MEDI-CLINIC

Private hospital group

2009 ANNUAL REPORT

Committed to Quality Care

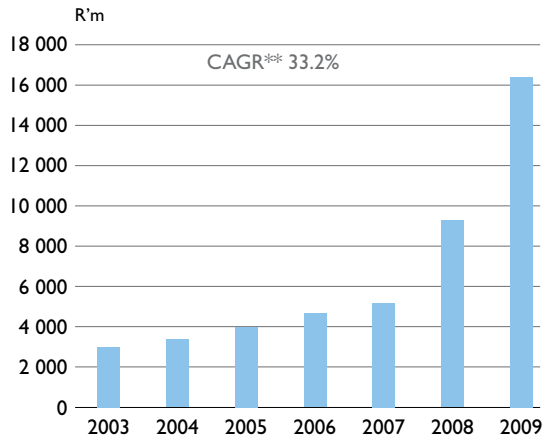
CONTENTS

SCOPE OF REPORT: The 2009 annual report of Medi-Clinic Corporation Limited presents the operating and financial results of the Group for the financial year ended 31 March 2009 and covers all our operations in Southern Africa, Switzerland and the United Arab Emirates. In this report "the Group" or "the Company" refers to Medi-Clinic Corporation Limited and its subsidiaries and "the group" or "the company" refers to one of the three operating platform groups, as the context may indicate. "MCSA" refers to the Medi-Clinic Southern Africa group, "MCCH" refers to the Medi-Clinic Switzerland group and "EHHL" or "MCME" refers to the Medi-Clinic Middle Eastern group. The report has been prepared in accordance with International Financial Reporting Standards, the Companies Act No. 61 of 1973, as amended, the Listings Requirements of the JSE Limited and the guidelines of the King Report on Corporate Governance for South Africa 2002.

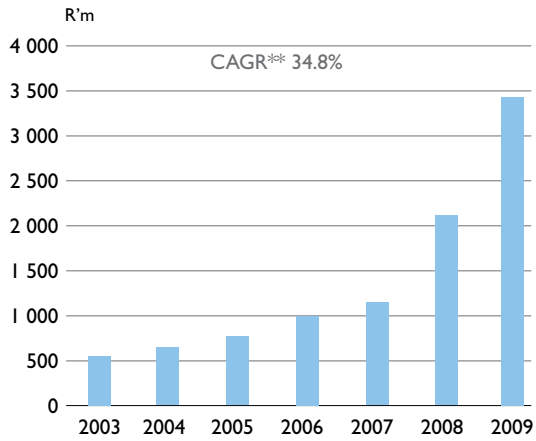
GROUP SUMMARY	2009 R'm	2008 R'm	Change %
Revenue	**16 351**	9 579	71%
EBITDA	**3 431**	2 062	66%
Headline earnings	**624**	608	3%
Total assets	**43 874**	41 599	5%
Shareholders' equity	**7 091**	8 560	(17)%
Return (headline earnings) on shareholders' equity	**8.8%**	7.1%	24%
	cents	cents	
Headline earnings per ordinary share – basic	**111.5**	144.5	(23)%
Headline earnings per ordinary share – diluted	**105.6**	133.6	(21)%
Total distribution per ordinary share	**68.6**	61.2	12%
Net asset value per ordinary share	**1 265.5**	1 527.9	(17)%
Adjusted net asset value per ordinary share*	**1 752.2**	1 657.6	6%

* The adjusted net asset value per ordinary share exclude the valuation of the derivative financial instruments and the Swiss pension liability (refer to page 19 and 20 of the Chief Financial Officer's report).

REVENUE

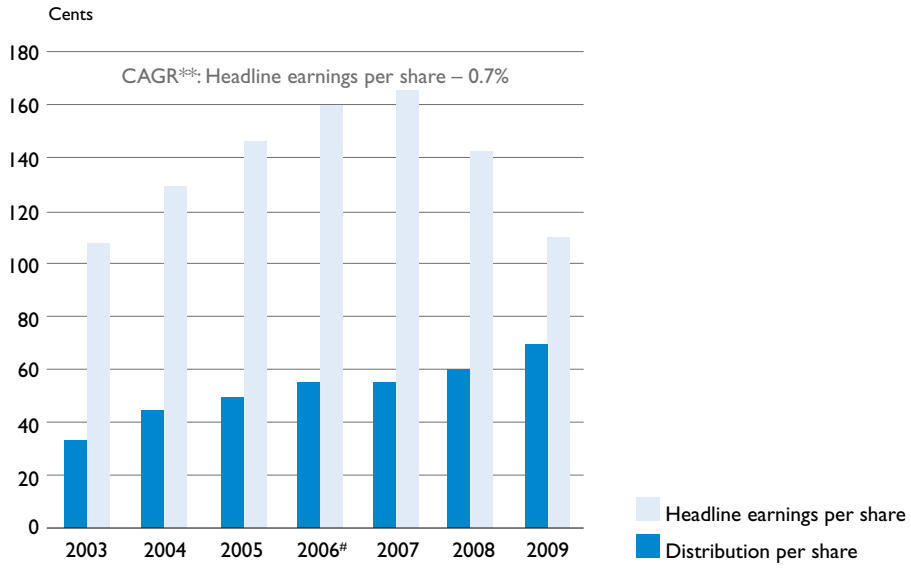


EBITDA



** 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.

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 by patients, doctors and funders of health care.

- 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.

Committed 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.

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

Team Approach

- 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

	CAGR*	2009 R'm	2008 R'm	2007 R'm	2006 R'm	2005 R'm	2004 R'm	2003 R'm
INCOME STATEMENTS								
REVENUE	33.2%	**16 351**	9 579	5 364	4 723	4 040	3 643	2 924
Operating profit before depreciation and amortisation (EBITDA)	34.8%	**3 431**	2 062	1 152	988	820	723	571
BEE share-based payment		**–**	–	–	(85)	–	–	–
Depreciation		**(672)**	(336)	(146)	(124)	(97)	(101)	(75)
Amortisation/impairment of goodwill		**(12)**	(5)	–	–	(3)	(3)	(2)
Operating profit	33.1%	**2 747**	1 721	1 006	779	720	619	494
Income from associates		**2**	–	1	13	25	18	19
Abnormal items		**–**	–	–	43	50	–	–
Finance income		**67**	49	44	70	58	46	43
Finance cost		**(1 602)**	(685)	(88)	(45)	(29)	(32)	(16)
Profit before taxation		**1 214**	1 085	963	860	824	651	540
Taxation		**(502)**	(364)	(270)	(428)	(214)	(174)	(145)
Profit for the year		**712**	721	693	432	610	477	395
Attributable to:								
Equity holders of the Company	9.7%	**636**	610	582	338	543	439	364
Minority interest		**76**	111	111	94	67	38	31
		712	721	693	432	610	477	395
Headline earnings attributable to holders of ordinary shares	9.3%	**624**	608	581	300	503	441	366
Earnings per ordinary share – cents								
Basic	1.1%	**113.7**	144.9	162.5	97.1	158.7	128.8	106.5
Diluted	0.4%	**107.6**	134.0	147.5	85.9	156.7	127.0	105.2
Headline earnings per ordinary share – cents								
Basic	0.7%	**111.5**	144.5	162.2	86.3	146.9	129.5	107.0
Diluted	0.0%	**105.6**	133.6	147.2	76.3	145.0	127.7	105.7
Distribution per ordinary share – cents	13.0%	**68.6**	**61.2**	**54.1**	**53.1**	**45.0**	**40.0**	**33.0**

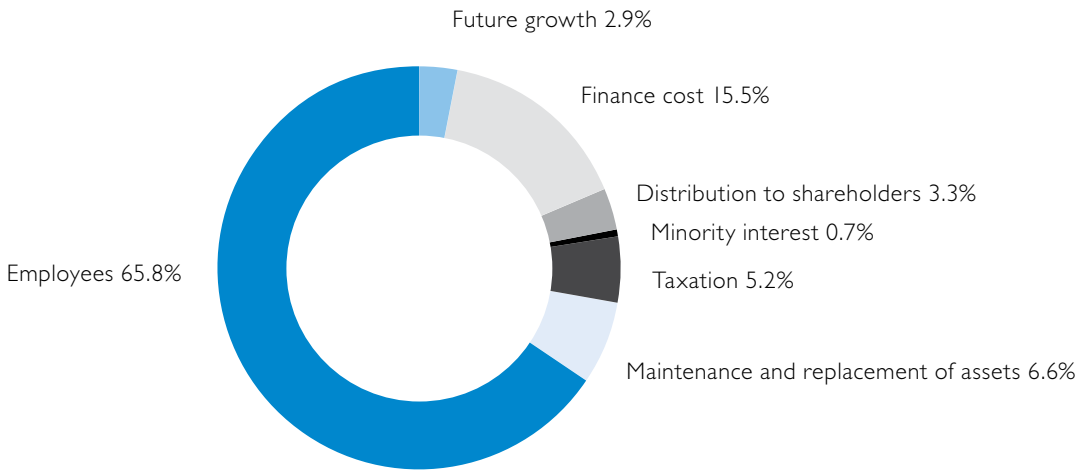
	CAGR*	2009 R'm	2008 R'm	2007 R'm	2006 R'm	2005 R'm	2004 R'm	2003 R'm
BALANCE SHEETS								
ASSETS								
Property, equipment and vehicles		**32 479**	30 972	3 124	2 327	1 997	1 846	1 611
Intangible assets		**6 293**	6 101	419	48	48	48	36
Investments and loans		**32**	34	46	119	114	103	92
Deferred income tax assets		**178**	123	120	123	92	89	69
Derivative financial instruments		**–**	43	–	–	–	–	–
Current assets		**4 892**	4 326	1 780	980	1 510	1 134	891
Total assets		**43 874**	41 599	5 489	3 597	3 761	3 220	2 699
EQUITY								
Capital and reserves attributable to equity holders of the Company		**7 091**	8 560	2 068	1 641	2 693	2 246	1 917
Minority interest		**898**	807	752	290	235	200	172
LIABILITIES								
Long-term interest-bearing borrowings		**24 349**	23 266	996	848	159	168	112
Deferred income tax liability		**5 162**	5 088	5	5	4	3	3
Retirement benefit obligations		**997**	639	129	102	73	58	48
Derivative financial instruments		**2 512**	595	–	–	–	–	–
Provisions		**229**	190	–	–	–	–	–
Current liabilities		**2 636**	2 454	1 539	711	597	545	447
Total equity and liabilities		**43 874**	41 599	5 489	3 597	3 761	3 220	2 699
Net asset value per ordinary share – cents	14.5%	**1 265.5**	1 527.9	575.5	460.7	783.7	657.2	562.7
CASH FLOW STATEMENTS								
Cash generated from operating activities	36.4%	**3 346**	1 517	1 187	994	923	819	520
Net finance income/(cost)		**(1 438)**	(419)	(44)	25	29	14	27
Abnormal item		**–**	–	–	–	50	–	–
Taxation paid		**(522)**	(360)	(306)	(448)	(243)	(196)	(143)
Cash flow from operating activities		**1 386**	738	837	571	759	637	404
Cash flow from investment activities		**(1 380)**	(16 898)	(672)	(388)	(178)	(325)	(276)
Cash flow from financing activities		**125**	16 461	43	(830)	(185)	(106)	(142)
Cash distributions to minorities		**(54)**	(41)	(40)	(39)	(34)	(32)	(19)
Distributions to shareholders		**(339)**	(189)	(178)	(166)	(142)	(120)	(100)
Special dividend to shareholders		**–**	–	–	(1 327)	–	–	–
Proceeds from issuance of ordinary shares		**–**	4 472	–	–	–	–	–
Movement in borrowings		**547**	12 219	248	689	(21)	40	(16)
Other		**(29)**	–	13	13	12	6	(7)
Net movement in cash and bank overdrafts		**131**	301	208	(647)	396	206	(14)
Opening balance of cash and bank overdrafts		**787**	357	149	796	400	194	208
Exchange rate fluctuations on foreign cash		**23**	129	–	–	–	–	–
Closing balance of cash and bank overdrafts		**941**	787	357	149	796	400	194

* Compounded Annual Growth Rate

VALUE ADDED STATEMENT
for the year ended 31 March 2009

	2009 R'm	%	2008 R'm	%
VALUE CREATED				
Revenue	**16 351**		9 579	
Cost of materials and services	**(6 100)**		(3 800)	
Interest received	**67**		49	
	10 318	**100.0**	5 828	100.0
DISTRIBUTION OF VALUE				
To employees as remuneration and other benefits	**6 785**	**65.8**	3 688	63.3
Taxation and other state and local authority levies (excluding VAT)	**535**	**5.2**	394	6.8
To suppliers of capital:				
Minority interest	**76**	**0.7**	111	1.9
Finance cost on borrowed funds	**1 602**	**15.5**	685	11.8
Distributions to shareholders	**339**	**3.3**	189	3.2
	9 337	**90.5**	5 067	87.0
VALUE RETAINED				
To maintain and replace assets	**684**	**6.6**	340	5.8
Income retained for future growth	**297**	**2.9**	421	7.2
	981	**9.5**	761	13.0

DISTRIBUTION OF VALUE 2009



ADMINISTRATION

COMPANY SECRETARY

G C Hattingh (44) 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 11 370 5000 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 2009

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 23 (21.6 cents per share):

Declaration date	5 November 2008
Last date to trade cum dividend	28 November 2008
First date of trading ex dividend	1 December 2008
Record date	5 December 2008
Payment date	8 December 2008

Final payment: Dividend number 24 (47.0 cents per share):

Declaration date	19 May 2009
Last date to trade cum dividend	19 June 2009
First date of trading ex dividend	22 June 2009
Record date	26 June 2009
Payment date	29 June 2009

BOARD OF DIRECTORS

Executive directors

Chairman

E de la H Hertzog (59)

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 67 of the report.

Executive Director

L J Alberts (61)

B.Comm., CA(SA)
(Chief Executive Officer)

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

Executive Director

J G Swiegers (54)

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.

Executive Director

D P Meintjes (52)

B.Pl. (Hons)
(Chief Executive Officer: Medi-Clinic Middle East)

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

Executive Director

K H S Pretorius (46)

B.Compt., MBL (Chief Executive Officer: Medi-Clinic Southern Africa)

Joined the Group in 1998 and appointed as a director of the Company in 2006.

Executive Director

T O Wiesinger (46) (Swiss)

Ph.D., Postgraduate Studies in Health Economics
(Chief Executive Officer: Medi-Clinic Switzerland)

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

Non-executive directors

Non-Executive Director

J C Cohen (42) (British)

B.Sc. in Economics

A managing partner of Trilantic Capital Partners (previously Lehman Brothers Merchant Bank). Appointed as a director of the Company in 2008.

Non-Executive Director

M K Makaba (56)

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

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

Non-Executive Director

M A Ramphele (61)

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 2005 as a director of the Company. Other directorships include Anglo American and MTN Group.

Independent non-executive directors

Non-Executive Director

M H Visser (55)

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

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

Independent Non-Executive Director

Z P Manase (47)

B.Compt. (Hons), H.Dip. (Tax), CA(SA)

Chief Executive Officer of the audit firm, Manase & Associates. Appointed as a director of the Company in 2008.

Independent Non-Executive Director

A R Martin (70)

B.Comm., CA(SA)

Appointed in 2002 as a director of the Company. Other directorships include Trans Hex Group, Barnard Jacobs Mellet Holdings Ltd and Datacentrix Holdings Ltd.

Independent Non-Executive Director

A A Raath (53)

B.Comm., CA(SA)

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

Independent Non-Executive Director

D K Smith (61)

B.Sc., FASSA

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

Independent Non-Executive Director

W L van der Merwe (57)

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

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

CHAIRMAN'S REPORT

During the past financial year the big issue has undoubtedly been the global financial crisis. Fortunately the Group could illustrate not only the defensive nature of the private healthcare industry, but also its own operational resilience by performing well in terms of financial results as well as its share price on the JSE. What is even more encouraging is that the Group also performed well when compared with listed, international peer-group, private hospital-operating companies in US dollar terms.

This was only possible because most of the building blocks for establishing success in the industry were in place. Twenty-six years after its formation the Group owns and operates successful hospitals in good locations in three international geographic areas where there is a firm demand for private healthcare services. To create value from this infrastructure and demand, competent management and dedicated service by every employee are, of course, essential. In this regard the Group has been particularly fortunate over many years and warm appreciation must again be expressed to all involved.

In my report last year I stated that two of the top priorities for the year ahead would be to unlock value and ensure efficient management at the Hirslanden group and furthermore to ensure the successful launch of The City Hospital in Dubai. These objectives have been achieved to the extent that they can be achieved in one year.

At the Hirslanden group the new Chief Executive Officer, Dr Ole Wiesinger, and his newly established Executive Committee of six members have clearly found their feet, as can be seen by the operational results of that group. The board of Hirslanden also functions particularly well.

The City Hospital in Dubai started slowly, but once agreement was reached with the healthcare insurers on the tariffs applicable, activity levels exceeded expectations. What is also positive about the performance of this hospital is that it did not take away patients from the Welcare Hospital (the group's other hospital quite close by), which remains very busy. Although the global financial crisis has impacted negatively on construction activities in Dubai, it has had the positive consequence for the group that the development of potentially competing hospitals has been postponed or has come to a standstill. This gives The City Hospital a welcome head start.

South Africa remains the home base of the Group and we continue to investigate and invest in sound opportunities. The regulatory environment has become more friendly during the year and the tariffs negotiated with medical schemes for 2009 were realistic. Operationally the Southern African platform remains the backbone of the Group with its approximately 6 855 beds in 51 hospitals, to which the Cape Gate Medi-Clinic with 140 beds north of Cape Town will be added early next year. South Africa can also currently be regarded as the training ground for senior staff of the Group to ensure their understanding and the success of operations in other parts of the world. However, as the synergy and convergence team of the Group develops, it is foreseen that staff will move around more freely between operating platforms and also be sourced from different platforms for possible new ventures in other countries.

For the moment the Group remains very much aware of the debt load on its balance sheet. We know that it is imperative that the Group must meet all its obligations and covenants in this regard. It is therefore really with great gratitude that we look back on a financial year where, although the financial markets around the globe have been in turmoil, the Group did not miss a beat in meeting all its obligations and is well within the relevant covenants.

On the whole the Group again had a busy and satisfactory year, culminating in another period of consistent growth in its financial results. Apart from the appreciation already expressed to the staff and management, we also have to, and would like to, express our sincere thanks to all the doctors and patients who supported our facilities throughout the year. As always, there will be challenges that remain or will develop in the new year. However, with the Group always striving "to be regarded as the most respected and trusted provider of hospital services by patients, doctors and funders of healthcare", as stated in our vision statement, we are confident that the Group will continue the consistent growth pattern it has demonstrated over the last 26 years.

DIRECTORATE MATTERS

As indicated and expanded on last year, Mr J du T Marais and Ms S Dakile-Hlongwane did not make themselves available for re-election at the Annual General Meeting of the Company on 30 July 2008.

Dr V E Msibi, who served as a non-executive director since 2005 representing Phodiso Holdings, one of the Group's strategic black partners, tragically passed away on 12 July 2008. He will be long remembered, both for his contribution to the Company and as a person. Dr R H Bider, who served as an executive director of Medi-Clinic since 2007 (in his capacity as the Chief Executive Officer of Hirslanden) retired and resigned from the Board of Medi-Clinic with effect from 5 November 2008. Dr Bider has 33 years of experience in the Swiss healthcare industry. His involvement and support of the Hirslanden acquisition by the Group, as well as during the critical first year after the transaction, were instrumental to the success of the venture. He remains on the board of Hirslanden as non-executive vice-chairman.

Ms Z P Manase was co-opted as an independent non-executive director and member of the Audit and Risk Committee with effect from 16 September 2008. After the death of Dr Msibi, Dr M K Makaba was co-opted as a non-executive director representing Phodiso Holdings with effect from 16 September 2008. Dr T O Wiesinger, the new Chief Executive Officer of Hirslanden, was co-opted as an executive director with effect from 5 November 2008.

It should lastly be mentioned that the Chief Executive Officer of the Group for the last decade and more, Mr Louis Alberts, will reach retirement age in May 2010. The Board and its Human Resources Committee will give this important issue the necessary attention during the months ahead.

E DE LA H HERTZOG
Chairman

CHIEF EXECUTIVE OFFICER'S REPORT

GROUP

Business performance

This report covers the first full year of the Group's activities since the acquisition of the Hirslanden group in October 2007.

The past year will be remembered as the year in which the world was shaken by the most severe financial crisis since the early 1930s, leading to the first global recession since World War II. None of today's generation have experienced anything like this and neither is there much to learn from the economic crises of the 1980s or 1990s. What we do know from previous downturns in the economy is that healthcare, compared to other sectors of the economy, seems to be less affected in a downturn but is again the last to benefit from an upturn. So far it seems as though this pattern is repeating itself under the present circumstances.

At none of the three operational platforms have we to date experienced any significant downturn in activities nor are there any trends indicating a severe contraction. In fact, all three platforms experienced encouraging or even strong patient attendances. Notwithstanding the positive signs, but also because of the uncertainties associated with these circumstances, the Group implemented an "early warning" risk management system at each platform. This was not only to identify and monitor trends of macro and micro indicators at an early stage, but also to have preventative plans ready for implementation should this become necessary.

The Group set itself an ambitious goal to establish an international framework of structures, business processes and business applications capable of integrating cross-border acquisitions seamlessly and unlocking value in the shortest time. It is a business philosophy to add value to every acquisition. In the South African context the Group developed a business model to achieve this with great success. In the past year we did not quite achieve the level of progress in building a similar model for cross-border acquisitions that we would have liked to. A lot has been learned, however, which should stand us in good stead going forward. With the new management team now firmly established at Hirslanden and a successful Group conference, where the management teams of the three operational platforms got to know each other better, we are confident that this initiative will gain momentum. Projects to standardise terminology, integrated risk management, clinical governance, information and communication technology governance, procurement and working capital management are already in progress.

Since the inception of Medi-Clinic the Group has striven to render quality care. Many initiatives have been launched to improve the structures and processes within which patient care is rendered, as well as to enhance the knowledge and art associated with it. Over the years a unified approach to clinical quality led to the implementation of structures and processes to ensure and promote quality care. This systemic approach, called clinical governance, is all about monitoring and managing quality that covers every aspect of clinical care. To this end MCSA became the first private hospital group in South Africa to subject its facilities and structures to external evaluation by an international healthcare accreditation body. This accreditation process has been ongoing and is an essential component of the clinical governance programme. The knowledge and experience gained through the accreditation process was transferred to The City Hospital in Dubai with excellent results. The City Hospital passed a rigorous licensing inspection with flying colours. The Clinical Governance Report published in the 2008 annual report was the first for MCSA and the first in the private hospital industry of South Africa. The 2009 report can be found on page 28. Clinical governance has been implemented in Dubai and a project is in progress to harmonise it on a national and international level.

The debate on healthcare reform is high on the political agenda of South Africa, Switzerland and Dubai. An overview of the progress in the regulatory environment is discussed under the business environment section of each platform. The Group decided to increase its active involvement in the reform process substantially by establishing a health policy unit at each platform. The units will comprise an internal team, consisting of management and other members of staff with specific skills, and a panel of external experts. The aim is to engage with government in a proactive and constructive manner in search of appropriate solutions. The units are encouraged to think independently and to engage in thought-provoking debate.

It remains difficult to predict clearly how the economic crisis will finally play out and what the possible impact on the business could be. Notwithstanding this uncertainty, we are optimistic about sustainability regarding the demand for private healthcare and the role it will continue to play in the provision of healthcare in the world.

SOUTHERN AFRICAN OPERATIONS

Business performance

South Africa will remain the home base of the Group. MCSA will always play an important role in the growth of the Group and the ability to pay dividends will for the foreseeable future be dictated by the performance and cash flow of the MCSA operations.

Fortunately the global economic downturn has had a limited impact on the South African economy and the general consensus is that the country's recession should be relatively mild.

Medical scheme membership has shown steady growth over the last couple of years, with 7.8 million lives now covered, according to the latest update on membership by the Council of Medical Schemes. According to labour market reports, the reported job losses in the country for the past nine months relate mainly to non-medical scheme members.

MCSA experienced pleasing growth in all facets of the business except in the cardiac field, which was negatively affected when the majority of the cardiac specialists at the Medi-Clinic Heart Hospital in Pretoria moved to a competitor hospital when we did not see our way open to meet their financial demands. Since their move a number of new cardiac specialists have joined the hospital and management has great confidence that the hospital will soon regain its former position amongst doctors and patients, albeit with a different profile. Notwithstanding the setback in the cardiac field, the number of patients admitted increased by 2.5% with a stable balance between surgical and medical admissions. There is a marginal increase in the trend of the average length of stay, with a 1% increase recorded from 2008 to 2009 culminating in a 3.3% increase in occupied bed days. The overall impact of the weighted average price changes amounted to 8.6% compared to an average CPI of 11.2% for the financial year. To ensure like-for-like comparability, the weighted average price changes percentage is compared to the average year-on-year CPI for the same period.

A number of hospitals experience continuous pressure on their available capacity. Applications to extend the existing capacity at these hospitals have been submitted to the various provincial health departments. Approval has been received

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to extend Limpopo Medi-Clinic with 30 beds and two operating theatres. A major upgrade of the hospital will also be undertaken. Planning is under way to expand Nelspruit Medi-Clinic with at least 20 beds. Both projects are due for commissioning in 2012. In addition to the aforesaid projects, the new 140-bed Cape Gate Medi-Clinic is expected to be commissioned in March 2010, while the extension of 25 beds to Hermanus Medi-Clinic was completed in May 2009.

The availability of suitably qualified nurses remains a huge challenge. In addition to the existing training programmes, MCSA continues with its foreign recruitment strategy. A total of 350 candidates are currently in various stages of the recruitment process. In the last quarter of 2008 the government announced the good news that nursing colleges closed in the 1990s would be reopened to address the critical shortage. To our knowledge, unfortunately nothing happened further after the announcement because of the shortage in qualified educators.

Clinical governance as a major component of total quality management has become an integrated responsibility of operations. The focus remains on quality care and patient safety with a multidisciplinary approach. Within the South African clinical model of autonomous and independent medical practitioners, it remains a challenge to get all the role players to participate actively and meaningfully. To improve the clinical presence at hospital level, it was decided to expand clinical management on a regional basis in order to promote, implement and support all the components of clinical governance as well as to improve coding and clinical database management at hospital level.

Significant progress has been made over recent years with the development and implementation of the company's transformation strategy. Based on the Department of Trade and Industry's BBBEE scorecard, MCSA currently ranks as a Level-5 contributor. The aim is to achieve Level-4 status during the coming year as well as independent verification of the scorecard from an accredited verification agency. The ownership element of the scorecard has already been verified.

Training

MCSA's training and development function has reached the level of maturity where organisational needs are met by means of rapid instructional design and deployment. From humble beginnings in 1986, this division managed to overcome various obstacles on the way to establishing a training and development infrastructure that sets and maintains high educational standards.

The nursing students who have passed through the educational programmes at the six learning centres, together with practical coaching at the hospitals, have consistently achieved excellent results over the years. The academic standards set at the learning centres are transferred to the hospitals, where a positive impact on quality patient care is ensured through continuing professional development.

The number of students trained at the learning centres may make a small impact on the often stated country-wide shortage of about 40 000 nurses, but it meets immediate needs and places MCSA in a position where it can collaborate with the state in further addressing the shortage.

A cooperation agreement with the University of Pretoria for the presentation of post-basic short courses has extended the MCSA training programmes to the hospitals in Dubai, where these courses have been accepted with enthusiasm over the past two years. This initiative is regarded as a future growth opportunity.

The new Nursing Act has introduced new nursing qualifications, heralding the demise of the Bridging Course, which will have its last intake in 2010. MCSA was proactive in meeting this challenge and was the first hospital group to present the SA Nursing Council with curricula for the new two-year Staff Nurse Course, the four-year Professional Nurse Degree and the post-basic Master's courses. MCSA's registration as a Higher Education and Training institution in December 2008 has paved the way for it to act as an independent provider and provides the opportunity to offer other courses under this banner.

The development programme for hospital and general managers from the previously disadvantaged groups has been successful, with five newly qualified hospital managers and one administration manager placed and a further three currently in training. A similar programme is in place for nursing management.

MCSA's professional approach to training and development has resulted in excellent relations with various tertiary institutions and regulating bodies. This positions MCSA well to meet future challenges in dealing with the skills shortage.

Business environment

The process to develop a National Health Insurance ("NHI") system for South Africa was reaffirmed at the ANC congress in Polokwane during December 2007 and has gained much momentum since then. The ruling party made it clear that the development of an NHI model will receive priority attention during the next five years. MCSA established a health policy unit which is well positioned to take part in the process that lies ahead and will endeavour to make a meaningful contribution towards finding sustainable solutions for the South African challenges.

The Reference Price List ("RPL") process, by which a methodology and framework to calculate benchmark tariffs will be established, is ongoing. The private hospital industry started its process of engagement with the National Department of Health, in terms of the current regulations, to determine an RPL for the 2010 calendar year. Two international independent accounting firms have been appointed by the Hospital Association of Southern Africa to provide their independent opinion on the methodology of the benchmark tariffs. The National Department of Health also appointed an international independent accounting firm as its consultant. Based on its own experience and tariff calculations, MCSA is convinced that the result of the exercise will show that current tariffs charged by it are in actual fact lower than the benchmark tariff, if scientifically calculated according to internationally accepted costing principles.

MCSA wishes to congratulate Dr Aaron Motsoaledi with his appointment as the new Minister of Health. It is looking forward to a constructive relationship between the public and private sectors, where cooperation between the sectors can lead to innovative solutions in addressing access to quality healthcare. It would also like to thank the outgoing Minister of Health, Ms Barbara Hogan, for the positive contribution that she has made towards uniting healthcare stakeholders during her relatively short period in office. Her vision and dynamic leadership were much appreciated.

SWITZERLAND OPERATIONS

Business performance

Hirslanden, the only private hospital group of significance in Switzerland, continued its excellent track record of growth and profitability. The group succeeded in growing the in-patient and day case admissions as well as out-patient attendances. The efficient employment of resources enabled them to further increase their operating margin which, together with the increased activities, resulted in excellent results for the year. Its contribution towards Group revenue increased to 53% and to 58% in terms of Group EBITDA.

Dr Robert Bider, the long-time serving Chief Executive Officer of Hirslanden, decided to step down as Chief Executive Officer on 30 September 2008. He served Hirslanden with distinction, first as director of Klinik Hirslanden and then as Chief Executive Officer of the first private hospital group in Switzerland. He will continue his association with the group as non-executive vice-chairman.

Dr Ole Wiesinger, former director of Klinik Hirslanden, was appointed as the new Chief Executive Officer of Hirslanden. Simultaneously with his appointment, the management structure of the company was changed to broaden the span of control and to increase the depth of the executive management. The new structure should lead to more efficient planning and co-ordination of operational and supportive services. The membership of the Executive Committee was strengthened from three to six to achieve these aims.

The new management team embarked on a complete review of all existing goals and objectives, including alignment to the long-term goals of Medi-Clinic. All the goals and objectives have either been confirmed or redefined with appropriate plans for execution. We are confident that the new management structure will enhance the implementation and execution of these plans.

Based on a full financial year, the Swiss operation recorded increased activities in all aspects of the business. Overall in-patient admissions grew by 5% and day case admissions by 8%, maintaining a stable balance between surgical and medical cases. The hospitals in the canton of Zürich and Vaud (Lausanne) are predominantly focused on the supplementary insured market and experienced growth in both the in-patient and out-patient segments of that market. In addition to the supplementary insured market, the hospitals in the other seven cantons are also listed on the cantonal Hospital List, allowing them to admit basic insured patients. The mix between basic insured and supplementary insured patients treated at these hospitals remained fairly constant with a more than satisfactory level of supplementary insured patients. The average length of stay for in-patients remained fairly stable at five days compared to an average of approximately eight days for the industry. This stable average length of stay is an indication of the efficiencies in the Hirslanden hospitals.

The additional bed capacity that was added to Klinik Hirslanden (27 beds) and Klinik St Anna (12 beds) in the previous financial year performed according to expectations. Projects to increase the capacity at Klinik Aarau (28 general beds), Klinik Im Park (two intensive care and four intermediate beds as well as one additional operating room) and Klinik St Anna (seven private rooms) were approved and will be commissioned towards the end of 2009 and early 2010.

The establishment of the Cyberknife, second linear accelerating oncology machine and centre for laparoscopic neuro-functional pelvic surgery units reported on last year were successfully commissioned during the second quarter of 2008.

During the coming financial year feasibility studies will also be performed to increase the capacity of Klinik Hirslanden (55 beds), Klinik St Anna (30 beds) and Klinik Beau-Site (23 beds).

Business environment

Within the worldwide economic crisis the Swiss economy has probably been the least affected compared to other European economies, despite the problems in the financial industry. The market for supplementary insurance is quite stable, given these adverse economic times. The resilience of that market is due to the individual risk rating applicable to supplementary insurance and the average age of the insured members.

On 1 January 1996 the Federal Government introduced a new law, 'Bundesgesetz über die Krankenversicherung' ("KVG"), which required all people living in Switzerland to be covered by mandatory health insurance (basic medical insurance) against illness, accident and pregnancy. Services that go beyond those listed in the basic insurance are covered by supplementary insurance. The supplementary insurance also allows the member free choice of hospital in any canton, a choice of private or semi-private room and a free choice of doctor while in hospital. In terms of the KVG each canton has the responsibility to provide medical care to its inhabitants. This responsibility includes hospital services. All hospitals, public or private, identified in the planning process are then listed on the canton's Hospital List. The reimbursement of a medical treatment in a listed hospital is covered in equal portions by the canton (public contribution) and the compulsory basic insurance. Listed private hospitals, however, are not entitled to the public contribution portion when treating a basic insured patient, but are remunerated by the compulsory basic insurance at agreed tariffs.

The Federal Government approved legislation for a partial reform of the KVG relating to hospital planning and financing. The new legislation is effective from 1 January 2009 and will have to be implemented by each canton commencing on 1 January 2012, with final implementation of all elements no later than 1 January 2015.

A Swiss DRG (diagnostic related groupings) as a payment mechanism on a flat rate per case will be introduced by not later than 1 January 2012 for all mandatory health insurance reimbursements.

In terms of the KVG reform all hospitals will in future be eligible for inclusion on the Hospital List and automatically qualify for the public portion of funding when treating a basic insured patient. The reform will result in a revised licensing system for acute care hospitals. The envisaged licensing system will mainly provide for two categories of hospitals: (a) listed hospitals – hospitals with a cantonal service mandate forming part of the public healthcare system; and (b) contracted hospitals – hospitals that are individually contracted by insurers.

The criteria for inclusion on the Hospital List will be based on quality measurements and cost effectiveness, and each canton will be responsible for determining their own regulations to govern the administrative processes. Because of the complexity and diversity of the regulatory implementation at cantonal level, the possible impact on Hirslanden's business cannot be readily determined. Hirslanden, together with the doctors practising at its hospitals, is known for quality and cost effective treatment and should be well placed in terms of the new legislation. The company decided to follow a dual approach in the hospital planning process until there is more clarity on the regulatory process. The health policy unit that was established will do an in-depth analysis of the potential impact of the new legislation. The unit will also advise the company on all regulatory changes.

In addition to the health policy unit an early warning system was also implemented, as alluded to earlier on. To date we have not experienced any signs of a downturn. It is virtually impossible to predict the effect that the current economic crisis could have on the industry. We are satisfied, however, that the hospitals are ready to adjust immediately should a downturn in the level of activities occur.

UNITED ARAB EMIRATES OPERATION

Business performance

The successful commissioning of The City Hospital, as the first state-of-the-art multidisciplinary private facility in the Dubai Healthcare City ("DHCC"), was an important milestone of Medi-Clinic's investment strategy in the United Arab Emirates. With the opening of The City Hospital, the local operation is undoubtedly the leader in the provision of private healthcare in Dubai, with its two acute care hospitals and four reference clinics. The opening of The City Hospital made it possible to rationalise cardiac and ophthalmology services into one unit. This rationalisation created additional capacity in the overcrowded Welcare Hospital and a saving in the overheads of the ophthalmology unit. The property that houses the ophthalmology unit was sold before the economic crisis hit Dubai.

The City Hospital was commissioned on 15 October 2008 after successfully passing rigorous international accreditation processes. The management and commissioning team attracted well deserved compliments from the DHCC officials for their preparation and readiness. The hospital opened three months later than originally planned and got off to a slow start in the last quarter of 2008. Agreements with all the health insurance companies are concluded on a calendar year basis and, since the conclusion of agreements in January 2009 for this hospital, the month on month increases in the number of admissions exceeded projections. It is expected that The City Hospital will reach breakeven at EBITDA level during the last quarter of 2009.

The Welcare Hospital exceeded all expectations during the year. Admissions increased by 12% after taking into account that all cardiac-related services were transferred to The City Hospital at the end of 2008. Revenue increased by 21% and, with a tight focus on operational expenses, management improved EBITDA by 48%. The EBITDA margin improved from 15.9% to 19.4%. A project to increase the bed capacity of the hospital by 19 beds and to address constraints in the efficient running of the hospital was approved and should be completed by the end of the third quarter of 2009.

The two clinics that were commissioned during the past 12 months both turned profitable on a monthly basis. Between the four clinics, out-patient visits reached a level of 14 000 per month. The loss of patients due to retrenchments is hardly noticeable and 1 800 new patient registrations were recorded for the month of March 2009.

Plans are in an advanced stage for the development of another clinic in Dubai, which will be a valuable addition to the company's footprint of reference clinics.

Business environment

Reforms in the financing and delivery of healthcare in the United Arab Emirates started in 2008 with the first initiative introduced by the Emirate of Abu Dhabi. The Emirate of Dubai also announced reforms, with the initial phases planned to start in January 2009. To date there has been no progress with the implementation of the reforms and officials involved with the process confirmed that the implementation process will only gain momentum in 2010.

The global financial and economic crisis is evident in the construction industry. Various developments have been postponed or cancelled, including a number of private hospital developments. On the assumption that the workforce will shrink to fit a contracting economy, one should then expect a change in the predicted shortage of hospital beds. The City Hospital with its 210 beds as the only new entrant of significance will have an even more significant first-mover advantage.

In a reported online discussion with reporters and the Ruler of Dubai, his first in eight years, he wrote that the economy has shifted "from the crisis mood to the solution mood". The solution includes reshaping the quasi-government companies with which the authorities have already started and confirmed in business circles. Considering all relevant information, we are optimistic about the future of the region and the growth prospects in healthcare.

L J ALBERTS
Chief Executive Officer

CHIEF FINANCIAL OFFICER'S REPORT

THE GLOBAL ECONOMIC OUTLOOK

The current global economic crisis has culminated in the first global recession since World War II. Although there are signs that we have reached the bottom of the slowdown, the International Monetary Fund predicts that the recovery will be slow and could take longer than expected, because of the fact that the recession resulted from a financial crisis.

The Group had to consider its own position carefully in the light of the economic crisis. Obligations and covenants in terms of the facility agreements were evaluated and stress tested.

To date, the Group's volumes have been unaffected by the economic crisis. In fact, the Group experienced strong patient attendance towards the end of the financial year and beyond at all three of its operating platforms. Early warning systems comprising the monitoring of macro indicators such as employment as well as micro indicators at hospital level, are in place at all three platforms. If required, immediate action will be taken.

GROUP OVERVIEW

Hirslanden acquisition

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. 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 was fully underwritten by Barclays Bank plc on a non-recourse basis to Medi-Clinic's Southern African operations. The base interest rate in respect of this facility was fixed for ten years at the time of the transaction. 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 from the date of the transaction.

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 ("the rights offer") and existing debt facilities within the Group. The rights offer was for a total of 198 675 497 Medi-Clinic shares.

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

IFRS and technical matters

Adjustment to prior year balance sheet

The adjustment to the prior year's balance sheet made was because of the following:

- The finalisation of the provisional purchase price allocation ("PPA") in respect of the Hirslanden acquisition. The adjustment was made in accordance with IFRS 3 Business Combinations and had no income statement effect.
- Previously, the Hirslanden pension plans disclosed a calculated surplus which was not recognised on the balance sheet of the Group in terms of the limit set by IAS 19 paragraph 58. During the finalisation of the provisional PPA, the values of the pension plans were reassessed, which resulted in the recognition of a pension liability at acquisition date, as well as at the prior year's balance sheet date. As a result of the recognition of the pension liability, further actuarial losses were recognised in the statement of recognised income and expense ("SoRIE") for the period ended 31 March 2008. See further comments under Swiss pension liability on page 20.

These adjustments had the following effect on the prior year balance sheet:

	As previously reported	Adjustments	As adjusted
Intangible assets	R6 079m	R22m	R6 101m
Retained earnings	R2 334m	(R320m)	R2 014m
Deferred income tax liabilities	R5 187m	(R99m)	R5 088m
Retirement benefit obligations	R177m	R462m	R639m
Trade and other payables	R2 273m	(R21m)	R2 252m

Fair value of Swiss liabilities

The Group manages its exposure to interest rates by entering into fixed interest rate hedges from time to time. As mentioned above, the base interest rate in respect of the Barclays facility of CHF2 450 million was fixed for ten years at the time of the transaction. The facility has a fixed term of seven years with a fixed interest rate of 5.62% for the entire period.

IAS 39 Financial Instruments requires derivative financial instruments to be measured at fair value, which was determined by the Group through discounted cash flow analyses, using prevailing and expected interest rates. On the other hand, borrowings are also required to be recognised at fair value, being at amortised cost which is effectively at face value.

The global financial crisis had, inter alia, two distinct consequences for the cost of third party funding. Firstly, short-term and long-term interest rates declined significantly because of the easing of monetary policies by central banks. Secondly, the credit spreads of funding (or margins charged by third party funders) increased dramatically because of the lack of liquidity and risk averseness by third party funders.

As a result of lower interest rates the hedge is recognised at its fair value, being a liability of R2 353 million (CHF283 million) included under "Derivative financial instruments" in the Group's balance sheet. However, the Barclays facility is recognised at its amortised cost, being its face value, which does not recognise the low total cost of funding of 5.62% available until October 2014. Current market rates, if funding is available at all, would conservatively range between 8% and 9%. Consequently, the Group's borrowings in respect of the Barclays facility are overstated at amortised cost compared to if the loan was properly valued. By only valuing the hedge, only one portion of the Group's borrowings is valued at fair value; hence the Group's total borrowings are overstated. This situation is further exacerbated by the fact that the fair value liability recognised in respect of the hedge is not a real liability for the Group, being a going concern, a fundamental premise on which the annual financial statements are compiled. The liability will disappear in the course of time. In the interim the fair value will be influenced by relative interest rates, which are not in the Group's control, precisely the reason why the hedge was taken out.

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This obviously also applies to the Southern African borrowings, of which interest rates are hedged, but with a much less material impact.

Swiss pension liability

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

Using the projected unit credit method prescribed for defined benefit plans, the pension liability calculated in accordance with IAS 19 amounted to R765 million (CHF92 million) (2008: R466 million (CHF57 million)) included under "Retirement benefit obligations" in the Group's balance sheet. However, under Swiss pension law and the consequent accounting approach, the underfunding in the pension funds amounted to R191 million (CHF24 million) at 31 March 2009. In addition, and importantly, if a statutory deficit occurs, the trustees of the funds have certain alternatives to address the deficit. They may, for example, reduce the benefits credited to members, albeit not below statutory required minimums. The plans were 93% funded at 31 March 2009 and, in terms of Swiss practice, it is acceptable for trustees not to take these measures at these levels. Therefore, from an economic and legal point of view, this underfunding does not lead to a liability for Hirslanden at 31 March 2009. In this respect, the Group's liabilities are overstated by a further amount of R765 million.

The prior year's adjustment of R462 million (CHF57 million) in respect of the Swiss pension liability came about because Hirslanden changed its actuaries during the year. The legal peculiarities of Swiss pension plans have the result that such plans do not fit well with the inflexible prescribed methodology of IAS 19. The allocation of the liability to accrued and future service is one area impacted on by this. Swiss actuaries use different methodologies to allocate the present value of future benefits to past and future service costs in order to determine the defined benefit obligations of a particular plan.

Using these different actuarial methodologies may lead to significantly different results. The newly appointed actuary used a different methodology than the previous actuary, which mainly explains the difference in the two valuations.

Group financial performance

Trading results

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

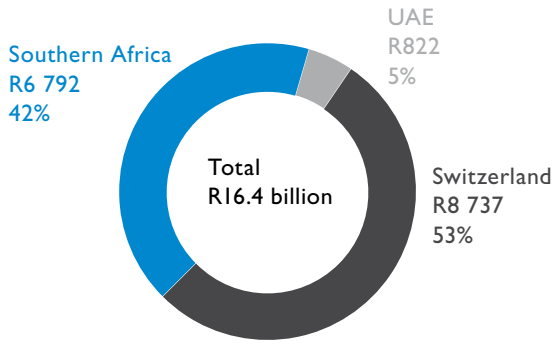
Group revenue increased by 71% to R16 351 million (2008: R9 579 million) for the year under review. Operating income before interest, taxation, depreciation and amortisation ("EBITDA") was 66% higher at R3 431 million (2008: R2 062 million). Headline earnings rose by 3% to R624 million (2008: R608 million) after incurring higher finance charges, mainly resulting from the Hirslanden transaction. Basic headline earnings per ordinary share declined by 23% to 111.5 cents (2008: 144.5 cents) as a result of the higher finance charges and the 33% increase in the weighted number of ordinary shares resulting from the rights offer. The decline in the Group's headline earnings per share was, therefore, mainly a result of the Hirslanden acquisition, as anticipated and communicated at the time of the acquisition.

The Group's EBITDA margin declined to 21.0% for the year under review from 21.5% for the comparative year under review. The decline was mainly due to start-up losses at The City Hospital in Dubai, as expected and alluded to in earlier reports. Excluding the results of The City Hospital, the Group's margin for the year under review would have increased to 21.8%.

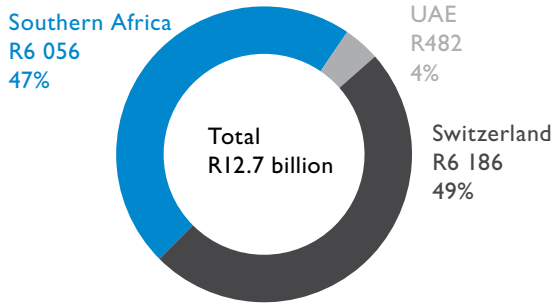
The EBITDA margins of the hospital services segments of the Group's operations, excluding the hospital properties segments, are 12.7% for Southern Africa, 7.4% for Switzerland, (2.1)% for the United Arab Emirates and 9.1% on a consolidated basis. Kindly refer to pages 116 to 118 of this annual report for the Segmental Report of the Group.

The geographical composition of the Group revenue for the year under review, compared to the previous year on a pro forma basis, is as follows:

Group revenue 2009 (R'm)

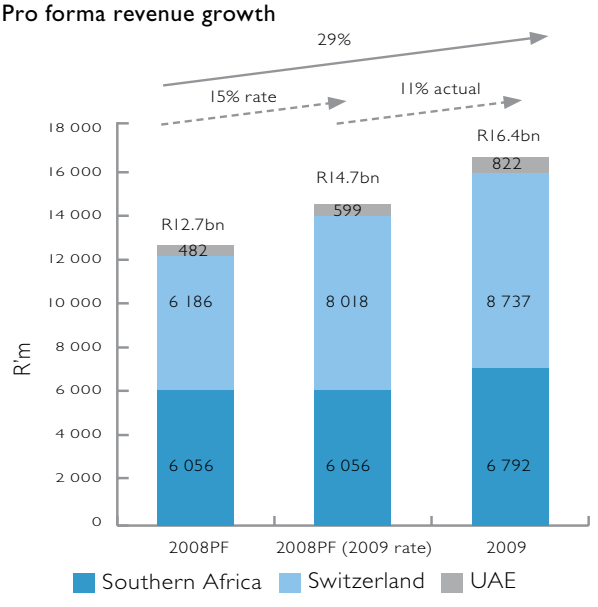


Group revenue 2008 pro forma (R'm)



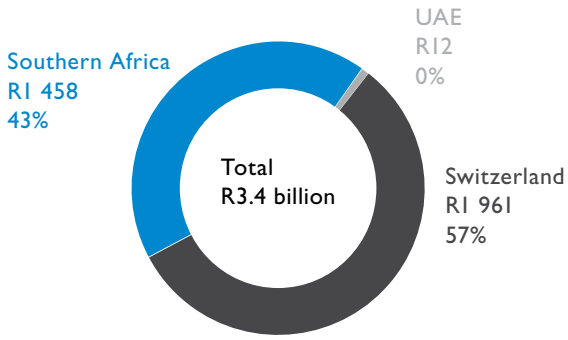
As illustrated in the graph below, revenue would have increased by 29% from R12.7 billion for the 2008 financial year on a pro forma basis to R16.4 billion for the current financial year. 15% of the increase would have related to exchange rate movements, while the revenue growth at constant foreign exchange rates would have been 11%.

Pro forma revenue growth

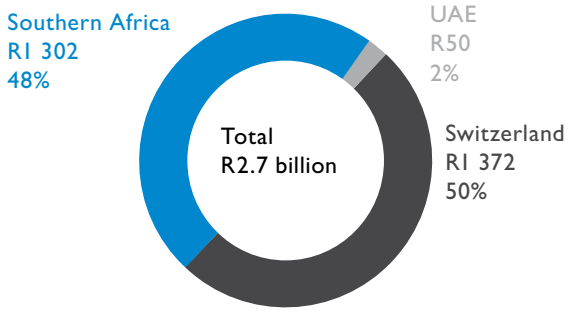


The geographical composition of the Group EBITDA for the year under review, compared to the previous year on a pro forma basis, is as follows:

Group EBITDA 2009 (R'm)

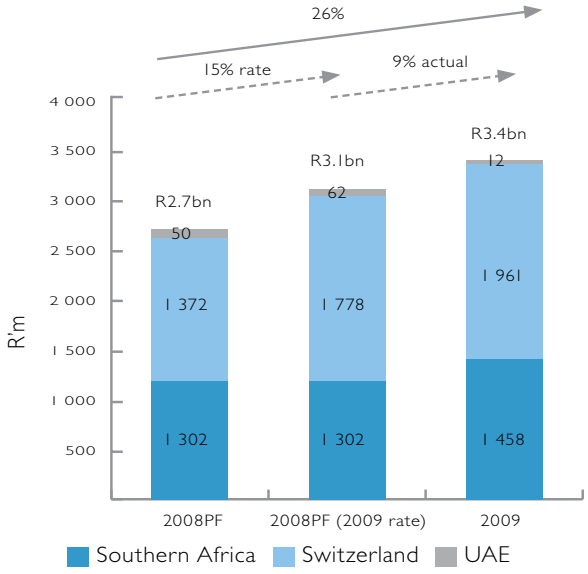


Group EDITDA 2008 pro forma (R'm)



As illustrated in the graph below, EBITDA would have increased by 26% from R2.7 billion for the 2008 financial year on a pro forma basis to R3.4 billion for the current financial year. 15% of the increase would have related to exchange rate movements, while the EBITDA growth at constant foreign exchange rates would have been 9%.

Pro forma EBITDA growth



The total dividend per ordinary share at 68.6 cents (2008: 61.2 cents) is 12% higher, in line with the Southern African group's performance.

During the reporting period the Group, through a wholly owned subsidiary, acquired 3 009 622 of its own shares in the market for about R55 million to be held as treasury shares. It utilised 1 271 889 of the treasury shares for the Group's executive share option scheme and management incentive scheme.

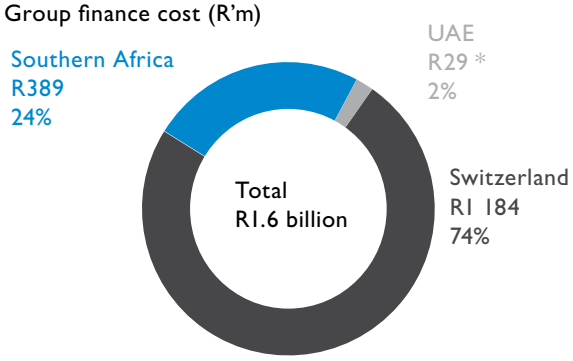
Finance cost

Included in the finance cost is an amount of R81 million (2008: R16 million) (R76 million and R5 million of which relate to the Swiss operations and the Southern African operations, respectively), representing the current year's amortisation in respect of raising fees paid on the Group's local and offshore debt. These amounts are amortised over the terms of the relevant loans in line with future cash payments as prescribed in IAS 39.

The margin applicable to the Barclays facility remained subject to a market flex to facilitate the syndication process. Barclays has now settled the margin finally, which brings the total interest rate payable on the Barclays facility to 5.62%, effective from 1 August 2008. Prior to 1 August 2008, a total interest rate of 5.27% was charged. Barclays communicated the increase in its margin to the Group on 14 October 2008.

The geographical composition of the Group's finance cost for the year under review is as follows:

Group finance cost (R'm)

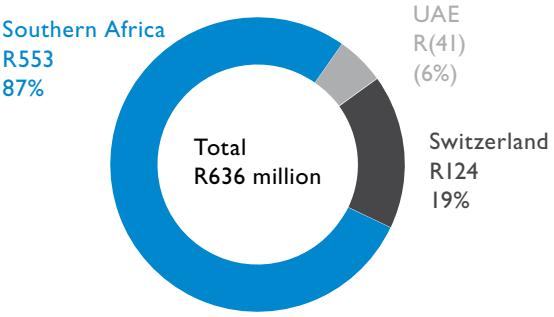


* excludes an intergroup preference share dividend of R12

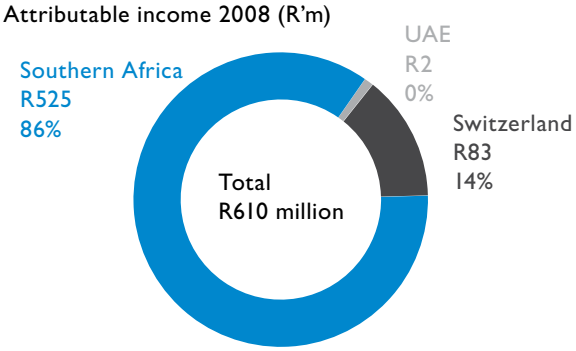
Contribution to the Group's attributable income

The geographical composition of the Group's attributable income for the year under review, compared to the previous year (with the contribution by Hirslanden for the period from the effective date of its acquisition, 26 October 2007), is as follows:

Attributable income 2009 (R'm)



Attributable income 2008 (R'm)



Foreign exchange rates

The rand displayed some volatility during the reporting period against the Swiss franc ("CHF") and the United States dollar (against which the UAE Dirham ("AED") is pegged at AED3.675 to the US dollar). The spot rate of the CHF moved from R8.14 at 31 March 2008 to R8.32 at year end, with an average rate of R8.01 for the year (R6.60 for the period from 26 October 2007 to 31 March 2008). The spot rate of the AED moved from R2.20 at 31 March 2008 to R2.58 at year end, with an average rate of R2.41 (2008: 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 difference between the spot rate and the average foreign exchange rate results in a distortion when 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 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 R267 million (2008: R2 326 million) and was credited to the SoRIE.

Cash flow

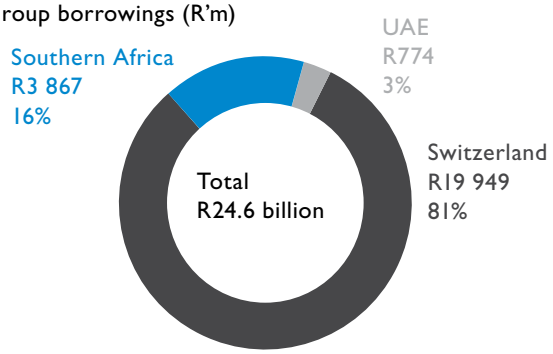
The Group's cash flow continued to be strong mainly because of efficient working capital management. The Group converted 98% of EBITDA into cash generated from operations. Cash and cash equivalents increased from R801 million at 31 March 2008 to R994 million at year end.

Interest-bearing borrowings

Interest-bearing borrowings ("debt") increased from R23 397 million at 31 March 2008 to R24 590 million. It is important to note that the foreign debt in Switzerland and Dubai, amounting R20 723 million, is matched with foreign assets in the same currencies. The foreign debt also has no recourse to the Southern African operations' assets, as stipulated by the South African Reserve Bank as well as applicable financing arrangements.

The geographical composition of the Group's interest-bearing borrowings at 31 March 2009 is as follows:

Group borrowings (R'm)



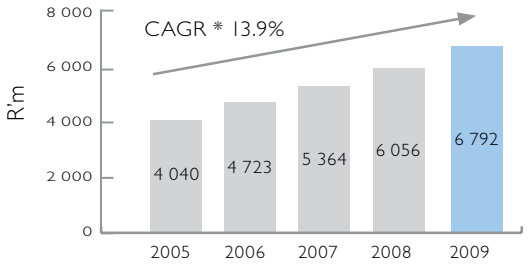
OPERATIONS IN SOUTHERN AFRICA

Financial performance

The Southern African group revenue increased by 12% to R6 792 million (2008: R6 056 million) for the year under review. EBITDA was 12% higher at R1 458 million (2008: R1 302 million).

The historical Southern African performance from a revenue perspective is set out in the following graph:

Medi-Clinic Southern Africa revenue growth

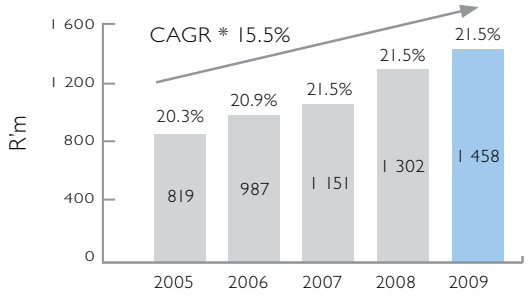


* Compounded Annual Growth Rate

The Southern African group operations maintained its EBITDA margin at 21.5% despite inflationary pressure during the last six months of the 2008 calendar year.

The historical Southern African performance from an EBITDA perspective is set out in the graph below:

Medi-Clinic Southern Africa EBITDA and margins



* Compounded Annual Growth Rate

After incurring depreciation charges of R177 million (2008: R159 million), net finance charges of R328 million (2008: R231 million), taxation of R284 million (2008: R278 million) and deducting the interest of minority shareholders in the attributable income of the Southern African group amounting to R117 million (2008: R109 million), the Southern African operations contributed R553 million (2008: R525 million) to the attributable income of the Group.

Business performance

The 12% revenue growth was achieved through a 3.3% increase in bed days sold and an 8.6% increase in the average income per bed day, while the profile of patients treated remained stable. The increase in utilisation was evident in both surgical and medical cases. The number of patients admitted increased by 2.5%, while the average length of stay increased by almost 1%.

During the reporting period the Southern African operations spent R381 million (2008: R195 million) on capital projects

and new equipment to enhance their business as well as R184 million (2008: R161 million) on the replacement of existing equipment. In addition, R185 million (2008: R173 million) was spent on the repair and maintenance of property and equipment, charged through the income statement. For the next financial year, R308 million is budgeted for capital projects and new equipment to enhance their business, while R197 million is budgeted for the replacement of existing equipment. Incremental EBITDA resulting from capital projects in progress or approved should amount to R8 million and R47 million in 2010 and 2011, respectively.

The number of hospital beds increased from 6 776 to 6 855 during the year under review.

The construction of the new 140-bed Cape Gate Medi-Clinic in the Western Cape is expected to be completed during March 2010. Extensive upgrade projects are in progress at Panorama Medi-Clinic, Constantiaberg Medi-Clinic and Hermanus Medi-Clinic, the latter of which includes the addition of 25 beds. Other significant projects that are planned to commence during the next financial year are the addition of 20 beds at Nelspruit Medi-Clinic and the addition of at least 30 beds at Limpopo Medi-Clinic. Both projects are only due for commissioning in the 2012 financial year.

The number of beds is expected to increase from 6 855 to 7 024 during the next financial year.

The Southern African operations' cash flow continued to be strong during the period under review. It converted 104% (2008: 96%) of EBITDA into cash generated from operations. Cash and cash equivalents increased from R360 million at 31 March 2008 to R368 million at year end.

Debt increased from R3 699 million at 31 March 2008 to R3 867 million at year end primarily to finance the capital expenditure referred to above.

OPERATIONS IN SWITZERLAND

The Group consolidated Hirslanden's results from the effective date of its acquisition, 26 October 2007. During the previous reporting period, Hirslanden's revenue was R3 041 million (CHF461 million) and EBITDA was R710 million (CHF107 million).

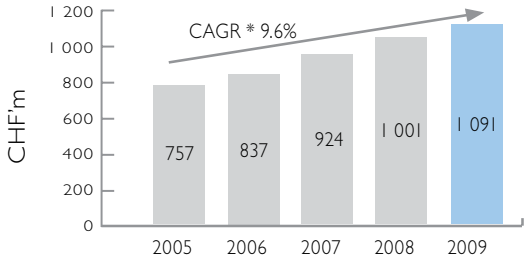
Although not included in the Group's results for the comparative year under review, the comparative figures and statements below are provided for a pro forma full year to give shareholders a better understanding of the underlying trends in the businesses.

Financial performance

Hirslanden's revenue increased by 41% (9% at constant foreign exchange rates) to R8 737 million (CHF1 091 million) (2008: R6 186 million (CHF1 001 million)) for the year under review. EBITDA was 43% (10% at constant foreign exchange rates) higher at R1 961 million (CHF245 million) (2008: R1 372 million (CHF222 million)).

The historical pro forma performance of Hirslanden from a revenue perspective is set out in the graph below:

Hirslanden revenue growth

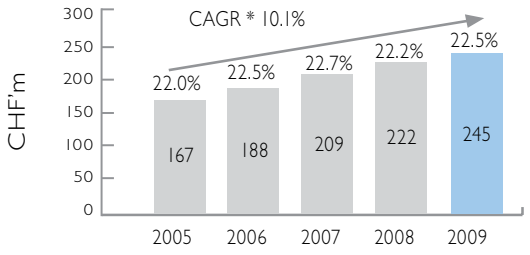


* Compounded Annual Growth Rate

The EBITDA margin of the group increased from 22.2% to 22.5%.

The historical pro forma performance of Hirslanden from a EBITDA perspective is set out in the graph below:

Hirslanden EBITDA and margins



* Compounded Annual Growth Rate

After incurring depreciation charges of R454 million (CHF57 million) (2008: R154 million (CHF23 million)), net finance charges of R1 166 million (CHF146 million) (2008: R387 million (CHF59 million)) and taxation of R218 million (CHF27 million) (2008: R86 million (CHF13 million)), Hirslanden contributed R124 million (CHF16 million) (2008: R83 million (CHF13 million)) to the attributable income of the Group. (Comparative amounts are for the period from the effective date of the Hirslanden acquisition, 26 October 2007, in this paragraph only and not for a pro forma full year.)

Business performance

In-patient admissions increased by 5%, while day-surgery admissions improved by 8%. The average length of stay remained fairly constant.

During the reporting period Hirslanden spent R227 million (CHF28 million) on capital projects and new equipment to enhance its business as well as R359 million (CHF45 million) on the replacement of existing equipment. In addition, R231 million (CHF29 million) was spent on the repair and maintenance of property and equipment, charged through the income statement. For the next financial year CHF42 million has been budgeted for capital projects and new equipment to enhance its business, while CHF58 million has been budgeted for the replacement of existing equipment. Included in the budgeted amount for capital projects is an amount of CHF25 million for capital projects, which was transferred to the 2010 financial year due to delays in approvals, which have now all been received. Incremental EBITDA resulting from capital projects in progress or approved should amount to CHF11 million and CHF21 million in 2010 and 2011, respectively.

A second linear accelerating oncology machine and a Cyberknife (a state-of-the-art non-invasive stereo tactic radiation device for the treatment of tumours and metastases, the first of its kind in Switzerland) were successfully commissioned at Klinik Hirslanden during June 2008 and March 2009, respectively. A state-of-the-art centre for neurology, neurosurgery and neuroradiology (with the neurology component still under development) and an international centre for laparoscopic neuro-functional pelvic surgery with two renowned surgeons were both opened at Klinik Hirslanden on 1 October 2008. The very successful Urology Centre at Klinik Hirslanden is being expanded by three renowned urologists in addition to the current two urologists. This expanded new Urology Centre will be commissioned on 1 November 2009. Planned investment in new technology, which provides for new treatment options and increased case load, includes a 3.0 tesla MR machine at Klinik Im Park as well as a dual source CT scanner and a catheterisation laboratory at Klinik Beau-Site.

The number of fully operational beds increased from 1 301 to 1 334 (based on the average number of beds for the year), with the addition of 27 (average) beds at Klinik Hirslanden and nine (average) beds at Klinik St Anna and a temporary reduction of three beds (average) at Klinik Cecil.

In addition, projects for the increase of capacity at Klinik Aarau (28 beds), Klinik Im Park (two additional ICU beds, four additional intermediate care beds and an additional operating theatre) and Klinik St Anna (seven new private rooms) were approved to be commissioned towards the end of 2009 and early in 2010 respectively. During the next financial year the total average number of beds is expected to increase slightly to 1 349 (Klinik St Anna three; Klinik Aarau nine; Klinik Cecil three). Feasibility studies will be performed in the next financial year on the extensions of Klinik Hirslanden (approximately 50 beds), Klinik Beau-Site (approximately 23 beds) and Klinik St Anna (approximately 30 beds).

Hirslanden produced strong cash flow during the period under review. It converted 99% (2008: 90%, after adjusting for the seasonality of cash flows and accrued transaction costs, both relating to the Hirslanden acquisition in the comparative period) of EBITDA into cash generated from operations. Cash and cash equivalents increased to R504 million (CHF61 million) (2008: R400 million (CHF49 million)) after financing capital expenditure.

Interest-bearing debt increased from R19 483 million (CHF2 393 million) at 31 March 2008 to R19 949 million (CHF2 398 million) at year end net of capitalised debt transaction fees because of foreign exchange rate fluctuations.

OPERATIONS IN UNITED ARAB EMIRATES

Financial performance

Revenue increased by 71% (37% at constant foreign exchange rates) to R822 million (AED341 million) (2008: R482 million (AED249 million)) for the year under review. EBITDA declined by 76% (81% at constant exchange rates) to R12 million (AED5 million) (2008: R50 million (AED26 million)) mainly due to start-up losses at The City Hospital as expected and alluded to in earlier reports. The EBITDA includes a once-off profit on sale of property of R19 million (AED8 million).

As a result, the EBITDA margin declined from 10.3% to 1.5%.

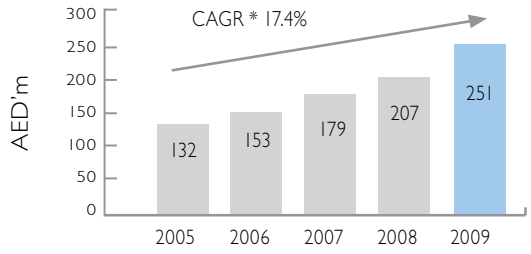
After incurring depreciation charges of R53 million (AED22 million) (2008: R28 million (AED14 million)), net finance charges of R41 million (AED17 million) (2008: R18 million (AED9 million)) and the sharing of minority shareholders in the attributable loss of MCME amounting to R41 million (AED17 million) (2008: sharing in the attributable income of R2 million (AED1 million)), MCME made a negative contribution of R41 million (AED17 million) (2008: a positive contribution of R2 million (AED2 million)) to the attributable income of the Group.

Business performance

Revenue of the units in full operation, being the Welcare Hospital, the Emirates Diagnostic Clinic, the Welcare Ambulatory Care Centre and the Welcare Eye Clinic, increased by 50% (21% at constant foreign exchange rates) to R718 million (AED298 million) (2008: R478 million (AED246 million)) and EBITDA by 77% (43% at constant foreign exchange rates) to R145 million (AED60 million) (2008: R82 million (AED42 million)).

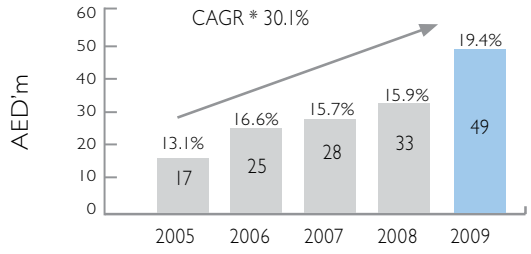
The historical pro forma performance of the Welcare Hospital, MCME hospital with an established track record, from a revenue and EBITDA perspective is set out in the two graphs below:

Welcare Hospital revenue growth



* Compounded Annual Growth Rate

Welcare Hospital EBITDA and margins



* Compounded Annual Growth Rate

The start-up operations, namely The City Hospital, EHL Management Services, Welcare Clinic Qusais and Welcare Clinic Mirdif, generated revenue of R104 million (AED43 million) (2008: R4 million (AED2 million)), but generated start-up operating losses at EBITDA level of R133 million (AED55 million) (2008: R32 million (AED16 million)). Except for The City Hospital, all the other units are now fully operational and will generate positive EBITDA during the next reporting period.

The City Hospital was commissioned successfully on 15 October 2008, after passing rigorous international accreditation requirements. Agreements with insurance companies are concluded on a calendar year basis and most agreements could therefore only be finalised from January 2009. Since then, it is pleasing to report that month on month increases in the number of admissions exceeded expectations. However, it is expected that The City Hospital will still incur start-up losses for the next financial year, with breakeven at an EBITDA level expected to be reached by about November 2009. During March 2009 The City Hospital had already generated revenue of more than AED10 million. The operations of the Welcare Eye Clinic were merged with The City Hospital in October 2008.

During the reporting period MCME spent R250 million (AED104 million) (2008: R336 million (AED174 million)) to complete and equip The City Hospital and R33 million (AED14 million) (2008: R30 million (AED16 million)) on the replacement of existing equipment. In addition, R24 million (AED10 million) (2008: R13 million (AED7 million)) was spent on the repair and maintenance of property and equipment, charged through the income statement.

In line with the start-up losses referred to above, MCME had a negative cash flow from operating activities before working capital changes of R7 million (AED3 million) (2008: positive cash flow of R51 million (AED26 million)), while the investment in working capital (mainly working capital for The City Hospital) required a further R108 million (AED45 million) (2008: a reduction in working capital of R114 million (AED59 million)). This resulted in a cash outflow from operations of R115 million (AED48 million) (2008: cash generated from operations of R165 million (AED85 million)).

After funding the capital expenditure and the cash outflow from operations, the bank facilities of MCME are now fully drawn in the amount of R774 million (AED300 million) (2008: R217 million (AED98 million)). Cash and cash equivalents amounted to R122 million (AED47 million) (2008: R40 million (AED18 million)).

GROUP DIVIDEND POLICY

In terms of the Group's current dividend policy, the dividend per share is derived from the performance of the Southern African operations. Although the Group's ability to pay dividends will be dictated by the cash flow of the Southern African operations, the Group will in future target a dividend cover of three times based on Group headline earnings, which is more in line with levels prior to the Hirslanden transaction. This does not imply a reduction in dividend per share, only an indicative target which the Board would seek to achieve over time.

RISK MANAGEMENT

Risk management receives top priority throughout the Group. The risk management policy is benchmarked against the international Committee of Sponsoring Organisations of the Treadway Commission framework and complies with the recommendations of the King II Report. The Group's risk management process is summarised in the Corporate Governance Report on pages 66 to 74, the Sustainable Development Report on pages 44 to 65 and notes 3.1 and 3.3 to the annual financial statements on pages 91 to 92.

ACCOUNTING POLICIES

The annual financial statements have been prepared in accordance with IFRS. During the year the Group elected to early adopt IFRS 8 Operating Segments in advance of its effective date. IFRS 8 is a disclosure Standard and has no impact on the reported results or financial position of the Group. Apart from the geographic platforms, the business is segmented into the hospital services and property segments consistent with the way in which the business as a whole is managed.

J G SWIEGERS
Chief Financial Officer

CLINICAL GOVERNANCE REPORT

INTRODUCTION

Medi-Clinic's commitment to quality care remains, as it has for the last 26 years, a key focus area in all activities throughout the Group. It has invested a significant amount of time and resources in measuring clinical data with the aim of improving clinical quality, and has established a proud reputation for delivering quality care.

The purpose of this report is to present an overview of clinical activities within the Group as well as its approach to quality care, to report on important quality indicators and to highlight notable trends in this field.

CLINICAL GOVERNANCE

Overview

Achieving internationally comparable quality care throughout the organisation is an ambitious goal. It requires a talented workforce, superior technological and electronic support systems, a set of clear quality objectives that are rigorously pursued, and a multidisciplinary team approach. MCSA, MCCH and MCME are following a unified approach to ensure and improve clinical quality in all its dimensions. Certain important principles are adhered to, namely self-governance at hospital level, being non-punitive, focusing 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 event management
   - Drug adverse events management
5. Clinical performance management
   - Clinical indicators
   - Clinical outcomes
6. Functional programmes
   - Emergency services
   - Critical care
7. Clinical standards
8. Health technology assessment
9. Patient satisfaction
10. Education and training
11. Clinical information systems

MCSA has been using and refining this framework for a number of years and has benefited from this structural approach.

MCCH has for some time had a uniform quality system and clearly defined quality policy that has covered all of the above components, which allowed for a seamless adoption of the same structural framework as MCSA and MCME. MCCH also participates in a number of quality activities in the Swiss public health system.

MCME has adopted the same structural approach towards quality improvement, and has spent much time and resources on implementing focused programmes on each of the components.

Co-ordination

MCSA, MCME and MCCH each has a central, multidisciplinary clinical committee that coordinates and oversees these initiatives. Each hospital has a clinical committee that is responsible for quality care and patient safety in its respective hospital. A critical success factor is the commitment and participation of nursing staff and doctors.

Information

Clinical governance at MCSA is supported by a clinical information department with unique data manipulation and statistical abilities. The department generates strategic, clinical and management information in order to support decision making, which is an important enabler in the management of quality care.

Although there is no clinical information department at MCCH, business intelligence software is used to access meaningful clinical information. Planning is under way to strengthen its data manipulation and statistical abilities even further. MCCH also participates in national and international data-collecting initiatives to measure and improve quality.

MCME also does not have a clinical information department. However, planning is under way for the clinical information department at MCSA to render a service to the MCME hospitals, and a number of data-collecting initiatives are under way.

MEDI-CLINIC SOUTHERN AFRICA

CLINICAL PROFILE

In the year under review MCSA experienced a steady growth in hospital admissions as well as emergency centre and out-patient cases, as can be seen in Table 1. However, the average length of stay and theatre time per surgical case remained virtually unchanged.

Table 1: Summary statistics (financial year)

	% Increase in 2009	% Increase in 2008
Emergency Centre and Out-Patient Cases	**2.6%**	4.3%
Hospital Admissions		
Day case admissions	**1.1%**	2.9%
In-patient admissions	**3.1%**	4.9%
Length of Stay (calendar days)		
All admissions	**1.0%**	0.0%
In-patient admissions	**0.4%**	0.0%
Average Theatre Time per Surgical Admission	**0.4%**	0.4%
Medical/Surgical Mix	**0.1%**	1.3%

Comorbidities

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

The proportion of patients who were admitted to hospital with one or more comorbidity for the period under review was 17.1% compared to 15.5% for the previous year.

Hypertension, diabetes mellitus and hypercholesterolemia were the most common underlying conditions.

Although obesity is not regarded as a chronic underlying medical condition unless it is quite severe, it impacts significantly on morbidity while in hospital. During the year under review almost 64% of all patients admitted were overweight or obese.

In this report "the Group" or "the Company" refers to Medi-Clinic Corporation Limited and its subsidiaries and "the group" or "the company" refers to one of the three operating platform groups, as the context may indicate. "MCSA" refers to the Medi-Clinic Southern Africa group, "MCCH" refers to the Medi-Clinic Switzerland group and "EHHL" or "MCME" refers to the Medi-Clinic Middle Eastern group.

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. Analysing these indicators as well as the underlying reasons for their occurrence is vitally important in the management of quality care.

Mortality

Mortality is one of the most important indicators for determining quality care. It needs to be interpreted with caution because of the influence of patient risk factors upon admission as well as the types of surgery performed. MCSA uses a statistical methodology to adjust hospital mortality rates for these factors in order to make justifiable comparisons between hospitals and time periods.

The expected mortality is a statistical calculation that takes into consideration the age and gender (demographic) profiles of patients, the presence and types of comorbidities, the reasons for admission and the types of surgery performed. The actual mortality is what actually happened. The mortality index is the actual mortality in relation to the calculated expected mortality.

Table 2 reports an increase in expected mortality. Expected mortality increased because of the increase in the age of admitted patients, an increase in HIV-related conditions and an increase in patients admitted with comorbidities.

Table 2: Mortality as a percentage of hospital admissions (financial year)

	2009	2008	2007	2006
Actual	**1.09%**	1.13%	1.12%	1.09%
Expected	**1.15%**	1.15%	1.12%	1.05%
Index	**0.95**	0.98	1.00	1.04

Actual mortality increased to a lesser extent than expected, which led to a decrease in the actual versus expected index. This means that the effective management of mortality outcomes improved from 4% higher than expected to 5% lower than expected over the last four years.

Extended stay indicator

Table 3 indicates the extended stay rates for a number of prominent admission types commonly used in the literature. It is the percentage of cases per admission type for which the hospital stay exceeds a calculated extended stay point. The indicator is regarded as a proxy measure for quality of care in certain medical and elective surgical admissions.

Table 3: Extended stay cases as a percentage of hospital admissions (financial year)

Extended Stay	**2009**	2008	
Medical			
Acute myocardial infarct	**11.3%**	10.8%	Δ
Asthma	**10.8%**	9.7%	Δ
Cardiac failure	**10.3%**	10.1%	Δ
Neonatal disorders	**9.8%**	10.9%	∇
Pneumonia	**10.0%**	9.6%	Δ
Surgical			
Coronary bypass graft	**10.5%**	9.9%	Δ
Cardiac catheterisation	**10.1%**	9.8%	Δ
Cholecystectomy	**9.5%**	9.7%	∇
Hysterectomy (abd)	**9.9%**	9.6%	Δ
Hysterectomy (vaginal)	**9.0%**	9.8%	∇
Hip replacement	**9.0%**	10.0%	∇
Knee replacement	**9.3%**	9.7%	∇
Resection large bowel	**8.8%**	11.5%	∇
Spinal fusion	**9.5%**	10.4%	∇
Obstetrics			
Caesarean section	**9.3%**	10.1%	∇
Normal vertex delivery	**9.0%**	9.7%	∇

The extended stay point was calculated as the 90th percentile of hospital stays for each admission type. Note that the percentages provided in Table 3 are unadjusted, and may reflect patient demographics, comorbidity profiles and complications. There is ongoing research in this area and further improvements to the methodology may be expected in the future. The extended stays of almost all admission types in the medical category increased in 2009 compared to 2008.

In the surgical category coronary artery bypass grafts (CABG), cardiac catheterisations and abdominal hysterectomies experienced a slight increase in extended stays. Both obstetric groups showed a downward trend in 2009, with progressively fewer patients experiencing extended hospital stays.

Hospitals are focusing on these results on an ongoing basis.

Re-admission

The re-admission indicator is calculated by counting the number of patients re-admitted to hospital within 30 days after discharge. This includes scheduled (planned) as well as unscheduled (unplanned) re-admissions, but it is the latter that are important as they represent late complications following from the initial admissions. Only unplanned re-admissions for selected admission types were reported in the past, but the approach showed some shortcomings such as data impurities and a narrow focus.

Although still an incomplete science, re-admission is generally accepted as one of the proxy measures for quality of care if used as a trend indicator.

Table 4 reports the 30-day re-admission rate for all hospital admissions during the period under review. As mentioned, it includes both scheduled and unscheduled re-admissions. The overall re-admission rate remained constant over the last two years. Comparable external benchmarks are unfortunately not available, and an internal benchmark will be calculated for hospitals to compare themselves against.

Table 4: Re-admission rate as a percentage of hospital admissions (financial year)

Category	**2009**	2008
Re-admissions	**9.3%**	9.3%

Adverse events and near misses

For the purposes of this report an adverse event is defined as any event which causes harm to a patient while he or she is in the care of the hospital. A near miss is any event which could have caused harm, damage or loss, but which was prevented from happening by design or luck. Patient safety remains the priority of all Medi-Clinic hospitals, and all events are therefore reported and analysed.

The Hospital Event Management initiative is a standardised system for managing, reporting and investigating incidents. The system ensures that risks are identified and actions implemented in order to prevent the recurrence of such events. Data are captured into a central database, which enables centralised reporting of hospital performance in determining the effectiveness of action plans implemented. Accurate reporting of all events is therefore compulsory.

The system includes both adverse events and near misses.

Table 5 provides a breakdown of the most prominent adverse event indicators together with incidence rates and benchmarks. The benchmarks were derived from results of studies performed in the USA, UK, Canada, Australia and New Zealand.

Table 5: Adverse events/near misses as a percentage of hospital admissions (financial year)

Category	**2009**	2008	Benchmark
Medication	**1.1%**	1.1%	1.1 – 1.6%
Falls	**0.5%**	0.6%	0.6 – 0.9%
Infections	**1.5%**	1.8%	1.8 – 2.7%
Skin	**0.7%**	0.9%	0.9 – 1.4%
Other clinical	**2.1%**	1.5%	2.1 – 3.2%
All events	**7.3%**	6.8%	8.0 – 12.0%

Medication-related events

Medication events as a percentage of admissions remained unchanged during the year under review. Errors in medication management can occur at various points in the medication pathway, such as in the prescribing, dispensing, delivery, storage and administration of medication. The Hospital Event Management system gives hospitals the ability to report, analyse and manage all these events.

Falls

Falls decreased to 0.5% of admissions during the year under review. Falls and injuries sustained by patients while in hospital remain an enormous challenge. There are many reasons why patients fall, and hospitals rely on the events management system to record and analyse falls systematically in order to implement preventative measures.

During the period under review 63% of all reported falls occurred in patients' rooms. Approximately 33% of all reported falls resulted in injuries. Most falls occurred amongst stroke patients, knee replacement patients and patients older than 80 years of age.

Hospital-acquired infections

Hospital-acquired infections decreased by approximately 16% in the period under review when compared with 2008. MCSA operates a robust and comprehensive infection surveillance programme using the Centres for Disease Control and Prevention 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. Clinical risk managers survey both bedside and laboratory data. Each hospital has an infection control committee that oversees infection prevention and control, and focuses on resistance patterns and the use of antibiotics.

Skin-related events

Skin-related events decreased to 0.7% of admissions during the period under review. These events can occur quite frequently in the treatment of seriously ill patients in the acute care setting, and can lead to substantial morbidity. Diligent prevention is therefore essential, as the treatment of skin lesions can be very challenging.

MCSA uses an assessment tool on admission to assess each patient's risk of developing a skin lesion. Seriously ill patients are frequently reassessed while in hospital. All skin lesions are reported and analysed on the Hospital Event Management system.

ACCREDITATION

Accreditation involves a quality assurance process under which the structures and processes of a healthcare facility are examined by an independent accrediting agency to determine if applicable quality standards are met. Patients receiving treatment in an accredited facility can have the peace of mind that quality and safety standards are achieved and continuously monitored.

MCSA chose the Council for Health Services Accreditation of South Africa ("COHSASA"), one of only a few agencies around the world accredited by the International Society for Quality in Healthcare, to accredit its hospitals. The process in the South African health sector is entirely voluntary, and MCSA was the first private hospital group to enrol its hospitals in 1996.

In 2007 MCSA entered into a new arrangement with COHSASA, in which 35 of its facilities participate in a renewable three-year quality-improvement and accreditation programme. As hospitals typically receive accreditation status for three years at a time, this arrangement ensures that all participating hospitals maintain their status in the long term. The formal process is not suitable for small hospitals and in order for them to benefit from the accreditation process, they are working closely with selected large hospitals in order to comply with standards.

CLINICAL OUTCOMES

Vermont Oxford Network

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

The VON is an initiative aimed at measuring and improving the quality of care in neonatal intensive care units. The project is based in Vermont, USA, with participating units all around the world. MCSA has been participating in the VON quality initiative since 2001. Currently 18 hospitals are participating in the initiative.

Although all babies admitted to the neonatal intensive care units are included in the programme, VON specifically focuses on the very low birth weight (<1 501g) infants because of the significant complexities involved in treating them. Table 6 deals with the general statistics of this subset of the neonatal intensive care population. This table, as well as Table 7, is derived from the official VON Annual Report for the 2007 calendar year. The VON Annual Reports only become available six months after year end, and the Report for 2008 was therefore not available in time to be included in this report.

Table 6:VON general statistics (calendar year)

Very Low Birth Weight Infants (<1 501g)	2007	2006	VON 2007
General			
Number of cases	264	164	54 068
Average birth weight in grams	1 107	1 141	1 043
Average gestational age in weeks	29	29	28
Average discharge weight in grams	2 208	2 209	2 178
Length of stay in days	50	53	54

During 2007 MCSA reported on 264 very low birth weight cases compared to 54 068 for the total network. Table 7 reports the quality outcomes for the participating MCSA hospitals.

Table 7:VON quality outcomes as a percentage of cases on the database (calendar year)

Very Low Birth Weight Infants (<1 501g)	2007	2006	VON 2007
Respiratory Support			
Respiratory distress syndrome	79%	82%	74%
Pneumothorax	2%	1%	5%
NCPAP	72%	76%	66%
Early CPAP	40%	33%	37%
Ventilation after early CPAP	41%	46%	44%
Ventilation	46%	52%	66%
Hifi Ventilation	23%	23%	23%
High-flow Nasal Cannula	37%	36%	45%
Nasal IMV or SIMV	10%	15%	13%
Chronic Lung Disease			
CLD 36 weeks	21%	20%	27%
CLD 36 weeks (gestational age < 33 weeks)	22%	21%	28%
Infections			
Early infections	3%	4%	2%
Nosocomial	26%	17%	21%
Other Outcomes			
Patent Ductus Arteriosus	23%	24%	39%
Necrotising Enterocolitis	7%	2%	7%
Periventricular-Intraventricular Haemorrhage	21%	18%	26%
Periventricular Leukomalacia	1%	1%	3%
Retinopathy of Prematurity	12%	24%	37%
Mortality	**16%**	**8%**	**17%**

For most of the respiratory support parameters, MCSA units were on par with, or outperformed, the VON averages. The occurrences of pneumothorax, as well as the use of ventilation and high-flow nasal cannulas were significantly lower than the VON averages. The nasal IMV/SIMV rate decreased from 2006 to 2007, becoming more in line with the VON average. However, the occurrence of respiratory distress syndrome was higher than the benchmark (p-value: 0.0745).

The MCSA units had lower rates of chronic lung disease than the VON benchmark during 2007. However, the nosocomial infection rate increased during 2007 and was higher than the VON average of 21% (p-value: 0.0305).

In a number of the other clinical outcomes, MCSA units performed better than the VON averages. MCSA had lower rates of patent ductus arteriosus, periventricular-intraventricular haemorrhages and retinopathy of prematurity. The necrotising enterolocolitis rate has increased since 2006, however, and is now on par with the VON benchmark.

For the very low birth weight infants, the MCSA mortality rate (16%) was slightly lower than the VON average, though not statistically significant.

Within the group of very low birth weight infants, chronic lung disease, periventricular leukomalacia and retinopathy of prematurity greatly determine survival and eventual quality of life. In all of these critical parameters and also with regard to mortality rate, MCSA performed better than average compared with the VON. These results can only be attributed to the professionalism, commitment and enthusiasm of the staff and doctors working in the units.

Adult Cardio-thoracic Database

The Adult Cardio-thoracic Database ("ACTD") is modelled on the database of the Society of Thoracic Surgeons, 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. As from January 2009 the database has also been rolled out in Dubai.

Table 8 reports some general volume statistics. It is important to note that some of the procedures reported in Table 8 were performed in combination but reported separately. A small number of previously unreported cases for 2008 have been included.

Table 8: Adult Cardio-thoracic Database volume statistics (financial year)

Indicator	**2009**	2008
Total number of cases	**472**	505
Procedures		
Coronary artery bypass graft	**401**	418
Valve surgery	**103**	124
Other cardiac procedure	**22**	25
Other non-cardiac procedure	**6**	18

Table 9 reports on general indicators, patient risk factors and clinical outcomes. Comparable international figures are not freely available, hence the year-on-year comparisons.

Table 9: General indicators, risk factors, outcomes as a percentage of cases on the database (financial year)

Indicator	**2009**	2008
Gender		
Female	**25%**	24%
Male	**75%**	76%
Age distribution		
< 40	**3%**	3%
41 – 60	**41%**	41%
> 60	**56%**	56%
Risk Factors		
Overweight/obese (BMI >25)	**81%**	77%
Hypertension	**77%**	73%
Dyslipidemia	**69%**	65%
Smoker	**47%**	50%
Family history of coronary artery disease	**42%**	52%
Diabetes	**23%**	25%
Renal failure	**7%**	8%
Other post-operative outcomes		
Infections	**2.5%**	2.2%
Re-operation	**4.9%**	2.6%
Renal failure	**1.1%**	2.2%
Prolonged ventilation	**5.5%**	6.9%
Mortality		
Expected mortality (EuroSCORE)	**6.6%**	6.3%
Actual mortality	**3.2%**	5.0%
Mortality index	**0.48**	0.79
Re-admit (30 days)	**8.1%**	12.3%

During the 2009 financial year about 85% of ACTD patients had coronary artery bypass procedures. This is slightly higher than the 2008 figure of 82.8%.

About three quarters of all cases in the ACTD database were male, with a small but steady increase in the proportion of female cases over the past three years.

Obesity and hypertension were the most predominant risk factors of the surgeries performed during the 2009 financial year. Approximately 81% of patients were overweight or obese, and 77% suffered from hypertension. Patients with dyslipidemia increased from 65% to 69%, while smokers decreased from 50% to 47%. Renal failure among patients in the ACTD database remained more or less 7% for the past three financial years.

The mortality index (actual/expected) fluctuated between 0.45 and 0.79 during the last three years. This is significantly lower than the benchmark index of 1.

From 2008 to 2009 the re-admission rate decreased by 52%, and only 8.1% of all patients in the ACTD database were re-admitted to hospital within 30 days of the original procedure in 2009.

In summary, the database is a very valuable tool in support of quality improvement and has been embraced by the team in the cardio-thoracic unit at Panorama Medi-Clinic.

Apache III

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

During the year under review the Apache III scoring system was implemented in the adult intensive care units of all MCSA hospitals. During the implementation phase a total of 16 513 cases were scored in 57 critical care units at 38 participating hospitals. Table 10 reports some important statistics, the most important being the mortality index, which is the relationship between the actual and predicted mortalities. The mortality index of 0.83 implies that the overall mortality of the scored cases was 17% better than expected.

Table 10: Apache III score (financial year)

Overall 2009	Total
Cases	**16 513**
Average age	**55.9**
Average physical score	**36.9**
Average length of stay (total hospital stay)	**8.0**
Average ICU days	**1.8**
Average high care days	**1.8**
Average days ventilated	**1.1**
Mortality index	**0.83**

The implementation of Apache III in all MCSA adult intensive care units is an important step towards a more measurable approach in quality care in this complex setting.

MEDI-CLINIC SWITZERLAND CLINICAL INDICATORS

Mortality

MCCH has been participating in the International Quality Indicators Project® ("IQIP") on a number of indicators since 2008. IQIP, an initiative that originated in the United States, assists healthcare organisations in identifying opportunities for improvement in patient care. It is important to note that IQIP data are gathered and aggregated for research purposes only. Weighted averages calculated on submitted data are in no way intended to be standards or to rank the quality of care provided by IQIP participants.

Table 11 reports the IQIP weighted average mortality figures for the 2008 calendar year. This compares favourably with other participating European hospitals.

Table 11: Mortality as a percentage of in-patient admissions (calendar year)

Quarter	1	2	3	4
MCCH	1.03%	0.91%	1.11%	0.81%
Europe	1.54%	1.37%	1.32%	1.37%

Re-admission

The IQIP weighted average figures for unscheduled re-admissions during the 2008 calendar year are reported in Table 12. Unscheduled re-admissions are not planned and are assumed to be a result of late complications. These figures are therefore not comparable with those of MCSA elsewhere in the report.

Table 12: Unscheduled re-admissions as a percentage of total in-patient admissions (calendar year)

Quarter	1	2	3	4
MCCH	0.70%	1.19%	1.17%	0.76%

Figures on participating European hospitals are not available and trends will therefore be reported in future.

Return to the operating theatre

The IQIP weighted average figures for unscheduled returns to the operating theatre for the 2008 calendar year are reported in Table 13. Unscheduled returns to the operating theatre are not planned and are assumed to be a result of complications. MCCH figures compare well with participating European hospitals.

Table 13: Unscheduled re-admissions to the operating theatre as a percentage of in-patient admissions (calendar year)

Quarter	1	2	3	4
MCCH	1.09%	1.29%	1.33%	1.08%
Europe	1.27%	1.42%	1.49%	1.39%

Adverse events and near misses

The Critical Incident Reporting System of MCCH is based on a uniform software platform for the registering of critical events and subsequent reporting of them to the national Critical Incident Reporting and Reacting System of the Swiss Foundation for Patient Safety.

Hospital-acquired infections

MCCH has been assisted by the Beratungszentrum Für Hygiene ("BZH") in Freiburg, Germany, in the control of infection, since 1998. Hospital-acquired infections have been recorded by some hospitals since 2000 by the standardised Hospital Infection Surveillance System ("HISS") of BZH, which is based on the criteria of the Centres for Disease Control and Prevention. Since 2008 all clinics have been recording hospital-acquired infections with the HISS. Figures will be published in the future.

Skin-related events

One of the IQIP indicators MCCH participates in is Pressure Ulcers in Acute Care. Its weighted average figures for the 2008 calendar year are reported in Table 14. This once again compares favourably with other participating European hospitals. The comparable figure for MCSA for the year under review is 0.2 per 1 000 bed days.

Table 14: Pressure ulcers in acute care per 1 000 bed days (calendar year)

Quarter	1	2	3	4
MCCH	0.4	0.3	0.4	0.2
Europe	1.8	1.5	1.7	1.4

Falls

MCCH also participates in the IQIP indicator for Documented Falls. Its weighted average figures for the calendar year are reported in Table 15. Once again, MCCH compares favourably with other participating European hospitals. The comparable figure for MCSA for the year under review is 2.0 per 1 000 bed days.

Table 15: Documented falls per 1 000 bed days (calendar year)

Quarter	1	2	3	4
MCCH	1.5	2.2	2.3	1.8
Europe	3.3	3.3	3.7	3.2

ACCREDITATION AND CERTIFICATION

A total of seven MCCH hospitals have received ISO 9001 certification from the International Organisation for Standards ("ISO").

All the hospitals are now working towards obtaining ISO 9001:2008 certifications in cooperation with the Swiss Association for Quality and Management Systems by the end of 2009.

MCCH also participates in the European Foundation of Quality Management ("EFQM") Excellence Model, which is a quality management model that covers all areas of management. The aim of the model is to guide users towards excellent management practices and operating results. The EFQM organisation awards two certificates, namely a first-level Committed to Excellence certificate and a second-level Recognised for Excellence certificate. There are currently three hospitals holding Level-1 certificates and one hospital holding a Level-2 certificate.

MEDI-CLINIC MIDDLE EAST

EVENTS

The Hospital Event Management system of MCME is currently paper-based and statistical data are not readily available. An improved version of the electronic MCSA Hospital Event Management system is planned to be implemented in Dubai during 2009.

This system will also incorporate the current paper-based hospital infection surveillance system at MCME.

ACCREDITATION

It is a legal requirement for hospitals in the Dubai Health Care City to be accredited by the Joint Commission International. MCME is currently preparing to accredit both its hospitals in Dubai and the aim is to achieve accreditation status by November 2009.

OUTCOMES

The cardio-thoracic team at the Welcare Hospital in Dubai has been collecting cardiac surgery data as part of their own initiative for the last few years. These data are reported in Table 16.

Table 16: Adult Cardio-thoracic Database volume statistics (calendar year)

Indicator	2008	2007
Total number of cases	73	85
Procedures		
Coronary artery bypass graft	65	68
Valve surgery	8	14
Other cardiac procedure	0	3

Table 17 reports on general indicators, patient risk factors and clinical outcomes. Comparative international figures are not freely available.

Table 17: General indicators, risk factors, outcomes as a percentage of cases on the database (calendar year)

Indicator	2008	2007
Gender		
Female	16%	15%
Male	84%	85%
Age distribution (years)		
< = 40	8%	8%
41 - 60	60%	74%
> 60	32%	18%
Risk factors		
Hypertension	63%	55%
Dyslipidemia	73%	59%
Smoker	53%	52%
Diabetes	58%	49%
Other post-operative outcomes		
Renal/kidney complication	2.7%	0.0%
Ventilation >24 hours	2.7%	4.7%
Mortality		
Actual mortality	1.4%	0.0%

The majority of patients underwent coronary artery bypass grafts and more than 80% of patients were male. The Welcare Hospital cardiac patients were of a younger age compared to those at Panorama Medi-Clinic, and with a different risk profile. As accurate body mass index figures are not available, obesity as a risk factor cannot be reported on. The most dominant risk factor was dyslipidemia, followed by hypertension, diabetes and smoking. Diabetes occurred in 57% of patients compared to 23% at Panorama Medi-Clinic.

The unadjusted mortality was 1.3% at the Welcare Hospital. An expected mortality and therefore comparable index could unfortunately not be calculated because of the unavailability of data. The unadjusted figures are not comparable and cannot be commented on.

The re-admission rate could not be calculated because of data constraints.

THE WAY FORWARD

Quality and safety of patient care will always require continued focus and relentless attention to detail. Medi-Clinic is satisfied with the progress that has been made in this field.

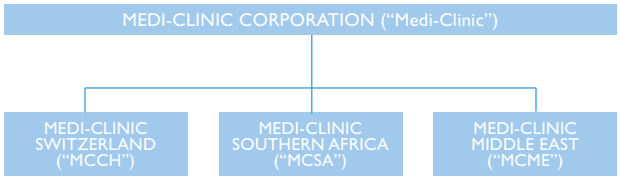
During the year ahead Medi-Clinic will continue to integrate and benchmark the quality initiatives of the three platforms into a single clinical governance framework and implement a number of new quality improvement initiatives.

An important focus area will be to strengthen the information management and clinical performance measurement abilities of both MCCH and MCME. Another focus area will be to establish a corporation data warehouse that combines information from all three platforms according to a standard set of definitions that will enable Medi-Clinic to make cross-platform comparisons.

OPERATIONAL PROFILE

Medi-Clinic was founded 26 years ago in 1983 when the Group's 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 MCSA operates 48 hospitals throughout South Africa and three in Namibia with more than 6 800 beds in total. MCCH operates 13 private acute care facilities in Switzerland with 1 334 beds. Following the commissioning of the first hospital in the Dubai Healthcare City, The City Hospital during 2008, MCME currently operates two hospitals with 321 beds and four clinics in Dubai and one clinic in Muscat, Oman. A complete list of our hospitals and clinics appears on pages 42 and 43.

Subsequent to the Group's international expansion during 2007, its management and operational structure were divided into three operating platforms, namely Medi-Clinic Southern Africa ("MCSA"), Medi-Clinic Switzerland ("MCCH") and Medi-Clinic Middle East ("MCME"). The current 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.

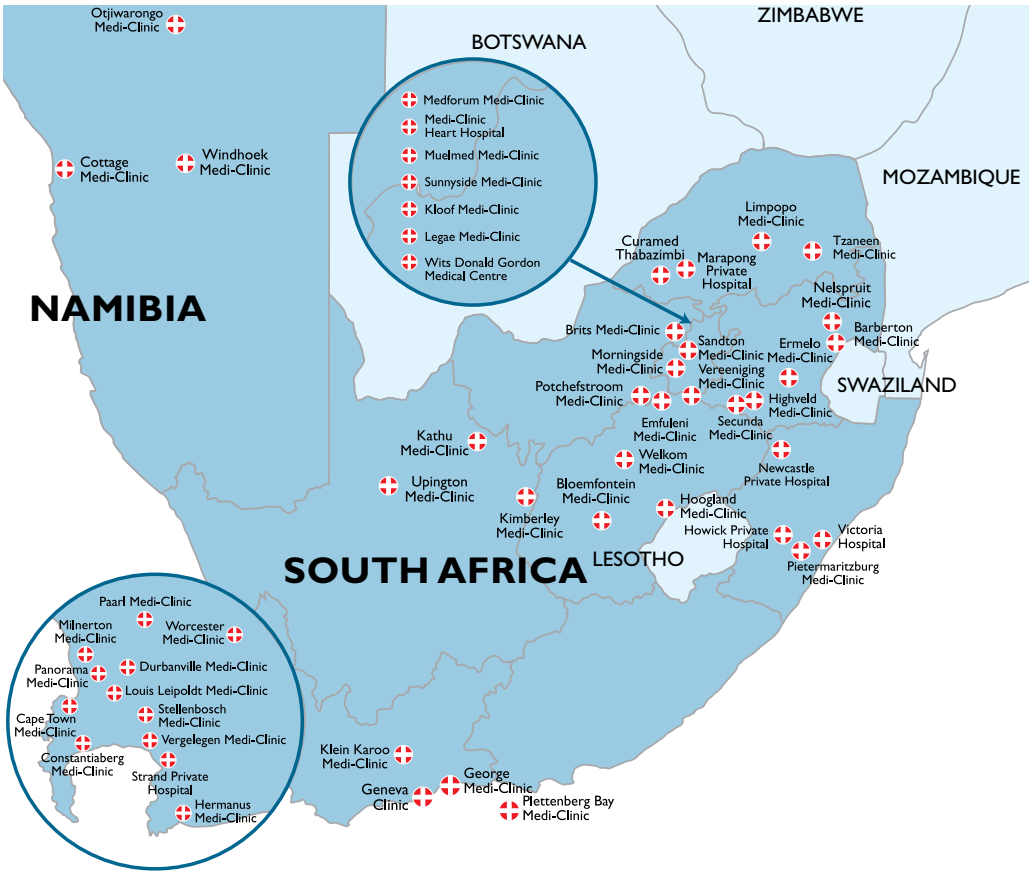
At year end the group had approximately 12 500 employees in Southern Africa. The management team consists of the following senior managers:

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	Funder Relations Executive
Mr Steve Drinkrow	Infrastructure Executive
Ms Clara Findlay	Legal Services Executive
Ms Estelle Jordaan	Nursing Executive
Mr Theo Pauw	Communication & Information Technology Executive
Mr Kobus Verster	Human Resources Executive
Dr Mvula Yoyo	Transformation Executive

ER24 renders emergency assistance services in line with international norms and standards, including 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 130 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 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 internationally. It obtained ISO 9001:2000 Certification for Quality Management System standards, which is a certification recognised as an international standard for product design, manufacturing and servicing.

Medical Human Resources provides temporary and permanent staff over the entire spectrum of the healthcare industry to more than 146 clients, mostly private hospitals, throughout South Africa and recently also in the United Arab Emirates. The company consists of two divisions, namely Medi-Nurse for placement of nursing staff and Medi-Staff for placement of administrative and medical staff. We currently have over 16 347 active employees available on a part-time basis and a growing database of qualified personnel for permanent positions.



MEDI-CLINIC SWITZERLAND

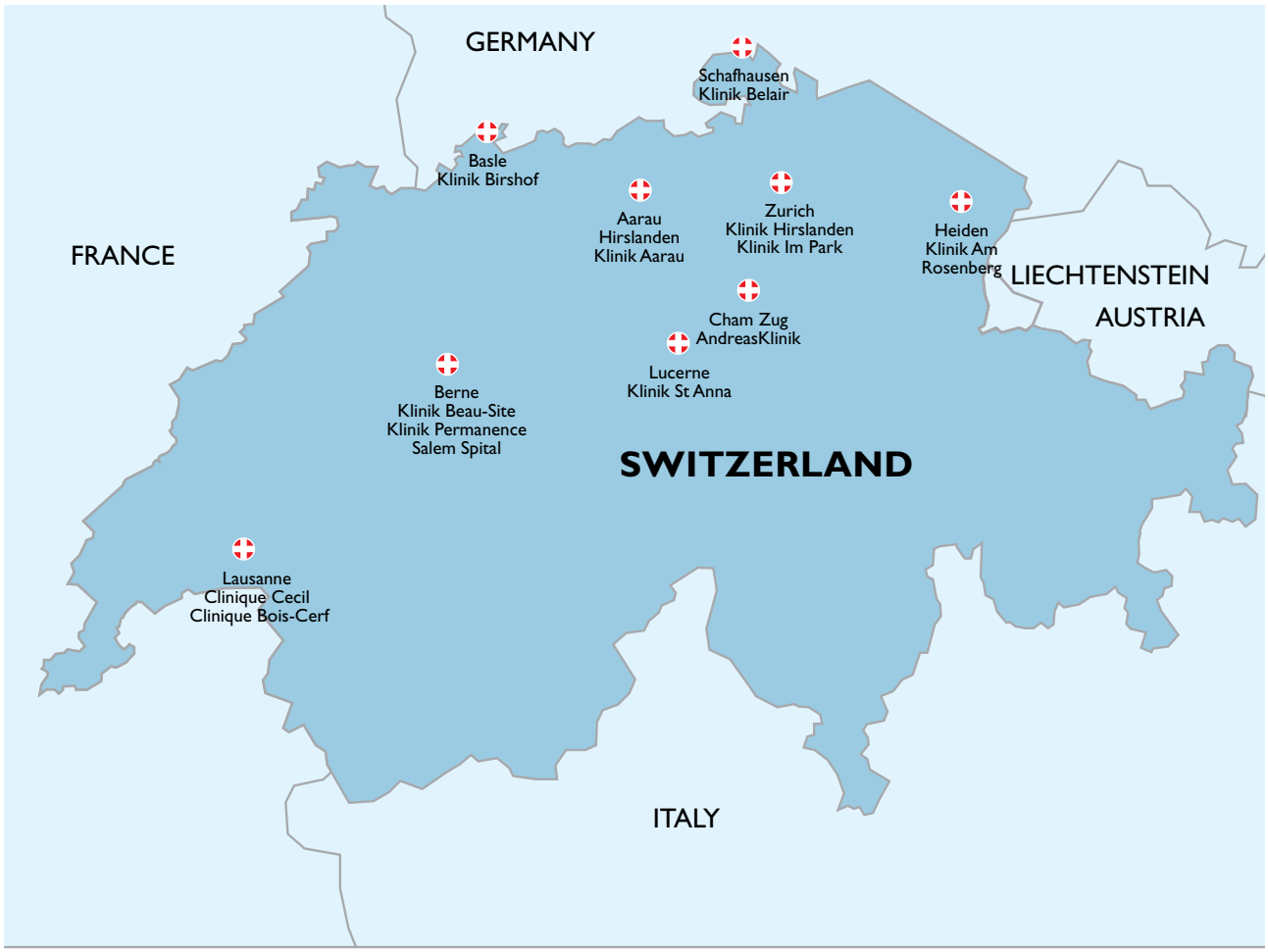
MCCH is the largest provider of acute healthcare in Switzerland and is renowned throughout the country and internationally for providing the highest level of clinical care and standard of facilities. MCCH's head office is situated in Zürich and operates a network of 13 private acute care facilities located in nine cantons throughout Switzerland with 1 334 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 4 100 staff. The management team consists of the following senior managers:

Dr Ole Wiesinger	Chief Executive Officer
Mr Andreas Kappeler	Chief Financial Officer
Mr Magnus Oetiker	Chief Hospital Services Officer
Mr Adrian Dennler	Chief Operating Officer: Western Region
Mr Nicolaus Fontana	Chief Operating Officer: Central Region
Mr André Steiner	Chief Operating Officer: Eastern Region

Expanding the group's management team during 2008 laid the foundation for further growth and innovation. Three regions were created in line with the geographical location of the hospitals. This new broad-based group management structure will make it possible for the hospitals to present their interests directly to the MCCH group management.

MCCH operates in Switzerland under the name of Hirslanden group of private hospitals. The name Hirslanden has always been highly valued in Switzerland and is very well known as it stems from the renowned Hirslanden hospital which opened in Zürich in 1932. Over the last ten years the Hirslanden brand building has become more professional with a clearly defined corporate identity. Today the Hirslanden brand stands for first-class medical quality, individual care, innovation and efficiency.



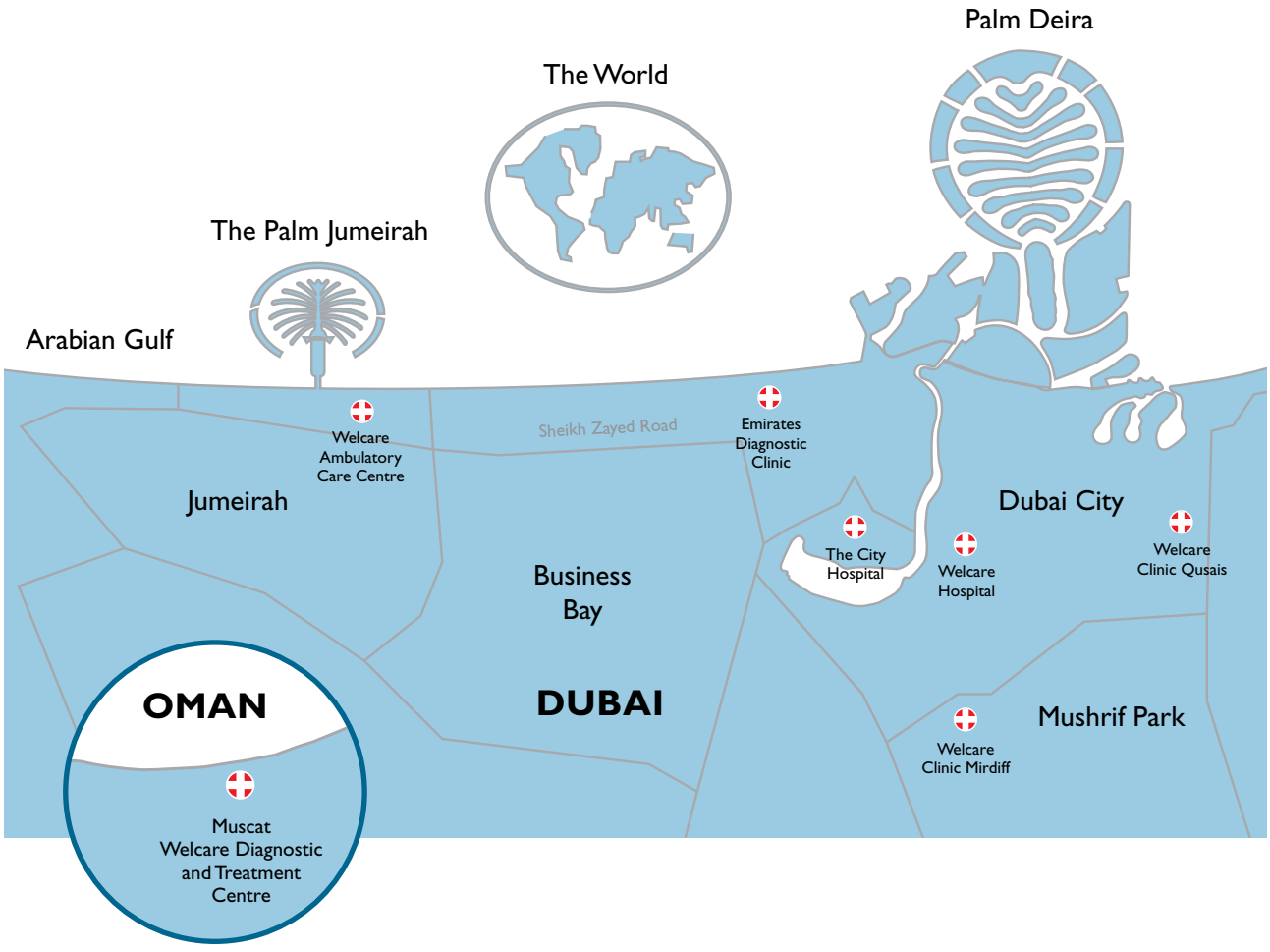
MEDI-CLINIC MIDDLE EAST

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 111-bed Welcare Hospital and the recently commissioned 210-bed The City Hospital, as well as five clinics. EHHL also owns vacant land in Dubai Healthcare City.

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

At year end the MCME group had approximately 1 200 employees. The management team consists of the following senior managers:

Mr Danie Meintjes	Chief Executive Officer
Mr Craig Tingle	Chief Financial Officer
Dr Pietie Loubser	Chief Clinical Officer
Mr David Hadley	Hospital Director: The City Hospital
Mr Sakkie van der Vyver	Hospital Director: Welcare Hospital
Mr Alaa Darwish	Group Manager: Business Development
Mr Mustafa Kantawala	Group Manager: Finance
Dr Lisa Pinto	Group Manager: Clinics
Mrs Malou Rojas	Group Manager: Human Resources
Dr Ottmar Schmidt	Group Manager: Marketing and Public Relations
Mr Cules Schoeman	Group Manager: Information Technology



	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	Ms Anne-Marie Nortjé	Hermanus	51	2
Klein Karoo Medi-Clinic	Ms Morongwe Mokwena (Acting)	Oudtshoorn	38	2
Louis Leipoldt Medi-Clinic	Ms Alosha Rayray	Bellville	200	7
Milnerton Medi-Clinic	Ms Carol Defty	Milnerton	139	5
Paarl Medi-Clinic	Mr Oelof Dippenaar	Paarl	139	4
Panorama Medi-Clinic	Mr George Harris	Parow	386	12
Plettenberg Bay Medi-Clinic	Ms Lawrine Zander	Plettenberg Bay	27	1
Stellenbosch Medi-Clinic	Ms Carol van Zyl	Stellenbosch	90	4
Strand Private Hospital	Mr Pieter Lotz	Strand	24	2
Vergelegen Medi-Clinic	Mr Pieter Lotz	Somerset West	237	8
Worcester Medi-Clinic	Mr Marquin Crotz	Worcester	187	5
GAUTENG				
Emfuleni Medi-Clinic	Mr Joe Sandows	Vanderbijlpark	155	4
Kloof Medi-Clinic	Ms Riëtte Swart	Pretoria	169	10
Medforum Medi-Clinic	Ms Joey le Roux	Pretoria	204	14
Medi-Clinic Heart Hospital	Ms Joey le Roux	Pretoria	90	3
Morningside Medi-Clinic	Mr Jaco Erasmus	Sandton	230	9
Muelmed Medi-Clinic	Mr Johan Verwey	Pretoria	222	8
Sandton Medi-Clinic	Ms Louise Sole	Sandton	379	10
Sunnyside Medi-Clinic	Ms Riëtte Swart (Acting)	Pretoria	53	2
Vereeniging Medi-Clinic	Mr Leon Lambrechts	Vereeniging	165	7
Wits Donald Gordon Medical Centre *	Vacant	Johannesburg	95	4
MPUMALANGA				
Barberton Medi-Clinic	Ms Carmen Savva	Barberton	30	1
Ermelo Medi-Clinic	Ms Welma Bertram	Ermelo	40	2
Highveld Medi-Clinic	Mr Willem Schoonbee	Trichardt	202	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 Rob Soutter	Howick	26	3
Newcastle Private Hospital	Mr Freddie Meiring	Newcastle	126	4
Pietermaritzburg Medi-Clinic	Mr Rob Soutter	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

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

	HOSPITAL / CLINIC MANAGER	LOCATION	LICENSED BEDS	LICENSED THEATRES
NORTH WEST				
Brits Medi-Clinic	Mr Jan Scheepers	Brits	80	3
Legae Medi-Clinic	Mr Dibate Lenong	Mabopane	137	4
Potchefstroom Medi-Clinic	Mr Blake van Aswegen	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				
Curamed Thabazimbi Hospital	Ms Charline van der Walt	Thabazimbi	21	1
Limpopo Medi-Clinic	Mr Antonius Spek	Polokwane	186	6
Marapong Private Hospital	Ms Charline van der Walt	Lephalale	12	1
Tzaneen Medi-Clinic	Mr Zane Fanie	Tzaneen	64	2
NAMIBIA				
Cottage Medi-Clinic	Mr Peter Sander	Swakopmund	70	2
Otjiwarongo Medi-Clinic	Ms Judith von Solms	Otjiwarongo	20	1
Windhoek Medi-Clinic	Ms Elmarie Vink	Windhoek	120	4
			6 855	248
SWITZERLAND				
Hirslanden Klinik Aarau	Mr Philipp Keller	Aarau	117	7
Klinik Beau-Site	Mr Adrian Dennler	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 Jean-Marc Zumwald	Lausanne	66	6
Clinique Cecil	Mr Pierre-Frédéric Guex	Lausanne	86	6
Klinik St Anna	Dr Dominik Utiger	Luzern	169	6
Klinik Birshof	Ms Simone Schwinger	Münchenstein	43	4
Klinik Belair	Mr Stephan Eckhart	Schaffhausen	28	2
Klinik Hirslanden	Mr Daniel Liedtke	Zürich	259	12
Klinik Im Park	Mr Nicolaus Fontana	Zürich	139	6
			1 334	71
UNITED ARAB EMIRATES				
Welcare Hospital	Mr Sakkie van der Vyver	Dubai	111	4
The City Hospital	Mr David Hadley	DHCC, Dubai	210	6
Welcare Clinic Qusais	Dr Ravi Gupta	Qusais, Dubai	n/a	n/a
Emirates Diagnostic Clinic	Dr Nedungat Gangadharan	Satwa, Dubai	n/a	n/a
Welcare Ambulatory Care Centre	Dr Lalith Uchil	Knowledge Village, Dubai	4	1
Welcare Clinic Mirdif	Dr Hateem Abdeen	Mirdif, Dubai	n/a	n/a
Welcare Diagnostic and Treatment Centre**	Dr Christopher Dias	Muscat, Oman	n/a	n/a
			325	11
			8 514	330

** only 20% financial interest

SUSTAINABLE DEVELOPMENT REPORT

This report is Medi-Clinic's seventh 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 it has also taken note of the G3 Sustainability Reporting Guidelines developed by the Global Reporting Initiative.

Medi-Clinic is focused on its core business of providing acute, specialist-orientated hospital care 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, contributing to the general well-being of the community, supporting broad-based black economic transformation and managing the environmental impact of our business.

Medi-Clinic has qualified for inclusion in all the JSE SRI (Socially Responsible Investment) Indexes conducted to date; these indexes 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 2007 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 MCSA have been implemented at our Swiss and UAE operations, the integration and exchange of knowledge and expertise have been receiving, and will continue to receive, ongoing attention. A Convergence and Synergy Committee was established during 2008 with top management representation from all three operating platforms. This committee envisions an international platform of structures, processes and business applications to extract value from immediate synergies and to find the best practices for taking the Group into the future. This committee has already identified various projects and initiatives with dedicated project teams. The seamless integration of financial reporting requirements and the exchange and implementation of best corporate governance practices have already been completed. Projects to standardise terminology, integrated risk management, clinical governance, information and communication technology governance, procurement and working capital management are already in progress.

The scope of this report covers our operations in South Africa, Switzerland and the UAE, but as a JSE-listed company with largely South African investors, particular emphasis is placed on our Southern African operations.

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 a high standard and care processes that are sophisticated, reliable and free of errors. Our commitment to quality in healthcare is demonstrated in our annual Clinical Governance Report, published since 2008 as part of the annual report. For more details on the Group's clinical quality initiatives see the report from pages 28 to 37.

Medi-Clinic 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 R381 million (2008: R195 million) on capital projects and new equipment to enhance its business, as well as R184 million (2008: R161 million) on the replacement of existing equipment. Similarly, MCCH has invested approximately R227 million (CHF28 million) on capital projects and new equipment to enhance its business as well as R359 million (CHF45 million) on the replacement of existing equipment. MCME also spent R250 million (AED104 million) (2008: R336 million (AED174 million)) to complete and equip The City Hospital and R33 million (AED14 million) (2008: R30 million (AED16 million)) on the replacement of existing equipment.

Because of the instability of the national power supply, the power-generating capacity of our hospitals was increased to ensure that they are able to function at 70% of the required capacity during electricity outages. Increasing the group's power-generating capacity involved the procurement of 29 additional generators at a cost of R35.8 million. At year end this project was 97% complete, with only one installation outstanding. On completion of this initiative the group would have invested R48 million over a three-year period on additional power-generating capacity to enable the South African hospitals to operate as normal during extended power outages.

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 system 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 remaining two categories of equipment are maintained according to Medi-Clinic's in-house policy by our technical staff, the agent or a contractor appointed by Medi-Clinic. The planned maintenance system and related procedures are constantly being evaluated to ensure that patient safety is paramount and that our staff delivers a value-adding service.

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 average overall score achieved by all hospitals remained at 80% during the period under review.

A computerised maintenance management system enables MCSA to provide quality service and complements the care of our patients and clients. We have accumulated ten 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 expected to be completed over the next three years.

The quality of our facilities in Switzerland is regarded as among the best in the world. The MCCH management team regards the provision of high-quality facilities as essential to ensure

In this report "the Group" or "the Company" refers to Medi-Clinic Corporation Limited and its subsidiaries and "the group" or "the company" refers to one of the three operating platform groups, as the context may indicate. "MCSA" refers to the Medi-Clinic Southern Africa group, "MCCH" refers to the Medi-Clinic Switzerland group and "EHHL" or "MCME" refers to the Medi-Clinic Middle Eastern group.

the successful development of the group. The hospitals are 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 to 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. The group is also developing a uniform quality management system for group-wide implementation.

MCCH attaches particular importance to quality management. 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. Seven of the group's 13 hospitals in Switzerland are ISO 9000: 2001 certified, with the aim of having the remaining hospitals certified by the end of 2009. With their ISO certification the hospitals will put into practice continual improvements in process quality and services provided in all areas, above all in nursing and medical technology. The group is also participating in the International Quality Indicator Project ("IQIP"), an international comparative research project for measuring quality aspects in medical care.

Although each hospital has a local team that is responsible for technical items and maintenance works, the central technical department ensures that common technical standards are applied, monitors compliance with regulations regarding, inter alia, safety and environment, ensures that new regulatory requirements are implemented; and facilitates knowledge transfer within the group. Especially larger projects are jointly handled with the centralised investment and maintenance team at the MCCH head office. A computer-aided facility management system for controlling all medical devices was implemented by MCCH in 2003. This system was expanded in 2007 to include the management of the group's facilities, including cleaning and technical infrastructure such as HVACR (heating, ventilation, air-conditioning and refrigeration), elevators and security aspects.

All the operational units of MCME in the UAE are in the process of obtaining accreditation of their 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 sets uniform, achievable expectations for structures, processes and outcomes for hospitals. The City Hospital was commissioned in the Dubai Healthcare City during October 2008 after passing stringent quality inspections by the Centre of Planning and Quality, which operates under the auspices of Harvard Medical International.

BROAD-BASED BLACK ECONOMIC EMPOWERMENT*

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

The Board 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. Our commitment to transformation is evidenced by an improvement in our overall results, as assessed in the Financial Mail/Empowerdex Top Empowerment Companies Survey 2009. The survey is a mechanism to measure and monitor the empowerment achievements of listed companies and ranks the top 200 JSE listed companies according to their scores.

Enhancing the group's current BBBEE initiatives is a priority for MCSA and the group has adopted a comprehensive BBBEE strategy that aims to facilitate initiatives across all seven pillars of the BBBEE scorecard. The group's Transformation Executive is a member of the MCSA Executive Committee, ensuring appropriate focus is placed on the group's 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 are set out in the table on page 47. Our self-assessment indicates that we have a total score of 64.98 (compared to 60.26 the previous year), 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, MCSA has not officially verified its BBBEE status, apart from the ownership element as specified below, but aims to have the other elements independently verified during the new financial year.

BBBEE SCORECARD			
ELEMENT	INDICATOR	WEIGHTING	OUR SCORE
Ownership	Percentage share of economic benefits	20	16.55
Management control	Percentage black persons in executive management and/or executive board and board committees	10	5.23
Employment equity	Weighted employment equity analysis	15	4.05
Skills development	Skills development expenditure as a proportion of total payroll	15	10.22
Preferential procurement	Procurement from black-owned and empowered enterprises as a proportion of total assets	20	9.74
Enterprise development	Average value of enterprise development contributions as a percentage of the target of 3% of net profit after tax	15	15
Socio-economic development	Corporate social investment for the benefit of black persons	5	4.19
TOTAL		100	64.98

Ownership

During the financial year the ownership pillar was independently verified, with a resulting improvement from our self-assessed score of 15.32 to 16.55 compared to last year.

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 this 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 trusts, two employee share trust formed in South Africa and Namibia specifically for that purpose. The Mpilo trusts held approximately 4% (currently 2.48%, excluding the Namibian shareholding trust) of Medi-Clinic's issued shares.

The Hirslanden acquisition in 2007 had a positive effect on this element of BBBEE for our strategic black partners, Phodiso and Circle Capital, who 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 have since then been 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% economic interest of black people for purposes of calculating Medi-Clinic's ownership scorecard with reference to our South African operations.

Management control

Our strategic black partners have been well represented within Medi-Clinic since 2005, with two of Phodiso's directors involved in key positions within the Group: Dr Nkaki Matlala as Chief Clinical Officer and board member of MCSA, and Dr Kabs Makaba as board member of Medi-Clinic; and Circle Capital's chairperson, Dr Mamphela Ramphele, as board member of Medi-Clinic.

MCSA's board and executive management is well represented, with four of the nine board members and three of the 13 Executive Committee members being black.

Employment equity

MCSA's focus on employment equity is in line with our overall transformation objectives. In support of our employment equity plans, the group will, inter alia, be rolling out diversity workshops for employees and will also focus on projecting MCSA as an employer of choice for employees from the designated groups. Although a continuous increase in black representation at management level has been recorded year

on year since 2006 (when it stood at 11%), with an increase from 17% to 19% during the past year, this level still presents the biggest challenge to the group, with low turnover remaining a limiting factor. The successful setting up of Equity Committees at national, regional and hospital levels has assisted us in reaching our stated goals.

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

MCCH and MCME also focus on employment equity matters in respect of gender and their overall gender split is set out below. MCCH has codified all ethical rules and regulations in compliance with Swiss national law. The revised terms of reference for employees (Personalreglement) of MCCH was implemented in January 2009 and further confirms the group's commitment to gender equality and to protection against discrimination in any form.

Race split	
African, Coloured, Indian	White
57.5%	42.5%

Gender split	
Female	Male
86%	14%

MCCH gender split	
Female	Male
78.3%	21.7%

MCME gender split	
Female	Male
55%	45%

Below is a summary per occupational level of MCSA's employment equity report (EEA12) as at 31 March 2009, as required in terms of section 22 of the Employment Equity Act:

	DESIGNATED							NON-DESIGNATED			TOTAL
	Male			Female				White Male	Foreign Nationals		
OCCUPATIONAL LEVELS	A	C	I	A	C	I	W	W	Male	Female	
Top management	1		1					8			10
Senior management	1	1					2	15			19
Professionally qualified and experienced specialists and mid-management	10	23	12	22	18	9	231	160		2	487
Skilled technical and academically qualified workers, junior management, supervisors, foremen and superintendents	97	97	19	772	731	128	2 801	180	4	59	4 888
Semi-skilled and discretionary decision-making	420	293	10	2 136	1 547	98	1 696	125	2	8	6 335
Unskilled and defined decision-making	131	80		345	247	1	63	27	5	9	908
TOTAL PERMANENT	**660**	**494**	**42**	**3 275**	**2 543**	**236**	**4 793**	**515**	**11**	**78**	**12 647**
Non-permanent employees	8	3		7	4		38	9	5	9	83
GRAND TOTAL	**668**	**497**	**42**	**3 282**	**2 547**	**236**	**4 831**	**524**	**16**	**87**	**12 730**

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

Skills development

Medi-Clinic's stated commitment to quality care has the effect that skills development is a priority at all levels, which is reflected in the number of learning initiatives undertaken each year. During the past year MCSA has facilitated in excess of 20 000 structured learning interventions. The group 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 on management levels, we have expanded our management development programmes to include various other functional disciplines and the successful completion of these programmes has increased the management talent pools. See pages 54 to 57 for more details on the Group's training and skills development initiatives.

Preferential procurement

MCSA 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, and has 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 40.74% 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.

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 trusts. The loans enabled these entities' acquisition of equity in Medi-Clinic.

Socio-economic development

MCSA's Corporate Social Investment ("CSI") strategy, as further reported on under our community involvement report on page 57, is being finalised and aims to significantly extend the group's CSI activities. The group 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. In order to achieve a greater impact, MCSA is investigating operational partnerships with organisations or role players in a particular social sphere, enabling them to expand their existing social outreach programmes through the group's expertise. The success of the group's CSI strategy rests on the continued 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 South Africa, 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 two years, although the drafting sub-committee 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

Medi-Clinic is the first Proudly South African private hospital group, underscoring our commitment to continuously strive to maintain a high standard of quality care, and is now in its fifth 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

Medi-Clinic believes that public private partnerships ("PPPs") may play a meaningful role in increasing access to affordable quality healthcare services. We continue to look for meaningful opportunities for PPP participation. MCSA participated in discussions between private hospital industry players and the Department of Health, as well as in the Health Public Private Partnership Workshops facilitated by National Treasury. At these events MCSA emphasised its belief that meaningful health PPPs would involve the private hospital sector's core competencies, namely the delivery of quality healthcare and hospital management services.

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 R65 million in WDGMC, 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 three registrars and ten 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

MCSA and Stellenbosch University established a successful partnership during 2004 in respect of the management of the Stellenbosch Biokinetics Centre. MCSA 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 for the honours degree in Biokinetics has increased substantially during the past five years, which is directly attributable to the success attained by the partnership.

MCCH is in the process of evaluating possible PPP opportunities in Switzerland and believes that it can play an important role in the management of governmental relations with the cantons.

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 is experiencing 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 the 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 2009, is between 7% and 8%.

Medi-Clinic believes that providing cost-effective quality care in a sustainable manner, and sustaining 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.

Access to and affordability of healthcare

Affordability will always remain a critical issue in the healthcare industry internationally, but especially in developing countries, such as in our Southern African operations. The Group will therefore continue its efforts to improve the affordability of healthcare with a specific focus on Southern Africa, where this issue is of critical importance. Although all Swiss residents have healthcare insurance, MCCH is committed to cost efficiency in healthcare by way of supporting market-orientated initiatives and reforming to reduce the increase in healthcare insurance premiums. MCME also places continuous focus on cost efficiencies, as affordability of healthcare is becoming more and more of a critical issue in the UAE as a

result of the current economic climate, rising costs because of the relatively high inflation of the region, and the government's initiative to introduce and roll out national health insurance.

Although the latest Monitor Report commissioned by Discovery Health once again rates the South African private healthcare sector amongst the top 10 in the world on the combination of access and quality, the price of quality healthcare remains high relative to the income of a large proportion of the South African population.

The South African government's focus on healthcare has recently increased considerably, with a particular focus on the affordability of and access to quality healthcare, which are the drivers of the National Health Insurance ("NHI") principles that government aspires to adhere to.

Paramount to the search for sustainable solutions is a common base of credible data. The introduction of proper information systems and processes in the public sector, as accepted by the Minister of Health in November 2008, encompassing, inter alia, clinical coding information, utilisation measurement and billing information, is a positive step in this regard. The issue of credible data is also one that affects the private sector. Although there are many data sources available in the private sector, the lack of clarity with respect to definitions sees the publication of many incorrect figures. Medi-Clinic has been proactive in engaging with the Council for Medical Schemes ("CMS") with respect to the hospital utilisation data published in their annual reports. Many of the measures in these reports, such as the hospital admission rate and the total number of hospital bed days were incorrect, because of the different medical schemes interpreting the definition of these measures differently. Medi-Clinic is positive about the minimum dataset project put in place by the CMS, which is anticipated to lead to more credible private sector data within the next two to three years.

The current lack of accurate information has led to incorrect conclusions being accepted as fact by stakeholders in respect of the private hospital sector, specifically in the following two areas:

1. Accurate financial data with respect to medical schemes' payments to private hospitals with incorrect utilisation data has spawned the misconception that the increase in the payments to private hospitals (in excess of inflation) is the result of tariff increases, rather than the actual reason, which is the increased utilisation of hospital services.
2. The underreporting of hospital utilisation by medical schemes (combined with the fact that non-medical scheme hospital utilisation – such as the Road Accident Fund, Compensation for Occupational Injuries and Diseases and private patient utilisation – is ignored), has led to the conclusion that the private hospital sector can accommodate another 7.5 million individuals within current capacity, which is completely unattainable.

Based on the CMS annual reports, it is clear that the medical scheme industry has grown significantly over the past number of years. This growth is largely the effect of growth in the Government Employees Medical Scheme ("GEMS") membership, which constitutes approximately 50% of previously uncovered individuals. This is, however, not the only source of growth. Of the 292 000 new lives who joined the medical scheme industry during 2006, almost 80% was due to growth in schemes other than GEMS. However, the inverse was true for 2007, when 77% of lives who entered the market for the first time joined GEMS. The percentage of principal members covered by medical schemes as a percentage of the number of formally employed has increased from 36.5% in 2003 to 37.7% in 2007, indicating that employment is a major driver of cover.

Regulations governing the process and method for determining the National Health Reference Price List ("NHRPL") were published by the Department of Health ("DoH") early in 2008. The regulations state that the costing methodology may not be suitable for all health disciplines and allows for alternative methodologies subject to prior approval by the Director-General of Health. HASA and Medi-Clinic support a transparent tariff model based on scientific research. To this end HASA constituted and mandated an NHRPL sub-committee with representatives from the three large private hospital groups and the New National Hospital Network ("NNHN") to deal with developing an NHRPL methodology for hospitals. This sub-committee contracted Deloitte & Touche ("Deloitte") to develop the actuarial zero-base pricing model, and PricewaterhouseCoopers ("PwC") to develop the appropriate return on investment methodology. Both the pricing and return on investment methodologies were submitted to the DoH by the end of April 2008, with the aim of obtaining approval of the methodologies in time for the final submission by mid-May 2008. Following numerous attempts by Deloitte and PwC for active engagement with the DoH, a final NHRPL for 2009 for the private hospital sector was published in December 2008, which ignored the Deloitte methodology in totality.

OUR PEOPLE

Employee remuneration

Medi-Clinic's remuneration policy is built on three pillars, namely internal equity, external equity and affordability. To ensure external equity balanced with affordability, MCSA 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.

MCSA's nursing staff benefits from our retention bonus scheme, which has contributed favourably towards the reduction of nursing staff turnover. Government, being the biggest employer of nursing and pharmacy resources, further contributed to this with the implementation of the Occupation Specific Dispensation agreement, under which substantial salary adjustments were approved for nursing staff in the public sector. However, nursing salaries in South Africa remain under pressure.

All Southern African employees up to, and including, first line management level participate in an employee share ownership scheme through the Mpilo trusts. The Mpilo trusts were established in 2005 as an employee share ownership scheme as part of the Group's Black Ownership Initiative. The trusts subscribed for approximately 4% of Medi-Clinic's issued shares; these shares are held for the benefit of almost 11 000 Participating Employees (of whom 52% are black and 89% are women), which include, inter alia, nursing staff, support staff and administrative staff. Following the rights issue and distribution of shares to entitled employees, the trusts held 2.55% of Medi-Clinic's issued shares as at year end.

A management incentive scheme for senior managers of MCSA, including executive directors of Medi-Clinic, 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.

The scheme is in essence a cash bonus scheme, in terms of which a portion of the after-tax value of the bonus is compulsorily invested in Medi-Clinic shares. The bonus payable to participants of the scheme is calculated by taking into account the participants' annual remuneration, their job grade and the percentage growth in the Medi-Clinic share price over a specified period, limited to a maximum growth of 20% over a 12-month period and/or such other considerations as may be determined by the Board from time to time.

MCCH offers a competitive set of fringe benefits, including private medical insurance, and has a bonus scheme in place for senior and junior management.

MCME also offers various benefits to its staff, including medical insurance, transport and housing for lower-level staff. MCME implemented new human resource management policies and processes to ensure a more equitable and sustainable human resource management approach. Amongst the policies and processes introduced was the grading of all positions in a new job grade structure, in line with MCSA's structures, to ensure a better structured remuneration approach. For the first time in the nine-year history of the group, a 13th cheque was paid as a bonus to all staff in 2008. A new productivity-linked reward scheme was also introduced to remunerate employed doctors. The reward calculation is only based on the professional fees generated by the doctor and not on any hospital services, which might be perceived as a perverse incentive.

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. 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 and this is communicated to staff via intranet and staff newsletters.

As referred to later in this report, MCSA's trade union membership continues to decline, with no trade union membership by our MCCH or MCME employees. MCSA maintains good working relationships with trade unions where we do have recognition agreements. The disciplinary and grievance procedures of the operational platforms 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 and retention 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. Medi-Clinic acknowledges that the ability to recruit and retain skilled staff is a critical factor in driving Group performance in the intensely competitive and dynamic business environment that we operate in.

Skills shortages remain a challenge throughout the MCSA group. For this reason an integrated Human Capital Management Strategy has been implemented to ensure that MCSA will have the ability to be responsive, competitive and sustainable amidst the talent challenges that the industry faces. A critical talent strategy forms an integral part of the abovementioned strategy. It focuses specifically on scientific sourcing, identification and enhanced utilisation of candidate pools, focused employer branding, candidate relationship marketing, and targeted recruitment and selection initiatives.

MCSA and MCME utilise a digital recruitment management system that has built up a significant talent database from which appointments are made. This technology is supported by the Medi-Clinic Career Centre, which provides a one-stop information and application service to candidates, employees and recruiters.

The Medi-Clinic Career Centre managed a total of 11 national campaigns during 2008, thereby reducing the cost of piecemeal market exposure, while their ongoing focus on the refreshment of candidate data ensures accurate information and candidate engagement.

The recruitment of candidates from abroad has been incorporated into the Human Capital Management Strategy as a strategic goal to address the shortage of specific, critical skills within the national talent pool. In addressing the nursing shortage in Southern Africa, MCSA's foreign nursing recruitment programme commenced three years ago with the successful integration of the pilot group of 16 candidates into three Western Cape hospitals. The group now conducts biannual foreign recruitment drives and this practice is expected to continue for the foreseeable future until we are able to train enough local nurses to staff our hospitals. An additional 350 candidates are in the pre-employment phase for incremental placement at hospitals across South Africa and Namibia stretching into 2010.

MCCH follows a strategic mission statement aimed at being the employer of choice in the industry and has adopted a policy to ensure that every aspect of being an attractive employer is addressed. The process is monitored by employee satisfaction surveys. MCCH has calculated the overall average length of employment of its employees at 6.1 years, which is remarkably high, given the mobility of nursing staff.

The recruitment of staff in the UAE is a major challenge as the majority of staff need to be recruited from other countries. In most cases the group takes the responsibility of securing housing for staff and providing transport services. The recent appointment of more than 300 new staff members for The City Hospital in a relatively short timeframe was a major accomplishment and proof of the attractiveness of MCME as an employer of choice.

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 health and safety audits are conducted by MCSA to monitor the function of the Health and Safety Committees and verify the competence of the responsible staff members. A legal register is maintained to ensure that all relevant legislation is adhered to and has been updated to include provincial acts and regulations, municipal by-laws and national standards applicable to the healthcare industry.

An integrated training programme for the group's safety, health and environment representatives has been launched at 12 hospitals. A legal liability training programme for hospital managers and competent persons at hospital level is planned for the next financial year.

MCCH is fully compliant with 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 46 of this report.

The health of the Group's employees is important and ensures the sustainability of our quality care to our patients. MCSA's Corporate Health Programme, which was implemented during 2002, is in the process of being re-evaluated with the aim of improving services to all employees. The new Corporate Health Programme will be rolled out in the group during 2009. The Corporate Health Programme 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. During the period under review 764 employees (compared to 716 during the previous financial year) made use of the EAP services provided. 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 our MCCH and MCME employees also receives the necessary attention, with intense focus at MCCH, which conducts an extensive awareness campaign among employees.

HIV/Aids

MCSA's HIV/Aids Programme consists of the following elements, as stated in the group's HIV/Aids policy:

- 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
- continuous support through the EAP as well as early intervention

Since the implementation of the programme approximately 5 938 (47.5%) of our employees have attended the ongoing awareness sessions as at year end, of whom 1 436 have voluntarily participated in the counselling and testing for HIV/Aids. We aim to reach all our employees through 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.

Ethics

Ethical behaviour remains a fundamental guiding principle in our business and therefore 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.

MCSA's Ethics Line is managed by an independent service provider, which ensures that each call will be treated with the utmost confidentiality; the service is available on a 24-hour basis to all staff and outside contractors. Regular feedback is received via the system and all complaints are investigated according to a set protocol. The Ethics Line has received only 100 calls since its implementation in 2001, 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 the group. Although MCCH has no Ethics Line, all employees are encouraged to report any wrong-doings anonymously without fear of repercussions. Incidents of fraud and corruption within the MCCH group are almost non-existent.

MCSA has also been a full member of the Ethics Institute of South Africa since 2005 in further support of its commitment to ethical behaviour as an organisation. In line with its ongoing commitment to establishing and maintaining ethical standards in South Africa, Medi-Clinic annually donates R100 000 towards the Bioethics Unit of the Centre for Applied Ethics at the University of Stellenbosch for ongoing research in this regard.

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

The Group makes no donations to political parties.

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 aimed at improving its human capital.

Our training activities continue to 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 is well positioned to meet the requirements of the new Nursing Act and to participate in any opportunities that may arise in training-related PPPs. We are confident that the private sector has a meaningful role to play at many levels in addressing the acute nursing shortage in the country. Our endeavours to achieve higher education status have paid off with the provisional registration of Medi-Clinic as a private higher education institution by the Department of Education. This achievement offers the potential to grow our nursing education to new levels and also to establish ourselves as an independent training provider.

MCSA continues to invest approximately 4% of its annual payroll in the development of its employees to meet the needs of individuals, teams and the business. During the year 497 (2008: 409) students successfully completed basic nursing courses, 194 (2008: 65) students completed post-basic courses and 576 (2008: 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 group well in rapidly meeting new challenges in competence development as they arise. Our General Management Development Programme has proved successful over the past four years and focuses on developing employees on an accelerated learning path with exposure to the business, industry and the responsibilities of a manager in a structured manner. Two of the three positions are reserved for candidates from the designated categories.

MCSA's in-house technical training programmes successfully address the shortage of skilled technical personnel. The first two electrical apprentices successfully completed a two-year structured apprenticeship programme meeting MERSETA standards. This success opens opportunities for further artisan training. Other programmes include technical manager development and training of clinical technicians. MCSA also continues 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 expenditure amounted to approximately 1% of its payroll. The group's career building is geared towards performance management, leadership building, quality control and client relationship building. Training initiatives are in support of these and many special courses are offered to staff, some of which are mandatory. Performance reviews are done annually with all employees and focus on employees' specific training needs and career objectives.

MCME's training department continues to use MCSA's nurse training programme to maintain and upgrade nursing skill levels. The group invested approximately 1% 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 throughout the Group.

MCSA 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 group's performance management system, which serves to align all employees with corporate goals and objectives as well as with the Group's risk management initiatives.

In Switzerland, public educational institutions and professional associations play a strong role in all aspects of professional development.

MCME's recently appointed Chief Clinical Officer will focus on the establishment of a Continued Professional Development programme for all clinicians employed by the group in close collaboration with the different authorities involved in accrediting these programmes.

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 top research universities in South Africa and MCSA is proud of its ongoing association with this premier academic institution located in the hometown of the Group. MCSA has renewed its cooperation agreement with this university to support research and training of medical specialists. For a number of years the group has made and continues to make annual financial contributions of more than R1 million to the Stellenbosch University Health Sciences Faculty for this purpose. Among the departments and disciplines benefiting from this partnership are:

- *Obstetrics and gynaecology:* Towards bursaries for the appointment of specialists to complete a fellowship in gynaecological oncology.
- *Haematology:* Towards a specialist physician for completing a fellowship in clinical haematology, contributing to training, research and service at Tygerberg Hospital and the broader community.
- *Unit for Infection Prevention and Control:* Towards research and the facilitation of a multidisciplinary unit for infectious diseases which focuses on training 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.

University of the Western Cape

MCSA continues its proud 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 providing access, equity and quality higher learning to the historically marginalised.

MCSA has partnered with the UWC School of Pharmacy in its efforts to train pharmacists over a three-year period, confirming our commitment towards an improved healthcare system. As in our first year, MCSA donated R143 000 in its second year of this association towards the following:

- a 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
- offering prizes for academic excellence to motivate student performance

University of the Witwatersrand, Johannesburg

MCSA continues to support the training of specialists at the Wits Donald Gordon Medical Centre, and contributed R3,6 million during the previous year to the academic activities of the centre. During 2008 MCSA also entered into a two-year agreement to contribute R250 000 annually towards funding a fellowship at the centre.

University of Pretoria

MCSA once again provided support to the Health Sciences Faculty of the university during the period under review by donating R200 000 towards a fellowship for research into gynaecological oncology.

University of Limpopo – Medunsa

Through the group's ongoing association with the University of Limpopo, MCSA has awarded 30 bursaries to the total amount of R210 000 to medical students at this university, as in previous years. These bursaries were awarded to MMed students who are completing specialist training.

University of the Free State

MCSA sponsors the subscription to the UpToDate clinical information resource service on behalf of the University of the Free State. This service offers associated academics and medical professionals access to evidence-based, peer-reviewed medical information that contains a vast selection of literature, latest evidence and specific recommendations for patient care. MCSA also contributed to a surgical laparoscopic laboratory for the simulation of laparoscopic procedures.

Colleges of Medicine of South Africa

The group donated R50 000 to the Colleges of Medicine of South Africa for their project to establish accurate information on the current number of medical professionals and to obtain an indication of the future need in South Africa.

Paul Roos Academy

MCSA proudly continues its commitment to the Paul Roos Academy in Stellenbosch with the sponsorship of R175 000 during the period under review. This renewed sponsorship provides advanced learning opportunities to talented indigent children from Khayelitsha, Nyanga and Langa and nearby farm schools in the Stellenbosch area.

OUR COMMUNITY INVOLVEMENT

During 2008 Medi-Clinic celebrated its 25-year history of caring for the communities in which it operates. Since the inception of the Group in 1983, social support has been a natural extension of our day-to-day services and today our commitment to quality care can be felt in many communities throughout South Africa, Switzerland and the UAE.

Corporate social investment ("CSI")

MCSA has recently finalised a CSI strategy in line with the group's business objectives. This strategy aims to facilitate the best use of our resources to address the healthcare needs of many more South Africans and was formally implemented in 2008. The support for it is gaining great momentum among employees, our associate doctors, communities as well as our suppliers who, together, form the foundation on which the strength and success of this strategy is built.

In line with the CSI strategy, all donations and sponsorship activities are coordinated and recorded, with all contributions being classified appropriately in terms of the percentage of black beneficiaries.

The group's CSI strategy has been developed around four core areas of involvement, namely health, education, sport and welfare, and is implemented across the following three levels:

- Establishment of MCSA as a social leader in a specific area of need, in line with our core offering. To this end, the group has identified seven public sector hospitals across three provinces, and will be assisting these hospitals with medical procedures in order to alleviate the backlog that these hospitals are currently experiencing, enabling them to reach out to more patients who have dire healthcare needs.
- Partnerships with approved non-profit organisations. Through these partnerships MCSA is able to provide stronger momentum to the existing efforts of these organisations, enabling them to extend their programmes into more areas of need. One of these initiatives is our partnership since 2008 with the national "Making a Difference" campaign driven by the M-Net Carte Blanche programme. Through this partnership MCSA has contributed R1 million to the campaign's trust fund.
- Staff engagement through volunteerism, support and involvement in social upliftment efforts and community-based projects.

MCSA believes that we could have a meaningful impact on the greater Southern African community, with much to contribute to the previously disadvantaged communities and destitute families in Southern Africa through our skills, technical expertise, financial resources and our employees' time.

Ensuring healthy communities

Medi-Clinic continues to contribute to the health and wellness of our communities. Through 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, sponsorships and medical care for the indigent

MCSA frequently donates linen, uniforms, equipment and furniture to organisations in need such as hospices, orphanages and children's homes, frail care centres and welfare organisations. Medical care for the indigent forms part of the group's CSI strategy as referred to above. In line with this strategy, Wits Donald Gordon Medical Centre performed a large number of vascular and endoscopic procedures free of charge and the centre will continue to perform pro bono procedures on state patients as part of its academic programme.

MCSA hospitals provide 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. In addition, MCSA has a long-standing relationship with the World Wildlife Foundation and is committed to an annual sponsorship of R30 000. The three hospitals in Namibia have sponsored the Cancer Association of Namibia for over seven years, and raised in excess of N$32 000 in the recent Breast Cancer Awareness Walk.

MCCH is the official supplier of medical advice of the international Solar Impulse project and its team members receive regular medical care from accredited doctors of MCCH before and during several test flights and, finally,

during the flight around the world. Solar Impulse aims to have an airplane take off and fly automatically, day and night, propelled by solar energy, round the world without using fuel or producing pollution.

MCCH is the official medical supporter of the Swiss national league football team. MCCH also provides arts and culture sponsorships to the Lucerne Symphony Orchestra (Luzerner Sinfonieorchester).

MCME made a donation of AED500 000 during the period under review 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.

Medical support

MCSA's 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. Many hospitals also offer disease-related support groups to patients and their families.

MCME also regularly participates in health awareness campaigns such as diabetic and breast cancer awareness campaigns and heart week.

Volunteerism

Our staff regularly volunteer time to support community organisations and events. Many of our nursing personnel participate in hospital and community-based antenatal classes, breast-feeding clinics and well baby clinics.

Training

MCSA's personnel regularly participate in CPR (Cardio Pulmonary Resuscitation) and first aid training at community service organisations, schools and other community hospitals. As an example, our staff at Paarl Medi-Clinic offered first aid training to 35 workers at the Thokozani Farm Workers Group and provided ten trauma bags to the various working stations on the farm. A training demonstration on CPR was also presented at secondary schools in Swakopmund.

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

Corporate events

MCSA's Corporate Events division is focused on event, disaster and medical support management. 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 the high-profile sporting and cultural events being supported include the Absa Cape Epic Mountain Bike Challenge, the Argus Pick n Pay Cycle Tour, the Augrabies and Addo Elephant Extreme Marathons, the Cape Odyssey, the Cape Times Big Walk, the National Craven Rugby Week for junior and senior schools, the Vista Nova Big Swim between Robben Island and Milnerton, as well as the Klein Karoo National and the Aardklop Arts festivals.

MCCH also provides medical support at various sporting and other community events, including the 2008 UEFA European Championship and the Ruderwelt Rowing World Cup in Lucerne.

Education and training

Please refer to the report on training and skills development on pages 54 to 57.

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 adopting 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 continuous improvement in our Environmental Management System
- CREATE an environmental awareness among all employees
- PREVENT pollution and minimise the impact of our activities on the environment
- IDENTIFY all aspects of our business that could have a significant impact on the environment and set objectives and targets with a review process to eliminate or reduce the impact of these on the environment

- ENCOURAGE reduction, re-use and re-cycling of general waste
- MANAGE hazardous waste, including medical waste, according to legal and other requirements, and where possible apply international best practices
- INFLUENCE 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's Environmental Management system is based on the ISO 14001:2004 Specification for Environmental Systems. The group has been certified by National Quality Assurance London and meets the requirements of the standard and has set specific action plans to achieve its goals, as set out in the table below.

Criteria	Specific assessment criteria	Performance	Revision and planning
Compliance with environmental and other legislation	28 pieces of applicable national legislation, excluding tax, business, medical and finance legislation	• Legal register version 7 established. Province-specific registers established for Free State, Gauteng, Mpumalanga, Northern Cape and Western Cape.	• Confirmation of legal compliance at 27 hospitals. Audits completed at 18 hospitals.
Environmental Management Systems	ISO 14001:2004 JSE SRI Index JSE Carbon Disclosure Project (CDP6) (an international initiative by the JSE to establish carbon footprint)	• 18 hospitals ISO certified. • ISO certification of additional 7 hospitals during 2009 in progress. • Inclusion in JSE SRI Index maintained.	• 18 hospitals ISO certified. • 27 hospitals ISO trained. • 10 additional hospitals to be trained in 2009. • 37 hospitals planned for ISO certification by the end of 2011. • Maintain inclusion in JSE SRI Index. • Participation in CDP7. • Verification of the carbon footprint during 2009/10.
Environmental awareness	ISO 14001:2004	• Network started between 27 hospitals. • Established programme for continuous environmental awareness. • Established ISO 14001 awareness calendar in line with international programmes. • Annual environmental awareness competitions at hospitals.	• Environmental awareness entrenched in all business activities.
Prevention and minimise of impacts	ISO 14001:2004	• 27 ISO-trained hospitals with programmes.	• Implementation of 10 additional ISO-certified hospitals during 2009. • Conferences, workshops and technical bulletins to be used in 2009/10 to establish baselines and phasing in of ISO principles at non-certified hospitals.
Aspect identification	Aspect register	• 27 ISO-trained hospitals with aspect registers.	• A generic aspect register with baselines, including medical waste, water, electricity, paper, hazardous and normal waste to be established in 2009/2010 at all non-certified hospitals.
Recycling of general waste	ISO 14001:2004	• 27 ISO trained hospitals with processes.	• Introduction of principles of recycling at all hospitals.
Management of hazardous waste	ISO 14001:2004 Local by-laws	• 27 ISO-trained hospitals with confirmed processes. • Various other processes in place.	• ISO 14001:2004 processes to be implemented at all hospitals with the aim of future certification. • Establishment of hazardous waste register at all hospitals.
Influencing suppliers and service providers	ISO 14001:2004	• 27 ISO-trained hospitals with programmes.	• Introduction of green approach to suppliers and providers. • Inclusion of environmental requirements in service agreements in 2009/10. • Establishment of an internal audit programme for service providers on site at 27 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. • Monitoring as required by ISO 14001:2004 in graph format on Medi-Clinic Information Portal.

Strict and comprehensive environmental legislation applies in Switzerland, to which MCCH complies, ensuring that the group maintains the highest degree of environmental care. Energy efficiency is a primary focus for MCCH and leading-edge solutions have been adopted where these are economically justifiable.

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

Through the implementation of systems and awareness projects the Group aims to broaden our commitment to quality care, including taking care of the environment.

Carbon disclosure project

MCSA participated for the first time in the second South African Carbon Disclosure Project 6 during 2008, which analysed how the Top 100 JSE-listed companies are addressing climate change-related issues. This project is aligned to a global initiative to collect information on how companies around the world are responding to climate change. MCSA was rated the top performer in the healthcare sector and third overall in the low-emissions sector in the Carbon Disclosure Leadership Index, recognising our initiatives to reduce our carbon footprint and environmental impact.

The carbon footprint of a company is determined by the measurement of three components, namely indirect emissions from the consumption of electricity, direct emissions (in the healthcare industry this will refer mainly to the emissions of anaesthetics gases), and indirect emissions from suppliers (in the healthcare industry this will refer mainly to pharmaceutical, bulk oxygen and waste removal suppliers). MCSA's carbon footprint is set out in the table below.

Total Greenhouse Gas Footprint of MCSA		
Emission source	Tons CO_2 equivalent	% of total
Indirect from electricity	145 428	87%
Direct from anaesthetics, ER24, pool cars, incinerators, generators and kitchen	13 008	8%
Indirect from company supply chain, business travel and waste removal	8 572	5%
Total	**167 008**	**100%**

The Carbon Disclosure Project assisted MCSA to implement the measurements and processes to monitor our carbon emissions. From the table on the following page it can be seen that electricity consumption is the main contributor to our carbon footprint. The group is committed to implementing measures to manage and, where possible, to reduce our direct and indirect carbon emissions, including specific initiatives on energy conservation as described on the following pages.

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. Eighteen (2008: 12) MCSA hospitals have obtained ISO 14001:2004 certification. A further seven hospitals will obtain certification during 2009. 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 on page 61.

MCCH's technical teams have placed a specific focus on environmental management, especially since 2000, when various projects were implemented to ensure compliance with Swiss environmental laws. The technical teams at the hospitals, under the guidance of the group's Head of Technical Services, continue to focus on improving existing measures. The group has established performance indicators, such as energy consumption per bed and energy consumption per patient.

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. Our initiatives include:

- recycling of autoclave and laundry water for irrigation of our gardens and/or recycled to the autoclaves;
- staff awareness training in compliance with ISO 14001:2004;
- testing of new technologies;
- monitoring of uncontrolled leakages;
- use of grey water;
- change of garden irrigation cycles; and
- control of laundry procedures.

The commitment of our staff to save water is a contributing factor to the successful results achieved with the reduction in water wastage. Through the above initiatives 12 of the group's hospitals that were measured achieved a saving of 378 236 litres per day, amounting to an annual saving of 138 million litres.

As part of its water waste management initiatives, MCCH has regularly been monitoring the consumption of water since 2000, which is reported annually to local authorities.

Energy conservation

MCSA's hospitals continued with energy management initiatives aimed to reduce energy consumption, which included:

- the redistribution of the electrical load;
- changing to energy-saving lamps;
- installation of energy-efficient equipment;
- optimising the effectiveness of existing equipment; and
- staff awareness training in compliance with ISO 14001:2004.

The implementation of the ISO 14001 standards and principles had a positive effect on our energy consumption, as illustrated by the saving of 19 236 kWh per day and an annual saving of 7 021 MWh measured at 13 of the group's hospitals.

A pilot project is in process 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 of 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, but because of financial constraints at Eskom, it will be financed by MCSA in the next financial year.

As mentioned on page 45 of the report, additional generators were installed to ensure continuous supply to our hospitals and the medical villages located at these hospitals. The electricity consumption during power failures is also logged on the Medi-Clinic Information Portal for monitoring purposes under the ISO 14001 Environmental Management system.

Waste management and recycling

Stringent protocols are followed to ensure that refuse removal within the Group complies with all legislation, regulations and by-laws.

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%. Various hospitals have also achieved a reduction of normal waste of up to 47% by implementing recycling and waste separation programmes, which include:

- optimal use of paper and printers (e.g. double-sided printing, use of PIN numbers); and
- staff awareness training in compliance with ISO 14001:2004.

Through the above initiatives 11 of the group's hospitals measured achieved a saving of 22 538 paper sheets per day, amounting to an annual saving of 8 million paper sheets.

MCSA has also participated in the drafting of the Health Technology Regulations relating to the management of healthcare risk waste, which is currently in its final draft stages.

MCCH complies with the ordinance relating to the treatment and movement of medical waste and has also established an initiative with external contractors with regard to waste management and recycling, which has resulted in a clear reduction of recycling costs. The group's Head of Technical Services is a qualified representative of dangerous goods, thereby authorising the group to handle dangerous goods within all hospitals according to regulations.

STAKEHOLDER ENGAGEMENT

The Group's stakeholders include 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 fundamental to maintaining a positive corporate reputation of our brand.

Corporate reputation assessment

Our stakeholder communication programmes follow a carefully planned and structured approach and are based on the outcomes of an independent corporate reputation assessment which was implemented in 2008 in order to assess the perception of the Medi-Clinic brand amongst key industry stakeholders in South Africa and to measure their loyalty to our brand.

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 Group make an important contribution to its success. The Group continuously evaluates existing communication channels in order to gauge their effectiveness, and adapts and introduces additional communication vehicles in order to ensure seamless dissemination of organisational messaging.

Our staff members are treated fairly, remunerated competitively and are 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. MCSA's trade union membership continues to decline, with no trade union membership by our MCCH or MCME employees. MCSA maintains good working relationships 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. MCSA's Equity and Training committees at hospital level act as a conduit for input from ground level on issues that involve staff members.

Throughout the Group, communication with our employees is conducted through a variety of channels, including staff magazines providing Group news, staff newsletters updating staff on human resources-related information, e-mail updates, video conferences and staff satisfaction surveys. In order to improve internal communication, MCME recently launched an intranet aimed at improving availability of information to employees.

MCSA annually conducts internal brand road shows, which serve to inform staff members of corporate and brand milestones in a relaxed and engaging environment. During 2008 MCSA also embarked on a group-wide communication assessment evaluating the flow of communication within the organisation. The outcome of this assessment confirmed the effectiveness of current communication vehicles, identifying communication gaps and providing guidance on methods of improving on existing structures. An ongoing Employee Relations Assessment ("ERA") programme continues to measure employee perceptions of their roles within the company and loyalty levels among the various employee groups. The outcomes of the previous ERAs clearly indicate that employee loyalty is increasing and that employee attitudes were generally favourable towards Medi-Clinic.

MCCH conducts triennial staff satisfaction surveys on an anonymous basis by an independent external consultant, the results of which are used to improve the relationship with staff.

Patients

MCSA continuously measures patient satisfaction through an ongoing survey conducted by an independent research organisation. This survey continues 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 our hospitals.

MCSA's quarterly hospital magazine, Gesundheit, is aimed at patients and contains informative articles promoting healthy lifestyle and general health-related information. The group's two Client Alliance Programmes, Medi-Twinkle and Medi-Clinic Senior, are aimed at increasing the value-added offering to patients. The Medi-Twinkle maternity programme provides mothers with tailor-made ante- and postnatal services, as well as various other value-add products. Medi-Clinic Senior is aimed at people 60 years and older and involves information sessions, health screening clinics and other hospitalisation value-adds.

MCCH conducts regular patient satisfaction surveys in cooperation 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 current and former patients through Mittelpunkt, the group's hospital magazine, the group's website and a call centre offering information on the group's doctors and hospitals and advice on medical and healthcare matters. The guest-relations staff assist patients with all their non-medical requirements, ensuring 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 have been conducted among referring doctors and specialists across the entire MCSA network. These assessments allow us to investigate the success of, and enhance our direct communication efforts with, this key target audience to enable us to strengthen our relationship with the supporting doctors and specialists. The ongoing support of existing supporting doctors as well as the recruitment of new doctors into our network of associated medical practitioners remains a critical focus area of the group.

In August 2008, Medi-Clinic introduced an innovative communications tool to reach referring doctors and specialists in a real-time and simultaneous manner, outside normal practice hours. A satellite broadcast was arranged via a dedicated DSTV channel during which relevant information regarding Medi-Clinic as a thought leader and partner in clinical excellence was shared. Emphasis was placed on Medi-Clinic's existing strategic platforms and international presence, confirming its commitment to the future of private healthcare in South Africa. Doctors were given the opportunity to send questions to the Medi-Clinic panel either prior to the broadcast, or to submit questions real-time via SMS or e-mail. The outcome of this initiative proved to be very successful and has been incorporated into the annual doctors communication calendar.

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

MCCH conducts triennial doctor satisfaction surveys and also hosts an annual doctors' congress, where developments in the healthcare market are addressed. A uniform questionnaire-based satisfaction survey will be conducted amongst the group's referring doctors in 2009 at three pilot hospitals, with the aim of rolling it out to the whole group in 2010 in order to obtain results on a group level; these surveys were previously conducted per hospital. Group information and medically related information are communicated to the doctors through a biannual medical periodical, Aktuelle Medizin. The MCCH annual report is also distributed to affiliated doctors. MCCH also offers 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 is 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 and therefore uses strict selection criteria, which include proven national service and support, the compliance of products with applicable local or international standards, and a responsible, affordable pricing structure. Supplier credentials are always scrutinised in order to ensure a sustainable source of product. This is especially important when it comes to our initiatives involving any form of standardisation to improve cost effectiveness.

In the past MCSA hosted an annual Supplier of the Year awards ceremony, acknowledging a supplier that 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. During 2008, as part of the group's 25th anniversary celebration, MCSA hosted an awards ceremony recognising 32 suppliers whom we believe to have contributed to our success over the last 25 years.

In order to maintain efficiency, more electronic processes in dealing with suppliers have been and are being introduced, including ordering, invoicing, receipt and statement reconciliation.

MCSA's Ethics Line, as referred to earlier in this report, is also available on a 24-hour basis to our suppliers.

MCCH has regular meetings with key suppliers and regularly cooperates 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 57 to 58.

Healthcare funders

MCSA's Funder Relations and Contracting Department actively pursues every opportunity to contract directly with every medical scheme in South Africa and the adjoining SADC countries. The local South African medical scheme market remains the group's largest client base. Within this market there are approximately 120 individual medical schemes, the greater majority of which are administered by a select group of medical scheme administrators, to whom the contracting and tariff negotiations are delegated. The combined buying power is, therefore, effectively consolidated into eight administrators, representing 70.2% of the total medical scheme market and more than 80% of medical scheme beneficiaries.

Over the past few years the collaborative initiatives of a number of schemes have seen the introduction of various alternative reimbursements models and other customised agreements.

Throughout the year MCSA made a concerted effort to communicate the actual underlying hospitalisation expenditure drivers and to elucidate, precisely, the costs to the schemes and assist them in identifying the areas of focus in managing those drivers. Contrary to general understanding, price should not be considered the only factor in increasing hospitalisation costs. Increasing utilisation should be recognised as a significant contributor.

A number of business processes have been reviewed and enhanced during the past year, with the objectives to maintain or improve administrative efficiency whilst maintaining cost effectiveness. As such, a number of processes have been automated and have contributed to better work flows. 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.

During the period under review MCSA continued its collaborative and contributory engagement with the funders of healthcare and other role players through our:

- participation in the continued "public/private" debate;
- contributions made in terms of a National Health Insurance proposal at industry forums, set to take precedence in the coming year; and
- investment of time and resources in contributing to the development of standardised utilisation reporting standards in order that complete, accurate and comparative cost and utilisation data can be published and employed in analysis and benchmarking.

MCCH's and MCME's managements hold regular meetings and conduct annual negotiations on tariffs with medical insurance companies.

Government and authorities

Departments of health – South Africa, Switzerland and UAE

MCSA is involved in ongoing communication and interaction with the National and Provincial Departments of Health ("DoH"). Issues pertaining to, inter alia, licence applications, inspection of facilities, approval of building plans and comment on draft legislation and regulations are dealt with on a continuous basis. During the past year dedicated stakeholder engagement plans have been implemented by both MCSA and the Hospital Association of South Africa, as detailed below. Through our engagement initiatives, MCSA aims to create greater understanding of, and insight into, key issues facing the private hospital industry.

Government aims to implement a National Health Insurance ("NHI") system to ensure that healthcare is provided to all citizens in an equitable manner. MCSA has accordingly formed a health policy unit which will focus on the research, development of position and debate with the DoH and other health bodies such as non-governmental organisations and universities' Health Economics departments. MCSA has actively taken part in various engagement forums, including the Development Bank of South Africa and the Private Health Sector Task Team, regarding the future of an NHI.

MCCH is actively taking part in the formulation of healthcare legislation and regulation in Switzerland through annual meetings between senior management and key public officers.

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

South African Nursing Council

MCSA engages with the South African Nursing Council on all issues relevant to the profession. At times this is done under the umbrella of HASA, and at other times directly. The group looks forward to the further transformation of the nursing profession with the leadership provided by the new Nursing Council appointed in 2008.

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, most recently with regard to the revision of the Good Pharmacy Practice guidelines in order to ensure a safe and professional pharmacy environment. Our General Manager: Pharmacy Services was elected to the council for a five-year term. We 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 councils

MCSA, through the South African Federation of Hospital Engineers, participates in the work groups with the Engineering Council of South Africa to develop the Health Technology Regulations relating to management of healthcare risk waste, which is currently in final draft stage.

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 MCSA'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.

Privatkliniken Schweiz ("PKS") and H+ Die Spitäler de Schweiz ("H+")

MCCH is an active member of PKS, the Swiss private hospital industry association, as well as H+, the overall industry for hospitals in Switzerland, ensuring that the group's concerns and suggestions are heard and to participate in the development of legislation and regulation in the healthcare industry in Switzerland.

Engineering associations

MCSA's Infrastructure Executive is the President of SAFHE (South African Federation of Hospital Engineering) and recently completed a term as President of IFHE (International Federation of Hospital Engineering). Several of the group's regional engineers and technical managers are members of their local SAFHE branch committees. SAFHE is also listed as a voluntary association with ECSA (Engineering Council of South Africa) and plays an active part in forums where healthcare risk waste management is discussed. MCSA's Group Procurement Manager is the current secretary of CEASA (Clinical Engineering Association of South Africa) and chairman of the Western Cape Branch of CEASA.

CORPORATE GOVERNANCE REPORT

Medi-Clinic is committed to maintaining strict principles of good corporate governance and the highest standards of integrity and ethics, as embodied in the King Report on Corporate Governance for South Africa 2002 ("the King Report"). The board of directors ("the Board") accepts full responsibility for corporate governance and is committed to ensuring a high standard of discipline, independence, ethics, equity, social responsibility, accountability, cooperation and transparency. The Board believes that the Group has materially complied with the principles of the King Report and has met the Listings Requirements of the JSE Limited ("the JSE").

Similar corporate governance practices have been implemented by the boards of the Group's three operating platform companies in Southern Africa, Switzerland and the United Arab Emirates, and receive ongoing attention by the Company. During the period under review an extensive Corporate Governance Manual has been implemented to assist and provide guidance to the directors and the company secretaries of the Group in ensuring their continued focus and compliance with the Group's strict principles of good corporate governance. The manual is maintained by the company secretary and distributed to the company secretaries of the three operating platform companies and also forms part of the induction process of new directors.

As in previous years, there has been no major non-compliance by, nor fines or prosecutions against, the Group during the period under review in respect of corporate governance-related matters.

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:

- creation of sustainable shareholder value;
- directing, assessing and authorising the Group's strategies;
- ensuring that the Group's strategic and operational objectives are achieved;
- the enforcement of adequate risk management practices;
- handling of all aspects that are of a material or strategic nature or that may impact on the Group's reputation;
- monitoring compliance with 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 their tasks along delegated authorities;
- ensuring that the Board's composition encompasses 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, and if required, measures exist to accommodate any resolutions that may have to be approved between meetings. Members of the Board and sub-committees receive an agenda containing comprehensive and accurate information well ahead of time. This enables them to meet their commitments and to determine whether or not prescribed functions have been executed according to set standards, within the margins of cautious and predetermined risk levels and according to international best practices.

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

Composition

The composition of the Board reflects the required balance between executive and non-executive directors to ensure that there is a clear division of responsibilities so that no one individual has unfettered decision-making powers. 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, it is considered to be 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.

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. There is a clear policy detailing procedures for appointments to the Board, which are formal and transparent. The appointment of directors is a function of the entire Board, based on recommendations made by the 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 executive 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 Ms Zodwa Manase, Dr Kabs Makaba and Dr Ole Wiesinger were appointed to the Board and underwent the induction programme.

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

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 for ensuring the proper administration of the proceedings and matters relating to the Board, the Company and the shareholders of the Company in accordance with applicable legislation and procedures.

The 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. Executive management's responsibilities are codified in a mandate from the Board, specifically with regard to their authority levels, which is reviewed regularly by the Board.

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 71) 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 also ensures that adequate succession planning measures are in place. The committee's responsibilities are codified in a mandate from the Board, which is reviewed regularly by the Board.

The committee is chaired by Prof Wynand van der Merwe, an independent non-executive director. The Group's Chief Executive Officer and MCSA's Human Resources Executive also attend meetings.

Independent consultancy studies are used by the committee to ensure that 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;
- there is no discrimination;
- good performance is acknowledged and encouraged;
- there is no conflict between individual wealth and long-term sustainability; and
- remuneration is cost effective and affordable.

Audit and Risk Committee

The responsibilities of the Audit and Risk Committee (the composition of which appears on page 71) are codified in a mandate from the Board, which is reviewed regularly by the Board. The main objectives of the committee are to assist the Board with its responsibilities regarding financial reporting and risk management. The committee fulfils the prescribed statutory requirements, including those applicable to the external auditor.

The specific responsibilities of the committee, which include all the statutory duties required in terms of the Companies Act, as amended by the Corporate Laws Amendment Act, No. 24 of 2006 ("the Act"), include, inter alia, the following:

- **Internal control and risk management**

  The committee is responsible for the ongoing identification and evaluation of the Group's exposure to risks and the evaluation of 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 in order to make appropriate recommendations to the Board. The committee meets with the internal and external auditors and the executive management at least three times per year to discuss matters pertaining to risk management, internal control and financial reporting. These include the internal and external audit process; interim and annual financial statements; accounting policies; the process for monitoring compliance with laws and regulations and procedures to safeguard the Group's assets.

- **External audit and auditor**

  The committee is responsible for nominating the external auditor who in its opinion is independent of the Group, approving its fee and determining its terms of engagement. A formal policy in respect of the independence and the provision of non-audit services by the external auditors of the Group and its subsidiaries ensures the maintained independence of the external auditors. The committee is responsible for determining the nature and extent of any non-audit services that the external auditor may provide to the Company and pre-approve any proposed contract with the external auditor for the provision of non-audit services to the Company. During the period under review non-audit services by the Company's external auditor included tax advice, the remuneration of which is disclosed in the annual financial statements. The MCCH Audit and Risk Committee also approved the tax services of Ernst & Young (Switzerland) in respect of the MCCH group's structure following the merger of Medi-Clinic and the Hirslanden group in 2007. The services of the internal and external auditors are adequately integrated.

- **Financial reporting**

  The committee is responsible for considering and making recommendations to the Board relating to the Group's annual report, the financial statements and any other reports (with reference to the financial affairs of the Group) for external distribution or publication, including those required by any regulatory or statutory authority.

The Audit and Risk Committees of the Group's three operating platform companies report to the Group's Audit and Risk Committee at each meeting.

The composition of the committee complies with the requirements of the Act and consists only of independent non-executive directors. The chairman of the Board also attends the meetings. The internal and external auditors have unlimited access to the chairman of the Audit and Risk Committee.

As required in terms of the Act, the committee is satisfied that it has complied with its requirements and performed its functions, and that the Company's external auditor is independent of the Company, as evident from the description above of how the committee performed its function.

The JSE Listings Requirements were amended with effect from 1 September 2008, requiring all listed companies to have a Financial Director, to which requirement the Company has always complied. A brief CV of the current Financial Director, Mr Gerhard Swiegers, appears on page 8 of the annual report. The committee has considered and has satisfied itself of the appropriateness of the expertise and experience of Mr Swiegers.

Attendance of Board and Sub-committee Meetings

Board meetings:

(6 meetings held)

Directors	Number of meetings attended / total meetings	Directors	Number of meetings attended / total meetings
E de la H Hertzog (Chairman) (Executive**)	6/6	V E Msibi* (Non-executive) (passed away 12 July 2008)	1/1
L J Alberts (Executive)	6/6	K H S Pretorius (Executive)	6/6
R H Bider* (Executive) (resigned 5 November 2008)	3/4	A A Raath (Independent non-executive)	5/6
J C Cohen (Non-executive)	6/6	M A Ramphele (Non-executive)	3/6
S Dakile-Hlongwane* (Independent non-executive) (resigned 30 July 2008)	1/2	J G Swiegers (Executive)	6/6
M K Makaba* (Non-executive) (appointed 16 September 2008)	3/3	D K Smith (Independent non-executive)	6/6
Z P Manase* (Independent non-executive) (appointed 16 September 2008)	4/4	W L van der Merwe (Independent non-executive)	5/6
J du T Marais* (Executive) (retired 30 July 2008)	2/2	M H Visser (Non-executive)	6/6
A R Martin (Independent non-executive)	5/6	O T Wiesinger* (Executive) (appointed 5 November 2008)	3/3
D P Meintjes (Executive)	5/6		

* Not a Board member for the full year.

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

Audit and Risk Committee meetings:

(5 meetings held)

Committee Members	Number of meetings attended / total meetings
D K Smith* (Chairman) (Independent non-executive) (appointed 14 May 2008)	4/4
M H Visser* (Non-executive) (resigned as member 30 July 2008)	2/2
Z P Manase* (Independent non-executive) (appointed 16 September 2008)	2/2
A R Martin (Independent non-executive)	5/5
A A Raath (Independent non-executive)	5/5
M A Ramphele* (Non-executive) (resigned as member 30 July 2008)	1/2

* Not a member of the relevant committee for the full year.

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

Human Resources Committee meetings:

(4 meetings held)

Committee Members	Number of meetings attended / total meetings
W L van der Merwe (Chairman) (Independent non-executive)	4/4
E de la H Hertzog (Executive**)	4/4
V E Msibi* (Non-executive) (passed away 12 July 2008)	1/1
M A Ramphele* (Non-executive) (appointed 5 November 2008)	0/1
M H Visser (Non-executive)	4/4

* Not a member of the relevant committee for the full year.

** Please refer to the explanation in respect of the classification of Dr Hertzog as executive chairman on page 67 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 commence two months prior to the expected publication date of the year end or interim financial results of the Company up to the publication date, alternatively from the last day of the financial year or the first six-month period of the financial year up to the publication date of the annual or interim financial results of the Company, whichever is the longest.

Conflict of Interests

All Board members and company secretaries of the Company and major subsidiaries 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.

All employees are also obliged to disclose any potential conflict of interests, which requirement has also been included in the MCSA group's conditions of employment.

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, in terms of a mandate by 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 MCSA, MCCH and MCME, the Group's internal and external auditors and the Group's risk management function.

Risk Management

The Group's Enterprise-wide Risk Management ("ERM") 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. During the year the updated policy was formally adopted by the respective Audit and Risk Committees within the Group.

The objective of risk management in Medi-Clinic is to establish an integrated and effective risk management framework where important risks are identified, assessed and managed in order to achieve an optimal risk/reward profile. An integrated approach ensures that risk management is integrated into the day-to-day operational management processes and therefore allows management to focus on core activities.

The Medi-Clinic risk management process, as documented in the ERM policy, consists of the following stages:

Event Identification

Potential events that might have an impact on the Group are identified in line with the ERM philosophy through workshops, risk assessment sessions or other appropriate assessment techniques. Event identification involves identifying potential risk events from internal or external sources affecting the achievement of objectives. A central risk register is maintained for the identified events.

Risk Assessment

Identified risk events are analysed in order to form a basis for determining how they should be managed. Risks, which are associated with objectives, are assessed on both an inherent and a residual basis, with the assessment considering risk likelihood, impact and control effectiveness. To assess the risks, a standardised rating methodology is being implemented within the Group.

Risk Response

The risk items are ranked in order of priority and management selects a set of actions to align risks with the entity's risk tolerances and appetite.

The actions include the drafting of a plan which indicates the strategy as to whether risk items should be:

– accepted;
– controlled;
– shared or transferred; or
– diversified or avoided.

Control Activities

Documenting the preventative and detective controls for identified risk events, with responsibilities and control intervals to indicate how the risks are managed.

Information and Communication

Relevant risk and control information is identified, captured and communicated in a form and timeframe that enable employees to carry out their responsibilities.

Monitoring

The effectiveness of the risk management process is monitored through an automated and integrated control self-assessment process which monitors compliance with key procedures in each hospital. This system caters for exception reporting of non-compliance and renders full transparency of risk management activities per region, hospital and discipline in each hospital.

A project has commenced to integrate the existing ERM processes of MCCH and MCME with the Group's ERM process. The first phase of the integration project, which required the development and adoption of a single ERM policy and methodology across the Group, was completed successfully. The second phase of the project is in progress and will focus on standardising of terminology and assessment measures and techniques.

Internal Control

The Group has a comprehensive system of preventative and detective internal controls in place, which is designed to ensure that risks are mitigated and that the Group's objectives are attained. The system identifies relevant information in order to monitor the effectiveness of controls and to rectify any control deficiencies.

In MCSA the effectiveness of the system of internal control is independently evaluated by the external auditor, PricewaterhouseCoopers Inc., for the purpose of expressing an audit opinion on the annual financial statements of the group, as well as through an extensive outsourced internal audit programme. In addition to the internal audits, the effectiveness of operational procedures and the controls of the self-assessment process of risk management is examined internally by the Medi-Clinic Quality Assurance Team (MQAT). The results of these assurance processes are monitored by a central Risk Management Committee comprised 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.

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

Medi-Clinic Southern Africa	Medi-Clinic Switzerland	Medi-Clinic Middle East
Physical and operational risks		
• medical malpractice • operational efficiency and effectiveness • quality care • reputation risks • health and safety risks	• medical malpractice • operational efficiency and effectiveness • quality care • reputation risks • health and safety risks	• medical malpractice • operational efficiency and effectiveness • quality care • reputation risks • health and safety risks
Human resources risks		
• availability and retention of skilled resource • communication • training	• availability and retention of skilled resource • communication • training	• availability and retention of skilled resource • communication • training
Technical risks		
• information technology systems availability and security • medical technology risks	• information technology systems availability and security • medical technology risks • radiation	• information technology systems availability and security • radiation
Business continuity and disaster recovery		
• fires, floods and allied perils • pandemics • power interruptions • disaster recovery	• fires, floods and allied perils • pandemics • power interruptions	• fires, floods and allied perils • pandemics • power interruptions • regional, political instability
Credit and market risks		
• availability and support of medical practitioner • credit risk • healthcare funders risk regulatory risks • economic and business environment	• availability and support of medical practitioner • credit risk • healthcare funders risk regulatory risks • economic and business environment	• credit risk • healthcare funders risk regulatory changes • economic and business environment • interest rate risk
Compliance risks		
• legal, regulatory and policy compliance • confidentiality	• legal, regulatory and policy compliance • confidentiality	• legal, regulatory and policy compliance

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 the effectiveness of the system of internal control is independently evaluated by their external auditor, Ernst & Young, to finalise their audit in terms of International Standards on Auditing of the annual financial statements of the group. A project was also completed successfully during the year which enabled the group to comply with new Swiss legislation which requires the external auditor to sign off on the system of internal control. The results of these and other operational assurance processes are monitored by the MCCH Executive Committee.

In MCME the effectiveness of the system of internal control is independently evaluated by their external auditor, KPMG to finalise their audit in terms of International Standards on Auditing of the annual financial statements of the group. All MCME operational processes and physical facilities were subject to rigorous evaluation by the Centre for Planning and Quality under the auspices of Harvard Medical International. All applicable criteria were met before the licences were issued. The group is in the process of preparing for the Joint Commission of International Accreditation for both hospitals and the larger clinics.

The company secretary is responsible for guidance in respect of 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 nominating the Company's external auditor. The external auditor, whose report appears on page 77, is responsible for providing an independent opinion on the financial statements. The external audit function offers reasonable, but not absolute, assurance on the fair presentation of the financial disclosures.

The JSE Listings Requirements were amended with effect from 1 September 2008, requiring the external auditors of all listed companies and their major subsidiaries to be registered with the JSE. The Company and MCSA's external auditor, PricewaterhouseCoopers Inc., is registered with the JSE. An extension of time to register has been granted by the JSE to MCCH's external auditor, Ernst & Young (Switzerland). MCCH and its auditor are in continuous contact with the JSE in this regard to ensure compliance with the JSE Listings Requirements.

Non-audit services provided by the external auditors have been dealt with earlier in this report on page 69. The remuneration payable in respect of these services is disclosed in the financial statements. The Audit and Risk Committee meets at least three times per year with the external and internal auditors and executive management to ensure that their efforts pertaining to risk management and internal control are properly 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 standards are maintained in all our dealings with stakeholders. Our sound long-term relationships with our supporting doctors are built on ethical and fair business practices, which also ensure the doctors' 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

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 78 to 128, have been approved by the Board of Directors and are signed on their behalf by:

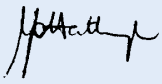
E DE LA H HERTZOG
Chairman

LJ ALBERTS
Chief Executive Officer

Stellenbosch
19 May 2009

Certificate by the company secretary

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



GC HATTINGH
Company secretary

Stellenbosch
19 May 2009

Audit committee report

In 2008, the Audit and Risk Committee was reconstituted to ensure compliance with the Corporate Laws Amendment Act which came into effect on 14 December 2007. The committee members are all independent non-executive directors of the Group. Five audit committee meetings were held during the year during which the members fulfilled all their functions as prescribed by the Companies Act. A detailed list of the functions of the Audit and Risk Committee is contained in the Corporate Governance Report. The Audit and Risk Committee has satisfied itself that the auditors are independent of the Group and are thereby able to conduct their audit functions without any influence from the Group.

D K SMITH
Chairman: Audit and Risk Committee

Stellenbosch
19 May 2009

Independent auditor's report

to the shareholders of Medi-Clinic Corporation Limited

We have audited the group annual financial statements and annual financial statements of Medi-Clinic Corporation Limited, which comprise the consolidated and separate balance sheets as at 31 March 2009, and the consolidated and separate income statements, the consolidated and separate statements of recognised income and expense and consolidated and separate cash flow statements for the year then ended, and a summary of significant accounting policies and other explanatory notes, and the directors' report, as set out on pages 78 to 128.

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

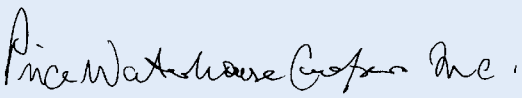
Our responsibility is to express an opinion on these financial statements based on our audit. We conducted our audit in accordance with International Standards on Auditing. Those standards require that we comply with ethical requirements and plan and perform the audit to obtain reasonable assurance whether 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 consolidated and separate financial position of Medi-Clinic Corporation Limited as at 31 March 2009, and its consolidated and separate financial performance and its consolidated and separate cash flows for the year then ended in accordance with International Financial Reporting Standards and in the manner required by the Companies Act of South Africa.



PRICEWATERHOUSECOOPERS INC.
Director: JH Loubser
Registered Auditor

Stellenbosch
19 May 2009

Directors' report

to the shareholders for the year ended 31 March 2009

NATURE OF ACTIVITIES

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

GENERAL REVIEW OF ACTIVITIES

The Group currently operates 51 hospitals in Southern Africa, 13 in Switzerland and two in the Middle East. A complete list of hospitals appears on pages 42 and 43.

The Group 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 Chief Financial Officer's report.

SHARE CAPITAL

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

There was no movement in the number of issued ordinary shares during the year, which remains at 593 013 946 shares of 10 cents each.

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 1 496 986 shares (2008: 1 368 921) have been released from the original 28 498 919 treasury shares issued to the BEE shareholders resulting in the balance of 14 749 335 shares (2008: 16 246 321). Furthermore the Mpilo Trust released 295 940 shares (2008: 124 760) to employees resulting in the balance of 15 119 058 shares (2008: 15 414 998). The Group also released 1 271 889 (2008: 1 225 395) treasury shares as well as acquiring 3 009 622 (2008: 503 678) shares through a wholly owned subsidiary.

DISTRIBUTION TO SHAREHOLDERS

The Board of Directors has declared a final dividend of 47.0 cents (2008: 41.9) per ordinary share on 19 May 2009. This, together with the interim dividend of 21.6 cents (2008: 19.3) per share, brings the total dividend for the year to 68.6 cents (2008: 61.2) per share.

	2009 R'000	2008 R'000
Interim distribution of 21.6 cents (2008: 19.3 cents)	**128 091**	76 107
Final distribution of 47.0 cents (2008: 41.9 cents)	**278 717**	248 473
	406 808	324 580

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 the Group. The Group does not own any shares in this company.

HOLDING COMPANY, SUBSIDIARIES, JOINT VENTURES AND ASSOCIATES

Remgro Limited, through a wholly owned subsidiary, presently holds 43.4% (2008: 43.4%) of the issued ordinary shares. Details of subsidiaries, joint ventures and associates appear in the annexure on pages 124 to 126.

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.

Mr J du T Marais and Ms S Dakile-Hlongwane retired as directors with effect from 30 July 2008. Dr R H Bider retired as director with effect on 5 November 2008. Dr V E Msibi tragically passed away on 12 July 2008.

Ms Z P Manase and Dr M K Makaba were co-opted as directors with effect on 16 September 2008.

Dr T O Wiesinger was co-opted as a director with effect on 5 November 2008.

The Board recommends that directors' fees for services rendered during the past financial year be fixed at R1 793 116 (2008: R1 454 360).

DIRECTORS' INTERESTS

Details of the direct and indirect interest in the issued permanent capital structure of the Company by directors are set out on page 128. 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 between the balance sheet date and the date of approval of the annual financial statements.

SPECIAL RESOLUTIONS BY SUBSIDIARIES

In terms of section 8.63(j) of the JSE Limited Listings Requirements, issuers are required to disclose special resolutions which were passed 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. The following special resolutions were passed for the year ended 31 March 2009:

1. Medi-Clinic Southern Africa Limited: It was resolved to replace this company's Memorandum of Association and Articles of Association in order to reflect the new name (previously named Abrina 6448 Limited), main business and object of the company.

2. Victoria Hospital Limited: It was resolved that the number of authorised shares of 40 000 ordinary shares of R0.10 each be subdivided into 400 000 ordinary shares of R0.01 each so that authorised share capital of this company after the subdivision consisted of R4 000 comprising 400 000 ordinary shares of R0.01 each. The effect of the special resolution was to increase the number of issued shares from 14 900 ordinary shares of R0.10 each to 149 000 ordinary shares of R0.01 each.

3. Hirslanden Klinik Am Rosenberg AG: It was resolved to change this company's name from Betriebsgesellschaft Am Rosenberg Heiden AG to Hirslanden Klinik Am Rosenberg Heiden AG.

Details of subsidiaries appear in the annexure to the annual financial statements on pages 124 to 126 of this annual report.

Balance sheets
at 31 March 2009

COMPANY 2008 R'm	COMPANY 2009 R'm		Notes	GROUP 2009 R'm	GROUP 2008* R'm
		ASSETS			
4 926	**4 942**	**Non-current assets**		**38 982**	37 273
–	**–**	Property, equipment and vehicles	5	**32 479**	30 972
–	**–**	Intangible assets	6	**6 293**	6 101
4 923	**4 941**	Interest in subsidiary	7	**–**	–
–	**–**	Investments in associates	8	**12**	11
–	**–**	Other investments and loans	9	**20**	23
–	**–**	Derivative financial instruments	20	**–**	43
3	**1**	Deferred income tax assets	10	**178**	123
–	**–**	**Current assets**		**4 892**	4 326
–	**–**	Inventories	11	**496**	448
–	**–**	Trade and other receivables	12	**3 371**	3 077
–	**–**	Cash and cash equivalents		**994**	801
–	**–**	Current income tax assets		**31**	–
4 926	**4 942**	**Total assets**		**43 874**	41 599
		EQUITY			
		Capital and reserves			
59	**59**	Ordinary shares		**59**	59
4 741	**4 741**	Share premium		**4 741**	4 741
–	**–**	Treasury shares		**(326)**	(297)
4 800	**4 800**	Share capital	13	**4 474**	4 503
17	**26**	Retained earnings	14	**2 066**	2 014
109	**116**	Other reserves	15	**551**	2 043
4 926	**4 942**	**Attributable to equity holders of the Company**		**7 091**	8 560
–	**–**	**Minority interest**	16	**898**	807
4 926	**4 942**	**Total equity**		**7 989**	9 367
		LIABILITIES			
–	**–**	**Non-current liabilities**		**33 195**	29 731
–	**–**	Borrowings	17	**24 349**	23 266
–	**–**	Deferred income tax liabilities	10	**5 162**	5 088
–	**–**	Retirement benefit obligations	18	**997**	639
–	**–**	Provisions	19	**175**	143
–	**–**	Derivative financial instruments	20	**2 512**	595
–	**–**	**Current liabilities**		**2 690**	2 501
–	**–**	Trade and other payables	21	**2 370**	2 252
–	**–**	Borrowings	17	**241**	131
–	**–**	Provisions	19	**54**	47
–	**–**	Current income tax liabilities		**25**	71
–	**–**	**Total liabilities**		**35 885**	32 232
4 926	**4 942**	**Total equity and liabilities**		**43 874**	41 599

* adjusted – refer to note 32

Income statements

for the year ended 31 March 2009

COMPANY				GROUP	
2008 R'm	**2009 R'm**		Notes	**2009 R'm**	2008 R'm
–	**–**	**Revenue**		**16 351**	9 579
–	**–**	Cost of sales		**(9 262)**	(5 381)
–	**–**	Administration and other operating expenses	23	**(4 342)**	(2 477)
–	**–**	**Trading profit**		**2 747**	1 721
225	**418**	Dividends received		**–**	–
225	**418**	**Operating profit**		**2 747**	1 721
–	**–**	Income from associates		**2**	–
–	**–**	Finance income		**67**	49
–	**–**	Finance cost	24	**(1 602)**	(685)
225	**418**	**Profit before taxation**		**1 214**	1 085
(23)	**(32)**	Taxation	25	**(502)**	(364)
202	**386**	**Profit for the year**		**712**	721
		Attributable to:			
		Equity holders of the Company		**636**	610
		Minority interest		**76**	111
				712	721
		Earnings per ordinary share attributable to the equity holders of the Company – cents			
		Basic	26	**113.7**	144.9
		Diluted	26	**107.6**	134.0

Statements of recognised income and expense

for the year ended 31 March 2009

COMPANY				GROUP	
2008 R'm	**2009 R'm**		Notes	**2009 R'm**	2008 R'm
–	**–**	Currency translation differences	15	**267**	2 326
–	**–**	Fair value adjustment – cash flow hedges	15	**(1 766)**	(394)
–	**–**	Actuarial gains and losses	14	**(245)**	(341)
–	**–**	**Net (loss)/income recognised directly in equity**		**(1 744)**	1 591
202	**386**	Profit for the year		**712**	721
202	**386**	**Total recognised (loss)/income for the year**		**(1 032)**	2 312
		Attributable to:			
		Equity holders of the Company		**(1 108)**	2 201
		Minority interest		**76**	111
				(1 032)	2 312

Cash flow statements

for the year ended 31 March 2009

COMPANY 2008 R'm Inflow/ (outflow)	COMPANY **2009 R'm Inflow/ (outflow)**		Notes	GROUP **2009 R'm Inflow/ (outflow)**	GROUP 2008 R'm Inflow/ (outflow)
		CASH FLOW FROM OPERATING ACTIVITIES			
–	**–**	Cash received from customers		**16 179**	9 121
–	**–**	Cash paid to suppliers and employees		**(12 833)**	(7 604)
–	**–**	Cash generated from operations	27.1	**3 346**	1 517
225	**418**	Dividends received		**–**	–
–	**–**	Finance income		**67**	49
–	**–**	Finance cost		**(1 505)**	(468)
(9)	**(31)**	Taxation paid	27.2	**(522)**	(360)
216	**387**	Net cash generated from operating activities		**1 386**	738
(4 464)	**(10)**	**CASH FLOW FROM INVESTMENT ACTIVITIES**		**(1 380)**	(16 898)
(4 464)	**(10)**	Investment to maintain operations	27.3	**(575)**	(275)
–	**–**	Investment to expand operations	27.4	**(866)**	(16 644)
–	**–**	Proceeds on sale of property, equipment and vehicles	27.5	**57**	21
–	**–**	Decrease in other investments and loans		**4**	–
(4 248)	**377**	Net cash generated/(utilised) before financing activities		**6**	(16 160)
4 248	**(377)**	**CASH FLOW FROM FINANCING ACTIVITIES**		**125**	16 461
4 500	**–**	Proceeds of shares issued		**–**	4 500
–	**–**	Cash distributions to minorities	16	**(54)**	(41)
(224)	**(377)**	Distributions to shareholders	27.6	**(339)**	(189)
(28)	**–**	Share issue costs		**–**	(28)
–	**–**	Proceeds from borrowings		**667**	12 475
–	**–**	Repayments of borrowings		**(120)**	(256)
–	**–**	Treasury shares purchased		**(29)**	–
–	**–**	Net increase in cash, cash equivalents and bank overdrafts		**131**	301
–	**–**	Opening balance of cash, cash equivalents and bank overdrafts		**787**	357
–	**–**	Exchange rate fluctuations on foreign cash		**23**	129
–	**–**	Closing balance of cash, cash equivalents and bank overdrafts	27.7	**941**	787

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 19 May 2009.

2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

The principal accounting policies applied in the preparation of these annual financial statements are set out below. These policies have been consistently applied to all the years presented, unless otherwise stated. The Group has elected to early adopt IFRS 8 – Operating Segments in advance of its effective date. IFRS 8 is a disclosure Standard and has no impact on the reported results or financial position of the Group.

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 Listings Requirements of the JSE Limited. The financial statements are prepared on the historical cost convention, as modified by the revaluation of certain financial instruments to fair value.

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

2.2 Consolidation and equity accounting

a) Subsidiaries

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

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

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

The Group applies a policy of treating transactions with minority interests as transactions with parties external to the Group. Disposals 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

Consistent with internal reporting, the Group's segments are identified as Hospital Services and Hospital Properties at the three platforms in Southern Africa, Switzerland and the Middle East.

2.4 Property, equipment and vehicles

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

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

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

The assets' residual values and useful lives are reviewed, and adjusted if appropriate, at each balance sheet date.

For a private hospital it is fundamentally important that the earnings potential of a building is placed on a permanent basis. The Group therefore follows a structured maintenance programme with 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 has 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 programs are recognised as an expense as incurred.

2.6 Impairment of non-financial assets

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

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

2.9 Trade and other receivables

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

2.10 Cash and cash equivalents

Cash and cash equivalents consist of balances with banks and cash on hand. 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.

2.11 Derivative financial instruments and hedging activities

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

The Group documents, at inception of the transaction, the relationship between hedging instruments and hedged items, as well as its risk management objectives and strategy for undertaking various hedging transactions. The Group also documents its assessment, both at hedge inception and on an ongoing basis, of whether the derivatives that are used in hedging transactions are highly effective in offsetting 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 is 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 are 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 cost. The gain or loss relating to the effective portion of forward foreign exchange contracts hedging export sales is recognised in the income statement within sales. However, when the forecast transaction that is hedged results in the recognition of a non-financial asset (for example, inventory or fixed assets), the gains and losses previously deferred in equity are transferred from equity and included in the initial measurement of the cost of the asset. The deferred amounts are ultimately recognised in cost of goods sold in case of inventory, or in depreciation in case of fixed assets.

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

2.12 Share capital

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

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

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

2.13 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 cost 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:

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

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

2.19 Cost of sales

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

2.20 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 into the presentation currency as follows:

- Assets and liabilities are translated at the closing rate at 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 were applicable during the year:
Average SA rand/Swiss franc exchange rate: CHF1 = R8.01 (2008: CHF1 = R6.60)
Closing SA rand/Swiss franc exchange rate: CHF1 = R8.32 (2008: CHF1 = R8.14)
Average SA rand/UAE dirham exchange rate: AED1 = R2.41 (2008: AED1 = R1.94)
Closing SA rand/UAE dirham exchange rate: AED1 = R2.58 (2008: AED1 = R2.20)

3. FINANCIAL RISK MANAGEMENT

3.1 Financial risk factors

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

a) *Market risk*

Foreign currency risk

i) Investment in foreign operation

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

ii) Transactions in foreign currency

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

Price risk

The Group is not exposed to commodity price risk.

b) *Credit risk*

Financial assets which potentially subject the Group to concentrations of credit risk consist principally of cash, short-term deposits and trade and other receivables. The Group's cash equivalents and short-term deposits are placed with quality financial institutions with a high credit rating. Trade receivables are represented net of the allowance for doubtful receivables. Credit risk with respect to trade receivables is limited due to the large number of customers comprising the Group's customer base, which consists mainly of medical aid funders. The financial condition of these clients in relation to their credit standing is evaluated on an ongoing basis. Medical schemes and insurance companies are forced to maintain minimum reserve levels.

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

The 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 monitor 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 2009 and 31 March 2008, 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.

	2009 R'm	2008 R'm
Unused overdraft facilities:	**1 158**	1 676

The following table details the Group's remaining contractual maturity for its financial liabilities. The tables have 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. The analysis of derivative financial instruments has been drawn up based on undiscounted net cash inflows/(outflows) that settle on a net basis.

Financial liabilities	**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 2009					
Interest-bearing borrowings	**24 590**	**34 422***	**1 873***	**10 940***	**21 609***
Trade payables	**1 304**	**1 304**	**1 304**	**–**	**–**
Other payables and accrued expenses	**910**	**910**	**910**	**–**	**–**
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	1 073	1 073	1 073	–	–

* 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. 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 2009 would increase/decrease by R52m (2008: increase/decrease by R23m). 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 R420m (2008: increase/decrease by R396m) 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 amount reported in the balance sheet approximate fair values.

Borrowings and trade and other payables: The carrying amount 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 annually reviews the capital structure on the basis of the debt-to-adjusted capital ratio. 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. The debt-to-adjusted capital ratios at 31 March 2009 and 31 March 2008 were as follows:

	2009 R'm	2008 R'm
Borrowings (note 17)	**24 590**	23 397
Less: cash and cash equivalents	**(994)**	(801)
Net debt	**23 596**	22 596
Total equity	**7 989**	9 367
Add back: amounts accumulated in equity relating to cash flow hedges	**2 160**	394
Add back: amounts accumulated in equity relating to Swiss pension benefits	**566**	333
Adjusted capital	**10 715**	10 094
Debt-to-adjusted capital ratio	**2.2**	2.2

The debt-to-adjusted capital ratio remained unchanged.

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	
	2009	2008
	R'm	R'm
5. PROPERTY, EQUIPMENT AND VEHICLES		
Land – cost	**9 246**	9 002
Buildings	**20 261**	19 132
Cost	**20 584**	19 262
Accumulated depreciation	**(323)**	(130)
Land and buildings	**29 507**	28 134
Equipment	**1 786**	1 470
Cost	**3 282**	2 581
Accumulated depreciation	**(1 496)**	(1 111)
Furniture and vehicles	**428**	331
Cost	**810**	602
Accumulated depreciation	**(382)**	(271)
Subtotal	**31 721**	29 935
Capital expenditure in progress	**758**	1 037
	32 479	30 972

Property, equipment and vehicles with a book value of R30 485m (2008: R27 416m) are encumbered as security for borrowings (see note 17).

Included in equipment is capitalised finance lease equipment with a book value of R30m (2008: R32m) (see note 17).

Land and buildings and capital expenditure include capitalised interest of R18m (2008: R8m).

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

5. PROPERTY, EQUIPMENT AND VEHICLES (CONTINUED)

GROUP

	Land and buildings R'm	Equipment R'm	Furniture and vehicles R'm	Total R'm
At 1 April 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
Year ended 31 March 2009				
Net opening book value	**28 134**	**1 470**	**331**	**29 935**
Capital expenditure	**395**	**650**	**207**	**1 252**
Prior year capital expenditure completed	**527**	**–**	**–**	**527**
Exchange differences	**656**	**48**	**8**	**712**
Disposals	**(28)**	**(1)**	**(4)**	**(33)**
Depreciation per income statement	**(177)**	**(381)**	**(114)**	**(672)**
Net closing book value	**29 507**	**1 786**	**428**	**31 721**
At 31 March 2009				
Cost	**29 830**	**3 282**	**810**	**33 922**
Accumulated depreciation	**(323)**	**(1 496)**	**(382)**	**(2 201)**
Net book value	**29 507**	**1 786**	**428**	**31 721**

	2009 R'm	2008 R'm
Capital expenditure		
Capital expenditure excluding expenditure in progress	**1 252**	691
Capital expenditure in progress	**174**	227
Total additions	**1 426**	918
To maintain operations	**567**	275
To expand operations	**859**	643

GROUP

	Software and Projects R'm	Trade names R'm	Goodwill R'm	Total R'm
6. INTANGIBLE ASSETS				
At 1 April 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	1 709	4 166
Exchange differences	8	810	609	1 427
Net closing book value	35	3 249	2 817	6 101
At 31 March 2008				
Cost	39	3 262	2 820	6 121
Accumulated amortisation and impairment	(4)	(13)	(3)	(20)
Net book value	35	3 249	2 817	6 101
Year ended 31 March 2009				
Net opening book value	**35**	**3 249**	**2 817**	**6 101**
Amortisation charge	**(12)**	**–**	**–**	**(12)**
Additions	**8**	**–**	**3**	**11**
Exchange differences	**1**	**72**	**120**	**193**
Net closing book value	**32**	**3 321**	**2 940**	**6 293**
At 31 March 2009				
Cost	**49**	**3 334**	**2 943**	**6 326**
Accumulated amortisation and impairment	**(17)**	**(13)**	**(3)**	**(33)**
Net book value	**32**	**3 321**	**2 940**	**6 293**

Impairment testing of goodwill and indefinite life trade name
The carrying amounts of goodwill and the indefinite life trade name allocated to the Swiss hospital operations are significant in comparison to the total carrying amount of intangible assets. The impairment tests for goodwill and the indefinite life trade name are based on value-in-use calculations.

	2009 R'm	2008 R'm
Carrying amount of Swiss goodwill	**2 327**	2 276
Carrying amount of Swiss indefinite life trade name – Hirslanden brand	**3 319**	3 247

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

- Budgeted margins – the basis used to determine the value assigned to the budgeted margins is based on the margins achieved in the previous years with a slight increase for expected efficiency improvements. The margins are driven by consideration of future admissions and case mix and based on past experience and management's assessment of growth.
- Discount rates – discount rates reflect management's estimate of the time value and the risks associated with the Swiss business. The weighted average cost of capital (WACC) has been determined by consideration of respective debt and equity costs and ratios. The post tax discount rate applied to cash flow projections is between 5% and 7%.
- Growth rates – growth rates are based on budgeted figures and management estimates. Cash flows beyond the five-year period are extrapolated using a 1.5% growth rate.

Sensitivity testing based on assessing the effect of changes in revenue growth rates and discount rates demonstrates that any reasonable likely combination of changes in these rates would not result in the carrying value of the goodwill and indefinite life trade names exceeding the recoverable amount.

COMPANY 2008 R'm	COMPANY 2009 R'm		GROUP 2009 R'm	GROUP 2008 R'm
		7. INTEREST IN SUBSIDIARY		
		Unlisted		
1	**1**	Shares at cost less amounts written off		
4 922	**4 940**	Due by subsidiary		
4 923	**4 941**			
		Details appear on page 124.		
		8. INVESTMENTS IN ASSOCIATES		
		Unlisted		
		Carrying value of investments in associates' equity		
		Opening balance	**11**	5
		Business acquisition	**–**	5
		Share in current year profits	**1**	–
		Exchange differences	**–**	1
			12	11
		Directors' valuation	**12**	11
		The total profit of associates is R14m (2008: R9m). Total revenue for the associates is R242m (2008: R178m).		
		The aggregate balance sheets of associates are summarised as follows:		
		Total assets	**82**	250
		Total liabilities	**(69)**	(216)
		Shareholders' funds	**13**	34
		Outside interests	**(1)**	(23)
		Group's share in net assets of associates	**12**	11
		Details appear on page 126.		
		9. OTHER INVESTMENTS AND LOANS		
		Unlisted – no active market		
		Loans and receivables	**4**	8
		Available-for-sale: Shares	**16**	15
			20	23
		Directors' valuation	**20**	23

COMPANY 2008 R'm	COMPANY 2009 R'm		GROUP 2009 R'm	GROUP 2008 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:		
17	**3**	Opening balance	**(4 965)**	115
		Taxation rate change	**–**	(3)
(14)	**(2)**	Income statement charge for the year	**(50)**	(18)
		Acquired during the year	**–**	(3 968)
		Exchange differences	**(115)**	(1 282)
		Charged directly to equity	**146**	191
3	**1**	Balance at the end of the year	**(4 984)**	(4 965)
		The balance consists of:		
		Accelerated wear and tear for tax purposes on property, equipment and vehicles	**(28)**	(32)
3	**1**	STC credits	**2**	5
		Temporary differences relating to Swiss assets	**(5 455)**	(5 281)
		Accruals and other temporary differences	**497**	343
3	**1**		**(4 984)**	(4 965)
3	**1**	Deferred income tax assets	**178**	123
		Deferred income tax liabilities	**(5 162)**	(5 088)
3	**1**		**(4 984)**	(4 965)
		11. INVENTORIES		
		Inventories consist of:		
		Pharmaceutical products	**432**	396
		Consumables	**54**	45
		Finished goods and work in progress	**10**	7
			496	448

The cost of inventories recognised as an expense and included in cost of sales amounted to R4 247m (2008: R2 510m).

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

	GROUP	
	2009	2008
	R'm	R'm
12. TRADE AND OTHER RECEIVABLES		
Trade receivables	**2 509**	2 253
Less provision for impairment of receivables	**(121)**	(124)
Trade receivables – net	**2 388**	2 129
Other receivables	**983**	948
	3 371	3 077
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	**980**	898
Swiss franc*	**2 145**	2 018
UAE dirham	**246**	161
	3 371	3 077
Included in the Group's trade receivables balance are trade receivables with a carrying value of R433m (2008: R795m) 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	**385**	665
Over 3 months	**48**	130
	433	795
Movement in the provision for impairment of receivables		
Opening balance	**124**	91
Provision for receivables impairment	**55**	42
Exchange differences	**4**	7
Business acquired	**–**	13
Amounts written off as uncollectable	**(71)**	(37)
Recovered during the year	**9**	8
Balance at the end of the year	**121**	124

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

Net trade receivables to the value of R532m (2008: R102m) 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 greater than CHF1m will be assigned to the bank (see note 17).

COMPANY 2008 R'm	COMPANY 2009 R'm		GROUP 2009 R'm	GROUP 2008 R'm
		13. SHARE CAPITAL		
		Share capital consists of ordinary shares and share premium.		
		Ordinary shares		
		Authorised:		
100	**100**	1 000 000 000 ordinary shares of 10 cents each (2008: 1 000 000 000)	**100**	100
59	**59**	Issued:	**59**	59
39	**59**	Opening balance	**59**	39
20	**–**	Shares issued	**–**	20
		593 013 946 ordinary shares of 10 cents each (2008: 593 013 946)		
		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.		
4 741	**4 741**	**Share premium**	**4 741**	4 741
289	**4 741**	Opening balance	**4 741**	289
4 480	**–**	Premium on shares issued	**–**	4 480
(28)	**–**	Costs of shares issued	**–**	(28)
		Treasury shares		
		32 698 361 (2008: 32 753 554) ordinary shares of 10 cents each	**(326)**	(297)
		Opening balance	**(297)**	(297)
		Shares acquired by wholly owned subsidiary	**(55)**	(11)
		Utilised by the Mpilo trusts	**5**	2
		Utilised for share option scheme	**21**	9
		During the year the Mpilo trusts, two employee share trusts, released 295 940 of its 15 414 998 shares to employees.		
		To date, no value was received for an equivalent of 14 749 335 (2008: 16 246 321) shares issued to the strategic black partners.		
		The Company, through a wholly owned subsidiary, holds 2 829 968 (2008: 1 092 235) shares in treasury. During the year 1 271 889 (2008: 1 225 395) of these shares were utilised in terms of the executive share option scheme and management incentive scheme and 3 009 622 (2008: 503 678) shares were acquired.		
4 800	**4 800**		**4 474**	4 503

	GROUP	
	2009	2008
	R'm	R'm

13. SHARE CAPITAL (continued)

Share options

In terms of the executive share option scheme 34 472 230 (2008: 34 472 230) ordinary shares are kept in reserve. To date 23 880 000 share options have been granted, 5 378 900 (2008: 4 937 800) share options have been forfeited and 16 212 185 (2008: 15 407 340) 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	R9.50	3 534 860	4 761 765
Options forfeited		(441 100)	(7 000)
Options exercised – treasury shares utilised	R8.36	(804 845)	(1 219 905)
Outstanding at the end of the year	R10.24	2 288 915	3 534 860

COMPANY 2008 R'm	COMPANY 2009 R'm		GROUP 2009 R'm	GROUP 2008 R'm
		14. RETAINED EARNINGS		
17	**26**	Company	**26**	17
		Subsidiaries and joint ventures	**2 040**	1 997
17	**26**		**2 066**	2 014
39	**17**	Opening balance	**2 014**	1 934
202	**386**	Profit for the year	**636**	610
(224)	**(377)**	Dividends paid	**(339)**	(189)
		Actuarial losses net of tax	**(245)**	(341)
17	**26**	Balance at end of the year	**2 066**	2 014
		15. OTHER RESERVES		
		Share-based payment reserve		
101	**109**	Opening balance	**109**	101
8	**7**	Employees: value of services	**7**	8
109	**116**	Balance at end of the year	**116**	109
11	**12**	Executive share option scheme	**12**	11
13	**19**	Employee share trust	**19**	13
85	**85**	Strategic black partners	**85**	85
		Foreign currency translation reserve	**2 595**	2 328
		Opening balance	**2 328**	2
		Currency translation differences	**267**	2 326
		Hedging reserve	**(2 160)**	(394)
		Opening balance	**(394)**	–
		Fair value adjustments of cash flow hedges net of tax	**(1 766)**	(394)
109	**116**		**551**	2 043
		16. MINORITY INTEREST		
		Opening balance	**807**	752
		Distributions to minorities	**(54)**	(41)
		Share of profit	**76**	111
		Business acquisitions	**–**	3
		Exchange differences	**72**	46
		Decrease in minority interest	**(3)**	(64)
		Minority interest in hospital activities	**898**	807

17. BORROWINGS

	GROUP 2009 R'm	GROUP 2008 R'm
Secured long-term bank loans	**2 760**	2 755
Long-term portion	**2 750**	2 750
Short-term portion	**21**	20
Capitalised financing expenses – long-term	**(11)**	(15)
These loans bear interest at variable rates linked to the three-month JIBAR plus a margin of 1.025% to 1.125% (2008: 1.025% to 1.125%) compounded quarterly. The capital portion is repayable after three and five years (2008: four and six years). Property, equipment and vehicles with a book value of R3 798m (2008: R3 805m) are encumbered as security for these loans. The interest on these bank loans has been hedged – note 20 contains information about the interest rate swap agreements.		
Secured long-term bank loans	**642**	670
Long-term portion	**605**	632
Short-term portion	**40**	38
Capitalised financing expenses – long-term	**(3)**	–
These loans bear interest at an average fixed rate of 9.3% per annum and is repayable in four to seven (2008: five) years. Gross trade receivables of R488m (2008: Rnil) has been ceded as security for these borrowings.		
Unsecured long-term bank loans	**132**	–
Long-term portion	**130**	–
Short-term portion	**3**	–
Capitalised financing expenses – long-term	**(1)**	–
This loan bears interest at interest rates linked to the three-month JIBAR plus a margin of 1.4% payable each quarter in arrears. The capital amount is repayable in 16 equal quarterly instalments the first being on 1 April 2010.		
Unsecured foreign bank loan	**203**	174
Long-term portion	**203**	174
Short-term portion	**–**	–
This loan is US dollar denominated, bears interest at a variable rate of 1.4% (2008: 1.4%) above the one month LIBOR per annum and has no fixed terms of repayment.		
Secured long-term bank loans	**16**	58
Long-term portion	**–**	25
Short-term portion	**16**	33
These loans bear interest at an average fixed rate of 14.36% (2008: 14.36%) per annum and is repayable in the following year (2008: within 2 years). Property with a book value of R86m (2008: R86m) are encumbered as security for these loans. Gross trade receivables of R83m (2008: R91m) has also been ceded as security for these loans.		
Secured long-term bank loans	**61**	28
Long-term portion	**57**	16
Short-term portion	**4**	12
These loans bear interest at variable rates linked to the prime overdraft rate and are repayable in periods ranging between one and thirteen years. Property, equipment and vehicles with a book value of R167m (2008: R102m) are encumbered as security for these loans. Gross trade receivables of R34m (2008: R17m) has also been ceded as security for these loans.		
Bank overdraft	**53**	14
Gross trade receivables of R10m (2008: R6m) has been ceded as security for these overdrafts.		
Borrowings in Southern African operations	**3 867**	3 699

	GROUP	
	2009 R'm	2008 R'm
17. BORROWINGS (continued)		
Secured long-term bank loans	**771**	211
Long-term portion	**685**	210
Short-term portion	**100**	13
Capitalised financing expenses – long-term	**(14)**	(12)
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 R817m (2008: R696m) are encumbered as security for these loans.		
Vehicle loans	**3**	4
Long-term portion	**2**	3
Short-term portion	**1**	1
These loans bear interest at rates ranging between 4.5% and 5.5% (2008: 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 (2008: R3m) are encumbered as security for these loans.		
Borrowings in Middle East operations	**774**	215
Secured long-term bank loan	**19 920**	19 454
Long-term portion	**20 331**	19 876
Short-term portion	**–**	–
Capitalised financing expenses – long-term	**(411)**	(422)
This loan bears interest at a variable rate linked to the three-month Swiss LIBOR plus 2% (2008: LIBOR plus 1.65%) and is repayable in October 2014. The interest on this bank loan has been hedged – note 20 contains information about the interest rate swap agreement.		
The loan is secured by : Swiss properties with a book value of R25 584m (2008: R25 033m); assignment of Swiss receivables in case of default (refer to note 12); and Swiss bank accounts with a book value of R500m (2008: R395m).		
Secured long-term finance	**29**	29
Long-term portion	**26**	29
Short-term portion	**3**	–
These loans bear interest at interest rates ranging between 4% and 12% and are repayable in equal monthly payments in periods ranging from one to thirteen years. Equipment with a book value of R30m (2008: R32m) are encumbered as security for these loans.		
Borrowings in Swiss operations	**19 949**	19 483
Total borrowings	**24 590**	23 397
Short-term portion transferred to current liabilities	**(241)**	(131)
	24 349	23 266

	GROUP	
	2009	2008
	R'm	R'm
18. RETIREMENT BENEFIT OBLIGATIONS		
Balance sheet obligations for:		
Pension benefits	**765**	466
Post-employment medical benefits	**232**	173
	997	639
Income statement charge for:		
Pension benefits	**209**	59
Post-employment medical benefits	**43**	33
	252	92
(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	**5 037**	4 621
Fair value of plan assets	**(4 272)**	(4 155)
Deficit	**765**	466
The movement in the defined benefit obligation over the period is as follows:		
Opening balance	**4 621**	–
Business acquisition	**–**	3 377
Current service cost net of employee contributions	**232**	79
Interest cost	**146**	49
Employee contributions	**183**	57
Benefits paid	**(157)**	(86)
Exchange differences	**118**	1 145
Actuarial gain	**(106)**	–
Balance at end of year	**5 037**	4 621
The movement of the fair value of plan assets over the period is as follows:		
Opening balance	**4 155**	–
Business acquisition	**–**	3 335
Employer contributions	**214**	68
Employee contributions	**183**	57
Benefits paid from fund	**(157)**	(86)
Expected return on assets	**169**	60
Exchange differences	**108**	1 055
Investment loss	**(400)**	(334)
Balance at end of year	**4 272**	4 155

	GROUP	
	2009	2008
	R'm	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	**232**	79
Interest on liability	**146**	49
Expected return on plan assets	**(169)**	(60)
Recognised directly in equity	**–**	(9)
Total expense	**209**	59
Balance sheet		
Opening net liability	**466**	–
Business acquisition	**–**	41
Expense as above	**209**	59
Contributions paid by employer	**(214)**	(68)
Exchange differences	**10**	4
Actuarial losses recognised in equity	**294**	430
Closing net liability	**765**	466
Actual return on plan assets	**216**	274
The estimate of contributions expected to be paid to the plan during the annual period beginning after the reporting period will be R214m.		
Principal actuarial assumptions on balance sheet date		
Discount rate	**2.90%**	3.25%
Expected rate of return on plan assets	**4.50%**	4.00%
Future salary increases	**2.00%**	1.50%
Future pension increases	**0.50%**	1.00%
Inflation rate	**1.50%**	1.00%
Number of plan members		
Active members	**5 239**	5 004
Pensioners	**370**	342
	5 609	5 346
Experience adjustment		
On plan liabilities: gain	**(106)**	–
On plan assets: loss	**(400)**	(412)
Opening balance	**(412)**	–
Actuarial losses recognised in the SoRIE	**(294)**	(412)
Cumulative actuarial losses recognised in the SoRIE	**(706)**	(412)
Asset allocation		
Fixed income investments	**52%**	49%
Equity investments	**17%**	24%
Real estate	**19%**	22%
Other	**12%**	5%

	GROUP	
	2009	2008
	R'm	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 2009 a 6.4% (2008: 7.5%) medical inflation cost and a 8.4% (2008: 9.5%) interest rate were assumed. The average retirement age was set at 63 years (2008: 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	**173**	129
Amounts recognised in the income statement	**43**	33
Current service cost	**27**	21
Interest cost	**19**	13
Contributions	**(3)**	(1)
Actuarial loss recognised in the SoRIE	**16**	11
Closing balance	**232**	173
Present value of unfunded obligations	**232**	173
Unrecognised actuarial differences	**-**	-
	232	173
The present value of the Group's post-employment medical benefits at 31 March 2007 was R129m, 2006: R102m and 2005: R73m.		
	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%**	(14%)
Expected post-employment medical benefits to be recognised for the year ended 31 March 2010 are R53m.		

19. PROVISIONS

GROUP

	Employee benefits R'm	Legal cases and other R'm	Tariff risks R'm	Total R'm
Year ended 31 March 2008				
Opening balance	–	–	–	–
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 the end of the year	128	18	44	190
At 31 March 2008				
Non-current	120	11	12	143
Current	8	7	32	47
	128	18	44	190
Year ended 31 March 2009				
Opening balance	**128**	**18**	**44**	**190**
Charged to the income statement	**33**	**14**	**5**	**52**
Utilised during the year	**(2)**	**–**	**–**	**(2)**
Unused amounts reversed	**(1)**	**(5)**	**(15)**	**(21)**
Exchange differences	**8**	**1**	**1**	**10**
Balance at the end of the year	**166**	**28**	**35**	**229**
At 31 March 2009				
Non-current	**9**	**20**	**25**	**54**
Current	**157**	**8**	**10**	**175**
	166	**28**	**35**	**229**

(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 Klinik Aarau, clinics in Berne and at Klinik St Anna relating to compulsory health insurance.

	2009 R'm	2008 R'm
Provisions are expected to be payable during the following financial years:		
Within 1 year	**54**	47
After one year but not more than five years	**71**	71
More than five years	**104**	72
	229	190

	GROUP	
	2009 R'm	2008 R'm
20. DERIVATIVE FINANCIAL INSTRUMENTS		
Assets		
Interest rate swaps – cash flow hedges	**–**	43
Liabilities		
Interest rate swap – cash flow hedges	**2 512**	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 2009, the Group had three interest rate swap contracts (2008: three). The value of borrowings hedged by the interest rate derivatives and the rates applicable to these contracts are as follows:

2009	**Borrowings hedged R'm**	**Fixed interest payable**	**Interest receivable**	**Fair value (loss)/gain R'm**
6 years + *	20 316	3.62%	3-month LIBOR	(1 644)
1 to 6 years **	2 750	9.8 –10.1%	3-month JIBAR	(159)
2008				
6 years + *	19 930	3.62%	3-month LIBOR	(418)
1 to 6 years **	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 on 5 October 2017. There is no ineffective portion recognised in the profit and loss that arises from the cash flow hedge.

** The interest rate swap agreements reset every 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.

	2009 R'm	2008 R'm
21. TRADE AND OTHER PAYABLES		
Trade payables	**1 304**	1 065
Other payables and accrued expenses	**910**	1 073
Accrued leave pay	**112**	70
Value added tax	**44**	44
	2 370	2 252

	GROUP	
	2009	2008
	R'000	R'000
22. DIRECTORS' REMUNERATION		
Executive		
E de la H Hertzog *	**4 764**	2 591
L J Alberts	**5 751**	3 261
J du T Marais	**772**	1 950
D P Meintjes	**4 383**	2 425
K H S Pretorius	**4 007**	2 678
J G Swiegers	**4 669**	2 390
R H Bider ***	**6 383**	983
T O Wiesinger **	**3 248**	–
	33 977	16 278
Non-executive fees	**1 793**	1 454
J C Cohen	**154**	20
S Dakile-Hlongwane	**33**	141
M K Makaba	**66**	–
Z P Manase	**145**	–
A R Martin	**249**	244
V E Msibi	**35**	180
D K Smith	**248**	–
A A Raath	**249**	230
M A Ramphele	**143**	172
W L van der Merwe	**214**	192
M H Visser	**257**	275
	35 770	17 732
Paid by:		
Subsidiaries	**32 963**	15 141
Management company *	**2 807**	2 591
	35 770	17 732

Detail for 2009: (R'000)	Salaries	Retirement fund	Other benefits ****	Bonus ◊	Share options	Total
Executive						
E de la H Hertzog *	**2 252**	**218**	**145**	**2 149**	**–**	**4 764**
L J Alberts	**3 355**	**302**	**20**	**2 074**	**–**	**5 751**
R H Bider ***	**3 059**	**493**	**235**	**2 596**	**–**	**6 383**
J du T Marais	**714**	**51**	**7**	**–**	**–**	**772**
D P Meintjes	**3 310**	**169**	**156**	**747**	**–**	**4 383**
K H S Pretorius	**2 082**	**192**	**74**	**1 249**	**410**	**4 007**
J G Swiegers	**2 529**	**243**	**218**	**1 679**	**–**	**4 669**
T O Wiesinger **	**2 104**	**329**	**147**	**667**	**–**	**3 248**
	19 406	**1 997**	**1 003**	**11 161**	**410**	**33 977**

GROUP

22. DIRECTORS' REMUNERATION (continued)

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

* Dr E de la H Hertzog also earned a further R1,5m (2008: R1,4m) from M & I Group Services Limited relating to other duties.

** Dr T O Wiesinger was appointed as a director on 5 November 2008. His director's remuneration is from this date.

*** Dr R H Bider was appointed as a director on 1 February 2008 and retired on 5 November 2008. His director's remuneration is for this period.

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

◊ Bonuses were paid out in terms of the management incentive scheme in 2009 (2008: Rnil).

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 2009.

The number of outstanding share options are:	Offer price	**2009 Number**	2008 Number
K H S Pretorius	R4.90	**–**	15 000
	R9.80	**40 000**	40 000
		40 000	55 000

	GROUP	
	2009	2008
	R'm	R'm
23. EXPENSES BY NATURE		
Auditors' remuneration – external audit	**12**	10
Auditors' remuneration – other services	**2**	2
Cost of inventories	**4 247**	2 510
Depreciation – buildings	**177**	74
– equipment	**381**	196
– furniture and vehicles	**114**	66
Employee benefit expenses	**6 785**	3 688
Wages and salaries	**6 425**	3 498
Post-employment medical benefits (note 18)	**43**	33
Retirement benefit costs – defined contribution plans	**101**	90
Retirement benefit costs – defined benefit plans	**209**	59
Share-based payment expense	**7**	8
(Decrease)/increase in impairment provision for receivables (note 12)	**(7)**	13
Maintenance costs	**440**	270
Managerial and administration fees	**6**	3
Operating leases – buildings	**189**	108
– equipment	**36**	28
Amortisation of intangible assets	**12**	5
Other expenses	**1 210**	865
General expenses	**1 325**	942
Profit on sale of equipment	**22**	2
Other income	**93**	75
	13 604	7 858
Classified as:		
Cost of sales	**9 262**	5 381
Administration and other operating expenses	**4 342**	2 477
	13 604	7 858
24. FINANCE COST		
Interest expense	**1 330**	614
Interest rate swaps	**191**	55
Amortisation of capitalised financing fees	**81**	16
	1 602	685

COMPANY 2008 R'm	COMPANY 2009 R'm		GROUP 2009 R'm	GROUP 2008 R'm
		25. TAXATION		
		Current taxation		
(9)	**(30)**	Current year	**(451)**	(344)
		Previous year	**(1)**	1
(14)	**(2)**	Deferred taxation	**(50)**	(21)
(23)	**(32)**	Taxation per income statement	**(502)**	(364)
		Composition		
(1)	**(1)**	Normal South African taxation	**(252)**	(239)
		Foreign taxation	**(219)**	(103)
(22)	**(31)**	Secondary taxation on companies ("STC")	**(31)**	(22)
(23)	**(32)**		**(502)**	(364)
		Reconciliation of rate of taxation:		
		Standard rate for companies (RSA)	**28.0 %**	29.0 %
		Adjusted for:		
		Capital gains taxation	**(0.1)%**	(0.2)%
		Non-taxable income	**(1.6)%**	(2.3)%
		Non-deductible expenses	**13.2 %**	8.8 %
		Minorities share of profit before taxation	**(1.1)%**	(1.3)%
		Rate differences	**0.2 %**	(2.6)%
		STC	**2.9 %**	2.1 %
		Prior year adjustment	**(0.1)%**	–
		Effective tax rate	**41.4 %**	33.5 %

	GROUP	
	2009	2008
	R'm	R'm
26. EARNINGS PER ORDINARY SHARE		
Earnings reconciliation		
Profit attributable to shareholders	**636**	610
Profit on sale of property, equipment and vehicles	**(12)**	(2)
Headline earnings	**624**	608
Weighted number of issued ordinary shares		
Number of issued ordinary shares at the beginning of the year	**593 013 946**	394 338 449
Weighted number of ordinary shares issued during the year	**–**	60 796 873
Weighted number of treasury shares	**(33 678 393)**	(33 697 872)
	559 335 553	421 437 450
Diluted number of issued ordinary shares		
Weighted number of issued ordinary shares	**559 335 553**	421 437 450
Weighted number of treasury shares held in terms of the BEE initiative not yet released from treasury stock	**30 567 373**	32 264 287
Adjustment for outstanding share options granted	**1 095 625**	2 046 389
	590 998 551	455 748 126
Earnings per ordinary share (cents)		
Basic	**113.7**	144.9
Diluted	**107.6**	134.0
Headline earnings per ordinary share (cents)		
Basic	**111.5**	144.5
Diluted	**105.6**	133.6
27. CASH FLOW INFORMATION		
27.1 Reconciliation of profit before taxation to cash generated from operations		
Operating profit before interest and taxation	**2 747**	1 721
Non-cash items		
Intangibles amortised	**12**	5
Movement in share-based payment reserve	**7**	8
Depreciation	**672**	336
Movement in provisions	**2**	(19)
Movement in retirement benefit obligations	**43**	25
Profit on sale of property, equipment and vehicles	**(22)**	(2)
Operating income before changes in working capital	**3 461**	2 074
Working capital changes	**(115)**	(557)
Increase in inventories	**(38)**	(6)
Increase in trade and other receivables	**(218)**	(390)
Decrease/(increase) in trade and other payables	**141**	(161)
	3 346	1 517

COMPANY 2008 R'm	COMPANY 2009 R'm		GROUP 2009 R'm	GROUP 2008 R'm
		27.2 Taxation paid		
		Liability at the beginning of the year	**(71)**	(8)
		Business acquisitions	**–**	(75)
		Exchange differences	**(35)**	(4)
(9)	**(32)**	Provision for the year	**(410)**	(344)
(9)	**(32)**		**(516)**	(431)
		Liability at the end of the year	**(6)**	71
(9)	**(32)**		**(522)**	(360)
		27.3 Investment to maintain operations		
		Property, equipment and vehicles purchased	**(567)**	(275)
		Intangible assets purchased	**(8)**	–
(4 464)	**(11)**	Loans to subsidiaries	**–**	–
(4 464)	**(11)**		**(575)**	(275)
		27.4 Investment to expand operations		
		Property, equipment and vehicles purchased	**(859)**	(643)
		Intangible assets purchased	**–**	(11)
		Business acquisitions	**–**	(15 803)
		Prior year business acquisition consideration outstanding	**–**	(82)
		Acquisition of minority interests in hospital activities	**(7)**	(105)
			(866)	(16 644)
		27.5 Proceeds on sale of property, equipment and vehicles		
		Book value of property, equipment and vehicles sold	**33**	19
		Profit per income statement	**22**	2
		Exchange differences	**2**	–
			57	21
		27.6 Distributions paid to shareholders		
(224)	**(377)**	Dividends declared and paid during the year	**(339)**	(189)
		27.7 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	**994**	801
		Bank overdrafts (note 17)	**(53)**	(14)
			941	787

	2009 R'm	2009 R'm	2009 R'm	2009 R'm

28. SEGMENTAL REPORT

The Group is organised into six reportable segments, namely: Southern Africa Hospital Services and Southern Africa Hospital Properties; Swiss Hospital Services and Swiss Hospital Properties; Middle East Hospital Services and Middle East Hospital Properties.

Year ended 31 March 2009:	Southern Africa Hospital Services	Southern Africa Hospital Properties	Adjustments and eliminations	Southern Africa Total
Revenue	6 792	611	(611)	6 792
EBITDA	865	593		1 458
Depreciation and amortisation	(177)	–		(177)
EBIT	688	593		1 281
Income from associates	1	–		1
Finance income	61	8	(8)	61
Finance cost	(89)	(308)	8	(389)
Taxation	(202)	(82)		(284)
Segment result	459	211		670
At 31 March 2009:				
Investments in associates	4	–		4
Capital expenditure	565	–		565
Total segment assets	4 150	5 484	(4 328)	5 306
Segment liabilities	2 366	3 463	(700)	5 129

Year ended 31 March 2009:	Swiss Hospital Services	Swiss Hospital Properties	Adjustments and eliminations	Swiss Total
Revenue	8 737	1 408	(1 408)	8 737
EBITDA	646	1 315		1 961
Depreciation and amortisation	(313)	(141)		(454)
EBIT	333	1 174		1 507
Income from associates	1	–		1
Finance income	15	3		18
Finance cost	(13)	(1 171)		(1 184)
Taxation	(58)	(160)		(218)
Segment result	278	(154)		124
At 31 March 2009:				
Investments in associates	8	–		8
Capital expenditure	340	246		586
Total segment assets	9 720	26 835		36 555
Segment liabilities	2 747	26 936		29 683

Year ended 31 March 2009:	Middle East Hospital Services	Middle East Hospital Properties	Adjustments and eliminations	Middle East Total
Revenue	822	29	(29)	822
EBITDA	(17)	29		12
Depreciation and amortisation	(53)	–		(53)
EBIT	(70)	29		(41)
Finance income	1	–		1
Finance cost	(29)	(13)		(42)
Taxation	–	–		–
Segment result	(98)	16		(82)
At 31 March 2009:				
Investments in associates	–	–		–
Capital expenditure	213	70		283
Total segment assets	1 217	1 013		2 230
Segment liabilities	827	457		1 284

	2008 R'm	2008 R'm	2008 R'm	2008 R'm

28. SEGMENTAL REPORT (continued)

Year ended 31 March 2008:	Southern Africa Hospital Services	Southern Africa Hospital Properties	Adjustments and eliminations	Southern Africa Total
Revenue	6 056	546	(546)	6 056
EBITDA	772	530		1 302
Depreciation and amortisation	(159)	–		(159)
EBIT	613	530		1 143
Income from associates	–	–		–
Finance income	55	–		55
Finance cost	(112)	(174)		(286)
Taxation	(175)	(103)		(278)
Segment result	381	253		634
At 31 March 2008:				
Investments in associates	4	–		4
Capital expenditure	356	–		356
Total segment assets	3 699	5 250	(4 216)	4 733
Segment liabilities	1 880	3 463	(700)	4 643

Year ended 31 March 2008:	Swiss Hospital Services	Swiss Hospital Properties	Adjustments and eliminations	Swiss Total
Revenue	3 041	483	(483)	3 041
EBITDA	259	451		710
Depreciation and amortisation	(105)	(49)		(154)
EBIT	154	402		556
Income from associates	–	–		–
Finance income	1	3		4
Finance cost	(6)	(385)		(391)
Taxation	(16)	(70)		(86)
Segment result	133	(50)		83
At 31 March 2008:				
Investments in associates	7	–		7
Capital expenditure	157	50		207
Total segment assets	9 418	26 059		35 477
Segment liabilities	2 780	24 297		27 077

Year ended 31 March 2008:	Middle East Hospital Services	Middle East Hospital Properties	Adjustments and eliminations	Middle East Total
Revenue	482	–		482
EBITDA	50	–		50
Depreciation and amortisation	(28)	–		(28)
EBIT	22	–		22
Finance income	5	–		5
Finance cost	(23)	–		(23)
Taxation	–	–		–
Segment result	4	–		4
At 31 March 2008:				
Investments in associates	–	–		–
Capital expenditure	67	299		366
Total segment assets	769	804		1 573
Segment liabilities	413	287		700

	2009 R'm	2009 R'm	2009 R'm	2009 R'm

28. SEGMENTAL REPORT (continued)

Year ended 31 March 2009:	Total Hospital Services	Total Hospital Properties	Adjustments and eliminations	Total
Revenue	**16 351**	**2 048**	**(2 048)**	**16 351**
EBITDA	**1 494**	**1 937**		**3 431**
Depreciation and amortisation	**(543)**	**(141)**		**(684)**
EBIT	**951**	**1 796**		**2 747**
Income from associates	**2**	**–**		**2**
Finance income	**77**	**11**	**(21)**	**67**
Finance cost	**(131)**	**(1 492)**	**21**	**(1 602)**
Taxation	**(260)**	**(242)**		**(502)**
Segment result	**639**	**73**		**712**
At 31 March 2009:				
Investments in associates	**12**	**–**		**12**
Capital expenditure	**1 118**	**316**		**1 434**
Total segment assets	**15 087**	**33 332**	**(4 545)**	**43 874**
Segment liabilities	**5 940**	**30 856**	**(911)**	**35 885**

	2008 R'm	2008 R'm	2008 R'm	2008 R'm

Year ended 31 March 2008:	Total Hospital Services	Total Hospital Properties	Adjustments and eliminations	Total
Revenue	9 579	1 029	(1 029)	9 579
EBITDA	1 081	981		2 062
Depreciation and amortisation	(292)	(49)		(341)
EBIT	789	932		1 721
Income from associates	–	–		–
Finance income	61	3	(15)	49
Finance cost	(141)	(559)	15	(685)
Taxation	(191)	(173)		(364)
Segment result	518	203		721
At 31 March 2008:				
Investments in associates	11	–		11
Capital expenditure	580	349		929
Total segment assets	13 886	32 113	(4 400)	41 599
Segment liabilities	5 073	28 047	(888)	32 232

	GROUP	
	2009	2008
	R'm	R'm
29. COMMITMENTS		
Capital commitments		
Incomplete capital expenditure contracts	**594**	680
Southern Africa	**382**	550
Switzerland	**198**	32
Middle East	**14**	98
Capital expenses authorised by the Board of Directors but not yet contracted	**432**	319
Southern Africa	**404**	248
Switzerland	**28**	71
Middle East	**–**	–
	1 026	999
These commitments will be financed from group and borrowed funds.		
Financial lease commitments		
The Group has entered into financial lease agreements on equipment. The future non-cancellable minimum lease rentals are payable during the following financial years:		
Within 1 year	**6**	8
1 to 5 years	**20**	18
Beyond 5 years	**25**	35
	51	61
Operating lease commitments		
The Group has entered into various operating lease agreements on premises and equipment. The future non-cancellable minimum lease rentals are payable during the following financial years:		
Within 1 year	**175**	187
1 to 5 years	**357**	530
Beyond 5 years	**1 149**	1 223
	1 681	1 940

COMPANY			GROUP	
2008 R'm	**2009 R'm**		**2009 R'm**	2008 R'm
		30. RELATED PARTY TRANSACTIONS		
		The major shareholder of the Group is Industrial Partnership Investments Limited (Remgro Limited), which owns 43.40% (2008: 43.40%). 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	**6**	3
		Interest received	**–**	2
		Internal audit services	**1**	1
		Balance due to	**3**	1
		Key management compensation		
		Directors		
		Information regarding the directors' remuneration appears in note 22.		
		Transactions with subsidiaries and associates		
		Medi-Clinic Investments Limited		
200	**390**	Dividend received		
4 922	**4 940**	Balance due from		
		Zentrallabor Zürich (ZLZ)		
		Fees earned	**(18)**	(5)
		Purchases	**74**	24

	GROUP	
	2008* R'm	2008 R'm

31. BUSINESS ACQUISITIONS

During the previous year 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.

Details of net assets and goodwill acquired are:	Fair value	Acquiree's carrying amount
Property, equipment and vehicles	(20 391)	(4 138)
Intangible assets	(2 457)	(20)
Investment in associates	(5)	(5)
Other investments and loans	(18)	(18)
Deferred taxation	3 968	176
Inventories	(186)	(186)
Trade and other receivables	(1 304)	(1 304)
Cash resources	(624)	(624)
Interest-bearing borrowings	4 963	4 963
Trade and other payables	1 059	1 075
Provisions	158	158
Pension liability	41	–
Taxation	75	75
Minority interest of existing shareholders	3	3
Value of interests acquired	(14 718)	155
Goodwill	(1 709)	
Purchase consideration	(16 427)	
Purchase consideration	(16 427)	
Purchase consideration outstanding	–	
Cash resources	624	
Cash outflow on acquisition	(15 803)	

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%.

* adjusted – refer to note 32

	GROUP		
	R'm	R'm	R'm

32. ADJUSTMENT TO PRIOR YEAR BALANCE SHEET

In accordance with IFRS 3 Business Combinations, adjustments to the provisional accounting of the Hirslanden acquisition has been made. This has resulted in adjustments to the 31 March 2008 balance sheet as follows:

	As previously reported	Adjustments	As adjusted
Intangible assets	6 079	22	6 101
Retained earnings	2 334	(320)**	2 014
Deferred income tax liabilities	5 187	(99)**	5 088
Retirement benefit obligations	177	462*	639
Trade and other payables	2 273	(21)	2 252

The adjustment to the prior year's balance sheet was caused by the finalisation of the provisional purchase price allocation (PPA) in respect of the Hirslanden acquisition, which has now been finalised. The adjustment has been made in accordance with IFRS 3 Business Combinations and had no income statement effect.

* Previously, the Hirslanden pension plans disclosed a surplus which was not recognised on the balance sheet in terms of the limit as set by IAS 19 paragraph 58. The finalisation of the provisional purchase price allocation (PPA) indicated that the Hirslanden pension plans were in fact underfunded at acquistion date (in terms of IAS 19), which resulted in the recognition of a pension liability at acquistion date, as well as the prior year's balance sheet. As a result of the recognition of the pension liability, further actuarial losses were booked through the statement of recognised income and expense (SoRIE) for the period ended 31 March 2008.

** Corresponding adjustments caused by the recognition of the retirement benefit obligation on the balance sheet.

33. STANDARDS AND INTERPRETATIONS NOT YET EFFECTIVE

Certain new standards, amendments and interpretations to existing standards have been published that are mandatory for the Group's accounting periods beginning on or after 1 April 2009 or later periods but which the Group has not early adopted.

Standards, interpretations and amendments which will affect the financial statements mainly by additional disclosures:

• IAS 1 (AC 101) Presentation of Financial Statements – Revised (Effective 1 Jan 2009)

The revised IAS 1 (AC 101) requires information in financial statements to be aggregated on the basis of shared characteristics and to introduce a statement of comprehensive income. This will enable readers to analyse changes in a Group's equity resulting from transactions with owners in their capacity as owners separately from 'non-owner' changes. The revisions include changes in the titles of some of the financial statements to reflect their function more clearly (for example, the balance sheet is renamed a statement of financial position). The new titles are not mandatory for use in financial statements.

• IFRS 3 (AC 140) Business Combinations – Revised (Effective 1 July 2009)

The new standard continues to apply the acquisition method to business combinations, with some significant 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.

Standards, interpretations and amendments which will have no material effects on the financial statements:

– IAS 23 (AC 114) Borrowing Costs – Revised (Effective 1 Jan 2009)
– IAS 27 (AC 132) Consolidated and Separate Financial Statements – Revised (Effective 1 July 2009)
– Amendment to IFRS 2 (AC 139) Share-Based Payment: Vesting Conditions and Cancellations (Effective 1 Jan 2009)
– Amendment to IAS 32 (AC125) Financial Instruments: Presentation and IAS 1 (AC 101) Presentation of financial statements – Puttable Financial Instruments and Obligations Arising on Liquidation (Effective 1 Jan 2009)
– Amendments to IFRS 1 (AC 138) First-Time Adoption of International Financial Reporting Standards and IAS 27 (AC 132) Consolidated and Separate Financial Statements: Cost of an Investment in a Subsidiary, Jointly Controlled Entity or Associate (Effective 1 Jan 2009)
– Amendments to IAS 39 (AC 133) Financial Instruments: Recognition and Measurement Exposures Qualifying for Hedge Accounting (Effective 1 July 2009)
– Amendments to IAS 39 (AC 133) Financial Instruments: Recognition and Measurement and IFRS 7(AC 144) Financial Instruments: Disclosures – Reclassification of Financial Assets (Effective 1 July 2008)
– IFRIC 13 (AC 446) Customer Loyalty Programmes (Effective 1 July 2008)
– IFRIC 15 (AC 448) Agreements for the Construction of Real Estate (Effective 1 Jan 2009)
– IFRIC 16 (AC 449) Hedges of a Net Investment in a Foreign Operation (Effective 1 Oct 2008)
– IFRIC 17 (AC 450) Distributions of Non-cash Assets to Owners (Effective 1 July 2009)
– IFRIC 18 (AC 451) Transfers of assets from customers (Effective 1 July 2009)

There are numerous other new standards or amendments to existing standards that are not yet effective for the Group. Each of these has been assessed, and will not have a material impact on the Group financial statements.

Annexure - investments in subsidiaries and associates

at 31 March 2009

	Issued share capital		Interest in capital		Book value of shares	
	2009	2008	**2009**	2008	**2009**	2008
	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 940m (2008: R4 922m).						
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 Southern Africa Limited			**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**	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**	100.0		
Legae Medi-Clinic (Proprietary) Limited			**100.0**	100.0		
Practice Relief (Proprietary) Limited			**100.0**	100.0		
Reef-Med (Proprietary) Limited			**61.0**	58.9		
Tshwane Private Hospitals (Proprietary) Limited			**100.0**	100.0		
Tzaneen Private Hospital (Proprietary) Limited *			**49.4**	49.4		
Victoria Hospital Limited *			**33.3**	33.3		

	Issued share capital		Interest in capital		Book value of shares	
	2009 Rand	2008 Rand	**2009** %	2008 %	**2009** R'm	2008 R'm
SUBSIDIARIES (continued)						
Indirectly held through Medi-Clinic Limited						
Kimberley Medi-Clinic (Proprietary) Limited $			**89.7**	89.7		
Ermelo Medi-Clinic (Proprietary) Limited $			**50.1**	50.1		
Barberton Medi-Clinic (Proprietary) Limited $			**77.0**	77.0		
Hermanus Medi-Clinic Limited *$			**34.9**	34.9		
Potchefstroom Medi-Clinic (Proprietary) Limited $			**94.6**	94.6		
Limpopo Medi-Clinic Limited $			**50.0**	50.0		
Upington Private Hospital (Proprietary) Limited *$			**40.9**	40.9		
Indirectly held through Medi-Clinic Europe (Proprietary) Limited						
Medi-Clinic Holdings Netherlands B.V.			**100.0**	100.0		
Medi-Clinic Luxembourg S.à r.l.			**100.0**	100.0		
Medi-Clinic Switzerland AG			**100.0**	100.0		
Klinik Hirslanden AG			**100.0**	100.0		
Klinik Im Park AG			**100.0**	100.0		
Hirslanden Klinik Aarau AG			**100.0**	100.0		
Beau-Site AG			**100.0**	100.0		
Clinique Cecil SA			**100.0**	100.0		
Klinik Belair AG			**100.0**	100.0		
Klinik St. Andreas-Liebfrauenhof AG			**100.0**	100.0		
AndreasKlinik AG			**100.0**	100.0		
Clinique Bois-Cerf SA			**100.0**	100.0		
Klinik Birshof AG			**100.0**	100.0		
Salem-Spital AG			**100.0**	100.0		
Sinomed AG			**100.0**	100.0		
Klinik St Anna AG			**100.0**	100.0		
Klinik am Rosenberg Heiden, Heiden			**100.0**	100.0		
Hirslanden Klinik Am Rosenberg AG, Heiden			**99.1**	99.1		
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		
The City Hospital FZ LLC			**100.0**	100.0		

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

* Controlled through long-term management agreements

$ Operating through trusts or partnerships

Annexure - investments in subsidiaries and associates

at 31 March 2009 (continued)

	Issued share capital		Interest in capital		Book value of shares	
	2009 Rand	2008 Rand	**2009** %	2008 %	**2009** R'm	2008 R'm
SUBSIDIARIES (continued)						
Indirectly held through Tshwane Private Hospitals (Proprietary) Limited						
Curamed Holdings Limited (Effective holding = 69% (2008: 67%))			**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	
	2009 %	2008 %	**2009** Rand	2008 Rand	**2009** R'm	2008 R'm
ASSOCIATES						
Group						
Unlisted:						
MediQi Cham	**49.0**	49.0	**1**	1	**–**	–
MediQi Zürich	**49.0**	49.0	**2**	2	**–**	–
First Medical Centre L.L.C., Oman	**20.0**	20.0	**–**	–	**–**	–
Zentrallabor Zürich, Zürich (ZLZ) **	**54.0**	46.3	**5**	4	**–**	–
Curamed-Thabazimbi Trust	**38.0**	38.0	**–**	–	**4**	4
			8	7	**4**	4

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

** The Group has not obtained control (voting rights are below 50%).

Analysis of shareholders

at 31 March 2009

	Number of shareholders	Number of shares	%
DISTRIBUTION OF ORDINARY SHAREHOLDERS			
Public shareholders	**4 137**	**190 478 103**	**32.12%**
Non-public shareholders	**21**	**402 535 843**	**67.88%**
Directors and associates	**13**	**4 429 667**	**0.75%**
Own holdings (treasury shares)	**2**	**3 633 373**	**0.61%**
Industrial Partnership Investments Limited (Remgro)	**1**	**257 346 286**	**43.40%**
Trilantic Capital Partners (previously Lehman Brothers International)	**1**	**59 301 395**	**10.00%**
Black Economic Empowerment shareholders	**4**	**77 825 122**	**13.12%**
	4 158	**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 31 March 2009:

Industrial Partnership Investments Limited (Remgro)	**257 346 286**	**43.40%**
Trilantic Capital Partners (previously Lehman Brothers International)	**59 301 395**	**10.00%**
Black Economic Empowerment shareholders	**77 825 122**	**13.12%**
Mpilo Investment Holdings 2 (Pty) Ltd (Phodiso Holdings)	**39 332 736**	**6.63%**
Mpilo Investment Holdings 1 (Pty) Ltd (Circle Capital Ventures)	**23 377 488**	**3.94%**
Mpilo trusts	**15 114 898**	**2.55%**
Distribution of local and foreign beneficial shareholding:	**593 013 946**	**100.00%**
South African	**515 393 832**	**86.91%**
Foreign	**77 620 114**	**13.09%**

	2009	2008
JSE LIMITED		
Market capitalisation as at 31 March (R'000)	**12 749 800**	**11 682 375**
Price (cents per share)		
31 March	**2 150**	**1 970**
Highest	**2 575**	**2 695**
Lowest	**1 535**	**1 811**
Number of shares traded (000's)	**116 798**	**153 885**

SHARE CLOSING PRICE FROM 1990 – 2009

Analysis of shareholders

at 31 March 2009 (continued)

	2009 Beneficial			2008 Beneficial		
	Direct	**Indirect**	**Associates**	Direct	Indirect	Associates
DIRECTORS' INTERESTS *						
E de la H Hertzog	**–**	**3 036 183**	**349 821**	–	3 000 808	349 821
L J Alberts	**369 904**	**32 330**	**34 416**	369 904	–	34 416
J C Cohen	**–**	**–**	**–**	–	–	–
M K Makaba **	**–**	**–**	**–**	n/a	n/a	n/a
Z P Manase	**–**	**–**	**–**	n/a	n/a	n/a
A R Martin	**–**	**2 880**	**–**	–	2 880	–
D P Meintjes	**107 022**	**–**	**–**	93 517	–	–
K H S Pretorius	**109 252**	**–**	**–**	89 306	–	–
A A Raath	**–**	**–**	**–**	–	–	–
M A Ramphele ***	**–**	**–**	**–**	–	–	–
D K Smith	**–**	**–**	**–**	–	–	–
J G Swiegers	**82 023**	**284 720**	**20 159**	82 023	258 664	20 159
W L van der Merwe	**957**	**–**	**–**	957	–	–
M H Visser	**–**	**–**	**–**	–	–	–
T O Wiesinger	**–**	**–**	**–**	n/a	n/a	n/a
	669 158	**3 356 113**	**404 396**	635 707	3 262 352	404 396

* There has been no change in the directors' interests between the end of the financial year and 19 May 2009.

** Dr M K Makaba holds an effective interest of 5.07% 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 18.5% 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	**2 224**	**53.49%**	**823 589**	**0.14%**
1 001 – 10 000 shares	**1 308**	**31.46%**	**4 593 909**	**0.77%**
10 001 – 100 000 shares	**418**	**10.05%**	**13 137 008**	**2.22%**
100 001 – 1 000 000 shares	**163**	**3.92%**	**51 595 792**	**8.70%**
Over 1 000 000 shares	**45**	**1.08%**	**522 863 648**	**88.17%**
	4 158	**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 is hereby given that the twenty-sixth Annual General Meeting of the Company will be held at the Protea Hotel Stellenbosch, Techno Avenue, Techno Park, Stellenbosch on Thursday, 30 July 2009 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 2009 be accepted.

2. REAPPOINTMENT 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 during the financial year ending 31 March 2010 is Mr J Loubser.

3. APPROVAL OF DIRECTORS' REMUNERATION – 2008/2009

Ordinary Resolution Number 3
Resolved that the joint remuneration of the non-executive directors in the amount of R1 793 116 for the year ended 31 March 2009 be approved.

4. APPROVAL OF DIRECTORS' REMUNERATION – 2009/2010

Ordinary Resolution Number 4
Resolved that the following fees be approved as the basis for calculating the remuneration of the non-executive directors for the year ending 31 March 2010 with only 50% of the respective fee per meeting being payable in the case of non-attendance of a meeting:

Meeting	Fee per meeting for the year ended 31 March 2009	Proposed fee per meeting for the year ending 31 March 2010
Board	R22 020	R23 890
Chairperson: Audit and Risk Committee	R23 482	R25 480
Member: Audit and Risk Committee	R17 616	R19 115
Chairperson: Human Resources Committee	R17 612	R19 115
Member: Human Resources Committee	R13 212	R14 335
Chairperson: Investment Sub-committee	R23 482	R25 480
Member: Investment Sub-committee	R17 616	R19 115

5. RATIFICATION OF CO-OPTION OF DIRECTORS

Ordinary Resolution Number 5
Resolved that the co-option of Dr M K Makaba and Ms Z P Manase on 16 September 2008 and Dr T O Wiesinger on 5 November 2008 as directors of the Company is ratified.

A brief CV of Dr Makaba, Ms Manase and Dr Wiesinger appears on pages 8 and 9 of the annual report.

6. ELECTION OF DIRECTORS

Ordinary Resolution Number 6

6.1 Resolved that Dr M K Makaba 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;

6.2 Resolved that Ms Z P Manase who retires in terms of clause 30.10 of the Company's Articles of Association and who, being eligible, offers herself for re-election be hereby re-elected as a director of the Company;

6.3 Resolved that Mr D P Meintjes who retires in terms of clause 30.1 of the Company's Articles of Association and who, being eligible, offers himself for re-election be hereby re-elected as a director of the Company;

6.4 Resolved that Mr K H S Pretorius 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;

6.5 Resolved that Dr M A Ramphele who retires in terms of clause 30.1 of the Company's Articles of Association and who, being eligible, offers herself for re-election be hereby re-elected as a director of the Company;

6.6 Resolved that Prof W L Van der Merwe who retires in terms of clause 30.1 of the Company's Articles of Association and who, being eligible, offers himself for re-election be hereby re-elected as a director of the Company;

6.7 Resolved that Dr T O Wiesinger 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;

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

7. AUTHORITY TO PLACE SHARES UNDER CONTROL OF THE DIRECTORS

Ordinary Resolution Number 7

Resolved that the unissued ordinary shares in the authorised share capital of the Company be hereby placed under the control of the directors of the Company as a general authority in terms of 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 of the Company in their sole discretion may deem fit, subject to the aggregate number of ordinary shares available for allotment and issue in terms of this resolution being limited to 10% of the number of ordinary shares in issue at 31 March 2009, 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").

8. AUTHORITY TO ISSUE SHARES FOR CASH

Ordinary Resolution Number 8

Resolved that, subject to Ordinary Resolution Number 7, 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 –

8.1 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;

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

8.3 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;

8.4 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;

8.5 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;

8.6 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;

8.7 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

8.8 in determining the price at which an issue of shares may be made in terms of this authority, the maximum discount permitted will be 10% of the weighted average traded price on the JSE of those shares over the 30 business days prior to the date that the price of the issue is determined or agreed to between the directors of the Company and the party subscribing for the securities. The JSE should be consulted for a ruling if the applicant's securities have not traded in such 30 business day period.

This Ordinary Resolution Number 8 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 shareholders present or represented by proxy and entitled to vote, at the Annual General Meeting.

9. AMENDMENTS TO MEDI-CLINIC MANAGEMENT INCENTIVE SCHEME

Ordinary Resolution Number 9

Resolved that the following amendments to the Medi-Clinic Management Incentive Scheme ("the Incentive Scheme") document adopted on 22 March 2006 be and is hereby approved in terms of the provisions of the recently amended Schedule 14 of the Listings Requirements of the JSE Limited ("the Listings Requirements"):

9.1 Inserting the following new definitions in clause 1:

""EBITDA"	Medi-Clinic and its relevant subsidiaries' consolidated earnings before interest, tax, depreciation and amortisation;
"targeted EBITDA"	target EBITDAs determined by the Board for the relevant period for purposes of the Incentive Scheme; and"

9.2 Inserting the following new clause 3.3 after the existing clause 3.2:

"3.3 Basis upon which Bonuses will be awarded

Bonuses will be awarded to senior management employees based on the factors set out in the second unnumbered paragraph of clause 3.4. A member of the Board shall recuse him- or herself from any deliberations by the Board relating to the awarding of a Bonus to him or her."

9.3 Deleting the wording of the second unnumbered paragraph of clause 3.4 (the old clause 3.3) and substituting it with the following wording:

"The Rules shall provide that the Bonus payable to a Participant in terms of the Incentive Scheme is to be calculated by taking into account the Participant's annual remuneration, his/her job grade and the achievement of the applicable targeted EBITDA over the relevant period."

9.4 Inserting the following new clause 3.5 after the clause 3.4 (the old clause 3.3):

"3.5 Mergers, takeovers and corporate action

The discretion to award a Bonus will be exercised by the Board at the end of the relevant period, after which the Bonus becomes payable to a Participant, and accordingly any merger, takeover or corporate action relating to the Company during that period will not affect a Bonus, but will be factors that the Board will take into account in the exercise of its discretion in awarding a Bonus, and determining the cash component and share component of a Bonus."

9.5 Deleting the wording of clause 3.6 (the old clause 3.4) and substituting it with the following wording:

"3.6 Consequences of termination of employment

A refund as specified below, will be applied if a Participant leaves the service of Medi-Clinic within 3 years following the payout of a Bonus for any reason other than the following:

- Normal retirement;
- Approved early retirement;
- Approved early retirement due to medical disability;
- Obligatory early retirement;
- Retrenchment initiated by the Company; and
- Death.

The refund to be applied, should a Participant leave the service of Medi-Clinic for any other reason than stated above, is to be calculated by multiplying the number of shares purchased for the Participant during the 3 years immediately prior to leaving the service of Medi-Clinic by the market price of the Medi-Clinic Shares on the final day of service. In the event of a sub-division or consolidation of the Medi-Clinic Shares, the Board shall make appropriate adjustments to the aforementioned refund with reference to the number of Medi-Clinic Shares which would have been purchased by the Participant had such sub-division or consolidation occurred prior to the purchase of the relevant Medi-Clinic Shares by the Participant."

9.6 Deleting the wording of the second unnumbered paragraph of clause 3.8 (the old clause 3.6) and substituting it with the following wording:

"Medi-Clinic's issued share capital currently comprises 593 013 946 Medi-Clinic Shares. The maximum aggregate number of new Medi-Clinic Shares and Treasury Shares which may be made available to Participants in terms of the Incentive Scheme will be 59 301 394 Medi-Clinic Shares, or such other number as may be approved by shareholders in general meeting. In the event of a sub-division or consolidation of the Medi-Clinic Shares, the Board shall make such adjustments to the aforementioned maximum threshold, as to ensure that such maximum threshold after such sub-division or consolidation represents the same percentage of the Medi-Clinic Shares in Medi-Clinic as it represented before such sub-division or consolidation."

9.7 Deleting the wording of the third unnumbered paragraph of clause 3.8 (the old clause 3.6) and substituting it with the following wording:

"The maximum number of Medi-Clinic Shares which may be made available to an individual Participant in terms of the Scheme is 5 930 139, or such other number as may be approved by shareholders in general meeting. In the event of a capitalisation issue, special dividend, rights issue or reduction of Medi-Clinic's capital, the Board shall make such adjustment to the aforementioned individual threshold, as to ensure that such individual threshold after such capitalisation issue, special dividend, rights issue or reduction of capital represents the same percentage of the Medi-Clinic Shares in Medi-Clinic as it represented before such capitalisation issue, special dividend, rights issue or reduction of capital."

In terms of the Listings Requirements, 75% (seventy-five percent) of the votes cast by shareholders present or represented by proxy at the Annual General Meeting, excluding all the votes attaching to all shares owned or controlled by persons who are existing participants in the Incentive Scheme which have been acquired in terms of the Incentive Scheme, must be cast in favour of this Ordinary Resolution Number 9 for it to be approved.

This Ordinary Resolution Number 9 is required to enable the Company to consolidate amendments made to Schedule 14 of the Listings Requirements relating to share option/incentive schemes and the interpretation thereof, to change the basis upon which bonuses will be payable to participants, to deal with the impact of a merger, takeover or corporate action on a bonus, to increase the maximum aggregate number of new shares in the Company and treasury shares which may be made available to participants in terms of the Incentive Scheme, albeit that such maximum number still represents 10% of the total number of issued shares in the Company, and to increase the maximum number of shares in the Company which may be made available to an individual participant in terms of the Incentive Scheme, albeit that such maximum number still represents 10% of the aforementioned maximum aggregate number of shares which may be made available to participants in terms of the Incentive Scheme.

The amended Incentive Scheme document will be available for inspection by the shareholders of the Company at the Company's principal place of business and at the address of the transfer secretaries of the Company in Johannesburg from the date of this notice to the date of the Annual General Meeting.

10. 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:

10.1 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;

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

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

10.4 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;

10.5 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;

10.6 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;

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

10.8 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:

10.9 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;

10.10 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;

10.11 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

10.12 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.

11. 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 127 of the annual report.
- **Material changes**
  There are no material changes to report on.
- **Directors' interests in securities**
  See page 128 of the annual report.
- **Share capital of the Company**
  See page 100 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

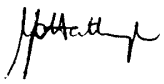
Shareholders who have not dematerialised their shares or who have dematerialised their shares with "own" name registration are entitled to attend and vote at the meeting. Any such shareholder is entitled to appoint a proxy or proxies to attend, speak and vote in their stead. The person so appointed need not be a shareholder of the Company. Proxy forms must be forwarded to reach the Company's transfer secretaries, Computershare Investor Services (Proprietary) Limited, 70 Marshall Street, Johannesburg, 2001 or posted to the transfer secretaries at P O Box 61051, Marshalltown, 2107, South Africa, so as to be received by them by not later than 15:00 on Tuesday, 28 July 2009. Proxy forms must only be completed by shareholders who have not dematerialised their shares or who have dematerialised their shares and registered them in their own name.

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

Shareholders who have dematerialised their shares, other than those shareholders who have dematerialised their shares with "own" name registration, should contact their Central Securities Depository Participant ("CSDP") or broker in the manner and time stipulated in their agreement, in order to furnish them with their voting instructions and to obtain the necessary authority to do so, in the event that they wish to attend the Annual General Meeting.

Equity securities held by a share trust or scheme will not have their votes at general/annual meetings taken into account for the purposes of resolutions proposed in terms of the JSE Listings Requirements.

By order of the Board of Directors.



GC HATTINGH
Company Secretary

STELLENBOSCH
30 June 2009

DIRECTIONS TO PROTEA HOTEL

R310 – BADEN POWELL OFF THE N2

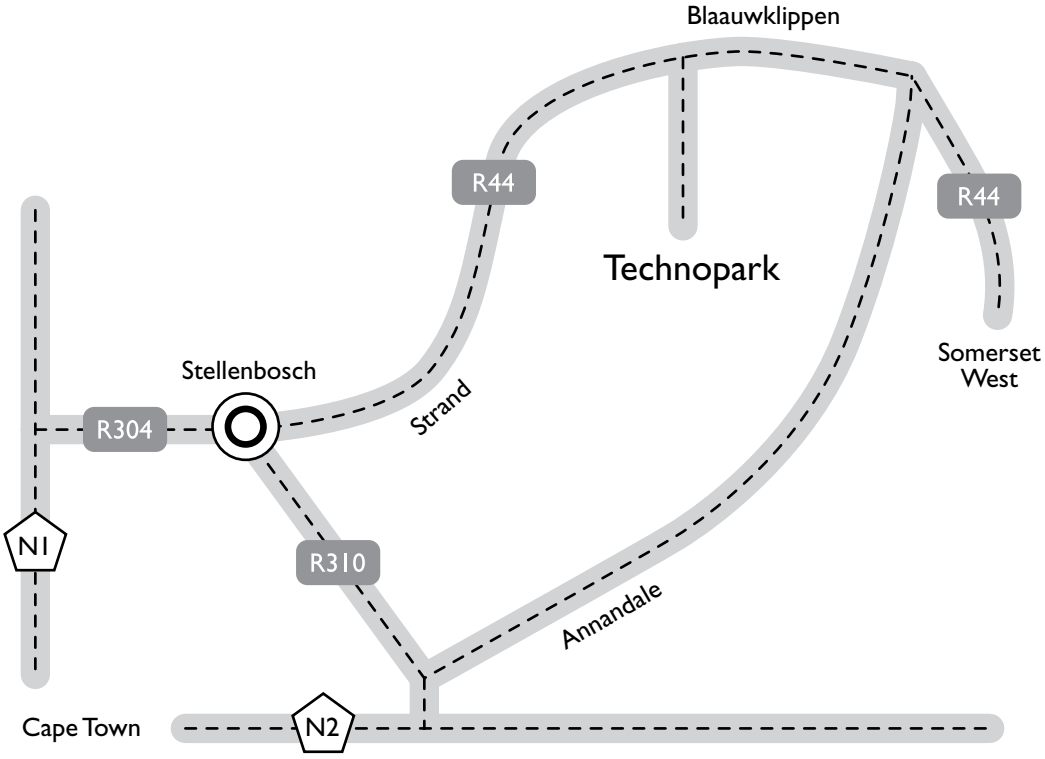
Take Annandale RIGHT turn-off across the Total Service Station. At the end of Annandale road, turn left onto the R44. Continue on the R44. Turn left into TECHNO PARK at the 2nd set of traffic lights. Continue 1 km up the road, PROTEA HOTEL STELLENBOSCH is situated on top of the hill, on the left-hand side.

N2 – or AIRPORT

Follow the N2 towards Somerset West. Take the R44 turn-off at Somerset West, and turn left. Continue on the R44. Turn left into TECHNO PARK at the 4th set of traffic lights. Continue 1 km up the road, PROTEA HOTEL STELLENBOSCH is situated on top of the hill, on the left-hand side.

N1 from Cape Town

Take the Stellenbosch and Klipheuwel turn-off to your left. At the T-junction turn right onto the R304. Continue on the R304 into Stellenbosch. Turn right onto the R44. Continue on the R44 and turn right at the 9th traffic light into TECHNO PARK. Continue 1 km up the road, PROTEA HOTEL STELLENBOSCH is situated on top of the hill, on the left-hand side.



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 SHAREHOLDERS WHO HAVE NOT YET DEMATERIALISED THEIR SHARES IN THE COMPANY, AND
2. REGISTERED SHAREHOLDERS 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 shareholders of the Company at the twenty-sixth Annual General Meeting of the Company to be held on Thursday, 30 July 2009 at 15:00 at the Protea Hotel Stellenbosch, Techno Avenue, Techno Park, 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 2009 or at any adjournment thereof, as follows (see note 2 and instruction 2 overleaf):

		Insert the number of votes exercisable (one vote per share)		
		For	Against	Abstain
Ordinary Resolutions				
1.	Consideration of annual financial statements			
2.	Reappointment of auditors			
3.	Approval of directors' remuneration – 2008/2009			
4.	Approval of directors' remuneration – 2009/2010			
5.	Ratification of co-option of directors			
	5.1 M K Makaba			
	5.2 Z P Manase			
	5.3 T O Wiesinger			
6.	Election of directors:			
	6.1 M K Makaba			
	6.2 Z P Manase			
	6.3 D P Meintjes			
	6.4 K H S Pretorius			
	6.5 M A Ramphele			
	6.6 W L van der Merwe			
	6.7 T O Wiesinger			
7.	Authority to place shares under control of the directors			
8.	Authority to issue shares for cash			
9.	Amendments to Medi-Clinic Management Incentive Scheme			
Special Resolution				
10.	Authority to repurchase shares			

Signed at _____ on _____2009.

Signature/s _____

Assisted by me (where applicable) _____

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

Notes:

1. A shareholder entitled to attend and vote at the Annual General Meeting is entitled to appoint one or more proxies to attend, speak and vote in his/her stead. A proxy need not be a shareholder of the Company.

2. Every shareholder present in person or by proxy and entitled to vote at the Annual General Meeting of the Company shall, on a show of hands, have one vote only, irrespective of the number of shares such shareholder holds, but in the event of a poll, every ordinary share in the Company shall have one vote.

3. Shareholders who have dematerialised their shares in the Company and are registered in their own names are shareholders who appointed Computershare Custodial Services as their Central Securities Depository Participant (CSDP) with the express instruction that their uncertificated shares are to be registered in the electronic sub-register of shareholders in their own names.

Instructions on signing and lodging of the proxy form:

1. A shareholder may insert the name of a proxy or the names of two alternative proxies of the shareholder's choice in the space/s provided overleaf, with or without deleting "the chairman of the Annual General Meeting", but any such deletion must be initialled by the shareholder. Should this space be left blank, the chairman of the Annual General Meeting will exercise the proxy. The person whose name appears first on the proxy form and who is present at the Annual General Meeting will be entitled to act as proxy to the exclusion of those whose names follow.

2. A shareholder's voting instructions to the proxy must be indicated by the insertion of the number of votes exercisable by that shareholder in the appropriate spaces provided overleaf. Failure to do so shall be deemed to authorise the proxy to vote or to abstain from voting at the Annual General Meeting, as he/she thinks fit in respect of all the shareholder's exercisable votes. A shareholder or his/her proxy is not obliged to use all the votes exercisable by his/her proxy, but the total number of votes cast, or those in respect of which abstention is recorded, may not exceed the total number of votes exercisable by the shareholder or by his/her proxy.

3. A minor must be assisted by his/her parent or guardian unless the relevant documents establishing his/her legal capacity are produced or have been registered by the transfer secretaries.

4. To be valid the completed proxy forms must be lodged with the transfer secretaries of the Company, Computershare Investor Services (Proprietary) Limited, 70 Marshall Street, Johannesburg, 2001, South Africa or posted to the transfer secretaries at PO Box 61051, Marshalltown, 2107, South Africa, to be received by them not later than **Tuesday, 28 July 2009** at 15:00 (South African time).

5. Documentary evidence establishing the authority of a person signing this proxy form in a representative capacity must be attached to this proxy form unless previously recorded by the transfer secretaries or waived by the chairman of the Annual General Meeting.

6. The completion and lodging of this proxy form shall not preclude the relevant shareholder from attending the Annual General Meeting and speaking and voting in person thereat to the exclusion of any proxy appointed in terms hereof, should such shareholder wish to do so.

7. The completion of any blank spaces overleaf need not be initialled. Any alterations or corrections to this proxy form must be initialled by the signatory/ies.

8. The chairman of the Annual General Meeting may reject or accept any proxy form which is completed other than in accordance with these instructions provided that he is satisfied as to the manner in which a shareholder wishes to vote.

NOTES