure that a comprehensive asset register is available at each hospital that can be updated electronically. The installation will include an assessment of assets in order to accurately budget for the replacement items on a yearly basis, based on a scoring system. The project is currently under way and will take a number of years to complete.

The quality of the facilities of our Swiss operations is regarded as among the best in the world. Our management team regards the provision of high-level facilities as essential to ensure the successful development of the MCCH group. The clinics are located in prime locations and built and maintained to the highest standard. The therapeutic and working environments are unparalleled, the medical infrastructure

is state-of-the-art and patients are provided with first-class facilities in which to receive treatment and recuperate. The emphasis is on the provision of a high-quality hotel-like service. The group invests heavily in providing the highest quality medical infrastructure, including theatre facilities, equipment and nursing staff to enable doctors to perform procedures using the best available technology. MCCH is committed to the total quality management approach according to the European Foundation for Quality Management ("EFQM"). The EFQM model is a framework management concept for business excellence with an integral view on the organisation. Six of the 13 clinics in Switzerland are ISO 9000:2001 certified, with the aim of having the remaining clinics certified by the end of 2009. Although each clinic has a local team that is responsible for technical items and maintenance works, the central technical department ensures that common technical standards are applied, monitors compliance with regulations regarding, for example, safety and environment, ensures that new regulatory requirements are implemented and facilitates the knowledge transfer within the group. Especially larger projects are jointly handled with the centralised investment and maintenance team at the MCCH head office.

Our UAE operations are in the process of obtaining accreditation of its facilities by the JCI (Joint Commission International), an international quality measurement accreditation organisation, aimed at improving quality of care. The accreditation is based on international consensus standards and set uniform, achievable expectations for structures, processes and outcomes for hospitals. The Dubai Health Care City ("DHCC") authorities approved Medi-Clinic as an international healthcare company that can offer academic affiliation services to DHCC hospitals, which is a requirement for DHCC facilities to ensure world-class services. Medi-Clinic and EHHL has entered into an academic affiliation agreement in respect of The City Hospital and consists of two components, namely clinical governance to ensure and improve quality and safety of patient care and academic collaboration, as a platform enabling continuous medical education, training, clinical consulting and second opinions.

## BROAD-BASED BLACK ECONOMIC EMPOWERMENT*

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

The Board of Medi-Clinic views our South African business as an integral part of the political, social and economic community in South Africa and is committed to sustainable transformation as part of its business strategy. Medi-Clinic remains committed to broad-based black economic empowerment ("BBBEE") as a strategic opportunity to strengthen the economic base of the company. The company endeavours to extend this philosophy across all pillars of transformation. We are proud to have received recognition for our commitment to transformation by being rated number 33 overall and number 1 in the health sector in the 2008 Top Empowerment Companies Survey conducted by Financial Mail/Empowerdex. The survey is a mechanism to measure and monitor the empowerment achievements of listed companies and ranks the top 200 listed companies according to their scores.

Enhancing the group's current BBBEE initiatives is a priority for Medi-Clinic, and the group is currently finalising a comprehensive BBBEE strategy that aims to facilitate initiatives across all seven pillars of the BBBEE scorecard. The appointment of a Transformation Manager towards the end of 2007 signals our commitment to the development and implementation of sustainable BBBEE initiatives.

MCSA assessed itself against the generic scorecard criteria set by the Department of Trade and Industry ("DTI"), the results of which is set out in Table 1 above. Our self-assessment indicates that we have a total score of 60.26, which means that we are a level 5 contributor (a level 1 contributor has a total of 100+ points and a level 8 contributor has less than 40 points). As the Health Charter has not been finalised yet, Medi-Clinic has not officially verified its BBBEE status. We are in the process of verifying the ownership pillar and aim to have the other pillars verified in the future.

| TABLE 1: BBBEE SCORECARD | | | |
|---|---|---|---|
| ELEMENT | INDICATOR | WEIGHTING | OUR SCORE |
| Ownership | Percentage share of economic benefits | 20 | 15.32 |
| Management control | Percentage black persons in executive management and/or executive board and board committees | 10 | 4.98 |
| Employment equity | Weighted employment equity analysis | 15 | 4.05 |
| Skills development | Skills development expenditure as a proportion of total payroll | 15 | 9.02 |
| Preferential procurement | Procurement from black-owned and empowered enterprises as a proportion of total assets | 20 | 9.54 |
| Enterprise development | Average value of enterprise development contributions as a percentage of the target of 3% of net profit after tax | 15 | 15.00 |
| Socio-economic development | Corporate social investment for the benefit of black persons | 5 | 2.35 |
| TOTAL | | 100 | 60.26 |

## Ownership

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 black partners and shareholders in Medi-Clinic. Following the initiative, our strategic black partners jointly held approximately 11%, with Phodiso holding approximately 6.87% (currently 6.63%) and Circle Capital holding approximately 4.12% (currently 3.94%), of the issued shares. All employees up to and including first-line management level were also introduced as shareholders of the company through the issue of Medi-Clinic shares to The Mpilo Trust, an employee share trust formed specifically for that purpose. The Mpilo Trust held approximately 4% (currently 2.53%) of Medi-Clinic's issued shares.

The Hirslanden acquisition (as referred to earlier in this annual report) had a positive effect on this element of BBBEE for our strategic black partners. Phodiso and Circle Capital chose to remain as shareholders of Medi-Clinic, now an international player in the healthcare industry with operations in Southern Africa, Switzerland and the UAE, and not only in the Southern African operations company, and followed the majority of their rights in terms of the Group's rights offer in December 2007. They are now sharing in the benefits of a South African multinational company. By applying the specific rules of the DTI's BBBEE Codes of Good Practice in respect of multinationals, Medi-Clinic meets the code's targets of 25% exercisable voting rights in the hands of black people and 25% economical interest of black people for purposes of calculating Medi-Clinic's ownership scorecard with reference to the South African operations.

## Management control

Our strategic black partners are well represented within Medi-Clinic. Two of Phodiso's directors, Dr Nkaki Matlala and Dr Vincent Msibi, are involved in key positions within the Group, with Dr Matlala as Chief Clinical Officer and board member of MCSA and Dr Msibi serving on the Board of Medi-Clinic, both since 2005. Circle Capital's chairperson, Dr Mamphela Ramphele, serves on the Board of Medi-Clinic since 2005.

The Executive Committee of MCSA currently consists of 13 members, with five members from designated groups.

## Employment equity

Employment equity is a key business imperative for Medi-Clinic and is critical in assisting us in achieving our overall transformation

objectives. Our overall race split indicates that there has been an increase in the number of black employees compared to the previous year, with black employees now constituting 56% of the workforce compared to 53% last year. Although an increase in black representation has also been recorded at management level, with an increase from 12% to 17%, this level still presents the biggest challenge to the Group.

Two new positions have been created on an executive and senior management level respectively which will expedite the transformation process and relationship building efforts in line with the Medi-Clinic BBBEE strategy. To this effect, a Transformation Manager and a Corporate Liaison Manager were appointed in 2007.

Employment equity committees at national, regional and hospital levels have already been established. We anticipate that the establishment of fully functional employment equity committees at hospital level will assist us in reaching our stated targets.

The overall race and gender representation of employees in Southern Africa is as set out below:

| Race split | |
|---|---|
| African, Coloured, Indian | White |
| 56% | 44% |

| Gender split | |
|---|---|
| Female | Male |
| 87% | 13% |

MCCH and MCME also focus on employment equity matters in respect of gender and their overall gender split is set out below. An upcoming revision of the terms of reference for employees (Personalreglement) of MCCH will explicitly address equal opportunity.

| MCCH gender split | |
|---|---|
| Female | Male |
| 78.5% | 21.5% |

| MCME gender split | |
|---|---|
| Female | Male |
| 51% | 49% |

## Skills development

The company's stated commitment to quality care has the effect that skills development is a priority at all levels. 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 programme to include six positions. See pages 61 to 63 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. To this end, the group proactively uses the BBBEE status of a supplier in identifying the preferred supplier and awarding contracts. Medi-Clinic has also implemented an electronic software procurement solution for the adjudication of tenders and contracts in order to ensure a systems-orientated approach ensuring policy enforcement. Our current BBBEE preferential procurement compliance level is measured at 39.77% based on the BBBEE contribution level as supplied to us by our suppliers. We are confident that we will reach a 50% compliance level by 2010, as set in the draft Health Charter.

Below is a summary per occupational level of MCSA's employment equity report (EEA12) as at 31 March 2008, as required in terms of section 22 of the Employment Equity Act:

| OCCUPATIONAL LEVELS | DESIGNATED | | | | | | | NON-DESIGNATED | | | TOTAL |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | Male | | | Female | | | | White Male | Foreign Nationals | | |
| | A | C | I | A | C | I | W | W | Male | Female | |
| Top management | 1 | | 1 | | | | | 6 | | | 8 |
| Senior management | 1 | 1 | | | | | 2 | 17 | | | 21 |
| Professionally qualified and experienced specialists and mid-management | 10 | 22 | 8 | 14 | 16 | 7 | 229 | 159 | | 2 | 467 |
| Skilled technical and academically qualified workers, junior management, supervisors, foremen and superintendents | 83 | 90 | 16 | 797 | 710 | 92 | 2 782 | 180 | 3 | 48 | 4 801 |
| Semi-skilled and discretionary decision-making | 345 | 286 | 9 | 1 817 | 1 509 | 86 | 1 896 | 128 | 2 | 9 | 6 087 |
| Unskilled and defined decision-making | 150 | 86 | | 448 | 280 | 2 | 61 | 38 | 5 | 22 | 1 092 |
| **TOTAL PERMANENT** | **590** | **485** | **34** | **3 076** | **2 515** | **187** | **4 970** | **528** | **10** | **81** | **12 476** |
| Non-permanent employees | 8 | 2 | | 7 | 6 | 1 | 33 | 11 | | | 68 |
| **GRAND TOTAL** | **598** | **487** | **34** | **3 083** | **2 521** | **188** | **5 003** | **539** | **10** | **81** | **12 544** |

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

## Enterprise development

Our self-assessment indicates that in terms of our contributions towards this element, MCSA achieves the target of 3% of net profit after tax. This has largely been achieved through the favourable terms of loans to our two strategic black partners, Phodiso and Circle Capital, and The Mpilo Trust. The loans enabled these entities' acquisition of equity in Medi-Clinic.

Prior to the Medi-Clinic rights offer during the end of 2007, Tshwane Private Hospitals (Pty) Ltd, a joint venture company owned 50.05% by Medi-Clinic and 49.05% by a SPV-company owned by Phodiso Clinics (Pty) Ltd, held a 63% interest in Curamed Holdings Limited, a group of five Pretoria-based specialist hospitals comprising approximately 700 beds. Medi-Clinic facilitated the initial transaction in 2002 and provided the black empowerment consortium at the time with interim finance of about R49 million to enable them to finance their part of the transaction. Phodiso 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.

Phodiclinics (Pty) Ltd ("Phodiclinics"), a company owned 51% by Medi-Clinic and 49% by Phodiso, acquired four hospitals of the Protector group (in liquidation) in November 2006 situated in Pretoria, Vanderbijlpark, Kathu and Lepalale.

Phodiso has however sold its 49.05% interest in Tshwane and its 49% interest in Phodiclinics to Medi-Clinic with effect from 1 April 2007, the proceeds of which were mainly used to follow its rights in terms of the rights offer of the Group during the end of 2007.

## Socio-economic development

A draft Corporate Social Investment ("CSI") strategy, as further reported on under our community involvement report on page 63, is currently under discussion and aims to significantly extend MCSA's CSI activities. The company intends giving national support in a specific area of need in line with its core offering, ensuring a long-term and sustainable influence on the greater South African community. Medi-Clinic is also investigating operational partnerships with regional organisations or role-players, enabling them to expand their existing social outreach programmes. The success of the group's CSI strategy rests on the continuing voluntary engagement of our staff through their support for community-based social projects.

## Health Charter

Medi-Clinic, as a member of the Hospital Association of Southern Africa ("HASA"), has been actively involved in the negotiations to establish a Charter for the Healthcare Industry and supports the goals and objectives of the draft Charter. Little progress has been made during the past 16 months, although the drafting subcommittee has made some progress with the outstanding issues. It is very difficult to predict when this process will be finalised, but Medi-Clinic remains committed to assist in trying to resolve the outstanding matters.

# ECONOMIC PERFORMANCE

## Proudly South African

As the country's first Proudly South African private hospital group, we continuously strive to maintain a high standard of quality care. Reaffirming our commitment as a truly South African company, Medi-Clinic is now in its fourth year of membership. As a promoter of the Proudly South African campaign, we encourage the use of local businesses in our supply chain.

## Public private partnerships and interactions

Medi-Clinic believes that public private partnerships ("PPPs") and the more informal public private interactions ("PPIs") 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 continue to look for meaningful opportunities for PPP and PPI participation. Medi-Clinic and the PPP Unit of National Treasury have met to share perspectives on PPPs and to express our interest in interaction with the National Treasury and the Department of Health to try and accelerate the delivery of public healthcare initiatives and the evaluation of PPPs and PPIs 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 its investment of R60 million in WDGMC during 2005 and a further R5 million during the previous financial year, obtaining a 49.9% share in the hospital.

This investment by Medi-Clinic has enhanced the ability of the University of Witwatersrand in Johannesburg ("Wits") to support sub-specialist training without requiring any government subsidy. The significant partnership with the public sector is designed to support the training of specialists and sub-specialists for both public and private sectors and to make the best clinical staff available to the Johannesburg academic hospitals. 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. The academic programme of the hospital is functioning well and the hospital currently supports the training of four registrars and four sub-specialists.

The management services of Medi-Clinic have added significant value to the operations of the hospital and occupancy levels have improved materially. The hospital focuses on specialised services and the transplant programme can be described as a centre of excellence.

### 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, administrative and financial 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 2008 for the honours degree in Biokinetics increased substantially during the period under review, which is directly attributable to the successes attained by the partnership.

### Hermanus Provincial Hospital

We previously reported that the group had 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 as well as the provision of non-core support services at the Hermanus Provincial Hospital. After reviewing the process to date and the status of the project, the group concluded that the parties were unlikely to form a partnership for this project with a PPP as the mechanism. In its view a PPP was also unnecessarily complex for this relatively small project. The group informed the Department of Health accordingly and indicated that it is willing to co-operate in a more practical manner and by means of a simplified mechanism.

## 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 as well as with healthcare companies internationally. Medi-Clinic's current return on capital, based on the replacement value of its assets at 31 March 2008, is between 7% and 8%.

Medi-Clinic believes that providing cost-effective quality care 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, including our supporting doctors, patients, shareholders and the community at large.

## Affordability of healthcare

Affordability will always remain a critical issue in the healthcare industry internationally, but especially in developing countries, such as our Southern African operations. The Group will therefore continue its efforts to improve the affordability of healthcare with specific focus in Southern Africa where this issue is of critical importance. Affordability and cost-effectiveness also receive continuous attention at our Swiss and UAE operations.

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. The situation is exacerbated by an international shortage of skilled nursing staff. This leads to and will for the foreseeable future continue to lead to sustained pressure for higher nursing salaries. In addition, South Africa experienced substantial increases in property prices and building costs which, according to the Bureau for Economic Research, escalated by 68% cumulatively over the last four years. The private hospital industry in South Africa plays a significant role in the delivery of healthcare services and is the biggest local investor in the healthcare industry. As a major role-player in the healthcare industry, private hospitals participated in the Private Healthcare Indaba in September 2007, hosted by the National Department of Health. Proposals were presented to address the challenges of access to and affordability of healthcare services. Some of the key role-players, including the Council for Medical Schemes ("CMS"), the Board of Healthcare Funders ("BHF") and the Health Professions Council of South Africa ("HPCSA") blamed private hospitals for the high cost escalations experienced by medical aid schemes during recent years and therefore called for stricter regulation of the industry. They argued that only the funding side of the industry is highly regulated, causing an imbalance between funders and providers.

In reaction to the outcome of the Indaba, the private hospital industry formed a Hospital Task Group ("HTG") to support HASA in its efforts to address the concerns raised at the Indaba. With the assistance of independent experts, the HTG produced a comprehensive response to the issues raised at the Indaba with the view of presenting these findings to the Minister of Health and the officials in her department, highlighting the fact that private hospital tariffs are reasonable and that private hospitals earn a fair return in relation to the high capital investment. The increase in total expenditure, by medical aid schemes on private hospitals, is a product of both price and utilisation increases. The main driver, however, is the increase in utilisation which, in line with international trends, is driven by an ageing population, increased burden of disease, consumerism and new technology. Unfortunately, up to the time of going to print, the HTG has not been afforded an opportunity to discuss the report with the Minister of Health. A copy of the document was forwarded to the Minister and released to the media in January 2008.

Furthermore, the Minister of Health decided to intervene in the tariff negotiation process for 2008, based on feedback by the CMS and the BHF with regard to tariff increases and the billing of anaesthetic gases. MCSA was afforded an opportunity to make a comprehensive presentation regarding these issues to the Department of Health and provided all the information requested. We believe that our tariff increases for 2008 are reasonable, given the underlying increases experienced in our input costs.

During a follow-up meeting in February 2008, the Minister informed the private hospital industry that she is not convinced by the industry's presentations. The National Health Amendment Bill was subsequently published for comment on 18 April 2008 without prior consultation with the private hospital industry. The Bill proposes to introduce a facilitator, appointed by the Minister of Health, to oversee

annual tariff negotiations between medical schemes and healthcare providers. Extensive and interventionist powers are given to the Minister of Health, the proposed Facilitator of Health Pricing, the proposed Health Pricing Tribunal and the envisaged team of inspectors. MCSA is concerned that the proposed amendments could send a negative message about the private sector's freedom to operate in South Africa, but also that the proposed tariff negotiation process appears anti-competitive and collusive and could lead to a lack of adequate competition in the private healthcare sector in South Africa. MCSA will however continue to engage with the Department of Health to try and develop a process of real consultation and engagement in a further attempt to find solutions that will address the challenges facing the healthcare industry in South Africa.

MCSA continuously reviews international attempts to find long-term solutions to the question of affordability. The USA has, to some extent, moved away from the highly restrictive integrated (capitation) tariff models toward an era of greater consumer choice. This change has resulted in an increase in the rate of inflation for the provision of healthcare services, mainly ascribed to a loss of consolidated purchasing of health services and an increase in utilisation of healthcare services. The European model, a balance between a DRG (Diagnostic Related Grouping) reimbursement system and a system of "waiting lists", has also not produced an appropriate solution. The process of greater government involvement through significant regulation of the operation of the medical scheme movement in South Africa, has led to a change for the worse in the demographic profile of the covered population. This is evidenced most clearly by the decrease in the member/dependant ratio and the number of healthy, young individuals who decline to join a scheme even though it is affordable.

Hospital costs constitute the largest individual component of the medical scheme premium expense pie chart. However, when benchmarked against the USA, statistics reveal that the ratio in South Africa of hospital costs to other costs (including non-healthcare costs), compare favourably to that in the USA.

Medi-Clinic's policy decision in 2003 to implement a fully transparent pricing system, where all ethical and surgical products are priced at net acquisition cost, has now been adopted by the entire private hospital industry in South Africa. We remain confident that the inflation price increase on these products will now be contained close to CPIX levels every year.

In order to ensure that the cost of medical scheme products remains affordable, it is essential that a comprehensive database of clinical as well as financial information is maintained. This will identify the appropriate cost drivers, monitor trends in utilisation patterns, measure the efficacy of management initiatives that have been implemented and measure the impact of legislative changes. To this end MCSA has invested significantly by way of its Funder Relations & Contracting and Clinical Service departments to monitor these trends, thereby ensuring constructive dialogue with all relevant role-players.

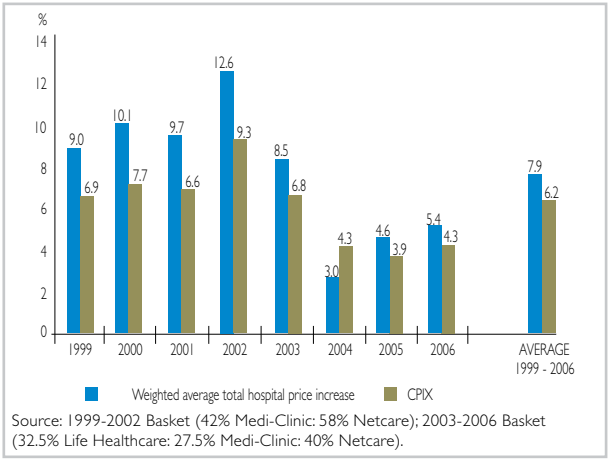
Our database was used in conjunction with information from other HASA members and recently published in the HASA Private Hospital Review 2008 Report ("PHR Report"). The cost drivers of hospitalisation expenditure were described under the following categories in the PHR Report:

### Increase in prices

The increase in prices comprises negotiated tariff increases, non-tariff increases effected by the Department of Health through single exit pricing (i.e. ethicals) and non-tariff increases determined by surgical manufacturers.

The research shows conclusively that the total price (including pharmacy products) has increased by 7.9% per annum, in comparison to a CPIX increase of 6.2% over the same period from 1999 to 2006. The difference of 1.7% per annum, indicating the seven-year average of pure hospital price escalations, is well within medical inflation for the period.

***Total hospital price increases versus inflation:***




Source: 1999-2002 Basket (42% Medi-Clinic: 58% Netcare); 2003-2006 Basket (32.5% Life Healthcare: 27.5% Medi-Clinic: 40% Netcare).

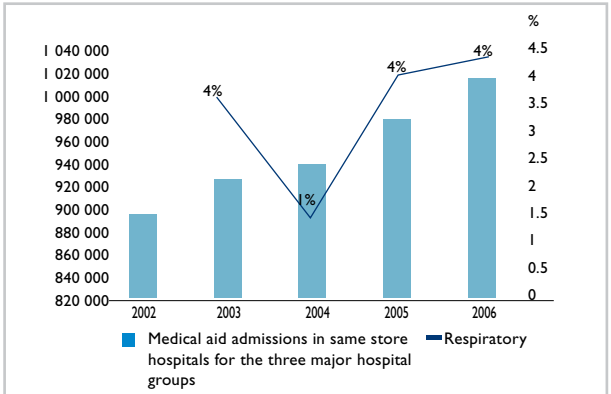
Clearly, price increases were not the primary contributors to the increases in hospitalisation expenditure over this period. Furthermore, the contribution towards the increase in hospitalisation expenditure attributable to price increases, is justified by the greater than inflation increase in input costs. Such cost increases include extraordinary increases in salaries and wages. These increases are primarily attributable to growing workforce shortages, particularly nursing staff shortages.

## Increase in utilisation

The increase in utilisation comprises increases in the number of admissions and increases in the average amount billed per admission in excess of price inflation.

The research furthermore shows that increases in utilisation, including increases in admissions (refer to the figure below), as well as greater intensity of care, are more relevant and have greater impact on hospitalisation expenditure than price increases. There are a number of reasons for the increases in utilisation. These include, *inter alia*, ageing of the medical scheme population, obesity, and the impact of the greater burden of disease, with reference to HIV/Aids and other communicable and chronic diseases.

***Medical scheme admissions into Netcare, Life Healthcare and Medi-Clinic hospitals:***




Source: Regional Business Analytics: Netcare and Medi-Clinic based on same store 2000; Life Healthcare based on same store 2002.

Medi-Clinic remains committed to a process of ensuring that every effort is made to:

- actively drive down the cost of products;
- investigate new financing and healthcare delivery models which will deliver healthcare at lower prices to the uninsured market;
- follow ethical practices, focusing on transparency as a priority; and
- practise fair pricing strategies, devoid of any collusive behaviour.

The affordability of quality healthcare services cannot only be ensured through mechanisms such as transparent prices, newer products, greater competition and cost-effective management techniques. To this end we are committed to the active participation in the process of reform. Our research and development team liaises with the Department of Health on such matters as:

- National Health Reference Price List (NHRPL);
- the definition of utilisation measurement norms; and
- redefining the Prescribed Minimum Benefits (PMB) package.

# OUR PEOPLE

## 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. Our Swiss and Dubai operations also review local benchmarks to ensure that market-related salaries are offered to staff. This ensures that the Group's salaries and related benefits remain competitive, thus enabling us to retain and attract high-calibre 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.

All Southern African employees up to, and including, first-line management level participate in an employee share ownership scheme through 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. Following the rights issue, the trust currently holds 2.53% of Medi-Clinic's issued shares.

A management incentive scheme for senior managers of MCSA 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.

MCCH offers a competitive set of fringe benefits and has a bonus scheme in place for management. MCME also offers various benefits to its staff, including medical insurance, transport and housing for lower-level staff.

## 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 and which is measured by regular employee satisfaction surveys and continuous assessment of our employment conditions. MCCH has calculated the overall average length of employment of its employees at 5.3 years, which is remarkably high given the mobility of nursing staff. Our policies and procedures are continuously evaluated to ensure that our employees are treated fairly and that they work in a safe environment.

We continuously strive to ensure that all our employees are informed of their benefits. For our MCSA staff, this information is supplied on our intranet and is regularly communicated through our *People's Interest* newsletter.

The disciplinary and grievance procedures of MCSA, MCCH and MCME are also available to all staff to ensure that employees are aware of the avenues to put grievances forward, should they have the need to.

## 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. The shortage of nurses remains a challenge throughout the Group. In Southern Africa there is a continuous decrease of suitably qualified staff, specifically technical staff with the average age of technical managers in South Africa being 52.

MCSA utilises a digital recruitment management system that has built up an extensive talent database from which appointments are made. This system has been extended to MCME, who also recently launched a recruitment drive for Emiratis (UAE nationals) supported by a focused training programme.

MCSA embarked on an international nursing recruitment programme two years ago to address the nursing shortage in South Africa. The group now conducts annual foreign recruitment drives in India and this practice is expected to continue for the next few years until we are able to train enough nurses to staff our hospitals. The selected nurses

complete the South African Nursing Council Foreign Registration Examination prior to their arrival in South Africa. The group has successfully placed 16 specialist unit nurses in three Western Cape hospitals, where the shortage is most critical.

## 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, patients and their visitors.

Annual planned maintenance audits are conducted by MCSA to monitor the function of the Health and Safety Committees and verify the competency of the responsible staff members. A legal register is maintained to ensure that all relevant legislation is adhered to. Regular training is given to safety representatives and other members of the team. MCCH is fully compliant to Swiss legal standards, best practices and industry recommendations in respect of workplace safety. MCME follows regulatory safety standards with safety committees in place to ensure the safety of employees and patients. This matter will receive greater attention as part of the JCI accreditation process, as mentioned on page 50 of this report.

The health of the Group's employees is important and ensures the sustainability of quality care to our patients. MCSA's Corporate Health Programme, 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 Programme (EAP). In addition, the EAP offers a 24-hour emergency helpline service for employees. Comprehensive in-house health services are delivered to employees free of charge at the health clinics that have been established at various hospitals, with more clinics being established in order to extend this service. 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 programmes are also presented to employees throughout the year to create a better understanding of their ailments and to ensure a healthy workforce.

The health of employees of MCCH also receives intense focus with a large awareness campaign among employees with a multitude of offerings.

## HIV/Aids

The MCSA HIV/Aids Programme consists of the following elements:

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

Since the implementation of the programme approximately 4 566 (36%) of our employees have attended the ongoing awareness sessions, of which 1 373 have voluntarily participated in the counselling and testing for HIV/Aids. We aim to reach all our employees with the programme, with 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 MCSA group.

MCSA's HIV/Aids and Corporate Health Programmes 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.

Due to the low prevalence level of HIV/Aids in Switzerland and the UAE, it is still being considered whether a similar programme is required at MCCH and MCME.

## 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 commitment to ethical standards is set out in the Group's values. MCCH's strategic mission statements also include their commitment to ethical behaviour.

MCSA's Ethics Line, established in 2001, is managed by an independent service provider, which assures that each call will be treated with the utmost 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. The Ethics Line has received only 70 calls since its implementation, 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.

Strict policies 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 for approval, have been adopted by MCSA, MCCH and MCME. Staff members involved in the purchasing of equipment or consumables are also bound to a strict ethical principles ensuring that an impeccable standard of integrity is maintained in our business relationships.

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

No donations to political parties are made by the Group.

## TRAINING AND SKILLS DEVELOPMENT

Medi-Clinic's training programmes 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 Group and our employees.

MCSA's training department has proactively prepared itself to meet the requirements of the Department of Education regarding Further Education and Training (FET) and Higher Education and Training (HET) as well as the requirements of the new Nursing Act. Medi-Clinic's collaboration agreement with the University of Pretoria has created an opportunity to offer its specialist short courses to meet a broad spectrum of training needs in nursing. These unique courses have proven to be popular and effective over the past year.

MCSA invests approximately 4% of its payroll in training and skills development, which we firmly believe contributes to empowering the talented people of Southern Africa to participate in growing the economy and to attain sustainable socio-economic freedom. During the year 409 students successfully completed basic nursing courses, 65 students completed post basic courses and 517 learners completed Medi-Clinic courses in various disciplines. Our in-service training is going from strength to strength with our own brand of continuing professional development for nursing staff being well established. Established expertise in instructional design continues to serve the company well in rapidly meeting new challenges in competence development as they arise.

MCSA's in-house technical training programmes were expanded in 2007 to address the shortage of skilled artisans in the market, from our technical manager development and clinical technicians training initiatives to include electrical apprentice training programmes. MCSA also continue to train pharmacist assistants, both basic and post-basic, in an effort to develop our staff as well as address some aspects relating to the shortage of pharmacists.

MCCH's education and training programme covers a broad spectrum and opportunities are offered to employees at all levels. Its annual training spent amounted to approximately 1% of its payroll. The MCCH Group's training initiatives are

geared towards performance management, leadership building, quality control on Swiss standards, norms and laws and client relationship building, many of which are mandatory.

MCME's training department has recently implemented an initiative to re-skill the nursing staff on a restricted cost basis, based on MCSA's nurse training programme. The MCME group invested approximately 0.75% of its payroll on training during the period under review. All staff are entitled to seven days study leave annually to attend training or educational career advancement initiatives.

## 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 Group's risk management initiatives.

## Supporting academic institutions

MCSA continues its commitment to educational development in Southern Africa, and has renewed its financial support agreements with a number of academic institutions.

### Stellenbosch University

Stellenbosch University has been recognised as one of the four top research universities in South Africa and Medi-Clinic is proud of its ongoing association with this premier academic institution located in the hometown of the Group. Medi-Clinic has renewed its co-operation agreement with this university to support research and training of medical specialists. A financial contribution of nearly R1.3 million was made to the Stellenbosch University Health Sciences Faculty for this purpose. Among the departments and disciplines benefiting from this partnership are:

*Neurosurgery*: Towards continuous support and exposure of two registrars to neurosurgery in the private sector.

*Obstetrics and gynaecology:* Towards bursaries for the appointment of specialists to complete a fellowship in gynaecological oncology.

*Haematology*: Towards a specialist physician for the completing of a fellowship in clinical haematology, contributing to training, research and service at Tygerberg Hospital and the broader community.

*Physiotherapy*: Towards the subsidisation of master studies of four students.

*Centre for infectious diseases:* Towards the facilitation of a multidisciplinary unit for infectious diseases which focuses on the training, research and service delivery in this vital area.

*Ukwanda*: Towards the remuneration of the director and the facilitation 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.

Stellenbosch University's Unit for Bioethics also benefits from an annual R100 000 donation by Medi-Clinic, which serves as conformation of our commitment to ethics in the complex field of healthcare.

### University of the Western Cape

Medi-Clinic is proud to announce a recently established association with the University of the Western Cape ("UWC"). UWC has been at the intellectual forefront of South Africa's historic change and consistently dedicated to provide access, equity and quality higher learning to the historically marginalised.

Medi-Clinic has partnered with the UWC School of Pharmacy in its efforts to train pharmacists, thus contributing towards an improved healthcare system. Medi-Clinic donated an initial R143 000 in the first year of this association, which will be allocated towards the following:

- leadership training programme for third year pharmacy students;
- expanding the Service Learning in Pharmacy (SLIP) programme for final year students;
- underwriting research areas which affect operations as part of the healthcare system;
- offering specific management courses more relevant to the private sector healthcare needs;
- providing financial support to deserving students; and
- offering prizes for academic excellence to motivate student performance.

Medi-Clinic is looking forward to a long-standing and mutually rewarding relationship with UWC.

### University of Witwatersrand, Johannesburg

The Group continues to support the training of specialists at the Wits Donald Gordon Medical Centre, and contributed R3.6 million during the period under review to the academic activities of the centre.

### University of Pretoria

The Group once again provided support to the Health Sciences Faculty of the university during the period under review by providing administrative support to the value of approximately R112 000 to the vascular unit of the academic hospital.

### University of Limpopo – Medunsa

Through this ongoing association with the University of Limpopo, Medi-Clinic has awarded 30 bursaries to the total amount of R210 000 to medical students at this university. These bursaries were awarded to MMed students who are completing specialist training.

### Paul Roos Academy

Medi-Clinic proudly continues its commitment to the Paul Roos Academy in Stellenbosch with the sponsorship of R100 000 during the period under review. This sponsorship continues to provide advanced learning opportunities to high performing indigent children from Khayelitsha, Nyanga and Langa and nearby farm schools in the Stellenbosch area.

## OUR COMMUNITY INVOLVEMENT

Medi-Clinic takes pride in our efforts to serve the communities in which we operate to the best of our abilities. Our hospitals are involved in a number of community-based activities which aim to extend our commitment to the quality and care experience beyond the walls of our hospitals and into our communities.

MCSA is developing a corporate social investment ("CSI") strategy that will help to facilitate the best use of our resources to address the healthcare needs of many more South Africans, for implementation during the next financial year. All donations and sponsorship activities will henceforth be better co-ordinated and sufficiently recorded, with all contributions being classified appropriately in terms of the percentage of black beneficiaries and in terms of the allocation of donations or corporate sponsorship. The CSI strategy is being developed in line with Medi-Clinic's business objectives.

### Corporate events

MCSA's Corporate Events division is a specialist team within the Marketing and Corporate Liaison department that aims to position itself as a leader in event, disaster and medical support management. The division was officially formed in 2004, although the group has been providing medical expertise and support at major sporting and cultural events for the past 13 years. The number of events supported by the corporate events team is growing annually, with some 30 events supported during the year under review. Some of their high-profile sporting and cultural events include the Cape Epic mountain bike challenge, Cape Argus Pick n Pay Cycle Tour, Cape Times Big Walk, Klein Karoo National Arts Festival and the Aardklop Arts Festival.

MCCH is also committed to being a good corporate citizen and provides medical support at various sporting and other community events, such as the Swiss Wrestling and Alpine Festival (Eidgenössisches Schwing- und Älplerfest). MCME renders medical support to large sporting events such as the Dubai Rugby 7s, Australian Rules Football Tournament and the BurJuman's Pink Walkathon.

## Ensuring healthy communities

For many years Medi-Clinic has been contributing to the health and wellness of our communities in the form of partnerships, donations and sponsorships, either through regional support or through individual hospital participation. Through these ongoing sustainable development initiatives our hospitals have established themselves as intrinsic members of their communities, extending our quality service offering beyond the walls of our hospitals and enriching the lives of the community members at all levels.

### Donations

MCSA's hospitals frequently donate linen, uniforms, equipment and furniture to organisations in need such as hospices, orphanages and children's homes, old age homes and animal welfare organisations. Our hospitals also donate first aid kits to schools, community sports development organisations and various other institutions. Generous donations to associations such as the Blood Transfusion services, the Cancer Association of South Africa ("CANSA") and other health service organisations are also made.

MCSA's wholly owned subsidiary, Medical Innovations, has assisted with the upgrade of seven crèches in the Cape Flats area, with carpet overruns, samples and redundant furniture from the Medical Innovations stores. Emergency cart and monitors were also donated to the Red Cross Children's Hospital.

Emirates Healthcare has made a substantial donation to Dubai Cares, a charitable educational initiative under the leadership of His Highness Sheikh Mohammed bin Rashid Al Maktoum, Vice President and Prime Minister of the UAE and Ruler of Dubai.

### Sponsorships

Medi-Clinic hospitals have annual and *ad hoc* sponsorships of community, school and regional sporting and cultural events. MCSA is a long-standing sponsor of National Cancer Survivors' Day and the individual hospitals take part in regional Cancer Survivors' Day activities. MCCH provides arts and culture sponsorships to the Lucerne Symphony Orchestra (Luzerner Sinfonieorchester) and the Zürcher Schauspielhaus.

### Medical support

Our hospitals take part in many annual national health awareness days by providing free health screenings, discussions and workshops during national awareness initiatives such as breast cancer month, heart and stroke week, diabetes, and pregnancy education months, and many others. MCME also offers regular awareness campaigns for breast cancer.

### Volunteerism

Many of our nursing personnel participate in hospital and community based antenatal classes, breastfeeding clinics and well baby clinics.

### Training

MCSA personnel regularly participate in CPR (Cardio Pulmonary Resuscitation) and first aid training at community service organisations, schools and other community hospitals.

The MCCH clinics organise public information events on a regular basis, providing first-hand information about certain conditions and the treatment thereof.

### Medical care for the indigent

The Wits Donald Gordon Medical Centre provides quality healthcare and support to many South Africans in need. In the past year a number of *pro bono* patients, who were not able to pay for treatment have undergone medical procedures, including medication, free of charge. These treatments included reconstructive surgery, liver transplants, colonoscopy and gastroscopy procedures.

In a recent joint initiative MCSA partnered with the Western Cape Department of Health in a bid to bring some relief to the increasing number of people in the Western Cape suffering from partial or complete blindness. In December 2007 Paarl Medi-Clinic, Panorama Medi-Clinic, Milnerton Medi-Clinic and Vergelegen Medi-Clinic hospitals were involved in a project through which the sight of 58 indigent South Africans were restored through standard cataract removal procedures. Participating ophthalmologists, anaesthetists and theatre personnel at the hospitals performed these procedures free of charge and medical kits were sponsored by suppliers. The immense success of this initiative, coupled with the historical backlog in cataract removal procedures at provincial hospitals across South Africa, have paved the way

for a possible future long-term, sustainable partnership with the Department of Health.

## Education and training

Please refer to the report on training and skills development on pages 61 to 63.

# ENVIRONMENTAL PERFORMANCE

Medi-Clinic is committed to protecting the environment, conserving our natural resources and utilising resources in an effective and responsible manner, 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

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

In support of the above policy, MCSA 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, as set out in the table on page 66.

Strict and comprehensive environmental legislation applies in Switzerland, to which MCCH complies. Consumption of electricity, oil, gas and water is constantly monitored and annually reported to local authorities. Energy efficiency is a primary focus for MCCH and leading edge solutions have been adopted where this is economically justifiable.

MCME also complies with all local regulatory requirements relating to environmental matters, including water consumption, water recycling and waste management.

| Criteria | Specific Assessment Criteria | Performance | Revision & Planning |
|---|---|---|---|
| Compliance with environmental and other legislation | 28 applicable legislation, excluding tax, business, medical & finance legislation | Legal register version 6 established. | Confirmation of legal compliance at 18 hospitals. Audits completed at 11 hospitals. |
| Environmental Management Systems | ISO 14001:2004<br>JSE SRI Index | 12 hospitals ISO certified.<br>ISO certification of additional 4 hospitals for 2008 in progress.<br>Inclusion in JSE SRI Index maintained. | 12 hospitals ISO certified.<br>18 hospitals ISO trained.<br>10 additional hospitals to be trained in 2008.<br>36 hospitals planned for ISO certification by the end of 2011.<br>Maintain inclusion in JSE SRI Index. |
| Environmental awareness | ISO 14001:2004 | Network started between 18 hospitals.<br>Programme for continuous environmental awareness was established. | Environmental awareness entrenched in all business activities. |
| Prevention and minimise of impacts | ISO 14001:2004 | 18 ISO trained hospitals with programmes. | Implementation of additional 10 ISO certified hospitals during 2008. Remaining hospitals to start establishing baseline and phasing in of ISO principles. |
| Aspect identification | Aspect register | 18 ISO trained hospitals with aspect registers. | Principles of aspect registers and baseline to be rolled out to all hospitals to start phasing in of ISO principles. |
| Recycling of general waste | ISO 14001:2004<br>Local by-laws | 18 ISO trained hospitals with processes. | Introduction of principles of recycling at all hospitals. |
| Management of hazardous waste | ISO 14001:2004<br>Local by-laws | 18 ISO trained hospitals with confirmed processes.<br>Various other processes in place. | ISO 14001:2004 processes to be implemented at all hospitals with the aim of future accreditation.<br>Establishment of hazardous waste register at all hospitals. |
| Influencing suppliers and service providers | ISO 14001:2004 | 18 ISO trained hospitals with programmes. | Introduction of green approach to suppliers and providers.<br>Establishment of an internal audit programme for service providers on-site at 18 ISO trained hospitals. |
| 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.<br>Monitoring via ISO 14001:2004 standards. |

## Environmental management and risk assessment

MCSA is committed to ensuring that its environmental management systems and practices are aligned with international best practices, such as the ISO 14001:2004 standard. Twelve MCSA hospitals have obtained ISO 14001:2004 certification. A further four hospitals will obtain certification during 2008. The remaining hospitals in the group 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

MCSA 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 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 bed 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

MCSA's 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 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 Eskom with regards to energy saving possibilities. We started a pilot project during the previous financial year at Hoogland Medi-Clinic in Bethlehem with involvement from Eskom 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. This project has been submitted to Eskom for financial assistance.

## 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 MCSA's ISO certified and/or trained 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%.

# STAKEHOLDER ENGAGEMENT

Our stakeholders cover a wide spectrum of audiences including our employees, patients, supporting doctors, shareholders, suppliers, funders of healthcare, healthcare regulatory bodies and industry associations. The nature of our business implies close personal engagement and we strive to achieve this through a variety of communication activities. Ongoing, proactive internal and external communication between Medi-Clinic, its stakeholders and industry opinion formers is therefore fundamental to maintaining this positive corporate reputation of our brand.

In 2007, for the second consecutive year, Medi-Clinic received the Markinor/Sunday Times Top Brand Award for South African healthcare facilities and specifically as the leading private hospital group in the country. Medi-Clinic regards this as clear confirmation and acknowledgment by corporate South Africa of the passion and dedication that drives the success of the Medi-Clinic brand.

MCCH follows a strategic mission statement that the company aims at being the partner of choice for its relevant stakeholders. MCME also follow various communication activities with its stakeholders.

## Corporate reputation assessment

The corporate reputation assessment was implemented in September 2007 and respondents were interviewed by an independent research organisation. The outcome of this extensive research was presented during April 2008. Our stakeholder communication programmes follow a carefully planned and structured approach and are based on the outcomes of the assessment, which aims to assess the perception of the Medi-Clinic brand amongst key industry stakeholders and measures their loyalty towards the Medi-Clinic brand. The outcome of this assessment will direct communication methods between Medi-Clinic and these external stakeholders. It will also serve as a guide in terms of our corporate branding positioning. Our key external stakeholders interviewed in the assessment included government, regulatory authorities, industry associations, media, investment analysts, suppliers and medical schemes.

## Employees and trade unions

At Medi-Clinic we believe that effective organisational communication and active participation by employees in the day-to-day running of the company make an important contribution to our success. We continuously evaluate existing communication channels in order to gauge its effectiveness, and adapt and introduce additional communication vehicles in order to ensure seamless dissemination of organisational messaging.

Our staff members are treated fairly, remunerated competitively and involved in the day to day running of the organisation. Effective human resources management, good communication and sound labour relations have

contributed to a stable workforce and the Group's low trade union membership. Good working relationships are maintained with trade unions where we do have recognition agreements.

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.

Communication with our MCSA employees is conducted through a variety of channels, including:

- *Milieu*, a quarterly staff magazine with human interest and corporate news;
- *People's Interest,* a bimonthly staff newsletter containing human resources related information;
- *HaemoHighway*, a bimonthly, intranet based electronic newsletter with corporate news;
- *Nursing*, a biannual publication containing nursing industry news and case studies;
- quarterly leadership conferences via satellite broadcast, filtered down to all staff through a structured line management briefing system; and
- biannual nurses satellite broadcast service between nursing staff and our General Manager: Nursing.

An annual, internal brand roadshow initiative was launched three years ago. This month-long roadshow serves to inform staff members of corporate and brand milestones in a relaxed and engaging environment. An internal assessment among staff post the 2007 brand roadshow indicated that staff continue to find these sessions most informative. Medi-Clinic received the coveted silver PRISA (Public Relations Institute of Southern Africa) PRISM Award for excellence in internal communication based on the roll-out and outcome of the 2007 brand roadshow initiative.

Early in 2008 MCSA also embarked on a group-wide communication assessment initiative that evaluates the flow of communication within the organisation. The outcome of this assessment will test the effectiveness of current communication vehicles, identify communication gaps and help guide methods of improving on existing structures. Moreover, the communication assessment will serve as a measurement of employees' perception of the Medi-Clinic brand. Some 400 employees are being polled during the communication assessment, with sample quotas carefully placed per region, payroll code and job grade.

An ongoing Employee Relations Assessment ("ERA") programme continues to measure employee perceptions of Medi-Clinic and their roles within the company and to measure loyalty levels among the various employee groups. The outcome of the previous ERA in 2007 clearly indicated that employee loyalty is increasing, and that employee attitudes were generally favourable towards Medi-Clinic. Three distinct drivers of loyalty were highlighted in the outcome and Medi-Clinic continues to address these drivers through dedicated communication interventions.

In addition to local employee periodicals, such as the *Voice* and *Mittelpunkt*, a group employee periodical, *Apropos*, is also circulated to our MCCH employees three times per year. Monthly meetings are held between management and employees in order to provide all employees the opportunity to voice any concerns.

MCME holds monthly management meetings with all operational units to ensure effective communication. Employees are also kept up to date with group matters via regular employee meetings and electronic newsletters. In order to improve internal communication, the group is in the process of launching an intranet aimed at improving availability of information to employees.

## Patients

MCSA continuously measures patient satisfaction through an ongoing survey conducted by an independent research organisation. The main objective of the survey is to identify potential focus areas in order to ensure quality service to our patients and to enable us to improve the overall customer experience at Medi-Clinic.

MCSA's quarterly hospital magazine, *Gesundheit*, is aimed at patients and contains informative articles promoting healthy lifestyle and general health-related information. The Medi-Twinkle maternity programme provides expectant mothers with tailor-made antenatal programmes, as well as various other value-add products. Medi-Clinic Senior,

launched in 2007, is aimed at people 60 years and older and involves information sessions, health screening clinics and other hospitalisation value-adds.

MCCH also conducts regular patient satisfaction surveys in co-operation with the Swiss branch of the Picker Institute, providing a national benchmark with other acute-care hospitals in Switzerland. Health-related information is provided to patients through regular clinic newsletters, the group's website and the Health Line, a call centre offering information on the group's doctors and hospitals and advice on medical and healthcare matters. The guest relation staff ensures patient satisfaction and is aimed at maintaining good relations with patients.

## Doctors

Supporting doctors are key stakeholders of the Group and play a vital role in Medi-Clinic's commitment to quality care, while acknowledging their freedom of association and clinical independence from Medi-Clinic.

Quantitative and qualitative research programmes are currently being conducted among referring doctors and specialists across the entire MCSA network. These assessments will allow us to investigate the success of, and enhance our direct communication efforts with this key target audience. This will ultimately enable us to strengthen our relationship with the supporting doctors and specialists in order to retain the current support and recruit new doctors to increase our network of associated medical practitioners.

MCSA continues to present regular continuous professional development programmes to supporting doctors throughout the year. 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.

MCCH conducts regular doctor satisfaction surveys and also hosts an annual doctors' congress, where developments in the healthcare market are addressed. Group information and medical-related information are communicated to the doctors through a biannual medical periodical, *Aktuelle Medizin*. We also offer doctors a dedicated comprehensive internet offering providing group and medical information and other online services.

At MCME the majority of the doctors are employed by the group. In addition to the employee communication initiatives mentioned above, regular communication and meetings are conducted with the doctors.

## 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 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.

MCSA annually hosts a Supplier of the Year Award ceremony, awarding a supplier who has provided the most exceptional service to the group according to a set of weighted criteria, which include response time, quality of product, service and support, as well as a responsible pricing structure. In order to add efficiency, more electronic processes in dealing with pharmacy suppliers are being introduced, including ordering, invoicing, receipt and statement reconciliation. Supplier credentials are also scrutinised in order to ensure that we have a sustainable source of product. This is especially important when it comes to our initiatives involving any form of standardisation to reduce costs. The Medi-Clinic Ethics Line, as referred to earlier in this report, is also available on a 24-hour basis to our suppliers.

MCCH regularly co-operates with suppliers in the development and implementation of new devices and services, as well as the pharmaceutical industry in the field of clinical research.

## Community

For more information regarding our engagement with the community, please refer to pages 63 to 65.

## Healthcare funders

MCSA's Funder Relations & Contracting Department actively pursues every opportunity to contract directly with every medical scheme in South Africa, the adjoining SADC countries, or abroad. The local medical scheme market, however, remains our largest client base. Although there are approximately 121 individual medical schemes, we find that the greater majority of members are accumulated under a select group of medical scheme administrators. By and large, the board of trustees of medical schemes delegated the contracting and tariff negotiations to these administrators. The combined buying power is, therefore, effectively consolidated into six administrators representing 71.6% of the total medical scheme market.

During the course of this past year, the collaborative initiatives of a number of schemes led to the introduction of various alternative reimbursements schedules and other agreements. These efforts continue to enhance the vision of becoming the most trusted and respected provider of hospital services.

In terms of administrative efficiency, our Business to Business initiative has expanded significantly, resulting in cost savings and more cost-effective interaction between our hospitals and contracted administrators. With the majority of contracted funds already receiving electronic claims, there is a drive among the smaller funds to implement this process as well, in order to reduce the administration of paper claims.

MCCH's and MCME's management also holds regular meetings and conducts annual negotiations on tariffs with medical insurance companies.

## Government and authorities

### Departments of Health

As more fully reported upon under the section dealing with our initiatives to improve the affordability of healthcare on pages 56 to 58 of this report, MCSA is involved in ongoing communication and interaction with the National and Provincial Departments of Health. Issues pertaining to, *inter alia*, licence applications, inspection of facilities, approval of building plans and comment on draft legislation and regulations are dealt with on a continuous basis.

MCCH is actively taking part in the formulation of healthcare legislation and regulation in Switzerland with annual meetings between senior management and key public officers. The proposed constitutional amendment ("Gesundheitsartikel") would not have an immediate impact on the current healthcare legislation but constitutes the basic framework for upcoming legislation. Its promoters intend to prevent future regulatory steps towards a socialisation of the healthcare industry by stipulating the application of market economics as a ruling principle. The bill is promoted by a broadly supported committee, with two members of the MCCH group represented on the committee.

MCME's senior management holds regular meetings with Dubai Health Care City and government authorities.

### South African Nursing Council

MCSA 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 further sections of the Nursing Act, No 33 of 2005, and accompanying regulations with effect from 19 February 2008. Community service for nursing practitioners is now a reality with the publishing of the regulations concerned.

### 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.

### South African Pharmacy Council

There is continued liaison with the South African Pharmacy Council and input is given on all legislative matters. The latest changes to the Good Pharmacy Practice guidelines have necessitated some changes within the pharmacies in order to ensure patient confidentiality which we support. We also continue to strive to ensure that our pharmacies comply with all legislative requirements and this is assessed by means of regular internal audits as well as inspections by the inspectorate of the Pharmacy Council.

### Engineering Council of South Africa

MCSA 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.

## Industry associations

### Hospital Association of South Africa ("HASA")

HASA is an industry association which represents the collective interests of the overwhelming majority of private hospital groups and independently-owned private hospitals in South Africa. Three of Medi-Clinic's executive management members serve 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.

### Private Hospitals Switzerland ("PKS")

MCCH is an active member of PKS, the Swiss private hospital industry association.

### Engineering Associations

MCSA's General Manager: Infrastructure is the President of SAFHE (South African Federation of Hospital Engineering) and IFHE (International Federation of Hospital Engineering). Several of the group's regional engineers and technical managers are members of their local SAFHE branch committees. SAFHE is also listed as a voluntary association with ECSA (Engineering Council of South Africa) and plays an active part in forums where healthcare waste management is discussed.

MCSA'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 CEASA.

# Corporate Governance Report

Medi-Clinic is committed to maintaining strict principles of good corporate governance and the highest standard of integrity and ethics, as embodied in the King Report on Corporate Governance for South Africa 2002 ("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, co-operation 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"). Similar corporate governance practices have been implemented by the boards of the company's three operating platform companies in Southern Africa, Switzerland and the United Arab Emirates and receive ongoing attention by the company.

## BOARD OF DIRECTORS

### Board charter and responsibilities

A formal code of conduct ("the board charter") sets out the responsibilities of the board, individual directors and the Company Secretary. Key responsibilities in terms of the board charter include 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 six times per annum and on an *ad hoc* basis, if required, 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.

## 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 Chief Executive Officer are segregated.

Although the Chairman of the board, Dr Edwin Hertzog, is classified as an executive director he is regarded as a semi-executive Chairman. The board acknowledges the recommendation in the King Report to preferably appoint an independent non-executive Chairman, but given his involvement in a chief executive capacity from the incorporation of the company until his appointment as Chairman in 1992 and the resultant in-depth industry knowledge and experience, considers it in the company's and the Group's best interest to have him as Chairman. He also serves as Deputy Chairman of Remgro and on the boards of three other Remgro associated companies, of which two are listed on the JSE. He was also the Chairman of the Stellenbosch University Council for four years until 31 March 2008.

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

The Chief Executive Officer, 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 evaluation and induction of new directors

The board conducts an objective and confidential evaluation in respect of the board's performance, strategic planning, composition, ethics, performance and the effectiveness of its procedures biannually.

Newly appointed directors are formally informed of their fiduciary duties by the Chairman and the Company Secretary. An extensive induction programme that includes information sessions with management, as well as visits to the company's hospitals, ensures that new directors obtain a good understanding of the company's core business. During the past year, Dr Robert Bider, Mr Joseph Cohen and Mr Desmond Smith were appointed to the board and underwent the induction programme.

Directors receive extensive information upon their appointment on the JSE Listings Requirements and the obligations therein imposed upon directors and are continuously informed of any amended and new relevant legislation, as well as any changes in business risks that may have an impact on the Group.

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 relating to 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 our management teams in Southern Africa, Switzerland and Dubai to ensure effective communication, decision-making and execution of strategies.

## 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 77) meets periodically to discuss matters such as remuneration policy, board structure and composition, executive management and staff remuneration, directors' remuneration and incentive schemes. The committee ensures that adequate succession planning measures are in place.

The committee is chaired by Prof Wynand van der Merwe, an independent non-executive director. The Chief Executive Officer and MCSA's General Manager: Human Resources 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 77) 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, approving their fee and determining their terms of engagement. Over the past years non-audit services by the external auditors were limited to tax advice. During the period under review non-audit services by the external auditors included tax advice, the remuneration of which is disclosed in the annual financial statements, as well as other services in respect of the Hirslanden transaction, as disclosed in the circular to shareholders dated 17 August 2007. A formal policy in respect of non-audit services by the external auditors has been adopted by the committee and the board during the period under review to ensure the maintained independence of the external auditors. The committee is responsible for determining the nature and extent of any non-audit services that the external auditors may provide to the company and pre-approve any proposed contract with the external auditors for the provision of non-audit services to the company. The services of the internal and external auditors are adequately integrated.

Prior to 14 May 2008, the committee was chaired by Mr Thys Visser, a non-executive director. In order to comply with the Companies Act, as amended by the Corporate Laws Amendment Act, No 24 of 2006, Mr Visser resigned and Mr Desmond Smith, an independent non-executive director, was appointed as the new committee Chairman. The Chairman of the board also attends some of 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 | 09/05/07 | 19/06/07 | 26/07/07 | 10/09/07 | 07/11/07 | 01/02/08 | 14/03/08 |
|---|---|---|---|---|---|---|---|
| E de la H Hertzog (Chairman) (Executive**) | √ | √ | √ | √ | √ | √ | √ |
| L J Alberts (Executive) | √ | X | √ | √ | √ | √ | √ |
| R H Bider (Executive) (appointed 1 February 2008) | n/a | n/a | n/a | n/a | n/a | √ | √ |
| J C Cohen (Non-executive) (appointed 1 February 2008) | n/a | n/a | n/a | n/a | n/a | n/a | √ |
| S Dakile-Hlongwane (Independent non-executive) | √ | √ | √ | √ | √ | √ | √ |
| J du T Marais (Executive) | √ | √ | √ | √ | √ | √ | √ |
| A R Martin (Independent non-executive) | √ | √ | √ | √ | √ | √ | √ |
| D P Meintjes* (Executive) | X | X | √ | X | √ | √ | √ |
| V E Msibi (Non-executive) | √ | √ | √ | √ | X | √ | √ |
| K H S Pretorius (Executive) | √ | √ | √ | √ | √ | √ | √ |
| A A Raath (Independent non-executive) | √ | √ | √ | √ | √ | √ | √ |
| M A Ramphele (Non-executive) | X | √ | √ | √ | √ | √ | √ |
| J G Swiegers (Executive) | √ | √ | X | √ | √ | √ | √ |
| D K Smith (Independent non-executive) (appointed 31 March 2008) | n/a | n/a | n/a | n/a | n/a | n/a | n/a |
| W L van der Merwe (Independent non-executive) | X | √ | √ | √ | √ | √ | X |
| M H Visser (Non-executive) | √ | √ | √ | X | √ | √ | √ |

√ = attended
X = absent with apology

* Due to his secondment to Dubai, Mr Meintjes is only required to attend every second board meeting.

## Audit and Risk Committee meetings:

| Directors | 08/05/07 | 06/11/07 | 13/03/08 |
|---|---|---|---|
| D K Smith (Chairman) (Independent non-executive) (appointed 14 May 2008) | n/a | n/a | n/a |
| M H Visser (Chairman) (Non-executive) (resigned as Chairman on 14 May 2008; member until 30 July 2008) | √ | √ | X |
| L J Alberts (Executive) (resigned 14 March 2008) | √ | √ | √ |
| A R Martin (Independent non-executive) | √ | √ | √ |
| A A Raath (Independent non-executive) | √ | √ | √ |
| M A Ramphele (Non-executive) (member until 30 July 2008) | X | √ | √ |
| J G Swiegers (Executive) (resigned 14 March 2008) | √ | √ | √ |
| √ = attended<br>X = absent with apology | | | |

## Human Resources Committee meetings:

| Directors | 04/06/07 | 26/07/07 | 12/10/07 | 01/02/08 | 14/03/08 |
|---|---|---|---|---|---|
| W L van der Merwe (Chairman) (Independent non-executive) | √ | √ | √ | √ | X |
| E de la H Hertzog (Executive**) | √ | √ | √ | √ | √ |
| V E Msibi (Non-executive) | X | √ | √ | √ | X |
| M H Visser (Non-executive) | √ | √ | √ | √ | √ |
| √ = attended<br>X = absent with apology | | | | | |

** Please refer to the explanation in respect of the classification of Dr Hertzog as executive chairman on page 74 of the report.

## Dealings in securities

Procedures have been put in place to ensure that directors and senior management of the Group 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 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.

# RISK MANAGEMENT AND INTERNAL CONTROL

The board is ultimately accountable for the company and its subsidiaries' risk management process and system of internal control. The Audit and Risk Committee, on behalf of the board, monitors the risk management process and systems of internal control for the Group by considering the activities of the Audit and Risk Committees for Medi-Clinic Southern Africa ("MCSA"), Medi-Clinic Switzerland ("MCCH") and Medi-Clinic Middle-East ("MCME"), the Group's internal and external auditors and the Group risk management function.

## Risk management

The Group Risk Management Policy, which is benchmarked against COSO (Committee of Sponsoring Organisations of the Treadway Commission) and complies with the recommendations of the King Report, defines the risk management objectives, methodology, process and the responsibilities of the various risk management role-players in the Group.

The objectives of the risk management process are to optimise the Group's residual risk profile and to exploit all viable opportunities within the risk appetite set by the board, whilst minimising exposure to potential losses.

The risk management process as implemented in MCSA to ensure timeous identification and response to risks and opportunities comprises the following:

### Risk assessment

Maintaining of the MCSA group's risk register based on the identification, evaluation and prioritisation of significant risks in terms of potential impact, probability of occurrence and control effectiveness.

### Risk treatment

Developing and maintaining a strategy on the treatment of all significant risks inherent to the MCSA group's core activities. These include the design and implementation of appropriate controls and monitoring activities as well as the implementation of risk sharing or risk avoidance steps.

### Risk monitoring

The effectiveness of the risk management processes is monitored through 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. It furthermore renders full transparency of risk management activities per region, hospital and discipline in each hospital.

### Risk funding

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

The integration of the existing risk management processes of MCCH and MCME with the Group's Risk Management Policy is planned for the next financial year, since these entities were only acquired during March and October 2007 respectively.

The following priority risk items are central to the Group's risk management processes:

| Medi-Clinic Southern Africa | Medi-Clinic Switzerland | Medi-Clinic Middle East |
|---|---|---|
| **Physical and operational risks** | | |
| • Medical practitioner selection and support<br>• Quality medical care<br>• Medical malpractice<br>• Health and safety risks | • Medical malpractice<br>• Health and safety risks<br>• Quality of air, water and oxygen | • Medical malpractice<br>• Developing commercial system |
| **Human resources risks** | | |
| • Availability and retention of trained personnel<br>• Communication | • Retention of key employees<br>• Competitiveness on labour market | • Availability and retention of trained personnel<br>• Management of multi-cultural workforce |
| **Technical risks** | | |
| • Information technology systems availability and security<br>• Medical technology risks | • Information technology systems availability and security<br>• Power interruptions<br>• Radiation | • Information technology systems availability and security<br>• Power interruptions<br>• Radiation |
| **Business continuity and disaster recovery** | | |
| • Pandemics<br>• Fire and allied perils | • Pandemics<br>• Fire and allied perils<br>• Hygiene | • Pandemics<br>• Fire and allied perils<br>• Regional instability |
| **Credit and market risks** | | |
| • Funders, medical schemes and fee structuring<br>• Regulatory changes | • Credit risk<br>• Decreasing number of privately insured patients<br>• Regulatory changes | • Credit risk / interest rate<br>• Rapid growth of competitor facilities<br>• Unethical competitor practices<br>• Regulatory changes |
| **Compliance risks** | | |
| • Legal compliance<br>• Licensing requirements | • Permissions for clinics, devices and specialised procedures<br>• Data security (patient data) | • Developing legal system and regulatory framework<br>• Legal compliance |



## Internal control

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

In MCSA the effectiveness of the system of internal control is independently evaluated by the external auditors, PricewaterhouseCoopers Inc., as well as through an extensive outsourced internal audit program. In addition to the internal audits, the effectiveness of operational procedures are examined internally by the Medi-Clinic Quality Assurance Team ("MQAT") and the controls self-assessment process of risk management. The results of these assurance processes are monitored by a central Risk Management Committee comprising of management, representing all disciplines considered core to the business, which is also responsible for drawing up policies and procedures on risk management as well as the financing of residual risks, including self-insurance.

MCSA has further implemented a comprehensive independent accreditation process with two independent organisations:

- COHSASA (Council for Health Services Accreditation of Southern Africa), which is accredited by ISQua (the International Society for Quality in Health Care), enables MCSA's participating hospitals to be measured against internationally accredited quality standards; and
- ISO 14001:2004 certification by NQA (National Quality Assurance Limited) / UKAS (United Kingdom Accreditation Service).

In MCCH and MCME the effectiveness of the systems of internal control are independently evaluated by the external auditors, Ernst & Young and KPMG respectively.

The Company Secretary is responsible for guidance in respect of the compliance with applicable laws and regulations.

## Effectiveness of risk management process and system of internal control

The board, via the Audit and Risk Committee, also regularly receives and considers the activities of the MCSA, MCCH and MCME Audit and Risk Committees, internal and external auditors, Risk Management Committee and the Group Risk Services function. Based on the work performed, the board is satisfied that there is an effective risk management process in place and that an adequate and effective system of internal control exists to mitigate the significant risks faced by the Group to an appropriate level for Medi-Clinic.

## EXTERNAL AUDIT

The Audit and Risk Committee is responsible for appointing the company's external auditors. The external auditors, whose report appears on page 83, 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.

Non-audit services provided by the external auditors are dealt with earlier in this report on page 75. The remuneration payable in respect of these services is disclosed in the annual 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. Our sound long-term relationships with 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. Further information regarding the Group's initiatives to ensure ethical practices by our employees is contained in the Sustainable Development Report.

## 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.

Further information regarding the Group's initiatives on shareholder communication is contained in the Sustainable Development Report.

# contents of financial statements

## DIRECTORS' RESPONSIBILITY STATEMENT
by the Board of Directors

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

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

Nothing has come to the attention of the directors to indicate that any material interruption in the functioning of these controls, procedures and systems has occurred during the year under review. The annual financial statements have been prepared on a going concern basis and the directors believe that the Company and the Group will continue to be in operation in the foreseeable future.

The annual financial statements and group financial statements as set out on pages 84 to 130, have been approved by the Board of Directors and are signed on their behalf by:

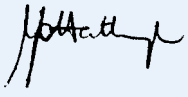
**E DE LA H HERTZOG**
Chairman

**L J ALBERTS**
Chief Executive Officer

**Stellenbosch**
14 May 2008

## 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.



**G C HATTINGH**
Secretary

**Stellenbosch**
14 May 2008

## 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 2008, the income statement and the consolidated income statement, the statement of recognised income and expense and the consolidated statement of recognised income and expense, 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 84 to 130.

*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*

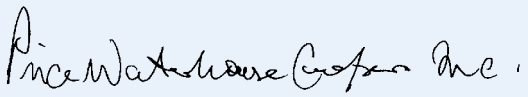
Our responsibility is to express an opinion on these financial statements based on our audit. We conducted our audit in accordance with International Standards on Auditing. Those standards require that we comply with ethical requirements and plan and perform the audit to obtain reasonable assurance whether 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 2008, 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: J H Loubser
Registered Auditor

**Stellenbosch**
14 May 2008

# DIRECTORS' REPORT
for the year ended 31 March 2008

## 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 50 hospitals in Southern Africa, 13 in Switzerland and one in the Middle East. A complete list of hospitals appear on pages 46 and 47.

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

The Southern African operations acquired a 51% interest in the 200-bed Protector hospitals effective from 7 November 2006. It also acquired from Phodiso Holdings its 49% interest in Tshwane Private Hospitals, which in turn holds a 63% interest in Curamed Holdings, as well as its 49% interest in Phodiclinics (which owns the Protector hospitals), effective from 1 April 2007.

Your Group also acquired 100% of Hirslanden, the holding company of the largest private hospital group in Switzerland, with effect from 26 October 2007.

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

## SHARE CAPITAL

The authorised share capital was increased from 450,000,000 shares to 1,000,000,000 shares during the year.

The Company raised R4,500 million through a rights offer on 10 December 2007. Approximately R4,000 million of the proceeds was applied towards the equity contribution for the acquisition of Hirslanden. The rights offer was for a total of 198,675,497 ordinary shares at a subscription price of 2,265 cents per share in the ratio of 50.38197 shares for every 100 Medi-Clinic shares held.

## TREASURY SHARES

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 for employees in terms of the executive share option scheme and the long-term management incentive scheme.

During the year under review 1,368,921 shares (2007: 1,251,810) have been released from the original 28,498,919 treasury shares issued to the BEE shareholders resulting in the balance of 16,246,321 shares (2007: 17,615,242). Furthermore the Mpilo Trust released 124,760 shares (2007: 233,780) to employees resulting in the balance of 15,414,998 shares (2007: 15,539,758). The Group also released 1,225,395 (2007: 1,653,233) treasury shares as well as acquiring 503,678 shares in respect of the rights offer held through a wholly owned subsidiary.

## DISTRIBUTION TO SHAREHOLDERS

The Board of Directors has declared a final dividend of 41.9 cents (2007: 37.6) per ordinary share on 14 May 2008. This, together with the interim dividend of 19.3 cents (2007: 16.5) per share, brings the total normal dividend for the year to 61.2 cents (2007: 54.1) per share.

| | **2008 R'000** | 2007 R'000 |
|---|---|---|
| Interim distribution of 19.3 cents (2007: 16.5 cents) | **76,107** | 65,066 |
| Final distribution of 41.9 cents (2007: 37.6 cents) | **248,473** | 148,271 |
| | **324,580** | 213,337 |

## DIRECTORS' REPORT
for the year ended 31 March 2008 (continued)

### 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% (2007: 43.4%) of the issued ordinary shares. Details of subsidiaries, joint ventures and associates appear in the annexure from pages 126 to 128.

### DIRECTORS AND SECRETARY

The names of the directors and secretary of the Company, as well as the latter's postal address, appear on pages 7 to 9.

Dr R H Bider and Mr J C Cohen were co-opted as directors with effect from 1 February 2008.

Mr D K Smith was co-opted as a director with effect from 31 March 2008.

Your Board recommends that directors' fees for services rendered during the past financial year be fixed at R1,454,360 (2007: R1,153,000).

### DIRECTORS' INTERESTS

Details of the direct and indirect interest in the issued permanent capital structure of your Company by directors are set out on page 130. 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 2008

| COMPANY 2007 R'm | COMPANY 2008 R'm | | Notes | GROUP 2008 R'm | GROUP 2007 R'm |
|---|---|---|---|---|---|
| | | **ASSETS** | | | |
| 468 | **4,926** | **Non-current assets** | | **37,251** | 3,709 |
| – | **–** | Property, equipment and vehicles | 5 | **30,972** | 3,124 |
| – | **–** | Intangible assets | 6 | **6,079** | 419 |
| 451 | **4,923** | Interest in subsidiary | 7 | **–** | – |
| – | **–** | Investments in associates | 8 | **11** | 5 |
| – | **–** | Other investments and loans | 9 | **23** | 41 |
| – | **–** | Derivative financial instruments | 20 | **43** | – |
| 17 | **3** | Deferred income tax assets | 10 | **123** | 120 |
| – | **–** | **Current assets** | | **4,326** | 1,780 |
| – | **–** | Inventories | 11 | **448** | 190 |
| – | **–** | Trade and other receivables | 12 | **3,077** | 874 |
| – | **–** | Cash and cash equivalents | | **801** | 716 |
| 468 | **4,926** | **Total assets** | | **41,577** | 5,489 |
| | | **EQUITY** | | | |
| | | **Capital and reserves** | | | |
| 39 | **59** | Ordinary shares | | **59** | 39 |
| 289 | **4,741** | Share premium | | **4,741** | 289 |
| – | **–** | Treasury shares | | **(297)** | (297) |
| 328 | **4,800** | Share capital | 13 | **4,503** | 31 |
| 39 | **17** | Retained earnings | 14 | **2,334** | 1,934 |
| 101 | **109** | Other reserves | 15 | **2,043** | 103 |
| 468 | **4,926** | **Attributable to equity holders of the Company** | | **8,880** | 2,068 |
| – | **–** | **Minority interest** | 16 | **807** | 752 |
| 468 | **4,926** | **Total equity** | | **9,687** | 2,820 |
| | | **LIABILITIES** | | | |
| – | **–** | **Non-current liabilities** | | **29,368** | 1,130 |
| – | **–** | Borrowings | 17 | **23,266** | 996 |
| – | **–** | Deferred income tax liabilities | 10 | **5,187** | 5 |
| – | **–** | Retirement benefit obligations | 18 | **177** | 129 |
| – | **–** | Provisions | 19 | **143** | – |
| – | **–** | Derivative financial instruments | 20 | **595** | – |
| – | **–** | **Current liabilities** | | **2,522** | 1,539 |
| – | **–** | Trade and other payables | 21 | **2,273** | 903 |
| – | **–** | Borrowings | 17 | **131** | 628 |
| – | **–** | Provisions | 19 | **47** | – |
| – | **–** | Current income tax liabilities | | **71** | 8 |
| – | **–** | **Total liabilities** | | **31,890** | 2,669 |
| 468 | **4,926** | **Total equity and liabilities** | | **41,577** | 5,489 |

# Income statements
for the year ended 31 March 2008

| COMPANY 2007 R'm | COMPANY 2008 R'm | | Notes | GROUP 2008 R'm | GROUP 2007 R'm |
|---|---|---|---|---|---|
| – | **–** | **Revenue** | | **9,579** | 5,364 |
| – | **–** | Cost of sales | | **(5,381)** | (2,928) |
| – | **–** | Administration and other operating expenses | 23 | **(2,477)** | (1,430) |
| – | **–** | **Trading profit** | | **1,721** | 1,006 |
| 240 | **225** | Dividends received | | **–** | – |
| 240 | **225** | **Operating profit** | | **1,721** | 1,006 |
| – | **–** | Income from associates | 24 | **–** | 1 |
| – | **–** | Finance income | | **49** | 44 |
| – | **–** | Finance cost | 25 | **(685)** | (88) |
| 240 | **225** | **Profit before taxation** | | **1,085** | 963 |
| (12) | **(23)** | Taxation | 26 | **(364)** | (270) |
| 228 | **202** | **Profit for the year** | | **721** | 693 |
| | | **Attributable to:** | | | |
| | | Equity holders of the Company | | **610** | 582 |
| | | Minority interest | | **111** | 111 |
| | | | | **721** | 693 |
| | | **Earnings per ordinary share attributable to the equity holders of the Company – cents** | | | |
| | | Basic | 27 | **144.9** | 162.5 |
| | | Diluted | 27 | **134.0** | 147.5 |

# Statements of recognised income and expense

for the year ended 31 March 2008

| COMPANY | | | | GROUP | |
|---|---|---|---|---|---|
| 2007 R'm | **2008 R'm** | | Notes | **2008 R'm** | 2007 R'm |
| – | **–** | Currency translation differences | 15 | **2,186** | 2 |
| – | **–** | Fair value adjustment – cash flow hedges | 15 | **(254)** | – |
| – | **–** | Actuarial gains and losses | 14 | **(21)** | – |
| – | **–** | **Net income recognised directly in equity** | | **1,911** | 2 |
| 228 | **202** | Profit for the year | | **721** | 693 |
| 228 | **202** | **Total recognised income for the year** | | **2,632** | 695 |
| | | **Attributable to:** | | | |
| | | Equity holders of the Company | | **2,521** | 584 |
| | | Minority interest | | **111** | 111 |
| | | | | **2,632** | 695 |

# Cash flow statements

for the year ended 31 March 2008

| COMPANY 2007 R'm Inflow/ (outflow) | COMPANY **2008 R'm Inflow/ (outflow)** | | Notes | GROUP **2008 R'm Inflow/ (outflow)** | GROUP 2007 R'm Inflow/ (outflow) |
|---|---|---|---|---|---|
| | | **CASH FLOW FROM OPERATING ACTIVITIES** | | | |
| – | **–** | Cash received from customers | | **9,121** | 5,456 |
| – | **–** | Cash paid to suppliers and employees | | **(7,604)** | (4,269) |
| – | **–** | Cash generated from operations | 28.1 | **1,517** | 1,187 |
| 240 | **225** | Dividends received | | **–** | – |
| – | **–** | Finance income | | **49** | 44 |
| – | **–** | Finance cost | | **(468)** | (88) |
| (7) | **(9)** | Taxation paid | 28.2 | **(360)** | (306) |
| 233 | **216** | Net cash generated from operating activities | | **738** | 837 |
| (24) | **(4,464)** | **CASH FLOW FROM INVESTMENT ACTIVITIES** | | **(16,898)** | (672) |
| (24) | **(4,464)** | Investment to maintain operations | 28.3 | **(275)** | (139) |
| – | **–** | Investment to expand operations | 28.4 | **(16,644)** | (542) |
| – | **–** | Proceeds on sale of property, equipment and vehicles | 28.5 | **21** | 9 |
| 209 | **(4,248)** | Net cash (utilised)/generated before financing activities | | **(16,160)** | 165 |
| (209) | **4,248** | **CASH FLOW FROM FINANCING ACTIVITIES** | | **16,461** | 43 |
| – | **4,500** | Proceeds of shares issued | | **4,500** | – |
| – | **–** | Cash distributions to minorities | 16 | **(41)** | (40) |
| (209) | **(224)** | Distributions to shareholders | 28.6 | **(189)** | (178) |
| – | **(28)** | Share issue costs | | **(28)** | – |
| – | **–** | Proceeds from borrowings | | **12,475** | 298 |
| – | **–** | Repayments of borrowings | | **(256)** | (50) |
| – | **–** | Treasury shares utilised | | **–** | 13 |
| – | **–** | Net increase in cash, cash equivalents and bank overdrafts | | **301** | 208 |
| – | **–** | Opening balance of cash, cash equivalents and bank overdrafts | | **357** | 149 |
| – | **–** | Exchange rate fluctuations on foreign cash | | **129** | – |
| – | **–** | Closing balance of cash, cash equivalents and bank overdrafts | 28.7 | **787** | 357 |

## 1. GENERAL INFORMATION

Medi-Clinic Corporation Limited (the Company) and its subsidiaries ("the Group") operates multidisciplinary private hospitals.

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

The Company is a limited liability company incorporated and domiciled in South Africa. The address of its registered offices is: Medi-Clinic Offices, Strand Road, Stellenbosch 7600.

The Company is listed on the JSE Limited.

These annual financial statements have been approved for issue by the Board of Directors on 14 May 2008.

## 2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

The principal accounting policies applied in the preparation of these annual financial statements are set out below. These policies have been consistently applied to all the years presented, with the exception of the implementation of IAS 19 (Amendment) – Employee Benefits – Actuarial gains and losses, Group Plans and Disclosures. All actuarial gains and losses are now recognised outside profit and loss in the period in which they occur and are presented in the statement of recognised income and expenses (SoRIE). This change in policy requires the Group to present the SoRIE as a primary statement instead of the statement of changes in equity.

### 2.1 Basis of preparation

The annual financial statements of the Group are prepared in accordance with International Financial Reporting Standards (IFRS), the requirements of the South African Companies Act (Act No 61 of 1973), as amended, and the Listing Requirements of the JSE Limited. The financial statements are prepared on the historical cost convention, as modified by the revaluation of certain financial instruments to fair value.

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

The following new accounting standards, amendments and interpretations have been published that are mandatory for accounting periods beginning on or after 1 April 2008 or later periods but which the entity has not early adopted :

- IAS 1 – Presentation of Financial Statements (effective from 1 January 2009)[1)]

This revised statement requires information in the financial statements to be aggregated on the basis of shared characteristics and to introduce a statement of comprehensive income. Changes in a company's equity resulting from transactions with owners in their capacity as owners (such as dividends) are separately disclosed from non-owner changes in equity (such as transactions with third parties).

- IFRS 8 – Operating Segments (effective from 1 July 2009)[1)]

This new standard replaces IAS 14. It redefines "operating segment" and prescribes various disclosures. This standard only affects disclosure and will not impact the Group's results.

- IFRS 3R – Business Combinations (effective from 1 July 2009)[1)]

The revised statement continues to apply the acquisition method to business combinations, with some changes. For example, all payments to purchase a business are to be recorded at fair value at the acquisition date, with some contingent payments subsequently re-measured at fair value through income. Goodwill may be calculated based on the parent's share of net assets or it may include goodwill related to the minority interest. All transaction costs will be expensed.

- IAS 27R – Consolidated and Separate Financial Statements (effective from 1 January 2009)[2)]
- IFRIC 12 – Service Concession Arrangements (effective from 1 January 2008)[2)]
- IFRIC 13 – Customer Loyalty Programmes (effective from 1 July 2008)[2)]
- IFRIC 14 – IAS 19 – The Limit on a Defined Benefit Asset, Minimum Funding Requirements and their Interaction (effective from 1 January 2008)[2)]
- IAS 23R – Borrowing Costs (effective from 1 January 2009)[2)]
- IFRS 2 – Share-Based Payment: Vesting Conditions and Cancellations (effective from 1 January 2009)[2)]
- IAS 32 – Financial Instruments: Presentation and IAS 1– Presentation of Financial Statements – Puttable Financial Instruments and Obligations Arising on Liquidation (effective from 1 January 2009)[2)]

[1)] *The consolidated financial statements will be affected mainly by additional disclosures.*
[2)] *No material effects on the consolidated financial statements are expected.*

## 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. These include 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 of minority interests result in gains and losses for the Group that are recorded in the income statement. Purchases of 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 venture's individual income and expenses, assets and liabilities and cash flows on a line-by-line basis with similar items in the Group's financial statements. The Group recognises the portion of gains or losses on the sale of assets by the Group to the joint venture that is attributable to the other venturers. The Group does not recognise its share of profits or losses from the joint venture that result from the Group's purchase of assets from the joint venture until it resells the assets to an independent party. However, a loss on the transaction is recognised immediately if the loss provides evidence of a reduction in the net realisable value of current assets, or an impairment loss.

*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.

*d) Separate financial statements*

In the Company's separate financial statements, the investment in a subsidiary is measured at cost.

## 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, equipment and vehicles

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

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

- Buildings: 50 – 100 years
- 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 licences 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 programme with regard 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 that are deemed to have an indefinite useful life are carried at cost less accumulated impairment losses. Trade names that are deemed to have a finite useful life are capitalised at the cost to the Group and amortised on the straight-line basis over its estimated useful lifetime. No value is placed on internally developed trade names.

Expenditure to maintain trade names is accounted for against income as incurred.

b) *Goodwill*

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

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

c) *Computer software*

Acquired computer software licences 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 programmes are recognised as an expense as incurred.

## 2.6 Impairment of non-financial assets

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

## 2.7 Financial assets

The Group classifies its financial assets in the following categories: loans and receivables, and available-for-sale financial assets. The classification depends on the purpose for which the asset was 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 rate method.

*Investments available-for-sale*

Other long-term investments are classified as available-for-sale and are included within non-current assets unless management intends to dispose of the investment within 12 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 Derivative financial instruments and hedging activities

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

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

The fair values of various derivative instruments used for hedging purposes are disclosed in note 20. The hedging reserve in shareholders' equity are shown in note 15. The full fair value of a hedging derivative is classified as a non-current asset or liability when the remaining hedged item's maturity is more than 12 months; it is classified as a current asset or liability when the remaining maturity of the hedged item is less than 12 months.

*Cash flow hedge*

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

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

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

### 2.9 Inventories

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

### 2.10 Trade and other receivables

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

### 2.11 Cash and cash equivalents

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

### 2.12 Share capital

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

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

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

### 2.13 Trade and other payables

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

### 2.14 Borrowings

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

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

### 2.15 Provisions

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

### 2.16 Current and deferred income tax

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

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. No deferred income tax is accounted for if it arises from initial recognition of an asset or liability in a transaction other than a business combination that at the time of the transaction affects neither accounting nor taxable profit or loss.

## 2.17 Employee benefits

a) *Retirement benefit costs*

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

*Defined contribution plans*

A defined contribution plan is a pension plan under which the Group pays fixed contributions into a separate entity. The Group has no legal or constructive obligations to pay further contributions if the fund does not hold sufficient assets to pay all employees the benefits relating to employee service in the current and prior periods. The Group's contribution to the defined contribution plans is charged to the income statement in the year to which they relate.

*Defined benefit plans*

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

Actuarial gains and losses arising from experience adjustments and changes in actuarial assumptions are charged or credited to equity in the statement of recognised income and expense (SoRIE) in the period in which they arise. Past service costs are recognised immediately in income, unless the changes to the pension plan are conditional on the employees remaining in service for a specified period of time (the vesting period). In this case, the past service costs are amortised on a straight-line basis over the vesting period. A net pension asset is recorded only to the extent that it does not exceed the present value of any economic benefit available in the form of reductions in future contributions to the plan, and any unrecognised actuarial losses and past service costs. The annual pension costs of the Group's benefit plans are charged to the income statement.

b) *Post-employment medical benefits*

Some group companies provide for actuarially determined post-employment medical contributions in relation to current and retired employees. The expected costs of these benefits are accounted for by using the projected unit credit method. Under this method, the expected costs of these benefits are accumulated over the service lives of the employees. Valuation of these obligations is carried out by independent qualified actuaries. All actuarial gains and losses are recognised outside profit and loss in the period in which they occur and are presented in the statement of recognised income and expense.

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.

### 2.18 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 bases:

- Interest income
  Interest income is recognised on a time-proportion basis using the effective interest rate method.
- Dividend income
  When the shareholders' right to receive payment is established.

### 2.19 Cost of sales

Cost of sales consists 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.

### 2.20 Leased assets

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

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

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

### 2.21 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.

### 2.22 Foreign currency transactions

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

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

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

- Assets and liabilities are translated at the closing rate on the balance sheet date.
- Income and expenses for each income statement are translated at average exchange rates for the year.
- All resulting exchange differences are recognised as a separate component of equity in the foreign currency translation reserve (FCTR).

On consolidation, exchange differences arising from the translation of the net investment in foreign operations, and of borrowings, are taken directly to the FCTR. Goodwill and fair value adjustments arising on the acquisition of foreign operations are treated as assets and liabilities of the foreign operation and translated at closing rates at balance sheet date.

*The following exchange rates applied during the year:*
Average SA Rand/Swiss Franc exchange rate: CHF1 = R6.60
Closing SA Rand/Swiss Franc exchange rate: CHF1 = R8.14
Average SA Rand/UAE Dirham exchange rate: AED1 = R1.94
Closing SA Rand/UAE Dirham exchange rate: AED1 = R2.20 (2007: 1.98)

## 3. FINANCIAL RISK MANAGEMENT

### 3.1 Financial risk factors

Normal business activities of a company expose 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 is 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. Medical schemes and insurance companies are forced to maintain minimum reserve levels.

The policy for patients who do not have a medical scheme or an insurance company paying for the Group's service, is to require a preliminary payment instead. After the provision for doubtful receivables has been brought into account, the Group does not have any significant exposure to any individual customer or counterparty.

The Group is exposed to credit-related losses in the event of non-performance by counterparties to hedging instruments. The counterparties to these contracts are major financial institutions. The Group monitors its positions and limits the extent to which it enters into contracts with any one party. The carrying amounts of financial assets included in the balance sheet represents the Group's exposure to credit risk in relation to these assets. At 31 March 2008 and 31 March 2007, the Group did not consider there to be a significant concentration of credit risk which had not been adequately provided for.

c) *Liquidity risk*

The Group manages liquidity risk by monitoring cash flow forecasts. The borrowing powers of the Group can only be limited by the Company's holding company. No such limitation currently exists.

| | **2008 R'm** | 2007 R'm |
|---|---|---|
| The Group's overdraft facilities are: | **1,676** | 1,283 |

The table below details the Group's remaining contractual maturity for its financial liabilities. The table has been drawn up based on the undiscounted cash flows of financial liabilities based on the required and expected date of repayment. The table includes both interest and principal cash flows.

| Financial liabilities | **Carrying value R'm** | **Contractual cash flows R'm** | **0 – 12 months R'm** | **1 – 5 years R'm** | **Beyond 5 years R'm** |
|---|---|---|---|---|---|
| **31 March 2008** | | | | | |
| Interest-bearing borrowings | **23,397** | **32,903*** | **1,597*** | **8,128*** | **23,178*** |
| Trade payables | **1,065** | **1,065** | **1,065** | **–** | **–** |
| Other payables and accrued expenses | **1,094** | **1,094** | **1,094** | **–** | **–** |
| **31 March 2007** | | | | | |
| Interest-bearing borrowings | 1,624 | 2,446 | 1,326 | 474 | 646 |
| Trade payables | 539 | 539 | 539 | – | – |
| Other payables and accrued expenses | 266 | 266 | 266 | – | – |

* The interest rate swaps' cash flows have been included (see note 20).

All the financial liabilities in the table above are categorised as other financial liabilities.

## 3.1 Financial risk factors (continued)

*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.

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

*Interest rate sensitivity*

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

- profit for the year ended 31 March 2008 would increase/decrease by R23m (2007: increase/decrease by R2m). This is mainly attributable to the Group's exposure to interest rates on its variable rate borrowings; and
- other equity reserves would increase/decrease by R396m (2007: increase/decrease by Rnil) mainly as a result of the changes in the fair value of the derivative financial instruments.

## 3.2 Fair value of financial instruments

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

- Cash and cash equivalents, trade and other receivables, and other investments and loans: The carrying amounts reported in the balance sheet approximate fair values.
- Borrowings and trade and other payables: The carrying amounts reported in the balance sheet approximate fair values.
- Interest rate swaps: The fair values are calculated by use of discounted cash flow analysis using the applicable yield curve for the duration of the instruments.

## 3.3 Capital risk management

The Group manages its capital to ensure that entities in the Group will be able to continue as a going concern while maximising the return to stakeholders through the optimisation of the debt and equity balance. The capital structure of the Group consists of debt, which includes the borrowings disclosed in note 17, cash and cash equivalents and equity attributable to equity holders of the parent, comprising issued capital, retained earnings and other reserves as disclosed in notes 13, 14 and 15 respectively. The Group's audit and risk committee reviews the capital structure on an annual basis. As part of this review, the committee considers the Group's commitments, availability of funding and the risks associated with each class of capital. Based on recommendations of the committee, the Group will balance its overall capital structure through the payment of dividends, new share issues and share buy-backs as well as the issue of new debt or the redemption of existing debt. The Group's overall strategy remains unchanged from the prior year.

## 4. CRITICAL ACCOUNTING ESTIMATES AND ASSUMPTIONS

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

a) *Estimated impairment of goodwill and intangible asset*
The Group tests annually whether goodwill and the intangible asset with an indefinite useful life have suffered any impairment, in accordance with the accounting policy stated in Note 2.5. 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 South Africa, Namibia and Switzerland. Significant judgement is required in determining the provision for income taxes. There are many transactions and calculations for which the ultimate tax determination is uncertain during the ordinary course of business. The Group recognises liabilities for anticipated tax audit issues based on estimates of whether additional taxes will be due. Where the final tax outcome of these matters is different from the amounts that were initially recorded, such differences will impact the income tax and deferred tax provisions in the period in which such determination is made.

c) *Pension benefits*
The cost of defined benefit pension plans is determined using actuarial valuations. The actuarial valuation involves making assumptions about discount rates, expected rates of return on assets, future salary increases, mortality rates and future pension increases. Due to the long-term nature of these plans, such estimates are subject to significant uncertainty. Further details are given in note 18.

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

| | GROUP | |
|---|---|---|
| | **2008 R'm** | 2007 R'm |
| **5. PROPERTY, EQUIPMENT AND VEHICLES** | | |
| Land – cost | **9,002** | 130 |
| Buildings | **19,132** | 1,560 |
| Cost | **19,262** | 1,606 |
| Accumulated depreciation | **(130)** | (46) |
| Land and buildings | **28,134** | 1,690 |
| Equipment | **1,470** | 593 |
| Cost | **2,581** | 1,491 |
| Accumulated depreciation | **(1,111)** | (898) |
| Furniture and vehicles | **331** | 121 |
| Cost | **602** | 329 |
| Accumulated depreciation | **(271)** | (208) |
| Subtotal | **29,935** | 2,404 |
| Capital expenditure in progress | **1,037** | 720 |
| | **30,972** | 3,124 |

Property, equipment and vehicles with a book value of R27,416m (2007: R264m) are encumbered as security for borrowings (see note 17).

Included in equipment is capitalised finance lease equipment with a book value of R32m (2007: Rnil), see note 17.

The register containing details of land and buildings is available for inspection by members or their proxies at the registered office of the Company. The directors are of the opinion that the market value of land and buildings exceeds their book value.

GROUP

| | Land and buildings R'm | Equipment R'm | Furniture and vehicles R'm | Total R'm |
|---|---|---|---|---|
| **5. PROPERTY, EQUIPMENT AND VEHICLES (CONTINUED)** | | | | |
| **At 1 April 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 |
| Exchange 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 |
| **Year ended 31 March 2008** | | | | |
| Net opening book value | **1,690** | **593** | **121** | **2,404** |
| Capital expenditure | **294** | **307** | **90** | **691** |
| Business acquisitions | **19,671** | **570** | **135** | **20,376** |
| Exchange differences | **6,560** | **205** | **54** | **6,819** |
| Disposals | **(7)** | **(9)** | **(3)** | **(19)** |
| Depreciation per income statement | **(74)** | **(196)** | **(66)** | **(336)** |
| Net closing book value | **28,134** | **1,470** | **331** | **29,935** |
| **At 31 March 2008** | | | | |
| Cost | **28,264** | **2,581** | **602** | **31,447** |
| Accumulated depreciation | **(130)** | **(1,111)** | **(271)** | **(1,512)** |
| Net book value | **28,134** | **1,470** | **331** | **29,935** |

| | 2008 R'm | 2007 R'm |
|---|---|---|
| **Capital expenditure** | | |
| Capital expenditure excluding expenditure in progress | **691** | 200 |
| Capital expenditure in progress | **227** | 125 |
| Total additions | **918** | 325 |
| To maintain operations | **275** | 139 |
| To expand operations | **643** | 186 |

GROUP

| | Software and projects R'm | Trade names R'm | Goodwill R'm | Total R'm |
|---|---|---|---|---|
| **6. INTANGIBLE ASSETS** | | | | |
| **At 1 April 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 |
| Exchange differences | – | – | 2 | 2 |
| Net closing book value | – | 3 | 416 | 419 |
| **At 31 March 2007** | | | | |
| Cost | – | 15 | 419 | 434 |
| Accumulated amortisation and impairment | – | (12) | (3) | (15) |
| Net book value | – | 3 | 416 | 419 |
| **Year ended 31 March 2008** | | | | |
| Net opening book value | **–** | **3** | **416** | **419** |
| Amortisation charge | **(4)** | **(1)** | **–** | **(5)** |
| Additions | **11** | **–** | **83** | **94** |
| Business acquisitions | **20** | **2,437** | **1,692** | **4,149** |
| Exchange differences | **8** | **810** | **604** | **1,422** |
| Net closing book value | **35** | **3,249** | **2,795** | **6,079** |
| **At 31 March 2008** | | | | |
| Cost | **58** | **3,262** | **2,804** | **6,124** |
| Accumulated amortisation and impairment | **(23)** | **(13)** | **(9)** | **(45)** |
| Net book value | **35** | **3,249** | **2,795** | **6,079** |

Trade names with a cost price of R2.5m (2007: R2.5m) have been fully impaired.

*A segment-level summary of the goodwill is presented below:*

| | 2008 R'm | 2007 R'm |
|---|---|---|
| Southern Africa | **133** | 48 |
| Switzerland | **2,255** | – |
| Middle East | **407** | 368 |
| | **2,795** | 416 |

The impairment tests for goodwill and indefinite life trade name are based on value-in-use calculations. Included in the Switzerland segment and cash-generating unit is a trade name, the Hirslanden brand, with a carrying value of R3,247m, which is deemed to have an indefinite useful life. These calculations use cash flow projections based on financial budgets covering a five-year period. The discount rates used reflect specific risks related to the hospital industry. These calculations indicate that there was no impairment in the carrying value of goodwill.

| COMPANY 2007 R'm | COMPANY 2008 R'm | | GROUP 2008 R'm | GROUP 2007 R'm |
|---|---|---|---|---|
| | | **7. INTEREST IN SUBSIDIARY** | | |
| | | *Unlisted* | | |
| 1 | **1** | Shares at cost less amounts written off | | |
| 450 | **4,922** | Due by subsidiary | | |
| 451 | **4,923** | | | |
| | | *Details appear on page 126.* | | |
| | | **8. INVESTMENTS IN ASSOCIATES** | | |
| | | *Unlisted* | | |
| | | Carrying value of investments in associates' equity | | |
| | | Opening balance | **5** | 3 |
| | | Business acquisition | **5** | 1 |
| | | Share in current year profits | **–** | 1 |
| | | Exchange differences | **1** | – |
| | | Balance at end of the year | **11** | 5 |
| | | Directors' valuation | **11** | 5 |
| | | The total profit of associates is R2m (2007: R2m). Total revenue for the associates is R9m (2007: R8m). | | |
| | | *The aggregate balance sheets of associates are summarised as follows:* | | |
| | | Non-current assets | **220** | 17 |
| | | Current assets | **30** | 7 |
| | | Total assets | **250** | 24 |
| | | Current liabilities | **(216)** | (10) |
| | | Shareholders' funds | **34** | 14 |
| | | Outside interests | **(23)** | (9) |
| | | Group's share in net assets of associates | **11** | 5 |
| | | *Details appear on page 128.* | | |
| | | **9. OTHER INVESTMENTS AND LOANS** | | |
| | | *Unlisted – no active market* | | |
| | | Loans and receivables | **8** | 41 |
| | | Available-for-sale: Shares | **15** | – |
| | | | **23** | 41 |
| | | Directors' valuation | **23** | 41 |

| COMPANY 2007 R'm | COMPANY 2008 R'm | | GROUP 2008 R'm | GROUP 2007 R'm |
|---|---|---|---|---|
| | | **10. DEFERRED TAXATION** | | |
| | | Deferred income tax assets and deferred income tax liabilities are offset when there is a legally enforceable right of offset and when the deferred income tax relates to the same fiscal authority. | | |
| | | **The movement on the deferred taxation account is as follows:** | | |
| 22 | **17** | Opening balance | **115** | 118 |
| | | Taxation rate change | **(3)** | – |
| (5) | **(14)** | Income statement charge for the year | **(18)** | (3) |
| | | Acquired during the year | **(3,976)** | – |
| | | Exchange differences | **(1,182)** | – |
| | | Charged directly to equity | **–** | – |
| 17 | **3** | Balance at end of the year | **(5,064)** | 115 |
| | | **The balance consists of:** | | |
| | | Accelerated wear and tear for tax purposes on property, equipment and vehicles | **(32)** | (27) |
| 17 | **3** | STC credits | **5** | 18 |
| | | Temporary differences relating to Swiss assets | **(5,292)** | – |
| | | Accruals and other temporary differences | **255** | 124 |
| 17 | **3** | | **(5,064)** | 115 |
| 17 | **3** | Deferred income tax assets | **123** | 120 |
| | | Deferred income tax liabilities | **(5,187)** | (5) |
| 17 | **3** | | **(5,064)** | 115 |
| | | **11. INVENTORIES** | | |
| | | **Inventories consist of:** | | |
| | | Pharmaceutical products | **396** | 173 |
| | | Consumables | **45** | 10 |
| | | Finished goods and work in progress | **7** | 7 |
| | | | **448** | 190 |
| | | The cost of inventories recognised as an expense and included in cost of sales amounted to R2,510m (2007: R1,568m). | | |
| | | There are no inventories that are valued at net realisable value. | | |

| | GROUP | |
|---|---|---|
| | **2008 R'm** | 2007 R'm |
| **12. TRADE AND OTHER RECEIVABLES** | | |
| Trade receivables | **2,253** | 726 |
| Less provision for impairment of receivables | **(124)** | (91) |
| Trade receivables – net | **2,129** | 635 |
| Other receivables | **948** | 239 |
| | **3,077** | 874 |
| Trade and other receivables are categorised as loans and receivables. | | |
| The carrying amounts of the Group's trade and other receivables are denominated in the following currencies: | | |
| SA Rand | **898** | 727 |
| Swiss Franc* | **2,018** | – |
| UAE Dirham | **161** | 147 |
| | **3,077** | 874 |
| Included in the Group's trade receivables balance are trade receivables with a carrying value of R795m (2007: R83m) which have been past due at the reporting date for which the Group has not impaired as there has not been a significant change in credit quality and the amounts are still considered to be recoverable. The ageing of these receivables are as follows: | | |
| Up to 3 months | **665** | 75 |
| Over 3 months | **130** | 8 |
| | **795** | 83 |
| **Movement in the provision for impairment of receivables:** | | |
| Opening balance | **91** | 82 |
| Provision for receivables impairment | **42** | 18 |
| Exchange differences | **7** | – |
| Business acquired | **13** | 19 |
| Receivables written off during the year as uncollectable | **(37)** | (35) |
| Recovered during the year | **8** | 7 |
| Balance at end of the year | **124** | 91 |
| Amounts written off during the year relate to individually identified accounts that are considered to be impaired. | | |
| Net trade receivables to the value of R102m (2007: R70m) have been ceded as security for banking facilities. | | |

* In the case of a default on the secured long-term bank loan in Switzerland, debtors that have a turnover of greater than CHF1m will be assigned to the bank (see note 17).

| COMPANY 2007 R'm | COMPANY 2008 R'm | | GROUP 2008 R'm | GROUP 2007 R'm |
|---|---|---|---|---|
| | | **13. SHARE CAPITAL** | | |
| | | Share capital consists of ordinary shares and share premium. | | |
| | | **Ordinary shares** | | |
| | | Authorised: | | |
| 45 | **100** | 1,000,000,000 ordinary shares of 10 cents each (2007 : 450,000,000) | **100** | 45 |
| 39 | **59** | Issued: | **59** | 39 |
| 39 | **39** | Opening balance | **39** | 39 |
| – | **20** | Shares issued | **20** | – |
| | | 593,013,946 ordinary shares of 10 cents each (2007: 394,338,449) | | |
| | | 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 | **4,741** | **Share premium** | **4,741** | 289 |
| 289 | **289** | Opening balance | **289** | 289 |
| – | **4,480** | Premium on shares issued | **4,480** | – |
| – | **(28)** | Costs of shares issued | **(28)** | – |
| | | **Treasury shares** | | |
| | | 32,753,554 (2007 : 34,968,952) ordinary shares of 10 cents each | **(297)** | (297) |
| | | Opening balance | **(297)** | (310) |
| | | Shares acquired by wholly owned subsidiary | **(11)** | – |
| | | Utilised by the Mpilo Trust | **2** | 4 |
| | | Utilised for share option scheme | **9** | 9 |
| | | During the year the Mpilo Trust, an employee share trust, released 124,760 of its 15,539,758 shares to employees. | | |
| | | To date, no value was received for an equivalent of 16,246,321 (2007:17,615,242) shares issued to the strategic black partners. | | |
| | | The Company, through a wholly owned subsidiary, holds 1,092,235 (2007: 1,813,952) shares in treasury. During the year 1,219,905 (2007: 1,305,273) of these shares were utilised in terms of the executive share option scheme and 503,678 were acquired. | | |
| 328 | **4,800** | | **4,503** | 31 |

| | GROUP | |
|---|---|---|
| | **2008 R'm** | 2007 R'm |

## 13. SHARE CAPITAL (continued)

**Share options**

In terms of the executive share option scheme 34,472,230 (2007: 34,472,230) ordinary shares are kept in reserve. To date 23,880,000 share options have been granted, 4,937,800 (2007: 4,930,800) share options have been forfeited and 15,407,340 (2007: 14,187,435) 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 | R9.29 | 4,761,765 | 6,722,038 |
| Options forfeited | | (7,000) | (655,000) |
| Options exercised – treasury shares utilised | R7.34 | (1,219,905) | (1,305,273) |
| Outstanding at the end of the year | R9.50 | 3,534,860 | 4,761,765 |

| COMPANY 2007 R'm | COMPANY 2008 R'm | | GROUP 2008 R'm | GROUP 2007 R'm |
|---|---|---|---|---|
| | | **14. RETAINED EARNINGS** | | |
| 39 | **17** | Company | **17** | 39 |
| | | Subsidiaries and joint ventures | **2,317** | 1,895 |
| 39 | **17** | | **2,334** | 1,934 |
| 20 | **39** | Opening balance | **1,934** | 1,530 |
| 228 | **202** | Profit for the year | **610** | 582 |
| (209) | **(224)** | Dividends paid | **(189)** | (178) |
| – | **–** | Actuarial losses net of tax | **(21)** | – |
| 39 | **17** | Balance at end of the year | **2,334** | 1,934 |
| | | **15. OTHER RESERVES** | | |
| | | **Share-based payment reserve** | | |
| 93 | **101** | Opening balance | **101** | 93 |
| 8 | **8** | Employees: value of services | **8** | 8 |
| 101 | **109** | Balance at end of the year | **109** | 101 |
| 9 | **11** | Executive share option scheme | **11** | 9 |
| 7 | **13** | Employee share trust | **13** | 7 |
| 85 | **85** | Strategic black partners | **85** | 85 |
| | | **Foreign currency translation reserve** | **2,188** | 2 |
| | | Opening balance | **2** | – |
| | | Currency translation differences | **2,186** | 2 |
| | | **Hedging reserve** | **(254)** | – |
| | | Opening balance | **–** | – |
| | | Fair value adjustments of cash flow hedges | **(254)** | – |
| 101 | **109** | | **2,043** | 103 |
| | | **16. MINORITY INTEREST** | | |
| | | Opening balance | **752** | 290 |
| | | Distributions to minorities | **(41)** | (40) |
| | | Share of profit | **111** | 111 |
| | | Business acquisitions | **3** | 391 |
| | | Exchange differences | **46** | 2 |
| | | Decrease in minority interest | **(64)** | (2) |
| | | Minority interest in hospital activities | **807** | 752 |

| | GROUP | |
|---|---|---|
| | **2008 R'm** | 2007 R'm |
| **17. BORROWINGS** | | |
| Secured long-term bank loans | **2,755** | – |
| Long-term portion | **2,735** | – |
| Short-term portion | **20** | – |
| These loans bear interest at an average variable rate of 11.0% per annum and are repayable in four and six years. Property, equipment and vehicles with a book value of R1,450m are encumbered as security for these loans. | | |
| Unsecured long-term bank loans | **670** | 694 |
| Long-term portion | **632** | 655 |
| Short-term portion | **38** | 39 |
| These loans bear interest at an average fixed rate of 9.3% per annum and are repayable in four years. | | |
| Unsecured foreign bank loan | **174** | 302 |
| Long-term portion | **174** | 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 | **58** | 90 |
| Long-term portion | **25** | 57 |
| Short-term portion | **33** | 33 |
| These loans bear interest at an average fixed rate of 13.1% per annum and are repayable in three years. Property, equipment and vehicles with a book value of R132m (2007: R135m) are encumbered as security for these loans. | | |
| Secured long-term bank loans | **28** | 87 |
| Long-term portion | **16** | 75 |
| Short-term portion | **12** | 12 |
| These loans bear interest at variable rates linked to the prime overdraft rate and are repayable in periods ranging between one and 13 years. Property, equipment and vehicles with a book value of R102m (2007: R100m) are encumbered as security for these loans. | | |
| Bank overdraft | **14** | 143 |
| **Borrowings in Southern African operations** | **3,699** | 1,316 |

| | GROUP | |
|---|---|---|
| | **2008 R'm** | 2007 R'm |
| **17. BORROWINGS (CONTINUED)** | | |
| Secured long-term bank loans | **211** | 80 |
| Long-term portion | **198** | 41 |
| Short-term portion | **13** | 39 |
| These loans bear interest at variable rates linked to EIBOR and are repayable in periods ranging between five and ten years. Properties with a book value of R696m (2007: R29m) are encumbered as security for these loans. | | |
| Vehicle loan | **4** | 5 |
| Long-term portion | **3** | 5 |
| Short-term portion | **1** | – |
| These loans bear interest at rates ranging between 3.65% and 4.25% and are repayable in equal monthly payments in periods ranging from four to six years. Vehicles with a book value of R3m (2007: R4m) are encumbered as security for these loans. | | |
| Unsecured long-term loan | **–** | 7 |
| Long-term portion | **–** | 7 |
| Short-term portion | **–** | – |
| The loan was unsecured, interest free and repayable within 12 to 24 months. | | |
| Bank overdraft | **–** | 216 |
| **Borrowings in Middle East operations** | **215** | 308 |
| Secured long-term bank loans | **19,454** | – |
| Long-term portion | **19,454** | – |
| Short-term portion | **–** | – |
| These loans bear interest at a floating rate linked to LIBOR and are repayable in seven years. | | |
| The loan facilities granted by the funding banks under the new financing structure are secured by: Swiss properties with a book value of R25,033m; assignment of Swiss receivables in the case of a default (see note 12); and Swiss bank accounts with a book value of R395m. | | |
| Secured long-term finance | **29** | – |
| Long-term portion | **29** | – |
| Short-term portion | **–** | – |
| These loans bear interest at interest rates ranging between 9% and 12% and are repayable in equal monthly payments in periods ranging from two to 15 years. Equipment with a book value of R32m are encumbered as security for these loans. | | |
| **Borrowings in Swiss operations** | **19,483** | – |
| Total borrowings | **23,397** | 1,624 |
| Short-term portion transferred to current liabilities | **(131)** | (628) |
| | **23,266** | 996 |

| | GROUP | |
|---|---|---|
| | **2008** | 2007 |
| | **R'm** | R'm |
| **18. RETIREMENT BENEFIT OBLIGATIONS** | | |
| **Balance sheet obligations for:** | | |
| Pension benefits | **4** | – |
| Post-employment medical benefits | **173** | 129 |
| | **177** | 129 |
| **Income statement charge for:** | | |
| Pension benefits | **59** | – |
| Post-employment medical benefits | **33** | 27 |
| | **92** | 27 |
| **(a) Pension benefits** | | |
| The Group's Swiss operations have three defined benefit pension plans. | | |
| **Balance sheet** | | |
| Amounts recognised in the balance sheet are as follows: | | |
| Present value of funded obligations | **4,090** | |
| Fair value of plan assets | **(4,154)** | |
| Surplus | **(64)** | |
| Asset not recognised in terms of IAS 19, paragraph 58 limit | **68** | |
| Net pension liability | **4** | |
| The movement in the defined benefit obligation over the period is as follows: | | |
| Business acquisition | **2,778** | |
| Current service cost net of employee contributions | **79** | |
| Interest cost | **40** | |
| Employee contributions | **57** | |
| Benefits paid | **(86)** | |
| Exchange differences | **944** | |
| Actuarial loss | **278** | |
| Balance at end of the year | **4,090** | |
| The movement of the fair value of plan assets over the period is as follows: | | |
| Business acquisition | **3,335** | |
| Employer contributions | **68** | |
| Employee contributions | **57** | |
| Benefits paid from fund | **(86)** | |
| Expected return on assets | **60** | |
| Exchange differences | **1,054** | |
| Investment loss | **(334)** | |
| Balance at end of the year | **4,154** | |

| | GROUP | |
|---|---|---|
| | **2008 R'm** | 2007 R'm |
| **18. RETIREMENT BENEFIT OBLIGATIONS (CONTINUED)** | | |
| **(a) Pension benefits (continued)** | | |
| **Income statement** | | |
| Amounts recognised in the income statement are as follows: | | |
| Current service cost | **79** | |
| Interest on liability | **40** | |
| Expected return on plan assets | **(60)** | |
| Total expense | **59** | |
| Business acquisition | **(2)** | |
| Expense as above | **59** | |
| Contributions paid by employer | **(68)** | |
| Exchange differences | **(3)** | |
| Actuarial loss recognised in equity | **690** | |
| Adjustment on the limit in paragraph 58(b) – IAS 19.93C | **(672)** | |
| Closing net liability | **4** | |
| Actual return on plan assets | **(274)** | |
| **Principal actuarial assumptions on balance sheet date** | | |
| Discount rate | **3.25%** | |
| Expected rate of return on plan assets | **4.00%** | |
| Future salary increases | **1.50%** | |
| Future pension increases | **0.00%** | |
| Inflation rate | **1.00%** | |
| Number of plan members | | |
| Active members | **5,109** | |
| Pensioners | **185** | |
| | **5,294** | |
| Experience adjustment | | |
| On plan liabilities: loss | **142** | |
| On plan assets: loss | **(334)** | |
| Actuarial losses | **(690)** | |
| Adjustment from the limit in paragraph 58(b) | **671** | |
| Cumulative actuarial loss recognised in the SoRIE | **(19)** | |
| Asset allocation | | |
| Fixed income investments | **48%** | |
| Equity investments | **24%** | |
| Real estate | **22%** | |
| Cash | **3%** | |
| Insurance contracts | **3%** | |

| | GROUP | |
|---|---|---|
| | **2008 R'm** | 2007 R'm |
| **18. RETIREMENT BENEFIT OBLIGATIONS (CONTINUED)** | | |
| **(b) Post-employment medical benefits** | | |
| The Group's Southern African operations have a post-employment medical benefit obligation. | | |
| The Group accounts for actuarially determined future medical benefits and provide for the expected liability in the balance sheet. | | |
| During the last valuation on 31 March 2008 a 7.5% (2007: 6.5%) medical inflation cost and a 9.5% (2007: 8.5%) interest rate were assumed. The average retirement age was set at 63 years (2007: 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 | **129** | 102 |
| Amounts recognised in the income statement | **33** | 27 |
| Current service cost | **21** | 18 |
| Interest cost | **13** | 10 |
| Contributions | **(1)** | (1) |
| Actuarial loss recognised in the SoRIE | **11** | – |
| Balance at end of the year | **173** | 129 |
| Present value of unfunded obligations | **173** | 129 |
| Unrecognised actuarial gains | **–** | – |
| | **173** | 129 |
| The present value of the Group's post-employment medical benefits at 31 March 2006 was R102m, 2005: R73m and 2004: R55m. | | |
| | Increase | Decrease |
| The effect of a 1% movement in the assumed health cost trend rate is as follows: | | |
| Aggregate of the current service cost and interest cost | 19% | (16%) |
| Defined benefit obligation | 18% | (15%) |
| Expected post-employment medical benefits payable for the year ended 31 March 2009 are R2.55m. | | |

GROUP

| | Employee benefits R'm | Legal cases and other R'm | Tariff risks R'm | Total R'm |
|---|---|---|---|---|
| **19. PROVISIONS** | | | | |
| Balance at 1 April 2007 | – | – | – | – |
| Business acquisitions | 82 | 11 | 65 | 158 |
| Charged to the income statement | 23 | 3 | – | 26 |
| Utilised during the year | – | – | (17) | (17) |
| Unused amounts reversed | (7) | – | (21) | (28) |
| Exchange differences | 30 | 4 | 17 | 51 |
| Balance at 31 March 2008 | 128 | 18 | 44 | 190 |
| Non-current | 120 | 11 | 12 | 143 |
| Current | 8 | 7 | 32 | 47 |
| | 128 | 18 | 44 | 190 |

**(a) Employee benefits**
This provision is for benefits granted to employees for long service.

**(b) Legal cases and other**
The legal cases and other provision relate to retentions for malpractice and provisions for doctors' practices in Switzerland.

**(c) Tariff risks**
The amount represents provisions for tariff risks in Switzerland at Hirslanden Klinic Aarau, clinics in Berne and at Klinic St. Anna for OKP ("obligatorische Krankenpflegeversicherung") risks.

At 31 March 2008, provisions are expected to be payable during the following financial years:

| | |
|---|---|
| Within 1 year | 47 |
| 1 to 5 years | 71 |
| Beyond 5 years | 72 |
| | 190 |

GROUP

| | 2008 R'm | 2007 R'm |
|---|---|---|
| **20. DERIVATIVE FINANCIAL INSTRUMENTS** | | |
| **Assets** | | |
| Interest rate swaps – cash flow hedges | **43** | – |
| **Liabilities** | | |
| Interest rate swap – cash flow hedge | **595** | – |

In order to hedge specific exposures in the interest rate repricing profile of existing borrowings, the Group uses interest rate derivatives to generate the desired interest profile. At 31 March 2008, the Group had three interest rate swap contracts (2007: nil). The value of borrowings hedged by the interest rate derivatives and the rates applicable to these contracts at 31 March 2008, are as follows:

| 2008 | Borrowings hedged R'm | Fixed interest payable | Interest receivable | Fair value gain/(loss) R'm |
|---|---|---|---|---|
| 6 years +* | 19,930 | 3 to 4% | 3-month LIBOR | (418) |
| 1 to 6 years Δ | 2,750 | 9.8 – 10.1% | 3-month JIBAR | 43 |

* The interest rate swap agreement resets every three months on 5 January, 5 April, 5 July and 5 October, with a final reset beyond six years. There is no ineffective portion recognised in the profit and loss that arises from the cash flow hedge.

Δ The interest rate swap agreements reset every three months on 1 June, 1 September, 1 December and 1 March, with a final reset on 1 December 2011 and 2 December 2013. There is no ineffective portion recognised in the profit and loss that arises from the cash flow hedges.

The interest rate swaps are categorised as derivatives used for hedging.

| | 2008 R'm | 2007 R'm |
|---|---|---|
| **21. TRADE AND OTHER PAYABLES** | | |
| Trade payables | **1,065** | 539 |
| Other payables and accrued expenses | **1,094** | 266 |
| Accrued leave pay | **70** | 66 |
| Value added tax | **44** | 32 |
| | **2,273** | 903 |

| | GROUP | |
|---|---|---|
| | **2008** | 2007 |
| | **R'000** | R'000 |
| **22. DIRECTORS' REMUNERATION** | | |
| Executive | | |
| E de la H Hertzog* | **2,591** | 5,060 |
| L J Alberts | **3,261** | 4,424 |
| J du T Marais | **1,950** | 2,736 |
| D P Meintjes | **2,425** | 1,014 |
| K H S Pretorius | **2,678** | 1,118 |
| J G Swiegers | **2,390** | 3,584 |
| R H Bider*** | **983** | – |
| Total | **16,278** | 17,936 |
| Non-executive fees | **1,454** | 1,153 |
| J C Cohen | **20** | – |
| W P Esterhuyse | **–** | 56 |
| S Dakile-Hlongwane | **141** | 99 |
| A R Martin | **244** | 194 |
| V E Msibi | **180** | 130 |
| A A Raath | **230** | 176 |
| M A Ramphele | **172** | 117 |
| W L van der Merwe | **192** | 158 |
| M H Visser | **275** | 223 |
| | **17,732** | 19,089 |
| Paid by: | | |
| Subsidiaries | **15,141** | 16,499 |
| Management company* | **2,591** | 2,590 |
| | **17,732** | 19,089 |

| **Detail for 2008: (R'000)** | Salaries | Retirement fund | Other benefits**** | Bonus | Share options | Total |
|---|---|---|---|---|---|---|
| Executive | | | | | | |
| E de la H Hertzog* | **2,069** | **200** | **147** | **175** | **–** | **2,591** |
| L J Alberts | **2,739** | **243** | **19** | **260** | **–** | **3,261** |
| R H Bider*** | **819** | **134** | **30** | **–** | **–** | **983** |
| J du T Marais | **1,644** | **148** | **19** | **139** | **–** | **1,950** |
| D P Meintjes | **1,519** | **152** | **754** | **–** | **–** | **2,425** |
| K H S Pretorius | **1,642** | **150** | **73** | **136** | **677** | **2,678** |
| J G Swiegers | **1,786** | **176** | **233** | **195** | **–** | **2,390** |
| | **12,218** | **1,203** | **1,275** | **905** | **677** | **16,278** |

GROUP

## 22. DIRECTORS' REMUNERATION (CONTINUED)

| 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 |

* Dr E de la H Hertzog also earned a further R1.4m (2007: R1.3m) from M&I Group Services Limited relating to other duties. Also refer to note 31.

** Mr D P Meintjes also earned R1.5m in 2007 from a subsidiary of Emirates Healthcare Holdings Limited BVI relating to other duties.

*** Dr R H Bider and Mr K H S Pretorius were appointed as directors on 1 February 2008 and 8 November 2006 respectively. Their director's remuneration is from the respective dates.

**** Other benefits include medical aid, car allowances, relocation allowance and UIF.

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 2008.

| The number of outstanding share options are: | Offer price | **2008 Number** | 2007 Number |
|---|---|---|---|
| K H S Pretorius | R4.90 | **15,000** | 60,000 |
| | R9.80 | **40,000** | 50,000 |
| | | **55,000** | 110,000 |

| | GROUP | |
|---|---|---|
| | **2008 R'm** | 2007 R'm |
| **23. EXPENSES BY NATURE** | | |
| Auditors' remuneration – external audit | **10** | 3 |
| Auditors' remuneration – other services | **2** | * |
| Cost of inventories | **2,510** | 1,568 |
| Depreciation – buildings | **74** | 4 |
| – equipment | **196** | 112 |
| – furniture and vehicles | **66** | 30 |
| Employee benefit expenses | **3,688** | 1,951 |
| Wages and salaries | **3,498** | 1,841 |
| Post-employment medical benefits (note 18) | **33** | 27 |
| Retirement benefit costs – defined contribution plans | **90** | 75 |
| Retirement benefit costs – defined benefit plans (note 18) | **59** | – |
| Share-based payment expense | **8** | 8 |
| Increase in impairment provision for receivables (note 12) | **33** | 9 |
| Maintenance costs | **270** | 172 |
| Managerial and administration fees | **3** | 3 |
| Operating leases – buildings | **108** | 39 |
| – equipment | **28** | 25 |
| Amortisation of intangible assets | **5** | * |
| Other expenses | **865** | 442 |
| General expenses | **1,147** | 510 |
| Profit on sale of equipment | **2** | 1 |
| Other income | **280** | 67 |
| | **7,858** | 4,358 |
| Classified as: | | |
| Cost of sales | **5,381** | 2,928 |
| Administration and other operating expenses | **2,477** | 1,430 |
| | **7,858** | 4,358 |

* Amounts less than R0.5m

**24. INCOME FROM ASSOCIATES**

| | | |
|---|---|---|
| Unlisted associates | | |
| Share of income before taxation | **–** | 1 |
| Share of taxation | | |
| Provided by the Group | **–** | – |
| | **–** | 1 |

| COMPANY 2007 R'm | COMPANY 2008 R'm | | GROUP 2008 R'm | GROUP 2007 R'm |
|---|---|---|---|---|
| | | **25. FINANCE COST** | | |
| | | Interest expense | **614** | 88 |
| | | Fair value losses on interest rate swaps | **55** | – |
| | | Amortisation of capitalised financing fees | **16** | – |
| | | | **685** | 88 |
| | | **26. TAXATION** | | |
| | | Current taxation | | |
| (7) | **(9)** | Current year | **(344)** | (267) |
| | | Previous year | **1** | – |
| (5) | **(14)** | Deferred taxation | **(21)** | (3) |
| (12) | **(23)** | Taxation per income statement | **(364)** | (270) |
| | | *Composition* | | |
| (1) | **(1)** | Normal South African taxation | **(239)** | (252) |
| | | Foreign taxation | **(103)** | (8) |
| (11) | **(22)** | Secondary taxation on companies ("STC") | **(22)** | (7) |
| | | Deferred income tax | | |
| – | **–** | Current year | **–** | 13 |
| – | **–** | STC credits | **–** | (16) |
| (12) | **(23)** | | **(364)** | (270) |
| | | | % | % |
| | | *Reconciliation of rate of taxation* | | |
| | | Standard rate for companies (RSA) | **29.0** | 29.0 |
| | | Adjusted for: | | |
| | | Capital gains taxation | **0.2** | 0.4 |
| | | Non-taxable income | **(2.7)** | (3.0) |
| | | Non-deductible expenses | **8.8** | 0.6 |
| | | Minorities share of profit before taxation | **(1.3)** | (1.5) |
| | | Rate differences | **(2.6)** | 0.2 |
| | | STC | **2.1** | 2.3 |
| | | Effective tax rate | **33.5** | 28.0 |

| | GROUP | |
|---|---|---|
| | **2008 R'm** | 2007 R'm |
| **27. EARNINGS PER ORDINARY SHARE** | | |
| **Earnings reconciliation** | | |
| Profit attributable to shareholders | **610** | 582 |
| Profit on sale of property, equipment and vehicles | **(2)** | (1) |
| Headline earnings | **608** | 581 |
| **Weighted number of issued ordinary shares** | | |
| Number of issued ordinary shares at beginning of the year | **394,338,449** | 394,338,449 |
| Weighted number of ordinary shares issued during the year | **60,796,873** | – |
| Weighted number of treasury shares | **(33,697,872)** | (36,732,391) |
| | **421,437,450** | 357,606,058 |
| **Diluted number of issued ordinary shares** | | |
| Weighted number of issued ordinary shares | **421,437,450** | 357,606,058 |
| Weighted number of treasury shares held in terms of the BEE initiative not yet released from treasury stock | **32,264,287** | 33,778,457 |
| Adjustment for outstanding share options granted | **2,046,389** | 2,722,055 |
| | **455,748,126** | 394,106,570 |
| **Earnings per ordinary share (cents)** | | |
| Basic | **144.9** | 162.5 |
| Diluted | **134.0** | 147.5 |
| **Headline earnings per ordinary share (cents)** | | |
| Basic | **144.5** | 162.2 |
| Diluted | **133.6** | 147.2 |
| **28. CASH FLOW INFORMATION** | **R'm** | R'm |
| **28.1 Reconciliation of profit before taxation to cash generated from operations** | | |
| Operating profit before interest and taxation | **1,721** | 1,006 |
| Non-cash items | | |
| Intangibles amortised | **5** | – |
| Movement in share-based payment reserve | **8** | 8 |
| Depreciation | **336** | 146 |
| Movement in provisions | **(19)** | – |
| Movement in retirement benefit obligations | **25** | 27 |
| Profit on sale of property, equipment and vehicles | **(2)** | (1) |
| Operating income before changes in working capital | **2,074** | 1,186 |
| Working capital changes | **(557)** | 1 |
| Increase in inventories | **(6)** | (18) |
| Increase in trade and other receivables | **(390)** | (60) |
| (Decrease)/increase in trade and other payables | **(161)** | 79 |
| | **1,517** | 1,187 |

| COMPANY 2007 R'm | COMPANY 2008 R'm | | GROUP 2008 R'm | GROUP 2007 R'm |
|---|---|---|---|---|
| | | **28.2 Taxation paid** | | |
| | | Liability at beginning of the year | **(8)** | (47) |
| | | Business acquisitions | **(75)** | – |
| | | Currency translation difference | **(4)** | – |
| (7) | **(9)** | Provision for the year | **(344)** | (267) |
| (7) | **(9)** | | **(431)** | (314) |
| | | Liability at end of the year | **71** | 8 |
| (7) | **(9)** | | **(360)** | (306) |
| | | **28.3 Investment to maintain operations** | | |
| | | Property, equipment and vehicles purchased | **(275)** | (139) |
| (24) | **(4,464)** | Loans to subsidiaries | **–** | – |
| (24) | **(4,464)** | | **(275)** | (139) |
| | | **28.4 Investment to expand operations** | | |
| | | Property, equipment and vehicles purchased | **(643)** | (186) |
| | | Intangible assets purchased | **(11)** | – |
| | | Loans granted | **–** | 75 |
| | | Business acquisitions | **(15,803)** | (426) |
| | | Prior year business acquisition consideration outstanding | **(82)** | – |
| | | Acquisition of minority interests in hospital activities | **(105)** | (5) |
| | | | **(16,644)** | (542) |
| | | **28.5 Proceeds on sale of property, equipment and vehicles** | | |
| | | Book value of property, equipment and vehicles sold | **19** | 8 |
| | | Profit per income statement | **2** | 1 |
| | | | **21** | 9 |
| | | **28.6 Distributions paid to shareholders** | | |
| (209) | **(224)** | Dividends declared and paid during the year | **(189)** | (178) |
| | | **28.7 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 | **801** | 716 |
| | | Bank overdrafts | **(14)** | (359) |
| | | Southern African operations (see note 17) | **(14)** | (143) |
| | | Middle East operations (see note 17) | **–** | (216) |
| | | | **787** | 357 |

| | GROUP | |
|---|---|---|
| | **2008 R'm** | 2007 R'm |
| **29. COMMITMENTS** | | |
| **Capital commitments** | | |
| Incomplete capital expenditure contracts | **680** | 415 |
| Southern Africa | **550** | 214 |
| Switzerland | **32** | – |
| Middle East | **98** | 201 |
| Capital expenses authorised by the Board of Directors but not yet contracted | **319** | 274 |
| Southern Africa | **248** | 274 |
| Switzerland | **71** | – |
| Middle East | **–** | – |
| | **999** | 689 |
| These commitments will be financed from group and borrowed funds. | | |
| **Financial lease commitments** | | |
| The Group has entered into financial lease agreements on equipment. At 31 March 2008, future non-cancellable minimum lease rentals are payable during the following financial years: | | |
| Within 1 year | **8** | – |
| 1 to 5 years | **18** | – |
| Beyond 5 years | **35** | – |
| | **61** | – |
| **Operating lease commitments** | | |
| The Group has entered into various operating lease agreements on premises and equipment. At 31 March 2008 and 31 March 2007, future non-cancellable minimum lease rentals are payable during the following financial years: | | |
| Within 1 year | **187** | 38 |
| 1 to 5 years | **530** | 87 |
| Beyond 5 years | **1,223** | – |
| | **1,940** | 125 |

| | GROUP | |
|---|---|---|
| | **2008 R'm** | 2007 R'm |
| **30. SEGMENTAL REPORT** | | |
| The Group is organised into three geographic segments, which is the basis on which primary segment information is reported. | | |
| The segments are as follows: | | |
| Southern African operations | | |
| Swiss operations | | |
| Middle East operations | | |
| Financial information pertaining to the geographic segments: | | |
| **Revenue** | **9,579** | 5,364 |
| Southern Africa | **6,056** | 5,364 |
| Switzerland | **3,041** | – |
| Middle East | **482** | – |
| **Operating profit** | **1,721** | 1,006 |
| Southern Africa | **1,143** | 1,006 |
| Switzerland | **556** | – |
| Middle East | **22** | – |
| **Depreciation and amortisation included in operating profit** | **341** | 146 |
| Southern Africa | **159** | 146 |
| Switzerland | **154** | – |
| Middle East | **28** | – |
| **Total assets** | **41,577** | 5,489 |
| Southern Africa | **4,545** | 3,951 |
| Switzerland | **35,456** | – |
| Middle East | **1,576** | 1,538 |
| **Total liabilities** | **31,890** | 2,669 |
| Southern Africa | **4,643** | 2,212 |
| Switzerland | **26,736** | – |
| Middle East | **511** | 457 |
| **Capital expenditure** | **930** | 325 |
| Southern Africa | **355** | 325 |
| Switzerland | **208** | – |
| Middle East | **367** | – |

The Group acquired the Middle East operations at the end of the 2007 financial year. Consequently no comparative income statement information is provided. During the 2008 financial year, the Group acquired operations in Switzerland and therefore no comparative information is required.

| COMPANY | | | GROUP | |
|---|---|---|---|---|
| 2007 R'm | **2008 R'm** | | **2008 R'm** | 2007 R'm |
| | | **31. RELATED PARTY TRANSACTIONS** | | |
| | | The major shareholder of the Group is Industrial Partnership Investments Limited (Remgro Limited), which owns 43.40% (2007: 43.36%). The remaining shares are listed and widely held. | | |
| | | The following transactions were carried out with related third parties: | | |
| | | **Transactions with shareholders** | | |
| | | M&I Group Services Limited (subsidiary of Remgro Limited) | | |
| | | Managerial and administration fees | **3** | 3 |
| | | Interest received | **2** | – |
| | | Internal audit services | **1** | 1 |
| | | Balance due to | **1** | – |
| | | **Key management compensation** | | |
| | | Directors | | |
| | | Information regarding the directors' remuneration appears in note 22. | | |
| | | **Transactions with subsidiaries** | | |
| | | Medi-Clinic Investments Limited | | |
| 217 | **200** | Dividend received | | |
| 450 | **4,922** | Balance due from | | |

GROUP

## 32. BUSINESS ACQUISITIONS

On 26 October 2007, the Group acquired 100% of the share capital of Medi-Clinic Luxembourg S.à r.l. ("Medi-Clinic Luxembourg"), a company owning 100% of Hirslanden, the largest private hospital group in Switzerland. The acquired business contributed R3,041m to the Group's revenue for the year. If the acquisition had occurred on 1 April 2007, Group revenue would have been R12,724m and profit before allocations would have been R740m.

During the previous year the Group 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.

| Details of net assets and goodwill acquired: | **Fair value 2008 R'm** | **Acquiree's carrying amount 2008 R'm** | 2007 R'm |
|---|---|---|---|
| Property, equipment and vehicles | **(20,391)** | **(4,138)** | (623) |
| Intangible assets | **(2,457)** | **(20)** | (362) |
| Investment in associates | **(5)** | **(5)** | (1) |
| Other investments and loans | **(18)** | **(18)** | – |
| Deferred taxation | **3,976** | **176** | – |
| Inventories | **(186)** | **(186)** | (19) |
| Trade and other receivables | **(1,304)** | **(1,304)** | (146) |
| Cash resources | **(624)** | **(624)** | – |
| Interest-bearing borrowings | **4,963** | **4,963** | 104 |
| Trade and other payables | **1,075** | **1,075** | 152 |
| Provisions | **158** | **158** | – |
| Taxation | **75** | **75** | – |
| Minority interest of existing shareholders | **3** | **3** | 391 |
| Value of interests acquired | **(14,735)** | **155** | (504) |
| Goodwill | **(1,692)** | | (4) |
| Purchase consideration | **(16,427)** | | (508) |
| Purchase consideration | **(16,427)** | | (508) |
| Purchase consideration outstanding | **–** | | 82 |
| Cash resources | **624** | | – |
| Cash outflow on acquisition | **(15,803)** | | (426) |

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

The Hirslanden brand (included in intangible assets) was valued using the royalty rate method. The calculation was based on financial projections from the financial plan covering the period to 2010. The discount rate applied is between 5% and 7% and the long-term growth rate approximately 0.5%. The royalty rate was estimated based on a peer group analysis and fixed at 2.0%.

# Annexure – Investments in subsidiaries and associates

at 31 March 2008

| | Issued share capital | | Interest in capital | | Book value of shares | |
|---|---|---|---|---|---|---|
| | **2008** | 2007 | **2008** | 2007 | **2008** | 2007 |
| | **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 R4,922m (2007: R450m). | | | | | | |
| 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 Europe (Proprietary) 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 | | |
| Medi-Clinic Properties (Proprietary) Limited | | | **100.0** | 100.0 | | |
| Medi-Clinic Properties (Windhoek) (Proprietary) Limited | | | **100.0** | 100.0 | | |
| Medi-Clinic Operations (Namibia) (Proprietary) Limited | | | **100.0** | 100.0 | | |
| Medi-Clinic Properties (Swakopmund) (Proprietary) Limited | | | **100.0** | 100.0 | | |
| Medi-Clinic Finance Corporation (Proprietary) Limited | | | **100.0** | – | | |
| Medi-Clinic Investments (Namibia) (Proprietary) Limited | | | **100.0** | 100.0 | | |
| Medipark Clinic (Proprietary) Limited | | | **100.0** | 100.0 | | |
| Newcastle Private Hospital Limited* | | | **15.1** | 15.1 | | |
| Paarl Medi-Clinic (Proprietary) Limited | | | **75.6** | 75.6 | | |
| Phodiclinics (Proprietary) Limited | | | **100.0** | 51.0 | | |
| Legae Medi-Clinic (Proprietary) Limited | | | **100.0** | 100.0 | | |
| Practice Relief (Proprietary) Limited | | | **100.0** | 100.0 | | |
| Reef-Med (Proprietary) Limited | | | **58.9** | 55.9 | | |
| Tshwane Private Hospitals (Proprietary) Limited | | | **100.0** | 51.0 | | |
| Tzaneen Private Hospital (Proprietary) Limited* | | | **49.4** | 49.4 | | |
| Victoria Hospital Limited* | | | **33.3** | 33.3 | | |

| | Issued share capital | | Interest in capital | | Book value of shares | |
|---|---|---|---|---|---|---|
| | **2008** | 2007 | **2008** | 2007 | **2008** | 2007 |
| | **Rand** | Rand | **%** | % | **R'm** | R'm |
| **SUBSIDIARIES (continued)** | | | | | | |
| ***Indirectly held through Medi-Clinic Limited*** | | | | | | |
| Kimberley Medi-Clinic (Proprietary) Limited[Δ] | | | **89.7** | 89.7 | | |
| Ermelo Medi-Clinic (Proprietary) Limited[Δ] | | | **50.1** | 50.1 | | |
| Barberton Medi-Clinic (Proprietary) Limited[Δ] | | | **77.0** | 77.0 | | |
| Hermanus Medi-Clinic Limited*[Δ] | | | **34.9** | 34.9 | | |
| Potchefstroom Medi-Clinic (Proprietary) Limited[Δ] | | | **94.6** | 94.6 | | |
| Limpopo Medi-Clinic Limited[Δ] | | | **50.0** | 50.0 | | |
| Upington Private Hospital (Proprietary) Limited*[Δ] | | | **40.9** | 40.9 | | |
| ***Indirectly held through Medi-Clinic Europe (Proprietary) Limited*** | | | | | | |
| Medi-Clinic Holdings Netherlands B.V. | | | **100.0** | – | | |
| Medi-Clinic Luxembourg S.à r.l. | | | **100.0** | – | | |
| Medi-Clinic Switzerland AG | | | **100.0** | – | | |
| Klinik Hirslanden AG | | | **100.0** | – | | |
| Klinik Im Park AG | | | **100.0** | – | | |
| Hirslanden Klinik Aarau AG | | | **100.0** | – | | |
| Beau-Site AG | | | **100.0** | – | | |
| Clinique Cecil SA | | | **100.0** | – | | |
| Klinik Belair AG | | | **100.0** | – | | |
| Klinik St. Andreas-Liebfrauenhof AG | | | **100.0** | – | | |
| AndreasKlinik AG | | | **100.0** | – | | |
| Clinique Bois-Cerf SA | | | **100.0** | – | | |
| Klinik Birshof AG | | | **100.0** | – | | |
| Salem-Spital AG | | | **100.0** | – | | |
| Sinomed AG | | | **100.0** | – | | |
| Klinik St. Anna AG | | | **100.0** | – | | |
| ***Indirectly held through Medi-Clinic Middle East (Proprietary) Limited*** | | | | | | |
| Emirates Healthcare Holdings Limited BVI | | | **50.0** | 50.0 | | |
| ***Indirectly held through Emirates Healthcare Holdings Limited BVI*** | | | | | | |
| Emirates Healthcare Limited BVI | | | **99.3** | 99.3 | | |
| Welcare Hospitals Limited BVI | | | **100.0** | 100.0 | | |

All increases in the above shareholdings were paid for in cash.

* Controlled through long-term management agreements

[Δ] Operating through trusts or partnerships

# Annexure – Investments in subsidiaries and associates

at 31 March 2008 (continued)

| | Interest in capital | | Book value of shares | |
|---|---|---|---|---|
| | **2008** | 2007 | **2008** | 2007 |
| | **%** | % | **R'm** | R'm |
| **SUBSIDIARIES (continued)** | | | | |
| **Indirectly held through Tshwane Private Hospitals (Proprietary) Limited** | | | | |
| Curamed Holdings Limited (Effective holding = 67% (2007: 35%)) | **63.0** | 63.0 | | |
| **Indirectly held through Medipark Clinic (Proprietary) Limited** | | | | |
| ER24 Holdings (Proprietary) Limited | **100.0** | 100.0 | | |
| **JOINT VENTURES** | | | | |
| Wits University Donald Gordon Medical Centre (Proprietary) Limited | **49.9** | 49.9 | | |

| | Interest in capital | | Book value of investment | | Amount owing by associates | |
|---|---|---|---|---|---|---|
| | **2008** | 2007 | **2008** | 2007 | **2008** | 2007 |
| | **%** | % | **R'm** | R'm | **R'm** | R'm |
| **ASSOCIATES** | | | | | | |
| Group | | | | | | |
| *Unlisted* | | | | | | |
| MediQi Cham | **49.0** | – | **1** | – | **–** | – |
| MediQi Zürich | **49.0** | – | **2** | – | **–** | – |
| Zentrallabor Zürich (ZLZ) | **46.3** | – | **4** | – | **–** | – |
| First Medical Centre L.L.C., Oman | **20.0** | 20.0 | **1** | 1 | **–** | – |
| Curamed Thabazimbi Trust | **38.0** | 38.0 | **–** | – | **4** | 4 |
| | | | **8** | 1 | **4** | 4 |

The nature of the activities of the associates is similar to the major activities of the Group.

## SPECIAL RESOLUTIONS BY SUBSIDIARIES

As required in terms of section 8.63(j) of the JSE Limited Listings Requirements, the only special resolution taken by the company's subsidiaries relating to capital structure, borrowing powers, the object clause contained in the memorandum of association or other material matter that affects the company and its subsidiaries for the period under review was as follows:

- Tshwane Private Hospitals (Pty) Ltd: Authorised share capital was increased from R4,000 (four thousand Rand) consisting of 4,000 (four thousand) ordinary shares with a par value of R1 (one Rand) each, to R8,000 (eight thousand Rand) consisting of 8,000 (eight thousand) ordinary shares with a par value of R1 (one Rand) each.

# Analysis of shareholders

at 31 March 2008

| | Number of shareholders | Number of shares | % |
|---|---|---|---|
| **DISTRIBUTION OF ORDINARY SHAREHOLDERS** | | | |
| Public shareholders | **4,085** | **192,607,860** | **32.48%** |
| Non-public shareholders | **25** | **400,406,086** | **67.52%** |
| Directors and associates | **19** | **4,350,542** | **0.73%** |
| Own holdings (treasury shares) | **1** | **1,138,158** | **0.19%** |
| Industrial Partnership Investments Limited (Remgro) | **1** | **257,346,286** | **43.40%** |
| Lehman Brothers International | **1** | **59,435,078** | **10.02%** |
| Black Economic Empowerment shareholders | **3** | **78,136,022** | **13.18%** |
| | **4,110** | **593,013,946** | **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 a beneficial interest of more than 5% in the Company on 28 March 2008:

| | | |
|---|---|---|
| Industrial Partnership Investments Limited (Remgro) | **257,346,286** | **43.40%** |
| Lehman Brothers International | **59,435,078** | **10.02%** |
| Black Economic Empowerment shareholders: | **78,136,022** | **13.18%** |
| Mpilo Investment Holdings 2 (Pty) Ltd (Phodiso Holdings) | **39,332,736** | **6.64%** |
| Mpilo Investment Holdings 1 (Pty) Ltd (Circle Capital Ventures) | **23,377,488** | **3.94%** |
| Mpilo Trusts | **15,425,798** | **2.60%** |
| Distribution of local and foreign beneficial shareholding: | **593,013,946** | **100.00%** |
| South African | **521,577,654** | **87.95%** |
| Foreign | **71,436,292** | **12.05%** |

| | 2008 | 2007 |
|---|---|---|
| **JSE LIMITED** | | |
| Market capitalisation as at 31 March (R'000) | **11,682,375** | 9,897,895 |
| Price (cents per share) | | |
| 31 March | **1,970** | 2,510 |
| Highest | **2,695** | 2,541 |
| Lowest | **1,811** | 2,510 |
| Number of shares traded (000's) | **153,885** | 200,096 |

## SHARE CLOSING PRICE FROM 1987 – 2008

# Analysis of shareholders

at 31 March 2008 (continued)

| *Ordinary shares* | 2008 Beneficial Direct | 2008 Beneficial Indirect | 2008 Associates | 2007 Beneficial Direct | 2007 Beneficial Indirect | 2007 Associates |
|---|---|---|---|---|---|---|
| **DIRECTORS' INTERESTS*** | | | | | | |
| E de la H Hertzog | **–** | **3,000,808** | **349,821** | – | 1,364,498 | 349,821 |
| L J Alberts | **369,904** | **–** | **34,416** | 257,177 | – | 24,416 |
| R H Bider | **–** | **–** | **–** | n/a | n/a | n/a |
| J C Cohen | **–** | **–** | **–** | n/a | n/a | n/a |
| S Dakile–Hlongwane | **–** | **–** | **–** | – | – | – |
| J du T Marais | **34,402** | **–** | **13,685** | 1,963 | – | 3,685 |
| A R Martin | **–** | **2,880** | **–** | – | 1,915 | – |
| D P Meintjes | **93,517** | **–** | **–** | 47,683 | – | 500 |
| V E Msibi** | **–** | **–** | **–** | – | – | – |
| K H S Pretorius | **89,306** | **–** | **–** | 7,066 | – | – |
| A A Raath | **–** | **–** | **–** | – | – | – |
| M A Ramphele*** | **–** | **–** | **–** | – | – | – |
| D K Smith | **–** | **–** | **–** | n/a | n/a | n/a |
| J G Swiegers | **82,023** | **258,664** | **20,159** | 54,543 | 157,135 | 13,405 |
| W L van der Merwe | **957** | **–** | **–** | 957 | – | – |
| M H Visser | **–** | **–** | **–** | – | – | – |
| | **670,109** | **3,262,352** | **418,081** | 369,389 | 1,523,548 | 391,827 |

* There has been no change in the directors' interests between the end of the financial year and 14 May 2008.

** Dr V E Msibi holds an effective interest of 24.89% in the issued ordinary shares of Mpilo Investment Holdings 2 (Pty) Ltd through his shareholding in Phodiso Holdings Limited.

*** Dr M A Ramphele holds an effective interest of 18.63% 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 | **2,151** | **52.34%** | **790,611** | **0.13%** |
| 1,001 – 10,000 shares | **1,344** | **32.70%** | **4,688,084** | **0.79%** |
| 10,001 –100,000 shares | **403** | **9.80%** | **12,318,018** | **2.08%** |
| 100,001 – 1,000,000 shares | **162** | **3.94%** | **52,674,221** | **8.88%** |
| Over 1,000,000 shares | **50** | **1.22%** | **522,543,012** | **88.12%** |
| | **4,110** | **100.00%** | **593,013,946** | **100.00%** |

MEDI-CLINIC
Private hospital group

MEDI-CLINIC CORPORATION LIMITED

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

# notice of annual general meeting

**Notice is hereby given that the twenty-fifth annual general meeting of the Company will be held at Medi-Clinic Offices, Strand Road, Stellenbosch on Wednesday, 30 July 2008 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 2008 be accepted.

## 2. APPOINTMENT OF AUDITORS

**Ordinary Resolution Number 2**

Resolved that the reappointment of PricewaterhouseCoopers Inc. as the Company's auditors is approved and to note that the individual registered auditor who will undertake the audit for the financial year ending 31 March 2009 is Mr J Loubser.

## 3. APPROVAL OF DIRECTORS' REMUNERATION

**Ordinary Resolution Number 3**

Resolved that the joint remuneration of the non-executive directors in the amount of R1 454 360 for the year ended 31 March 2008 be approved.

## 4. RATIFICATION OF CO-OPTION OF DIRECTORS

**Ordinary Resolution Number 4**

Resolved that the co-option of Dr R H Bider and Mr J C Cohen on 1 February 2008 and Mr D K Smith on 31 March 2008 as directors of the Company is ratified.

A brief CV of Dr Bider and Messrs Cohen and Smith appears on pages 8 and 9 of the annual report.

## 5. ELECTION OF DIRECTORS

**Ordinary Resolution Number 5**

5.1 Resolved that Dr R H Bider who retires in terms of clause 30.10 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;

5.2 Resolved that Mr J C Cohen who retires in terms of clause 30.10 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;

5.3 Resolved that Mr D K Smith who retires in terms of clause 30.10 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;

5.4 Resolved that Mr L J Alberts 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;

5.5 Resolved that Dr V E Msibi 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;

5.6 Resolved that Mr A A Raath 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;

5.7 Resolved that Mr J G Swiegers 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;

5.8 Resolved that Mr M H Visser 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.

## 6. AUTHORITY TO PLACE SHARES UNDER CONTROL OF THE DIRECTORS

**Ordinary Resolution Number 6**

Resolved that the unissued ordinary shares in the authorised share capital of the Company be hereby placed under the control of the directors 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 aggregate number of ordinary shares available for allotment and issue in terms of this resolution being limited to 10% of the number of ordinary shares in issue at 31 March 2008, and further subject to the provisions of the Companies Act, the Articles of Association of the Company and the JSE Limited ("JSE") Listings Requirements ("the JSE Listings Requirements").

# Notice of annual general meeting (continued)

## 7. AUTHORITY TO ISSUE SHARES FOR CASH

**Ordinary Resolution Number 7**

Resolved that, subject to Ordinary Resolution Number 6, the directors of the Company be and are hereby authorised by way of a general authority, to issue any such number of ordinary shares from the authorised, but unissued shares in the share capital of the Company for cash, as and when the directors in their sole discretion may deem fit, subject to the Companies Act, the Articles of Association of the Company, the JSE Listings Requirements, when applicable, and the following limitations, namely that –

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

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

7.3 the number of equity securities which are the subject of the issue for cash may not in the aggregate in any one financial year exceed 10% of the Company's relevant number of equity securities in issue of that class. The number of securities which may be issued shall be based on the number of securities of that class in issue added to those that may be issued in future arising from the conversion of options/convertible securities, at the date of such application:

- less any securities of the class issued, or to be issued in future arising from options/convertible securities issued, during the current financial year; and
- plus any securities of that class to be issued pursuant to a rights issue which has been announced, is irrevocable and is fully underwritten or pursuant to an acquisition, the final terms of which has been announced, as though they were securities in issue at the date of application;

7.4 for purposes of determining the number of securities which may be issued in any one year, account must be taken of the dilution effect in the year of issue of options/convertible securities, by including the number of any equity securities which may be issued in future arising out of the issue of such options/convertible securities;

7.5 the equity shares which are the subject of the issue for cash of a particular class, will be aggregated with any securities that are compulsorily convertible into securities of that class, and, in the case of the issue of compulsorily convertible securities, aggregated with the securities of that class into which they are compulsorily convertible;

7.6 this authority is valid until the Company's next annual general meeting, provided that it shall not extend beyond 15 months from the date that this authority is given;

7.7 a paid press announcement giving full details, including the impact on the net asset value and earnings per share, will be published at the time of any issue representing, on a cumulative basis within one financial year, 5% or more of the number of shares in issue prior to the issue; and

7.8 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 7 is required, under the JSE 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.

## 8. 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 JSE Listings Requirements, when applicable, and provided that:

8.1 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;

8.2 any repurchase of securities will be effected through the order book operated by the JSE trading system and done without any prior understanding or arrangement between the Company and the counter party (reported trades are prohibited);

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

8.4 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;

8.5 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;

8.6 the Company and/or any subsidiary of the Company may not repurchase securities during a prohibited period, as defined in the JSE Listings Requirements, unless the Company has a repurchase programme in place where the dates and quantities of securities to be traded during the relevant period are fixed and not subject to any variation and full details of the programme have been disclosed in an announcement over SENS (the Securities Exchange News Service) prior to the commencement of the prohibited period;

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

8.8 a press announcement will be published giving such details as may be required in terms of the JSE Listings Requirements as soon as the Company and/or any subsidiary has cumulatively repurchased 3% of the number of shares in issue at the date of the passing 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:

8.9 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 general repurchase;

8.10 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 general repurchase;

8.11 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 general repurchase; and

8.12 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 general repurchase.

The Company will ensure that its Sponsor has confirmed the adequacy of the Company's working capital in writing to the JSE in terms of the JSE Listings Requirements, prior to entering the market to proceed with a repurchase.

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

9. 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 JSE Listings Requirements require the disclosure of the following information, some of which appears elsewhere in the annual report of which this notice forms part as set out below:

- Directors and management
  See pages 8 to 9 of the annual report.

- Major shareholders of the Company
  See page 129 of the annual report.

- Material changes
  As reported in the Group's unaudited interim group results for the six months ended 30 September 2007, Medi-Clinic acquired 100% of Hirslanden, the holding company of the largest private hospital group in Switzerland, at an enterprise value of CHF3 364 million, effective on 26 October 2007. The transaction has transformed the Group into a truly international business. The financial effects of this transaction are reflected in the annual financial statements in the annual report.

# Notice of annual general meeting (continued)

- Directors' interests in securities
  See page 130 of the annual report.

- Share capital of the Company
  See page 107 of the annual report.

- Litigation statement
  In terms of section 11.26 of the JSE Listings Requirements, the directors, whose names appear on pages 8 to 9 of the 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 JSE Listings Requirements.

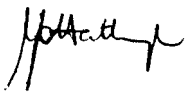
## VOTING AND ATTENDANCE AT THE ANNUAL GENERAL MEETING

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 (Proprietary) Limited, 70 Marshall Street, Johannesburg, 2001 or posted to the transfer secretaries at PO Box 61051, Marshalltown, 2107, South Africa, so as to be received by them by not later than 15:00 on **Monday, 28 July 2008**. 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
4 July 2008

MEDI-CLINIC
Private hospital group

MEDI-CLINIC CORPORATION LIMITED

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

# proxy form

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-fifth annual general meeting of the Company to be held on Wednesday, 30 July 2008 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 30th day of July 2008 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. | Appointment of auditors | | | |
| 3. | Approval of directors' remuneration | | | |
| 4. | Ratification of co-option of directors | | | |
| | 4.1 R H Bider | | | |
| | 4.2 J C Cohen | | | |
| | 4.3 D K Smith | | | |
| 5. | Election of directors: | | | |
| | 5.1 R H Bider | | | |
| | 5.2 J C Cohen | | | |
| | 5.3 D K Smith | | | |
| | 5.4 L J Alberts | | | |
| | 5.5 V E Msibi | | | |
| | 5.6 A A Raath | | | |
| | 5.7 J G Swiegers | | | |
| | 5.8 M H Visser | | | |
| 6. | Authority to place shares under control of the directors | | | |
| 7. | Authority to issue shares for cash | | | |
| Special Resolution | | | | |
| 8. | Authority to repurchase shares | | | |

Signed at _____ on _____2008.

Signature/s _____

Assisted by me (where applicable) _____

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

# Proxy form (continued)

## 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 of 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 (Proprietary) Limited, 70 Marshall Street, Johannesburg, 2001, South Africa or posted to the transfer secretaries at PO Box 61051, Marshalltown, 2107, South Africa, to be received by them not later than **Monday, 28 July 2008** 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.