



CARE

**NETCARE
LIMITED**
2015 ANNUAL
INTEGRATED
REPORT



You're in safe hands

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REFERS TO INFORMATION CONTAINED IN THE 2015 ANNUAL INTEGRATED REPORT (OUR PRIMARY REPORT TO STAKEHOLDERS)

Available in print and online

- + Primary report: 2015 Annual Integrated Report including abridged annual financial statements
- + Notice of annual general meeting and proxy form

Available online

Financial performance

- + Complete Group annual financial statements
- + Analysis of shareholders

Governance

- + Complete corporate governance report
- + King III compliance checklist

Non-financial performance

- + GRI G3.1 disclosure index

SA additional reports

- + Quality and clinical governance report
- + Our people report
- + Transformation report
- + Corporate social investment report
- + Environmental report

UK additional reports

- + Superior patient care report
- + People, performance and culture report
- + Corporate social investment report
- + Facilities and sustainability report



REFERS TO INFORMATION AVAILABLE ON OUR INVESTOR RELATIONS WEBSITE, AT www.netcareinvestor.co.za.



PROFILE

The Netcare Group invests in growing and continually improving our capabilities and capacity, and in partnering with the public sector, to support the effectiveness of the national healthcare systems in which we operate.

In South Africa (SA), we provide the largest comprehensive network of private healthcare services. This comprises our 52 hospitals, which are differentiated by their high-acuity services, our ancillary emergency medical and primary care services, and our joint ventures in renal and cancer care. We also manage four Public Private Partnership (PPP) hospitals in conjunction with the respective provincial departments of health.

In Lesotho, in our PPP with the national government, we manage the facilities and provide clinical services in a major hospital and filter clinics. This innovative model has broadened our role in public sector healthcare delivery in an African context.

In the United Kingdom (UK), our network of 56 private hospitals is the largest in the country. This puts 90% of the population who are covered by Private Medical Insurance (PMI) within an hour's drive of a BMI Healthcare facility.

We have extensive experience in providing services to the National Health Service (NHS).

113
hospitals



13 206
hospital beds (registered)



95
primary healthcare
facilities/clinics



83
retail pharmacies*



59 renal
dialysis facilities*



85 Netcare 911
emergency bases*



7 Netcare
training colleges*



28 763
employees



* SA only.



Our annual integrated report for the year ended 30 September 2015 is our primary report to stakeholders.

It caters for a broad stakeholder readership, while also providing the information that shareholders have traditionally required. We provide comprehensive supplementary reports online to cater for the information needs of specific stakeholders.

Scope and boundary

This report incorporates all our operating subsidiaries, joint ventures and key associates in SA, Lesotho and the UK, unless otherwise stated.

We report the non-financial data of joint ventures where we have management responsibility, specifically those that are co-located at our facilities, as well our PPPs in SA and Lesotho.

Our report is framed by the longer-term intent of our strategy and our expectations for the future of healthcare, as well as the macroeconomic conditions and prospects of the countries in which

we operate. As such, it includes information pertaining to other entities that are critical to our ability to create value, for example regulatory authorities, funders, industry associations and third-party service providers.



OUR KEY RELATIONSHIPS AND THE KEY ISSUES RAISED BY OUR STAKEHOLDERS, THE CHANNELS WE USE TO ENGAGE WITH THEM AND OUR RESPONSES CAN BE FOUND ON PAGES 18 TO 21.

No changes to the Group structure have been made.

TERMS AND ABBREVIATIONS USED IN THIS REPORT ARE EXPLAINED ON PAGE 159.

FOR IMPORTANT INFORMATION ON FORWARD-LOOKING STATEMENTS IN THIS REPORT, REFER TO THE INSIDE BACK COVER.

WE WELCOME FEEDBACK ON OUR ANNUAL INTEGRATED REPORT AND THE SUPPLEMENTARY INFORMATION WE PROVIDE. PLEASE EMAIL YOUR FEEDBACK TO ir@netcareinvestor.co.za.

Materiality

Netcare’s annual integrated report aims to provide concise and material information on the Group’s strategy, performance and prospects.

In line with the International Integrated Reporting Framework, we have identified our material issues as those issues with the potential to have a substantial impact on our ability to create and sustain value for stakeholders. The Group Executive Committee, which is significantly involved in preparing the integrated report, has determined the material issues for the year based on the attention they required from the Board and executive teams, the views of operational management and the concerns of key stakeholders. In determining our material issues we have considered our top business risks, as well as additional operational risks highlighted in the interviews with operational management conducted as part of the integrated report process. Our material issues have been approved by the Netcare Board and are reported on in greater detail on pages 22 to 27. They are:

- + Positioning our operations to compete effectively in a challenging economic environment and highly regulated sector;
- + Achieving strategic differentiation in delivering quality patient care;
- + Facilitating affordable quality healthcare; and
- + Maintaining an innovative, robust and proactive asset and utilities management strategy.



OUR RISK MANAGEMENT SYSTEM AND PROCESSES, INCLUDING OUR TOP BUSINESS RISKS AND INFORMATION ON OUR COMBINED ASSURANCE MODEL IN SA, ARE DETAILED IN OUR RISK MANAGEMENT REPORT ON PAGE 94.

Reporting frameworks

We have prepared our report in accordance with all applicable reporting requirements, including:

- + South African Companies Act No 71 of 2008;
- + JSE Limited (JSE) Listings Requirements;
- + King Report on Corporate Governance for South Africa (King III);
- + International Integrated Reporting Framework, published in December 2013;
- + Global Reporting Initiative’s (GRI) G3.1 Sustainability Reporting Guidelines (meeting the requirements of a level B report);
- + International Financial Reporting Standards (IFRS); and
- + South African Institute of Chartered Accountants (SAICA) Financial Reporting Guides.

Assurance

In accordance with our combined assurance model, Netcare has obtained assurance from management, and internal and external audit on financial information and certain non-financial performance indicators for the reporting period. A Combined Assurance Committee implements and oversees the combined assurance model and feedback is provided to the Group Risk and Group Audit committees, as well as the Group Executive Committee.

Group Risk, Audit and Forensic Services (Internal Audit), assessed the effectiveness of the Group’s system of internal control and risk management, which is overseen by the Audit Committee, and found it to be effective. Internal Audit assures non-financial information presented in the annual integrated report on a cyclical basis.

Accredited rating agency, Empowerdex, has assured the Group’s Level 8 contributor rating according to the revised Department of Trade and Industry’s Codes of Good Practice for Broad-Based Black Economic Empowerment (B-BBEE), effective 1 May 2015.



OUR B-BBEE SCORECARD IS AVAILABLE IN THE SA: TRANSFORMATION REPORT.

Global Carbon Exchange SA Proprietary Limited (GCX) have independently assured our results for the purpose of reporting to the Carbon Disclosure Project (CDP). The verification was performed at a limited level of assurance and in accordance with the principles of the WBCSD/WRI Greenhouse Gas Protocol Corporate Accounting Standard, 2nd Edition, 2004.



OUR SA: ENVIRONMENTAL REPORT IS AVAILABLE ONLINE.

Our external auditor, Grant Thornton, has provided unqualified assurance on the Group annual financial statements.

The Group consolidated annual financial statements are presented in this annual integrated report in a condensed format and are correctly quoted.



THE ASSURANCE STATEMENT CAN BE FOUND IN THE COMPLETE GROUP ANNUAL FINANCIAL STATEMENTS ONLINE.

Approval

The Board acknowledges its responsibility to ensure the integrity of the annual integrated report. In the Board’s opinion, this report provides a fair and balanced account of the Group’s performance on those material issues that we believe have a bearing on the Group’s capacity to create value over the short, medium and long term. The annual financial statements of the Group for the year ended 30 September 2015 were approved by the Board of directors on 19 November 2015 and signed on its behalf by:

Meyer Khan
Non-executive Chairman

Dr Richard Friedland
Chief Executive Officer



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Adjusted
HEPS
189.0 cents
up 12.6%

Total
dividend
per share
92.0 cents
up 15.0%

CHAIRMAN'S REVIEW

In the context of the world-class clinical outcomes we deliver and the high expectations our stakeholders rightly have of private healthcare, the quality of care we provide is our most important competitive differential.

Introduction

I am pleased to present the Netcare Group's 2015 integrated report to stakeholders. At the outset, I wish to acknowledge the talent and dedication of our leadership and staff who work tirelessly to deliver and continually improve the high quality of care and facilities the Group offers. Our people ultimately determine the Group's ability to provide healthcare to rival the best in the world, and to do so as efficiently as possible. It is this that gives us our licence to operate and grow the business in a sector that provides an essential service to society.

Our business is underpinned by a pragmatic approach to governance that seeks to apply best practice in our frameworks, policies and controls, in a manner that constantly improves the way the business is managed. This integration of governance and risk management supports the Board's objective to ensure a sustainable business that generates good returns, which in turn attracts investment into the private healthcare sector.

Ongoing investment in optimising our operations

Our properties, plant and equipment are the backbone of delivering a world-class standard of medical treatment and innovation, and they represent significant value on our balance sheet. However, it is important to recognise that our facilities are sterile without our three most important assets, which carry no value on the balance sheet. They are the competence and commitment of our management and staff, the competitive strength of our brands, and the perceptions of our many stakeholders which collectively determine the health of our reputation.

Our strategic intentions to grow the Group require that our operating models are optimised to the extent that they can be effectively replicated wherever we choose to operate.

In this regard I am struck year in and year out by the awards the Group receives, which are listed at the end of this review. The extent of these accolades endorse our significant and sustained investment in our intangible assets, and our careful management of the risks that pertain to each of them.

Our ability to operate wide-ranging healthcare services effectively, affordably and responsibly relies on managing the complex relationships that comprise the private healthcare value chain. While doctors are in effect the single most important factor in attracting patients to our facilities, it is our patients that must be placed at the centre of the private healthcare universe. This requires combining the activities of many diverse role players in a way that supports the best clinical outcomes and patient experience, while doing our part to ensure the sustainability of increasingly constrained healthcare funding.

We focus as a matter of course on competing for scarce doctor and nursing skills. The availability and cost of these skills is a key risk that needs to be managed carefully, especially as the higher levels of acuity of our hospitals require more specialised skills that come at a higher cost. We train close to 4 000 nurses and paramedics a year in SA in our seven training colleges, well beyond our own requirements. As regulations restrict the training of doctors in the private sector, attracting and retaining doctors depends on constantly investing in the quality of our facilities, equipment and nursing care, and managing our relationships with doctors as critical partners through well-developed committee structures at unit level.

In the context of the world-class clinical outcomes we deliver and the high expectations our stakeholders rightly have of private healthcare, the quality of care we provide is our most important competitive differential. Our ongoing efforts to embed ***the Netcare Way*** of doing things right, which has included interventions focused on treating patients with dignity and respect, recognises that achieving a consistent quality of care is the most important factor in delivering an excellent patient experience.

The Group has systematically optimised its operations over the last few years.

Specifically, we have strengthened our underlying management and governance systems relating to quality leadership, human resources, information technology (IT) optimisation and environmental sustainability. Operational Excellence, a Group-wide efficiency programme aimed at digitalising and improving business processes, is a key priority and is delivering efficiencies and supporting operating margins.

As this discussion shows, Netcare's strategy rests on fanatical attention to doing things right every day, in each individual facility and across all our operations. This tactical approach is the springboard for the Group's broader corporate strategy to grow our businesses within our existing markets and in new markets. Put differently, our strategic intentions to grow the Group require that our operating models are optimised to the extent that they can be effectively replicated wherever we choose to operate.

Geographic expansion remains a focus of Netcare's growth strategy, and we identified and investigated a number of acquisition opportunities in the year. None of the assets considered met our strategic investment criteria.

A solid performance in challenging conditions

In SA, the combination of low economic growth, high unemployment and stagnant job creation led to a decline in medical aid beneficiaries. However, demand for our services was held up by SA's heavy burden of disease, aging population and the challenges faced by the public healthcare sector. Whereas the competition among major private hospital groups in the country has driven up the quality, efficiency and productivity of the sector over many years, of late we have seen competition across all areas of private healthcare escalate as smaller players have entered specific segments of the market.

Against this difficult backdrop, the Group's results reflected a solid performance from our operations in SA. Of note was the record total of 584 new beds added to our hospital network during the year, an increase of 6.1% to 9 996 registered beds, and the long-term

The Board is confident in the Group's strategic direction, and the specific actions management is taking to optimise all aspects of our operations and respond to the targeted growth opportunities in our markets.

efficiency programmes and strict cost management that lifted margins and delivered strong operating leverage.

In the UK, the economic recovery has yet to filter through to the PMI market, which has continued to feel the impact of declining subscriber numbers, stringent claims management processes and directional products. However, increasing funding challenges and capacity constraints in the NHS has resulted in higher volumes of NHS caseload moving to the private sector.

BMI Healthcare benefitted from this trend, recording an improvement in NHS funded activity. Supporting this was the large-scale restructuring programme completed in the year, which delivered productivity gains and savings that widened margins despite the higher proportion of NHS caseload at lower tariffs.

These operational achievements enabled the Group to grow revenue by 6.1% to R33.7 billion for the year. Pleasingly, earnings before interest, tax, depreciation and amortisation (EBITDA) rose by 13.1% to R5.0 billion.

Adjusted headline earnings per share rose 12.6% to 189.0 cents. The Board declared a final dividend of 54.0 cents per share, up 12.5% on the year before, which combined with our interim dividend of 38.0 cents amounted to 15.0% growth in the total dividend to 92.0 cents per share.

The Group's financial position is healthy. Strong cash generation by the SA operations, which rose 17.8% in the year at an excellent cash conversion ratio of 105.1%, has supported the balance sheet by allowing the Group to contain the increase in net debt levels. This was achieved notwithstanding the R4.4 billion allocated to capital expenditure, tax and dividend distributions.

Besides the ordinary dividends of R1 166 million paid to shareholders, R211 million was paid to beneficiaries of our Health Partners for Life trusts. This brought the combined cash payments to shareholders, empowerment partners and revenue authorities to R2 539 million, 27.1% higher than the year before.

The restructure of the General Healthcare Group (GHG) PropCo 1 debt facility finally concluded on 29 May 2015 after

protracted negotiations between lenders. Netcare no longer has any equity interest in the GHG PropCo 1 entities but our leases for 35 BMI Healthcare hospitals are in place until 2031, with a further 10-year renewal option. The agreement makes provision for the possibility of a rental reduction arrangement and discussions with lenders are ongoing in this regard.

Key developments in governance, risk and remuneration

My association with Netcare is a longstanding one. I have been a non-executive director for 15 years and was appointed Acting Chairman in June 2015 after Jerry Vilakazi retired. Following the Board's ratification of my appointment as non-executive Chairman in November 2015, as part of our succession planning for key positions, the Nomination Committee reviewed the Board's composition and made recommendations in line with King III and JSE Listing Requirements.

Thevendrie Brewer was appointed as lead independent non-executive director and Deputy Chair, and Azar Jammine and Norman Weltman have replaced me as Chair of the Remuneration Committee and Chair of the Risk Committee, respectively. We have also reviewed and augmented the membership of various Board sub-committees.

We also welcomed Bukelwa Bulo and Mark Bower as independent non-executive directors. Bukelwa has worked in private equity for over 10 years, giving her exposure to a wide range of sectors. Her external board appointments include Capital Appreciation Limited, Jade Capital Partners Proprietary Limited, Unispan Holdings Proprietary Limited and Franki Geotechnical Proprietary Limited. In addition to his academic expertise and professional acumen in accounting and auditing, Mark has held leadership positions at Deloitte, SAB Miller and Edcon. He is on the board of Rhodes Food Group Holdings Limited and is a trustee of Thuthuka Bursary Fund.

In the UK, GHG's Chief Executive Officer (CEO), Jill Watts, is responsible for the strategic development and day-to-day operations of BMI Healthcare.

As reported last year, Jill was appointed to both the GHG and Netcare Boards in November 2014. Henry Davies was appointed as the Chief Financial Officer (CFO) of GHG on 1 September 2015. In January 2015, the composition of the Executive Board was augmented to include GHG's largely new executive management team, and the terms of reference and key performance indicators of GHG's national committees, which include a Governance Committee, were revised in June 2015.

As part of the Group's combined assurance model, we are strengthening the Group's Quality Risk Management programme by way of an external review of the Group Quality Management System. This will include all divisions in SA under a single, multi-site group certification process for ISO9001.

Phase 1 of the IT Governance (COBIT) project was concluded in the year. The project was initiated three years ago and implements 208 unique controls to manage the Group's top IT risks. These controls were partially reviewed by Internal Audit in the year, which led to minor rectifications. Grant Thornton performed a governance maturity assessment on the framework in October and November 2015 and a satisfactory rating was received. Planning for the remaining phases, which will address medium to lower risk controls, will be completed in the first quarter of 2016 with implementation to follow.

During 2015, we engaged a number of shareholders to obtain their views on the Group's remuneration structures and have endeavoured to respond to their views in the Remuneration report and policy review on page 114. The main areas of concern related to the disclosure of bonuses in relation to the performance metrics applied in the Forfeitable Share Plan (FSP). We have therefore improved our disclosure of the bonus payments paid to the CEO, CFO and top three prescribed officers, and the performance targets relating to the FSP.

In July 2015, the restructure of the Health Partners for Life B-BBEE share scheme was successfully completed. This has settled the internally funded debt of the B-BBEE trusts, leaving them unencumbered. The restructure will enhance value for future participants and simplify the administration of the scheme.

Outlook and appreciation

The Board is confident in the Group's strategic direction, and the specific actions management is taking to optimise all aspects of our operations and respond to the targeted growth opportunities in our markets.

In SA we expect demand for our services to remain robust. The new hospitals and beds opened late in the 2015 financial year are located in areas of high demand with strong doctor support. However, overall occupancy levels will be affected as activity levels build up, with a more pronounced impact in the first half of the 2016 year. Capital expenditure for 2016 will remain high at approximately R2 billion, covering the relocation of Netcare Christiaan Barnard Memorial Hospital in Cape Town, major and minor refurbishments and brownfield expansion projects.

Netcare is committed to participating fully in the Competition Commission's Private Healthcare Market Inquiry, and we are hopeful that the process will subject the anecdotal commentary on the drivers of healthcare expenditure to evidence-based scrutiny. The Competition Commission has amended the completion date of the Inquiry and a final report, which may include recommendations, is expected by 15 December 2016.

In the UK, BMI Healthcare's large footprint and available capacity position it to benefit from the growing supply gap as waiting lists and capacity constraints in the NHS drive volumes in the private healthcare sector. Efficiency initiatives will be further entrenched to support operating margin stability. BMI Healthcare will invest in projects to enhance its hospital infrastructure and equipment, with planned capital expenditure of approximately £40 million in the year ahead. With strong management in place and a clear strategy to optimise the business in relation to the drivers in its environment, the Board is confident that the prospects of the UK operation in the medium to longer term are strong.

The Group is well positioned for international growth, based on the maturity of our operating models and the Group's strong financial position, and we will continue to evaluate international expansion opportunities against our investment expectations.

I am confident the composition of the Netcare Board is suitably diverse, both in its proportion of independent non-executive directors and in the relevant expertise and experience that is brought to bear on our deliberations. I look forward to working closely with my fellow Board members, and the Executive Committee, to provide the stewardship the Group requires in a sector that is highly regulated, increasingly competitive and capital intensive.

I extend my thanks to our stakeholders who continue to show confidence in the strength of our business and the calibre of its leadership. Dr Richard Friedland and his executive team have once again done an outstanding job of navigating economic uncertainties and regulatory pressures to deliver excellent results while ensuring that the Group is fit for the future.



Meyer Khan
Non-executive Chairman

Striving for continual improvement

The awards Netcare received in the year recognise the progress we are making to continually improve our employment practices, quality leadership, service excellence, empowerment and corporate social responsibility. The contribution of these strategic efforts to our overall sustainability has also been recognised. The most notable Group accolades achieved this year included:

- + Won Best Workplace Diversity and Inclusion Strategy and recognised as a finalist in Best Learning and Development Strategy in the first annual Careers24 HR Future Awards.
- + Won 14 out of a potential 30 awards at the Best Care Always (BCA) Quality Improvement Summit in collaboration with the Hospital Association of South Africa; with four BCA Quality Improvement Awards in the areas of medication safety, healthcare associated infections, family-centred care in neonatal intensive care, and improving patient satisfaction outcomes, and 10 BCA Excellence Awards for other quality improvement projects.
- + Won the 2014/15 Ask Afrika Orange Index Award in the Private Hospitals category. The index acknowledges customer service excellence across various industries.
- + Ranked 17th in Brand Finance South Africa's 50 Most Valuable Brands survey for 2015, conducted in partnership with Brand South Africa and Brand Africa.
- + Ranked 44th in the Sunday Times Top 100 Companies Awards, which track the best-performing businesses on the JSE, acknowledging those with the highest shareholder returns over the past five years.
- + Achieved first place in the Hospital Management category of the 2015 Top 500 Companies Awards for the sixth consecutive year.

- + Recognised as the top ranked company in the healthcare sector in the 2015 Mail & Guardian's survey of the Most Empowered Companies in the JSE's Top 100 companies, with an overall ranking of 11th, up from 15th last year.
- + 2015 PMR.africa Diamond Arrow Award for Corporate Social Responsibility Initiatives.
- + The JSE FTSE Responsible Investment Index assesses performance in terms of corporate governance and the environmental, economic and social sustainability practices of listed companies. From 2016 assessment will take place in collaboration with FTSE Russell and Netcare has been included in this new index in 2015.
- + Retained inclusion in the Dow Jones Sustainability World Index and the Dow Jones Sustainability Emerging Markets Index in 2015, for the second consecutive year.
- + Received a 2015 RobecoSAM Bronze Class Sustainability Award.
- + In the UK, a number of BMI Healthcare hospitals were awarded the Macmillan Quality Environment Mark, a detailed quality framework that assesses whether cancer care environments meet the standards required for people affected by cancer.



AWARDS RECEIVED AT AN INDIVIDUAL HOSPITAL LEVEL ARE LISTED IN THE OPERATIONS SECTION STARTING ON PAGE 48.



OUR BOARD OF DIRECTORS



Executive directors

1 RH (Richard) Friedland (54)

Group Chief Executive Officer ♦ ○ +

Qualifications: BvSc, MBBCh, Dip Fin Man, MBA
Appointed: 15 May 1997

Prior to joining Netcare, Richard was Operations Director of Medicross responsible for overall operations and establishing medical centres on a national basis. He joined Netcare early in 1997 as Chief Operating Officer to lead the transformation and re-engineering of the businesses. He established Netcare UK and was CEO of the Netcare International Division from 2002 until August 2005. Richard was appointed CEO of the Netcare Group on 1 September 2005.

2 KN (Keith) Gibson (45)

Group Chief Financial Officer ♦

Qualifications: BAcc, CA(SA)
Appointed: 10 November 2011

Keith joined Netcare in July 2006 as Financial Manager of Netcare's International Operations. He was appointed as Acting Chief Financial Officer of Netcare on 1 August 2011, and as executive director and Group Chief Financial Officer from 10 November 2011. Prior to joining Netcare, he held senior financial positions with PPC Cement and Barloworld Limited. Keith also chairs the Finance and Investment Committee and Working Capital Committee.

3 JM (Jill) Watts (57)

Chief Executive Officer – General Healthcare Group (GHG)

Qualifications: MBA (Griffith University), Grad Diploma in Health Administration and Information Systems, Wharton J&J Leadership Program.
Appointed: 17 November 2014

Committee membership

♦	AUDIT COMMITTEE
♦	RISK COMMITTEE
✱	NOMINATION COMMITTEE
✱	REMUNERATION COMMITTEE
○	QUALITY LEADERSHIP COMMITTEE
+	SOCIAL AND ETHICS COMMITTEE

* All non-executive directors are independent.

Non-executive directors*

1 JM (Meyer) Kahn (76)

Board Chairman
Nomination Committee Chair
♦ ✱ + ✧

Qualifications: BA (Law), MBA, DCom (hc), SOE
Appointed: 14 April 2000
Other directorships: Former Chairman of SABMiller Plc.

Meyer is the former Chairman and Group Managing Director of SABMiller Plc. During 1997 to 1999 he was seconded full-time to the South African Police Service as its Chief Executive and was awarded the South African Police Star for Outstanding Service (SOE) in 2000. He is also a director of various companies and trustee of numerous organisations.

2 T (Thevendrie) Brewer (43)

Deputy Board Chair
Audit Committee Chair ✧ ✧ ✱

Qualifications: BCom, Postgraduate Diploma in Accountancy, CA(SA)
Appointed: 24 January 2011
Other directorships: NM Rothschild and Sons (SA) Proprietary Limited.

Thevendrie has had a distinguished career as an accountant, being a former Partner at Ernst & Young. Thevendrie has subsequently garnered extensive corporate finance experience while at Deutsche Securities (SA) Proprietary Limited and NM Rothschild & Sons (South Africa) Proprietary Limited.



3 M (Mark) Bower (60) ✧ ✧

Qualifications: BCom (cum laude), BCompt, BCompt Honours, CA(SA)
Appointed: 23 November 2015

Apart from his academic expertise and professional acumen in the field of accounting and auditing, Mark has held a series of leadership and senior executive positions at Deloitte, SABMiller and Edcon. His external board and trustee appointments include Rhodes Food Group Holdings Limited and Thuthuka Bursary Fund respectively. He was also a previous Edcon Limited board member.

4 B (Bukelwa) Bulu (38) ○ ✧

Qualifications: BBusSci Hons, CA(SA)
Appointed: 23 November 2015

Bukelwa has worked in the Private Equity industry for over 10 years and has procured extensive exposure to a wide spectrum of sectors. Her external board appointments include Capital Appreciation Limited, Jade Capital Partners Proprietary Limited, Unispan Holdings Proprietary Limited and Franki Geotechnical Proprietary Limited.

5 APH (Azar) Jammine (66)

Remuneration Committee
Chair ✧ ✱ ✧

Qualifications: BSc (Hons), BA (Hons), MSc, PHD
Appointed: 14 December 1998
Other directorships: Econometrix Proprietary Limited, Federated Employers' Mutual Assurance Co Limited, York Timber Holdings Limited, ETM Analytics and Iron Fireman (SA) Proprietary Limited.

Azar has been a director and Chief Economist of Econometrix since 1985 and is a non-executive director of Federated Employers' Mutual Assurance Co Limited and York Timber Holdings Limited.

6 MJ (Martin) Kuscus (60)

Quality Leadership Committee
Chair ○ +

Qualifications: BA Cur, Dip Company Direction, EDP
Appointed: 1 July 2008
Other directorships: Synergy Income Fund and Mineworkers Provident Fund.

Martin is an independent businessman active in the technology services industry. Prior to this, he served as President and CEO of the South African Bureau of Standards for five years. His career in Health Services and Provincial Government Finance spans almost three decades. In 2004 he was appointed as a Commissioner on the Financial and Fiscal Commission. In 2006 he was elected to the Council for the International Standards Organisations (ISO) and was a member of the PRI Board, a UN Global Compact Initiative on Responsible Investment, from 2006 to 2009. He was also Chairperson of the Board of Trustees for the Government Employees Pension Fund until July 2009. He is currently Chairperson of Synergy Income Fund and Chairperson of the Mineworkers Provident Fund.

7 KD (Kgomotso) Moroka SC (61)

Social and Ethics Committee Chair +

Qualifications: BProc, LLB
Appointed: 23 July 2006
Other directorships: Standard Bank Group Limited, South African Breweries Limited, MultiChoice South Africa Proprietary Limited and Royal Bafokeng Platinum Limited.

Kgomotso is a practising senior advocate and serves on a number of boards, including Standard Bank Group Limited, South African Breweries Limited and Multichoice South Africa Proprietary Limited. She is the Chairman of Royal Bafokeng Platinum Proprietary Limited and Gobodo Forensic & Investigative Accounting Proprietary Limited. She is also trustee of the Nelson Mandela Children's Fund, Project Literacy and Tshwaraneng Legal Advocacy Centre.

8 N (Norman) Weltman (66)¹

Risk Committee Chair ✧ ✧ ○

Qualifications: CTA, CA(SA)
Appointed: 3 November 1999
Other directorships: None.

Norman has been with the Group since 1993. He has over 15 years' experience in the healthcare industry and has previously served as Chairman of the Hospital Association of SA (HASA). Norman became a non-executive director with effect from 1 September 2008.

1. Executive director from 3 November 1999 and non-executive director from 1 September 2008.

OUR LONG-TERM GOAL

WHAT WE AIM FOR

As a comprehensive healthcare group, **Netcare's strategy is to provide the most effective, efficient and highest quality care** through our core hospital business and ancillary services. We achieve this through a relentless commitment to improving systems and processes, and eliminating harm and waste in every area of operation.

We execute our strategy through six strategic priorities, which ensure a **balanced approach to growth, profitability and value creation** for all our stakeholders. This is inseparable from generating competitive returns for our shareholders over the long term.

Our six strategic priorities are included in management balanced scorecards to ensure strategic alignment across divisions. Key performance indicators measure our progress in achieving our strategic priorities.

The transformation programme implemented in the UK during 2015 comprises eight work streams developed to support BMI Healthcare's vision for the next five years. The programme touches all aspects of the business, across governance, superior patient care, human capital, business growth, maximising efficiency and cost management, facilities, communications, and information management.

OUR VISION

WHAT WE ASPIRE TO

- + Develop and implement solutions to **provide quality, affordable healthcare** by inspiring our people, creating new healthcare horizons and delivering value for all stakeholders.
- + Strive for excellence in a unique brand of patient care delivered by people who are **passionate about the sanctity of life, personal respect and dignity**.
- + **Invest in people, infrastructure and technology**, and establish lasting relationships with healthcare professionals.
- + Be a **leading corporate citizen**, proud of our heritage and what we give to society.

OUR CORE PURPOSE

WHY WE EXIST

HELPING **CARE** FOR THE HEALTH OF HUMANKIND

STRATEGIC INTENT

HOW WE CREATE VALUE

TO BECOME A LEADING GLOBAL HEALTHCARE SERVICES GROUP BEST KNOWN FOR:

- + Successfully broadening access to affordable, quality healthcare.
- + Building strong and trusted healthcare brands with expertise across the healthcare services spectrum.
- + Delivering innovative, quality healthcare solutions to patients in SA and internationally.

OUR VALUES

WHAT WE STAND FOR

AT NETCARE, OUR CORE VALUE IS **CARE**

We care about the **dignity** of our patients and all members of the Netcare family. We care about the **participation** of our people and our partners in everything we do. We care about **truth** in all our actions. We are **passionate** about quality care and professional excellence.

STRATEGIC PRIORITIES

ORGANISATIONAL GROWTH

Strategic intent

- + Identify opportunities for growth in new and existing operations.
- + Strengthen our position as a provider of choice to the NHS in the UK.
- + Explore new markets outside SA and the UK for expansion.

OPERATIONAL EXCELLENCE

- + Focus on excellence.
- + Enhance efficiency in all our operations.
- + Contain costs without compromising quality.
- + Develop affordable healthcare services.
- + Achieve sustainable cost savings through reducing consumption of utilities.

PHYSICIAN PARTNERSHIPS

- + Partner with doctors that are highly qualified and competent.
- + Develop quality doctor networks and assist doctors in their professional development.
- + Create and maintain facilities and equipment to ensure the best clinical outcomes.
- + Promote leading centres of excellence.

BEST AND SAFEST PATIENT CARE

Strategic intent

- + Work towards best clinical outcomes and best patient experience.
- + Entrench quality as a strategic priority.
- + Achieve consistency in the quality of service delivery across multiple facilities.
- + Measure outcomes and processes to drive quality improvement.
- + Stay abreast of developments in clinical protocols and continue to define new clinical pathways.
- + Live **the Netcare Way**.
- + Ensure security of supply of electricity and water.

GROWING WITH PASSIONATE PEOPLE

- + Attract and retain the skills we require to achieve our objectives.
- + Provide training and development opportunities.
- + Recognise and reward performance.
- + Be an employer of choice.

ACCELERATING TRANSFORMATION

- + Embrace transformation and normalisation.
- + Fulfil the requirements of the revised B-BBEE Codes of Good Practice.



OUR TOP BUSINESS RISKS STARTING ON PAGE 100 LINK TO OUR STRATEGIC PRIORITIES. OUR PROGRESS IN SA IN TERMS OF OUR STRATEGIC PRIORITIES CAN BE FOUND IN THE OPERATIONAL REVIEWS ON PAGES 40 TO 41. IN THE UK, PROGRESS AGAINST THE EIGHT-POINT PLAN CAN BE FOUND IN THE OPERATIONAL REVIEW ON PAGES 74 TO 75.

OUR BUSINESS MODEL

CAPABILITIES

- 01

ABILITY TO DESIGN, PROJECT
MANAGE, BUILD, OPERATE
AND MAINTAIN LARGE
HEALTHCARE FACILITIES
- 02

EXPERTISE TO OPERATE
MULTI-SITE FACILITIES
ON AN INDUSTRIAL SCALE
- 03

ABILITY TO INTEGRATE,
CONSOLIDATE AND EXTRACT
ECONOMIES OF SCALE
- 04

ABILITY TO EXTRACT
EFFICIENCIES
- 05

IMPLEMENTATION OF IT
SYSTEMS TO INTEGRATE
MULTIPLE PLATFORMS INTO
ENTERPRISE-WIDE SYSTEMS
- 06

MANAGEMENT DEPTH
AND EXPERTISE
- 07

ABILITY TO TRAIN
HEALTHCARE
PROFESSIONALS

Netcare's core purpose to help care for the health of humankind is expressed in the work our people do with care and compassion, every hour of every day. This is our greatest contribution to the societies we serve.

OUR ACTIVITIES

OUR CORE BUSINESS

Private hospitals in SA and the UK

We operate a high-acuity network of hospitals, which provide the latest medical technology and treatment protocols. Our hospitals comprise a mix of multi-disciplinary tertiary institutions, centres of excellence, and same-day surgical units.

In SA we have five nursing training colleges that provide for our own requirements, and deepen the national skills pool.

OUR SA HOSPITAL OPERATIONS ARE REVIEWED ON PAGES 48 TO 55 AND THE UK ON PAGES 78 TO 83.

ANCILLARY SERVICES

Emergency medical services

Our network of emergency services in SA includes specialised road ambulances, fixed wing operations and helicopters, and skilled paramedics. We also provide on-site emergency services to industrial and corporate clients.

We run two colleges, which train paramedics beyond our own requirements.

NETCARE 911 IS REVIEWED ON PAGES 56 TO 59.

Retail pharmacies

We operate a national network of retail pharmacies in SA located within our hospitals and Medicross clinics.

Cancer care

Our network of oncology practices specialise in the treatment of cancer through chemotherapy and radiotherapy. Our clinical development initiatives and investment in technology and equipment enables oncologists to remain at the forefront of cancer care.

Primary Care facilities

We operate an extensive and well-equipped network of Primary Care facilities for group medical practices in SA. Our facilities provide access to general practitioner (GP) and dental consultations, preventive and chronic disease management services, as well as referrals to specialist care, radiology, pathology, pharmacy, physiotherapy and day theatres.

In the UK, we have three primary care clinics.

OUR SA PRIMARY CARE OPERATIONS ARE REVIEWED ON PAGES 60 TO 63.

Dialysis services

We have a 50% interest in National Renal Care, which provides dialysis services to patients with compromised kidney function, improving their quality of life and life expectancy.

It also runs four training academies, and has 19 and 18 units accredited for training clinical technology and nephrology nursing students respectively.

NATIONAL RENAL CARE OPERATIONS ARE REVIEWED ON PAGES 64 TO 67.

PUBLIC PRIVATE PARTNERSHIPS

Lesotho

In Lesotho we partner with the government to provide clinical services. Through this incubator project we have refined our approach to public healthcare delivery in Lesotho. The success of delivering improved clinical outcomes through this model have been independently verified.

South Africa

We are involved in four PPPs with provincial governments, encompassing the construction, refurbishment and management of hospital facilities, but excluding the provision of clinical services. National Renal Care has 12 PPPs ensuring that public sector patients have access to dialysis.

United Kingdom

We have provided publicly funded healthcare to UK citizens as part of a mixed delivery model for more than a decade. NHS-funded patients can access treatment from private healthcare providers as long as these providers meet set quality standards.

EXCELLENCE, QUALITY AND EFFICIENCY

The **Triple Aim** provides the foundational principle for our strategic approach. It is embedded in our operations through our pervasive quality leadership programmes and organisational culture initiative, **the Netcare Way**, which underpin our drive to deliver excellent clinical outcomes and consistently high quality care. It also informs the continual optimisation of our operational processes, which includes the increasing digitalisation of our business, to ensure efficiency.

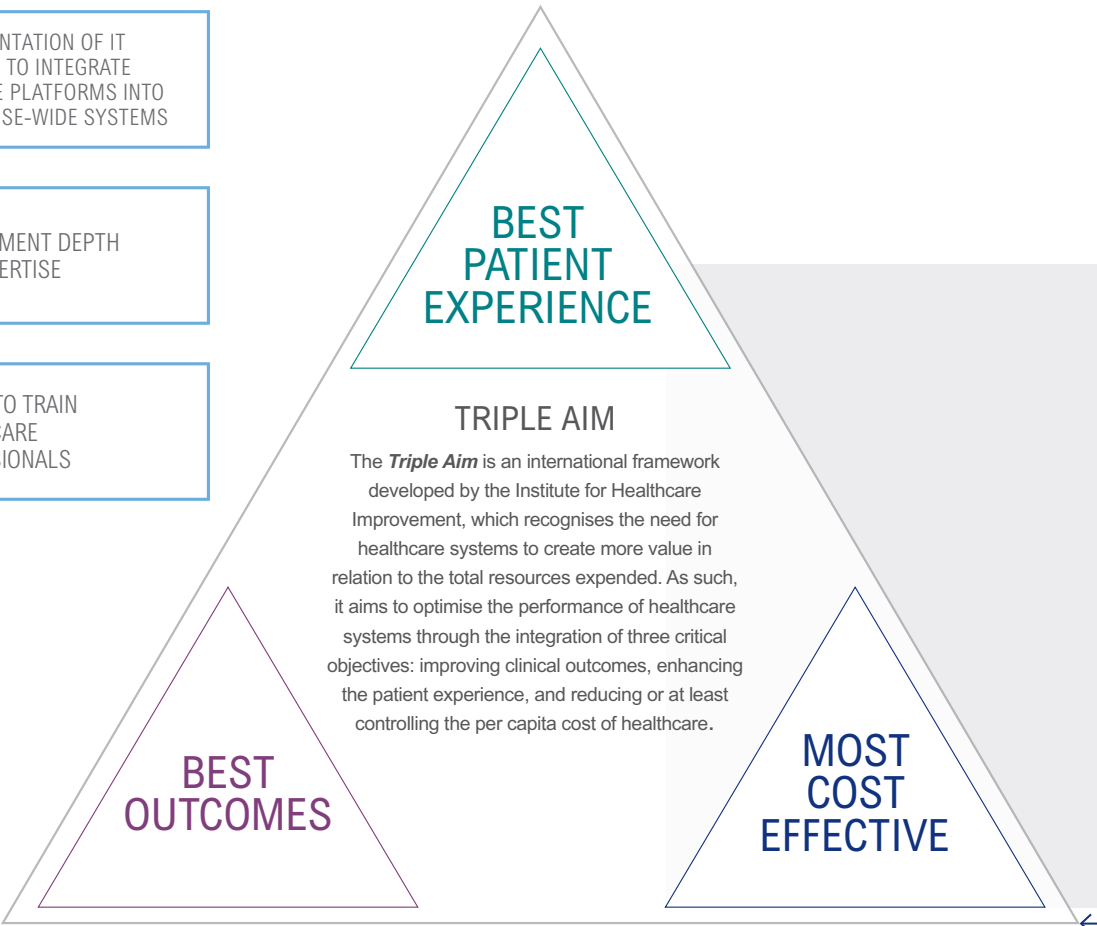
RISK MANAGEMENT, COMPLIANCE AND GOVERNANCE

We ensure a co-ordinated approach in adhering to all applicable regulatory frameworks. This is achieved through an entrenched governance model and an enterprise-wide approach to managing Group risk. Good corporate governance is central to managing the Group in a way that is efficient, accountable, transparent and ethical.

OUR ABRIDGED CORPORATE GOVERNANCE REPORT CAN BE FOUND ON PAGES 84 TO 93, AND OUR RISK MANAGEMENT REPORT ON PAGES 94 TO 113.

ASSET AND UTILITIES MANAGEMENT

We allocate significant capital expenditure to maintaining and refurbishing our facilities, as they are a key component of Netcare's value proposition and underpin the overall patient experience. We invest significantly in cutting-edge medical technology and conduct regular maintenance and repairs to our equipment. Our environmental sustainability strategy is aimed at securing critical utilities such as water and energy.



INPUTS → ACTIVITIES → OUTPUTS AND OUTCOMES

To provide the most effective, efficient and highest **quality of care to our patients**, we require:

HUMAN AND INTELLECTUAL CAPITAL

Skilled **employees** able to deliver the highest standard of medical care and define new clinical pathways, while ensuring that our facilities and equipment are sustainably maintained and operated at optimum efficiency. This is closely linked to intellectual capital, which is the **knowledge** required to operate a high-acuity network of hospitals, manage quality outcomes and identify areas for improvement.

SOCIAL AND RELATIONSHIP CAPITAL

The ability to attract a high calibre of **specialists, doctors** and **healthcare professionals** to our facilities, which in turn impacts patient volumes. Our relationship with **funders** is critical as it represents our most significant source of patient funding.

In the UK, our relationship with the **NHS** is increasingly important in driving volumes.

We also depend on strategic partnerships with a wide range of **suppliers** who facilitate our business activities, providing support services, as well as medicines, technology, equipment and consumables.

Our relationships with **regulators** and other legislative bodies are pivotal to maintaining our licences to operate, and our ability to contribute to healthcare development in each country of operation depends on our relationships with **governments**.

MANUFACTURED CAPITAL

Continuous investment in medical infrastructure and equipment, as well as in administrative and operational technology, so that we remain 'future fit' and are able to support the latest medical developments.

NATURAL CAPITAL

A constant, predictable supply of water and electricity to facilitate the delivery of medical interventions and operations.

FINANCIAL CAPITAL

The ability to attract **investors** as we operate capital-intensive businesses with long-term investment horizons.

OUR KEY RELATIONSHIPS CAN BE FOUND ON PAGE 18.

We deliver our services through our **portfolio of strong brands**.



You're in safe hands



Serious about health.
Passionate about care.



All the quality care you need.



Achieving the objectives of the **Triple Aim**, in themselves key outcomes of our activities, depends on managing the outputs and outcomes of our business model in a way that aligns to the expectations of our stakeholders.

HUMAN AND INTELLECTUAL CAPITAL

28 763 employees.

Outputs

- + Learning and skills development programmes.
- + 20 796 employees across the Group participated in a training initiative in 2015.

Outcomes

- + For each Netcare employee in SA, 2.4 additional jobs are sustained in the rest of the economy, of which approximately 78% are for individuals from previously disadvantaged backgrounds.
- + A skilled workforce able to deliver the highest quality healthcare.
- + Healthcare practitioners trained in excess of our needs, contributing to medical skills development in SA.

OUR PEOPLE PRACTICES ARE SUMMARISED ON PAGE 44 AND 77.

NATURAL CAPITAL

Outputs

- + 351 983 tonnes carbon dioxide equivalent emissions (Scope 1, 2 and 3).
- + Medical waste.

Outcomes

- + Our strategic priority to grow the Group will increase our carbon emission and water footprint. However, our environmental sustainability strategy will contribute to reduced demand on the national electricity and water supply grid in SA and reliability of supply. Similar initiatives are in place for the UK operation. These initiatives will also reduce our operating costs.

OUR SA: ENVIRONMENTAL REPORT REVIEWS OUR SUSTAINABILITY STRATEGY.

MANUFACTURED CAPITAL
Outputs

- + Converting hospital beds to high demand disciplines.
- + Refurbishing existing and building new facilities.
- + Implementing new IT systems.

Outcomes

- + Increased capacity to service demand while being cognisant of the need to provide affordable healthcare supported by efficient systems and processes.
- + Investing in new equipment to support medical innovation.
- + Efficient administration to allow for patient-centred care.

DETAILS ON OUR INVESTMENTS IN OUR FACILITIES IN SA ON PAGE 51 AND IN THE UK ON PAGE 81.

SOCIAL AND RELATIONSHIP CAPITAL
Outputs

- + Managing stakeholder relationships.
- + Infection control.

Outcomes

- + 1 782 indigent patients needing emergency care treated. Netcare 911 responds to any emergency, irrespective of whether the patient is medically insured or not. Treating emergency indigent cases incurs unrecoverable financial cost but contributes to our social licence to operate.
- + We facilitate knowledge sharing through our partnerships and memberships, contributing to quality healthcare outcomes and the continuous professional development of specialists and other healthcare professionals. We share health knowledge publicly to empower patients and communities.
- + We contribute to healthier societies.

QUALITY LEADERSHIP SCORES ON PAGES 46 AND 76.

FINANCIAL CAPITAL
Outputs

- + 0.2% increase in SA hospital patient days.
- + 2.3% increase in UK inpatient and day caseload.
- + 160 125 emergency incidents attended to (SA).
- + 371 978 chronic dialysis sessions (SA).
- + 3.2 million visits to Primary Care facilities (SA).

Outcomes

	2015 Rm	2014 Rm
Revenue	33 711	31 783
EBITDA*	4 981	4 404
Operating profit	3 728	3 253
HEPS ¹ (cents)	174.1	158.2
Return on equity	25.4%	26.7%
Total distributions	1 426	1 173
Market capitalisation (billion)	48.9	42.3

* Included in executive balanced scorecard measures.
1. Headline earnings per share.

WEALTH CREATED

R24 617 million

2014: R22 715 million; 2013: R19 707 million

Wealth distributed



49% Employees
7% Providers of capital
10% Government
34% Reinvested in the group



48% Employees
8% Providers of capital
10% Government
34% Reinvested in the group

FULL VALUE-ADDED STATEMENT AND ABRIDGED FINANCIALS ON PAGES 143 AND 144 RESPECTIVELY.

OUR KEY RELATIONSHIPS

Our ability to deliver affordable quality healthcare means we must manage a complex interplay of critical relationships. We have well-developed structures and processes in place to manage these relationships and our senior executives engage with stakeholders when required. The table below sets out the top stakeholder issues raised in 2015.

PATIENTS
Medically insured Self-pay Indigent Public sector

How this relationship contributes to value creation

To be responsive to patient concerns and the quality of their experience, we conduct real-time patient feedback surveys. We assess the healthcare needs of communities to establish the feasibility of extending our footprint into areas where we are under-represented. We also change the mix of licenced beds to accommodate different medical needs in our existing facilities.

EMPLOYEES
Nurses Paramedics Other healthcare practitioners Pharmacists Management teams Administration teams Facilities management teams Contract staff

How this relationship contributes to value creation

We invest in ongoing training and professional development of our employees who play a vital role in our ability to deliver the highest standards of medical care and remain at the forefront of developments in medical science. To ensure we remain abreast of our legislated responsibility to our employees, we build strong working relationships with unions and engage with them on a wide range of issues.

SPECIALISTS
Specialists across all clinical disciplines How this relationship contributes to value creation To ensure the best clinical outcomes for patients, specialists need us to provide quality nursing support, the most clinically advanced and appropriate medical equipment, instruments, consumables, medicine, support staff and facilities that deliver an exceptional patient experience. We regularly facilitate training sessions and forums that add to the continuous professional development requirements for specialists and other healthcare professionals.
ENGAGEMENT CHANNELS
Regular interaction with doctors through the Physician Advisory Boards and Netcare Clinical Ethics Committee (SA), and the national and hospital Medical Advisory committees (UK). Consultant Reference Group and magazine (UK). Doctor surveys (UK).
TOP ISSUES RAISED AND OUR RESPONSE
Administration of hospitals and employee strategy: Our management teams focus on the quality, effectiveness and wellbeing of employees, who directly support doctors and administer our facilities, as part of the annual performance management process. Access to sufficient and appropriate beds, and theatre slates: Invested R1.9 billion and £39 million to expand our facilities, and replace and upgrade medical equipment and facilities. Hospital beds increased by 584 new beds in SA. Restrictions by funders that impact the ability of specialists to manage appropriate and affordable care: We maintain strong working relationships with medical schemes and administrators and we respond to the regulator on matters that may affect the ability of insurers to fund healthcare costs.

PRIMARY HEALTHCARE PROVIDERS AND ALLIED HEALTHCARE PROFESSIONALS (SA ONLY)
Primary healthcare providers: GPs and dentists Allied healthcare professionals: therapists How this relationship contributes to value creation Primary care practitioners play a vital role in early detection, prevention, management and treatment of disease. Our facilities offer access to state-of-the-art equipment, medical and IT infrastructure, and a broad range of practice management, administration and support services. Allied healthcare professionals are an important part of the healthcare value chain; the therapeutic services they provide expedite recovery after surgical or medical treatment, provide counselling and psychiatric support, as well as rehabilitation after a traumatic incident.
ENGAGEMENT CHANNELS
Clinical advisory panels and localised medical forums including mortality and morbidity meetings. Clinical Practice committees.
TOP ISSUES RAISED AND OUR RESPONSE
Concerns that the technology platform does not meet the efficiency, cost and demands of modern primary care medical and dental practices: Our medium-term objective is to implement further standardisation of the IT platform across our network to better accommodate a group practice environment. Concerns that medical scheme tariff and benefit designs have diminished the value for primary care providers: We will continue revising the Medicross operating model to maximise cost efficiency and decrease the cost of administration charged to general practitioner and dental practices operating from Medicross facilities. We proactively engage with regulators regarding policy matters that impact the supply of doctors in SA and their future retention in the country. Availability of consulting rooms: Balancing demand and supply of consulting rooms remains challenging, given limited space in hospitals. Our decisions are informed by patient needs and established healthcare providers at each facility. We also consult widely with Physician Advisory Boards.

FUNDERS
Medical schemes (SA) Compensation for Occupational Injuries and Diseases (SA) Private Medical Insurance (UK) NHS (UK) How this relationship contributes to value creation Funders use managed care principles and clinical protocols to manage admissions and levels of utilisation as part of their benefit and network design. They pay a negotiated fee to Netcare companies for services rendered on either a fee-for-service or alternative reimbursement basis. Medical surgical consumables are billed at net acquisition cost and drugs at the Single Exit Price.
ENGAGEMENT CHANNELS
Daily engagements regarding patient pre-authorisations, admissions, case and discharge management. Regular engagement relating to operational issues and quality outcomes. Contract negotiations.
TOP ISSUES RAISED AND OUR RESPONSE
Contribution of healthcare service providers, particularly hospitals, to reducing healthcare costs to facilitate more affordable medical cover (SA): Healthcare utilisation and therefore expenditure is increasing globally. Expenditure is set to continue rising as populations age and the burden of chronic illnesses increases. However, we undertake a number of initiatives to contain costs, including: Standardising procurement processes, which have contained the cost of consumable increases. Our automated ward planning tool, which is helping us manage direct nursing costs. Re-engineering processes to remove duplication of data capturing between front and back office. We apply appropriate levels of care in line with funder-managed care protocols and focus on preventative measures to reduce the need for curative procedures. Cost of medical innovation: Our centres of excellence ensure more efficient healthcare outcomes at lower cost. Whether private hospitals make a profit on the procedures allocated to them by the NHS (UK): We have engineered our medical pathways and protocols, and standardised procurement, to manage costs within the national NHS tariff.

REGULATORS, GOVERNMENT AND COMMUNITIES
Authorities that regulate providers within the healthcare system. Public sector partners including national and provincial departments of health. Communities, sponsorship partners, non-profit organisations. How this relationship contributes to value creation In each country of operation our interactions with regulatory bodies differ in scope and intensity. We adhere to stringent licencing requirements as well as the relevant laws, regulations, standards, codes and guidelines. In SA, through our PPPs, and in the UK, through servicing NHS-funded patients, our relationships with the public sector enable us to contribute to the effectiveness of national healthcare systems. In SA, we invest in healthcare accessibility initiatives, and academic, community, health and welfare sponsorships.
ENGAGEMENT CHANNELS
Engagement takes place with government officials and regulators at various levels in SA and the UK. Membership (SA): Hospital Association of South Africa. Memberships of NHS and private healthcare representative organisations (UK): NHS Partners Network, Association of Independent Healthcare Organisations, and Independent Sector Reference Group and the Private Healthcare Information Network.
TOP ISSUES RAISED AND OUR RESPONSE
Increased access to healthcare (SA): Through our training colleges and academies we train healthcare practitioners in excess of our needs, contributing to medical skills development. Our capital expenditure contributes to healthcare infrastructure in the country. Through partnerships, we have extended free access to healthcare to over 140 000 patients in the last 10 years through emergency assistance, our Sexual Assault centres and our programmes for cochlear implants, craniofacial procedures, cataracts and cleft lip and palate procedures. Access to healthcare (SA and Lesotho): Through our PPPs, we provide increased access to quality care. Our participation in government initiatives includes national incident responses. Private Healthcare Market Inquiry (SA): Netcare has made comprehensive submissions to the Competition Commission, which has revised the completion date of its Market Inquiry to December 2016. Patient access to better information (UK): BMI Healthcare is working with the Private Healthcare Information Network to provide accurate and up-to-date information relating to its performance and fees, as required by the Competition and Markets Authority. Broaden access to healthcare for disadvantaged and underprivileged South Africans: In 2015, our CSI spend in SA was R25 million (2014: R47 million) representing 1.03% of net profit after tax. Some 86% (2013: 84%) of the Netcare Foundation's beneficiaries were black people, as defined by the dti Codes.

SUPPLIERS
From suppliers of medicines, equipment and consumables, to IT systems, professional services and outsourced services. How this relationship contributes to value creation We procure support services, as well as medicines, technology, equipment and consumables from our suppliers. We provide fair and transparent tender processes, fairly negotiated contractual terms, delivery to schedule and additional value-added services. To advance the aims of B-BBEE in SA, we seek to do business with and help develop enterprises that increase the representation of previously disadvantaged groups in the economy.
ENGAGEMENT CHANNELS
Regular interactions and review sessions. Contract negotiations. Online supplier surveys.
TOP ISSUES RAISED AND OUR RESPONSE
Given the macroeconomic environment in SA, our engagement with suppliers centred on factors influencing the price of goods and services, including rate of exchange, impact of consumer price index and wage inflation: We monitor all cost increases and seek alternatives where unsustainable increases are enforced and quality substitutes are available. Opportunity to supply in accordance with commercially reasonable contractual terms: Preference is given to ISO-accredited companies to ensure a consistent quality of products and services. Annual joint audits are undertaken for selected suppliers of high-risk commodities and services to evaluate their performance against set criteria.

INVESTORS
Shareholders Investment community How this relationship contributes to value creation We endeavour to deliver competitive financial performance and invest in growing and managing our business prudently. This ensures that we create long-term shareholder value and generate market-related returns, as well as attract continued investment in the healthcare sector.
ENGAGEMENT CHANNELS
Investor results presentations, road shows and conferences. Analysts' days. Maintaining access and interactive engagement between the investment community and management. Annual general meeting and SENS announcements. Online and annual reporting. Investor relations website.
TOP ISSUES RAISED AND OUR RESPONSE
Understanding the business model and associated risks: The 2015 Annual Integrated Report discloses a reworked business model showing Netcare's business activities, inputs, outputs and outcomes. Our top business risks are set out on page100. Group balance sheet structure, capital expenditure and dividend policy: The leverage of the Group, measured by the net debt to EBITDA ratio, remains healthy at 1.2 times, compared to 1.1 times at September 2014. Capital expenditure increased 36.4% to R2.7 billion in 2015 and dividend distributions increased 15% from 80.0 cents in 2014 to 92.0 cents. Comparison with competitors: Netcare offers a comprehensive network of healthcare services while our listed competitors are more hospital centric. While the structure of our Group and our activities differs from our major competitors we report in detail to allow comparisons. Margin outlook and managing cost: We improved EBITDA margins to 14.8% in 2015 (2014: 13.9%), but remain cautious on providing forward guidance as many factors are outside our control. See issues raised by funders on page 20 for further details on these factors and initiatives to contain costs. UK funding, swaps and rent structures: In September 2015 the revolving credit facility was refinanced. Swaps are valued on a mark-to-market basis and discussions on possible rent restructuring are underway, although it is premature to provide guidance as to whether such a transaction will ultimately be concluded.

OUR MATERIAL ISSUES

01

POSITIONING OUR OPERATIONS TO COMPETE EFFECTIVELY IN A CHALLENGING ECONOMIC ENVIRONMENT AND HIGHLY REGULATED SECTOR

Market conditions in SA and the UK remained challenging, resulting in a decline in medically insured lives. In addition, the competitive landscape is intensifying across all areas of private healthcare service delivery. In the current market, medical funders are placing increasing pressure on tariffs while input and staffing costs are increasing at rates above inflation. To sustain our performance, we need to achieve volume and gain market share. This requires that we manage the business efficiently and strategically invest our capital on both growth and the maintenance and replacement of equipment and infrastructure.

Links to other material issues	01	02	03	04
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COMPONENT

Economic conditions

RISKS

Top business risks:

- + Slow or declining medical aid membership growth in SA and the UK.
- + Ability to invest sufficiently in facilities, medical equipment and growth initiatives in the UK.
- + Low tariff increases required by funders.

Additional risks:

- + Unstable labour market.
- + Declining discretionary spend on ancillary healthcare services.

STRATEGIC INITIATIVES

- + Ensuring the long-term sustainability of our business requires careful and responsible optimisation of our operations to achieve efficiencies and reduce costs without compromising the quality of care provided. This enables us to contain annual tariff increases. Ongoing initiatives include standardising consumables, refining clinical pathways and leveraging IT.
- + We negotiate tariffs with most of our funders on an annual basis.
- + We proactively manage our risks in a cost-effective manner.
- + We negotiate with unions annually and interact regularly through the year.

COMPONENT

Ability to compete for specialist healthcare practitioners

RISKS

Additional risks:

- + Loss of healthcare practitioners.
- + Inability to take advantage of expansion opportunities.

STRATEGIC INITIATIVES

- + Attracting specialists is a key value driver for Netcare. Proactive engagement with physicians takes place through dedicated committees in both SA and UK hospitals. This enables us to build strong partnerships, understand needs, and assess and address satisfaction levels.
- + Our investment in high-acuity facilities and state-of-the-art equipment contributes to our ability to attract specialists, by helping them remain at the forefront of medical innovation. Our reputation for quality leadership, able and caring nurses, our success in operating leading healthcare facilities, and the strength of our brand also enhances our ability to attract specialists.
- + We engage proactively with newly qualified specialists to ensure Netcare is appropriately marketed as a favourable hospital group from which to practise.
- + We are exploring doctor shareholding structures that are attractive to physicians and meet the Health Professions Council of South Africa's ethical requirements.



OUR DEFINITIONS OF MATERIALITY AND THE PROCESS FOLLOWED TO DETERMINE OUR MATERIAL ISSUES ARE SET OUT IN OUR REPORT ON PAGE 02.

COMPONENT

Changes in healthcare industry regulation and funder regime

RISKS

Top business risks:

- + Regulated price benchmarking or negotiation processes.
- + Non-compliance (fines and reputation).
- + Medical scheme consolidation strengthening the negotiating position of larger schemes.
- + Management of healthcare utilisation by funders.

STRATEGIC INITIATIVES

- + Participation in the Competition Commission's Private Healthcare Market Inquiry gives us the opportunity to contribute to a comprehensive evidence-based review of cost drivers in the private healthcare market.
- + Regular engagement with regulatory bodies and funders.
- + Our new five-year employment equity plan to 2020 focuses on achieving greater national demographic representation in management and leadership, and driving interventions to support organisational culture change, to ensure we comply with the relevant legislation.
- + Quarterly reports and training on regulatory change are provided to the Board. A legal newsletter, legal alerts and compliance training are provided to staff.
- + Compliance enhances our reputation and is part of our social licence to operate, despite the changes needed to meet regulatory requirements driving up costs.
- + The regulatory environment is constantly monitored to ensure that we can respond appropriately to changes.

COMPONENT

Rapidly changing competitor environment

RISKS

Additional risks:

- + Loss of market share.
- + Increasing competition across all areas of the business.
- + Acquiring licences and changing licences to higher demand disciplines in SA.
- + Pressure on margins, the ability to negotiate with funders and capital required to grow in the UK.

STRATEGIC INITIATIVES

- + We continue to invest in growing, upgrading and updating our operations and facilities.
- + We maintain a constant focus on our core purpose and values in delivering a high quality of care to our patients.
- + Greater connectivity between the SA and UK operations allows for the sharing of lessons learned and best practices.

South Africa

- + Our focus is on expanding our core business into areas where there is demand. Factors influencing an investment decision include population demographics and potential utilisation of a private hospital, existing hospital services, return on investment, and availability of doctors and nurses in the area or our ability to attract them to the area.
- + Our forecasting models enable us to plan ahead and apply for licences.
- + We convert beds into higher demand disciplines on an ongoing basis.
- + We are also looking to further grow and diversify the business:
 - Primary Care is seeking to extend its services, giving it exposure to more of the healthcare value chain.
 - National Renal Care is investigating shared care options where patients are involved in their own treatment.
 - Netcare 911 is expanding the provision of emergency services to industrial sites through capitated and access contracts.
 - As another high-growth area, we are looking to extend our footprint of specialised and holistic oncology treatment facilities.

United Kingdom

- + Our focus is to better utilise existing capacity by re-engineering how care is delivered. We are investing in intensive care units (ICUs), theatres and diagnostic equipment to increase our market share of more complex cases.
- + Targeted initiatives are underway to ensure we are able to secure an increasing volume of NHS work.
- + We expect further efficiencies to be achieved by facilitating a more networked approach for the group of UK hospitals to work together.

International expansion

- + Based on our experience as a private hospital operator, we are looking to acquire high-quality assets with the potential to achieve scalable growth and market leadership in the market concerned. We consider both emerging and developed markets, provided that there is demand for private healthcare, a well-regulated healthcare market and secure funding mechanisms.

02

ACHIEVING STRATEGIC
DIFFERENTIATION IN
DELIVERING QUALITY
PATIENT CARE

Gaining market share and competitive advantage is a function of several factors, one of the most important being the quality of care we provide. As a people-driven business, our employees are a critical factor in our ability to deliver the best patient care. **the Netcare Way** initiative serves to align the culture of the organisation to the objectives of the **Triple Aim**. It includes education and training, embedding a deep quality improvement capability and ongoing process optimisation.

Links to other material issues	01	02	03	04
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COMPONENT

Quality clinical outcomes

RISKS

- Top business risks:**
- + Reduced clinical outcomes, including the risk of multidrug-resistant infections.
 - + Growing resistance to antibiotics.
 - + Preventable death or injury to a patient.

STRATEGIC INITIATIVES

- + We measure over 300 different aspects of quality across all divisions. Quality measures are reviewed monthly to provide a view of accomplishments and areas for improvement.
- + Clinical outcomes are benchmarked within the Group and against international data to ensure early detection of risk and identification of opportunities for improvement and best practice.
- + Infection risk is managed using electronic microbiology laboratory data at hospital and Group level.
- + The antibiotic stewardship programme promotes the responsible use of antibiotics and reduces associated costs.
- + We drive improvements in diagnostic abilities and support less invasive procedures, leading to quicker recovery times, better clinical outcomes and lower cost of care.
- + Our focus on health and safety risk management, including the Group-wide adverse event monitoring system, contributes to ensuring the health and safety of our patients.
- + Quality process measures and outcomes are included in executive and operational management's balanced scorecards.

COMPONENT

Best patient experience

RISKS

- Additional risk:**
- + Loss of market share.

STRATEGIC INITIATIVES

- + Patient feedback is benchmarked locally and internationally for both the SA and UK operations, enabling our patients to assess their experience in a Netcare or BMI Healthcare hospital. The survey is extended to all patients admitted to our hospitals.
- + In SA, we continually reinforce **the Netcare Way** across facilities and in training and induction programmes. Supporting programmes of action include **Caring the Netcare Way**, which guides our interactions with our patients, and **the Netcare Way of Improvement**, which focuses on our quality management systems. The impact of **the Netcare Way** is measured through patient and employee feedback.

COMPONENT

Data management

RISKS

- Additional risk:**
- + Completeness and accuracy of clinical record-keeping.

STRATEGIC INITIATIVES

- + Digitalisation improves the accuracy of record-keeping and data analysis, which drives improvements that in turn build our reputation.
- + Information relating to clinical outcomes is shared across Group facilities and with key stakeholders such as healthcare practitioners and funders.
- + We embrace quality and clinical benchmarking across the industry, shared data is used to support our efforts in continuous improvement.
- + We contribute to healthcare forums and research, locally and internationally, and benefit from the healthcare networking opportunities these provide.

COMPONENT

Shortage of healthcare professionals (including doctors and nurses)

RISKS

- Top business risks:**
- + Poor quality of clinical outcomes.
 - + Threat to the long-term delivery of healthcare.
 - + Rise in nursing costs.

STRATEGIC INITIATIVES

- + Netcare Education is the largest private trainer of nurses in SA.
- + The Netcare Faculty of Emergency and Critical Care trains graduates in excess of the requirements of Netcare 911, increasing the pool of healthcare professionals in the sector.
- + Through the Netcare Foundation we sponsor registrar and fellowship training.
- + In the UK, we have implemented a national framework to develop the right profile of staff to meet our future needs, and are working with international agencies to recruit nurses from the Philippines and India to address the shortage in our sector.

COMPONENT

Engaged employees

RISKS

- Additional risks:**
- + High workforce turnover.
 - + Dissatisfied employees may impact negatively on the level of care provided.

STRATEGIC INITIATIVES

- + We seek to remunerate employees competitively and appropriately, with incentive and share ownership schemes (including Health Partners for Life) supporting efforts to attract and retain key skills.
- + Our investment in training, talent management and career development, as well as our drive to provide a diverse and inclusive workforce, contributes to staff motivation.
- + Employee satisfaction is monitored and measured through annual engagement surveys. The 2015 survey results indicate a pleasing improvement in employee satisfaction levels in SA to 65.09 from 62.16 in 2014.
- + In the UK, two change-focused surveys were undertaken in 2015. Results showed that 95% of respondents agreed that they understood the purpose of the changes being implemented and 85% agreed that they were being held accountable for managing the change.

03
FACILITATING
AFFORDABLE
QUALITY HEALTHCARE

Strict cost management and extracting operational efficiencies are key priorities. IT is driving fundamental shifts in the way healthcare is managed and delivered. To remain 'future fit' we invest in the digitalisation of our business as an important enabler of our strategy and to meet the objectives of the **Triple Aim**. Alongside financial benefits, operational efficiencies benefit the full healthcare value chain, positively impacting our patients, healthcare practitioners and funders.

Links to other material issues	01	02	03	04
COMPONENT	COMPONENTS			
IT-enabled business change and digitalisation	Managing costs			
RISKS	RISKS			
Top business risks: + IT system availability. + System security – data loss. Additional risks: + Use of personal information. + Reliance on key third-party service providers.	Additional risks: + Rise in operating costs.			
STRATEGIC INITIATIVES	STRATEGIC INITIATIVES			
+ We continually invest in leveraging our IT infrastructure to optimise the way we manage our administration processes and facilities. This facilitates accurate record-keeping and prevents duplication of processes that produce unnecessary costs. + Our optimisation projects aim to digitalise aspects of our operations to free up resources to focus on care or on supporting those that provide care. + The introduction of new systems and processes requires a change in behaviour. Our Leading the Netcare Way programme focuses on change management, teamwork, and building agility and resilience in individuals. + A strong IT governance framework is in place to manage the risks related to system security and availability. + Responsibly and securely sharing information with physicians and funders is critical to good clinical outcomes. We work towards understanding the constraints imposed by current and proposed future regulatory developments applicable to the protection of personal information. + Maintaining strong relationships with third-party IT service providers is critical as they play an integral part in the performance and stability of our IT systems, and in identifying potential areas of concern and enhancements.	+ A sustained focus on cost containment is seen in initiatives including: – Automated ward planning tool, which ensures we have the right ratio of nurses with the right skills to efficiently deliver care and meet the clinical requirements of each ward. – Managing the balance between permanent and agency staff to optimise consistent delivery of patient care at optimal cost. – Standardisation of consumables and procurement practices throughout the business, which provides economies of scale.			

04
MAINTAINING AN
INNOVATIVE, ROBUST AND
PROACTIVE ASSET AND
UTILITIES MANAGEMENT
STRATEGY

To attract specialists to work in our facilities and enhance our reputation among patients and funders, we need to provide the latest medical equipment in good working order and to maintain our properties. This enables the best clinical outcomes and patient experience. In addition, these **Triple Aim** objectives cannot be achieved without the secure and continuous supply of power and water to our facilities. In SA, this requires investment in initiatives that ensure these resources are available even during increasingly frequent electricity or water cuts.

Links to other material issues	01	02	03	04
COMPONENT	COMPONENT			
Medical innovation through investment in new equipment and proactive maintenance of existing assets	Security of utilities including electricity and water			
RISKS	RISKS			
Top business risks: + Appropriate maintenance of existing plant and equipment. + Compromised quality of patient care and clinical outcomes. + Fire and electrical safety. Additional risks: + Loss of competitive advantage and healthcare specialists. + Health and safety risk for patients and employees. + Shortage of skills required to maintain systems and equipment.	Top business risks: + Aging national electricity grid and water infrastructure capability. + Medium-term availability of electricity and water supply. + Interruption of business operations and compromised quality of patient care.			
STRATEGIC INITIATIVES	STRATEGIC INITIATIVES			
+ We invest in the latest medical equipment and systematically maintain our property, plant and equipment as this enables us to deliver high-quality clinical outcomes and meet the needs of healthcare specialists. + Ongoing supervision of suppliers ensures that consistent and cost-effective machine maintenance takes place as required. We have preventative maintenance programmes in place that are regularly evaluated and upgraded. + We are proactive in ensuring that facilities provide a safe and secure environment through strict adherence to compliance certification processes. + Comprehensive insurance cover is in place to mitigate physical damage and interruptions to business operations. + A five-year strategy is in place in SA to secure the supply of power and water. Initiatives will limit our dependency on national utilities, realise cost savings and reduce our impact on the environment. + Performance measures are included in the balanced scorecards of executive management and senior staff overseeing sustainability projects. + Participation in sustainability indices contributes to our social licence to operate and enhances our reputation.				

OPERATIONS



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Group
EBITDA
R5.0 billion
up by 13.1%

EBITDA
margin
14.8%
(2014: 13.9%)

CHIEF
EXECUTIVE
OFFICER'S
REVIEW

The international **Triple Aim** objectives for improved health system performance stands as the foundational principle of Netcare's approach, guiding our investment in increasing the capacity and capability to provide the best clinical outcomes and the best patient experience in the most cost-effective way. Achieving these inter-related objectives is at the heart of our contribution to the health of society, and the economic and social agency this enables.

It has been an exceptionally busy year for Netcare, both in South Africa (SA) and the United Kingdom (UK). In SA we substantially increased our hospital footprint and opened two new hospitals, while in the UK we largely completed a significant restructuring of the business that began some eighteen months ago. Despite persistent economic, competitive and regulatory pressures, we achieved good operating performances in both geographies.

We have focused on ensuring that not only are we able to weather the vicissitudes in the market, but that we will also emerge in a stronger position to deliver growth.

Overview of performance

Two important features of this year's performance demonstrated the balance we seek to achieve in delivering on our strategic imperatives. We improved our clinical quality and outcomes across the Group, narrowing the gap between the highest and lowest performing units. This indication of a greater consistency in quality care across our facilities is testament to our comprehensive quality leadership initiatives over the last number of years.

In tandem, we managed to expand margins in all our divisions, which allowed us to maintain our track record of growth and returns. This was due to our embedded efficiency programmes in SA, and the wide-reaching restructuring programme in the UK which offset the margin impact of the ongoing shift in case mix to National Health Service (NHS) funded patients.

In SA, demand for private healthcare has remained resilient in the face of low economic growth and a decline in total medical scheme membership, and patient days for the first three quarters of the year grew by 1.7%. However, we experienced a drop-off in activity in the traditionally busy months of the fourth quarter as a result of six new competitor hospitals opening in the market. This resulted in overall patient day growth of 0.2% for the full year.

Our Primary Care division experienced stable demand and posted a good performance despite the mild winter, again due to the operational leverage achieved. Our plans to expand our network saw us open a new Medicross facility in Brakpan, Gauteng, in August 2015.

In our National Renal Care joint venture we continued to add dialysis stations to our network, growing our number of stations by over 10%.

In Lesotho, a new coalition government was inaugurated in March 2015, bringing greater stability to the political situation in the country. As it enters its fifth year of operation, our Private Public Partnership (PPP) continues to deliver outstanding clinical outcomes and service levels, which have been independently verified. This is being achieved while treating volumes of around 350 000 public patients a year.

In the UK, 2015 was a year of transition with Jill Watts assuming the helm in November 2014. Jill has focused on assembling and reorganising a new management team, now largely in place, and implementing a five-year strategy to optimise the business. BMI Healthcare's business-wide transformation programme achieved process improvements and savings, which translated into a much improved performance notwithstanding the non-recurring restructuring costs incurred.

BMI Healthcare's inpatient and day caseload increased 2.3%, with NHS caseload up 13.5%. The NHS now accounts for 39.2% of total caseload, up from 35.3% the year before, compensating for the 4.7% decline in Private Medical Insurance (PMI) cases. Self-pay caseload increased by 3.5%, enjoying further growth in the second half of the year. Outpatient activity was up, supported by the increasing range of services provided in this environment.

The context for our medium-term strategy

In setting out the strategic direction of the Group over the medium term, it is important to contextualise this in terms of the dynamics in our operating environments.

In SA, we expect no substantial improvement in Gross Domestic Product (GDP) growth in the next few years. Additionally, the potential for higher inflation, interest rates and taxes is becoming more of a reality. From a healthcare perspective, the lack of formal sector job creation and the possibility of a contraction in formal employment may perpetuate the decline in medical aid membership, which was down 0.6% from 8.81 million lives at 31 December 2014 to 8.76 million lives at 30 June 2015 (reported by the Council for Medical Schemes).

Furthermore, competition in our sector has intensified with over 1 500 new competitor beds coming on stream in the last 18 months. We expect competitors to commission a further 1 548 additional beds in 2016. We have also seen increased activity in day clinics and sub-acute facilities, as well as primary care medical and dental centres. This is in line with the emphasis funders are

placing on lower levels of care for minor health cases and dentistry. In emergency pre-hospital services, the number of service providers is estimated to have doubled over the past five years. Specialist oncology and renal care units have also become attractive to independent providers.

Additional strain is being placed on businesses as a result of the instability of the national power grid. Whereas in 2014, we had 65 power outages due to load shedding, this escalated to 790 in 2015. Although our generators and uninterrupted power supply systems have mitigated the potential threat to our operations and patient safety has not been compromised, the cost to generate electricity via diesel generators is on average 2.5 times more than that purchased from the national utility.

From a regulatory perspective, the Competition Commission's Private Healthcare Market Inquiry has deviated from its original timelines and is now expected to conclude by the end of calendar 2016. Our standpoint remains that the Inquiry will confirm that the cost drivers in private healthcare are primarily due to increased utilisation, driven by past growth in the medically insured population, an aging patient base and an increasing burden of disease. Furthermore, an assessment of the non-confidential elements of the submissions received, published on 5 February 2015, shows that most of them digress from matters of competition to focus on health policy, specifically the unintended consequences of regulation. This certainly informs the functioning of the private healthcare market and we welcome the clarity that the process may provide in this respect.

In the UK, GDP has continued to grow at a rate close to its pre-2008 crisis average, but the economic recovery has not filtered into the PMI market. PMI membership has declined and schemes have sought to manage their costs through stringent claims management as well as favouring alternative treatments and outpatient services.

The significant financial limitations and capacity constraints in the NHS persist. The NHS reported a £1.6 billion funding deficit in the first six months of the financial year, and more than 3.4 million

patients are waiting for procedures, the highest level since 2008. As the private sector delivers only 4.4% of total NHS elective surgery, we are confident that in the medium to longer term the political will exists to reduce waiting lists by utilising the capacity available in the private sector. The processes to achieve this are well embedded in the UK healthcare system. These are the patient choice system, which allows NHS patients to elect to go to a private facility, and the awarding of spot contracts, which are aimed at reducing backlogs of specific procedures.

Alternatively, the pressure on the NHS may well see more patients electing PMI or to pay for services themselves.

The key area of uncertainty is the level of NHS tariffs, which are to be implemented in April 2016. Final proposals in this regard are expected from the sector regulator in January 2016.

Strategic initiatives to position the Group for the future

In addition to the outline of our specific strategic initiatives provided below, further detail can be found in the operational reviews that follow, starting on page 34.

Delivering targeted growth

We have focused on ensuring that not only are we able to weather the vicissitudes in the market, but that we will also emerge in a stronger position to deliver growth.

We have invested heavily in growing the capacity of our hospital network in SA, concentrating on areas of high demand. We added 584 new beds in the year, or 6.1%, bringing the total number of beds in the Hospital division to 9 996 beds. Whereas the Group's historic annual capital expenditure (capex) has been around R1 billion, with approximately 75% allocated to maintenance, a large part of the nearly R3 billion we spent in the last year was allocated to expansion projects.

Our 200-bed Netcare Pholoso Hospital in Limpopo province opened on 21 September 2015. This is our first facility in this region and provides a number of highly specialised medical services that were previously unavailable. Our 100-bed

Netcare Pinehaven Hospital, opened on 30 September 2015, is situated in one of the fastest growing areas in Gauteng.

A further 256 beds were opened at various Netcare facilities and the 28-bed Netcare Ceres Private Hospital in the Western Cape was acquired with effect from 1 November 2014. We disposed of our 50% interest in the 12-bed Optimed Clinic earlier in the year. As 75% of the new beds were opened towards the end of the financial year, we expect this new capacity to start contributing to performance from 2016, although our occupancy levels will be lower initially as activity builds up to expected levels.

Our bed demand model is well developed and involves an in-depth review of demographic data and estimated market size, as well as the extent of competing facilities and availability of doctor and nursing skills in the catchment area. Both of our new greenfield developments were thoroughly assessed and we are confident of sustained demand and availability of the necessary skills. As such, we expect to achieve 50% occupancy in our new hospitals by the end of their first year of operation. Our brownfield developments have also been undertaken in facilities where we are certain of the demand, or where the demand for greater capacity in a specific discipline indicates the need to re-license existing beds.

Our new flagship facility, the 248-bed state-of-the-art Netcare Christiaan Barnard Memorial Hospital, situated on the Cape Town foreshore, is on track to open in December 2016 – the 49th anniversary of the world's first heart transplant in SA.

In 2016, the majority of our capex spend will again be on expansion projects, such as a substantial expansion at Netcare Milpark hospital in Johannesburg. In total, we plan to open at least 44 new beds in the year ahead.

In Primary Care, we are looking to expand our network of facilities and optimise the utilisation of our day clinics and theatres. There are also opportunities to extend our range of services, giving us greater exposure to more of the healthcare value chain.

Our proven experience in treating public patients in Lesotho and the UK positions us to assist in servicing the demand for public sector healthcare services in SA. We remain ready to engage with the relevant authorities to find workable ways to make our available capacity and capability more broadly accessible. In this regard we hope to build on our support of the public sector at national, provincial and operational levels. This includes sharing expertise, making our facilities available in specific circumstances and, most importantly, training nurses and paramedics in excess of our own requirements.

In the UK, BMI Healthcare's annual capex of around £40 million will be allocated to management's five-year vision to extend complex services, refurbish key sites and meet national quality standards. Management's priorities include utilising existing capacity by taking on greater NHS volumes, and freeing up additional capacity by streamlining patient pathways and re-engineering staffing models. Extracting further sustainable operational efficiencies will ensure that the business is able to preserve margins.

We continue to carefully consider international expansion, either in developing markets where the growth potential may be higher but where more fluid regulatory environments pose greater risk, or in developed markets where the opposite is true. However, while our geographic scope of assessing opportunities is wide, conducive regulatory environments and stable funding structures are an important aspect of our assessments. We will continue to investigate assets that are core to our business of operating private hospitals, scalable and capable of meeting our rates of return. Ensuring that the target operations are aligned to Netcare's ethos and culture is another important consideration. Over the past year, we conducted two extensive due diligences but withdrew as our investigations indicated that our strategic investment criteria would not be met.

Embedding quality leadership
Our comprehensive quality leadership programme is aligned to the **Triple Aim** objectives, and we made good progress

in raising the levels of quality and care in our SA operations. Year-on-year improvements were recorded in quality audits, patient feedback, clinical outcomes and a range of process and safety measures, as well as in overall compliance with both the National Core Standards and Netcare specific standards.

In respect of healthcare associated infections, which constitute a major risk across the healthcare sector, the trends within the Group have been positive. We have strengthened the processes in our hospitals to deal with the risk of multidrug-resistant organisms, and over 30 of our hospitals are now using the electronic infection surveillance and antibiotic stewardship system. Similar to antibiotic stewardship, our antimicrobial stewardship programme seeks to co-ordinate efforts to prevent the inappropriate use of antimicrobial medications, which enhances clinical outcomes, reduces resistance to these medications and avoids unnecessary costs. This programme is being extended to the Primary Care division. An intensive focus on hand-hygiene, a key element in the management of infection, is underway as part of our **Caring the Netcare Way** initiative.

Our hospitals have also remained vigilant with regard to Ebola Virus Disease, although this risk has largely abated.

Patient feedback remains invaluable in bringing any service-related shortfalls to our attention and enables us to prioritise those areas that are most important to patients in enhancing their experience in our hospitals. Patient satisfaction scores for the year showed an improvement in all categories over the previous year's figures. We surveyed more than 275 000 patients in our SA hospitals over the year and achieved an overall satisfaction rating of 8.62 out of 10.

In the UK, amid the organisational changes, the focus has been to ensure that BMI Healthcare hospitals are able to meet the new Care Quality Commission audit criteria and processes. The lessons learned in hospitals that have completed audits are being shared across the network. Following an initial gap analysis performed in October 2015 by the British

Standards Institution, an international standards and certification organisation, a detailed roadmap for achieving certification has been formulated.

BMI Healthcare achieved 98.1% in their patient satisfaction score for the year.

Investing in our people
The effectiveness of our strategic initiatives, and our ability to maintain and improve the quality of care we deliver, rests firmly in the hands of our people.

Notwithstanding the difficulties we faced in the year, our annual employee survey in SA indicated a pleasing improvement in the Employee Engagement Index, a composite overall score, to 65.09 from 62.16 in 2014, with uncommonly high participation levels.

Our **Leading the Netcare Way** development programme aims to build individual resilience and equip our managers to engage positively with their teams in dealing with the constant change that is a feature of our operating environments. The programme, which has included nursing and human resources managers, has shown significant improvement in individual psychometric assessments when measured against the original benchmarks. The programme concludes early in the next calendar year.

We restructured the debt in our Health Partners for Life Trusts, which has added significant value to the Trusts and simplified the various share schemes. This is expected to build on the constructive engagement we enjoy with our recognised trade unions. An amicable wage negotiation was concluded in March 2015 without disruption to our operations.

Our human resources team has invested significant effort in evaluating the impact of the revised Codes for Broad-based Black Economic Empowerment (B-BBEE) issued by the Department of Trade and Industry (dti Codes), which took effect in May 2015. The process has included workshops with all internal stakeholders to develop plans to address the new framework. Verification of our contribution status in terms of the revised dti Codes confirms a drop to Level 8 from Level 2, which we would have maintained against the previous codes. Although the impact

of the revised dti Codes is dramatic, it has reset the base for the sector, and we are as committed as ever to our strategic priority of accelerating transformation in our SA operations.

In the UK, an extensive change management programme was implemented to support staff during the restructuring process. A key element of this process was the focus on people, performance and culture, which includes standardising people management practices and introducing targeted development programmes for leaders and staff. An important objective of the latter is to address BMI Healthcare's recruitment challenges, given the chronic industry-wide shortages of skilled nursing and allied medical professional staff. In October 2015, the UK Government simplified the requirements for recruiting nurses from outside of Europe, allowing BMI Healthcare to look at recruiting nurses from the Philippines and India.

Driving operational excellence
In line with providing care of the highest quality, we remain focused in doing so in the most cost-effective and efficient manner. To this end, five key areas of our business have been identified to drive efficiencies. These include the standardisation of medical and surgical consumables, efficient centralised procurement, optimising staffing levels through our bespoke digital ward labour tool, automation of key administrative processes, and enhancing energy efficiencies throughout the Group.

BMI Healthcare's business-wide transformation programme undertaken over the past 18 months is largely complete but will continue to drive efficiencies by streamlining patient pathways, standardising operating models, support functions and hospital activities. The sustainable annualised savings will provide resilience to counter margin compression from an increasing NHS-funded patient base.

Leveraging our IT platform
Information technology (IT) is one of the most important enablers of our businesses. The implementation of an enterprise-wide IT platform has provided us with an opportunity to re-engineer our

administrative and financial processes in order to optimise efficiencies and move to an increasingly digital operating system that is less paper-based. The initial focus over the past three years has been on centralising key functions, which will continue in certain areas.

However, we have now embarked on a five-year journey of fundamentally changing the way we operate within our facilities. Our ultimate aim is to accelerate service delivery, productivity, efficiency and innovation in our hospitals and primary care centres. This has already been completed at Netcare 911 where, for example, the entire patient experience, medical record and clinical pathway is seamlessly and electronically recorded from the time a call is received by the call centre, to the patient being treated and transported to an appropriate facility, including relevant response and transportation times.

Ensuring a sustainable operational platform
Our response to the electricity and emerging water crisis in SA is codified in our five-year environmental sustainability strategy, aimed at ensuring operational stability while driving energy and water efficiency. We anticipate this strategy will reduce our energy consumption by 35%, resulting in cumulative savings of an estimated R1 billion on our forecast electricity costs, over a 10-year period. Despite good progress in 2015, with savings of some R20 million achieved, the roll out of our energy efficient lighting replacement throughout all of our facilities (90 000 light fittings) and installation of solar power at several sites was delayed due to contractor-related challenges. These have been addressed and these projects will be accelerated in the year ahead.

We are in the process of completing a sustainable water strategy, which incorporates water saving initiatives and mitigation plans in the event of water supply disruptions.

We have also developed a comprehensive disaster management plan to deal with the unlikely event of a total failure on a regional or national level in basic power, water, sewage and communication

services. Eleven of our hospitals have been identified as key sites that will be able to remain open for up to two weeks if necessary.

Outlook and appreciation
In SA, we face the likelihood of growth beyond 2015 that will be largely organic. Within this context, we remain galvanised to optimise every aspect of our business to ensure that we continue to achieve our growth objectives. In the UK, developments have necessitated a shift to a lower-cost business model to position BMI Healthcare to take on increasing volumes of NHS work while preserving margins, as the PMI and self-pay markets recover over the medium to longer term.

Our pursuit of quality leadership remains pervasive, with the **Triple Aim** objectives informing interventions that extend to all areas of the business. The deep quality improvement capability we have embedded throughout the Group will underpin our drive to differentiate Netcare through a consistently high quality of patient care in every one of our facilities. Recognising that IT is a powerful enabler of meeting the **Triple Aim** objectives and supporting more effective processes across the board, the digitisation of our businesses will continue.

My sincere thanks go to Meyer Kahn for his wise and invaluable stewardship, and the Board for their sage counsel over the past year. I am grateful to be surrounded by an exceptional executive team, who have concentrated on delivering our strategic initiatives despite a myriad of challenges. In closing, I speak on behalf of the executive, in conveying our appreciation to the people of Netcare for their unwavering focus on our higher purpose to care for the health of humankind, which continues to inspire our best efforts.



Dr Richard Friedland
Chief Executive Officer

LEADERSHIP

OVERVIEW

SOUTH AFRICA

front: left to right

Dr Charmaine Pailman (59)
Managing Director – Primary Care

Qualifications:
BMChB, MPH
Joined in 2006

Keith Gibson (45)*
Group Chief Financial Officer

Qualifications:
BAcc, CA(SA)
Joined in 2006

Dr Richard Friedland (54)*
Group Chief Executive Officer

Qualifications:
BvSc, MBCh, Dip Fin Man, MBA
Joined Medicross in 1995

Jacques du Plessis (51)
Managing Director – Hospitals

Qualifications:
BCompt (Hons) Accounting
Joined Medicross in 1996

Noeleen Phillipson (47)
Managing Director – Netcare 911

Qualifications:
RN, MBA
Joined Clinic Holdings in 1994

back: left to right

Dr Dena van den Bergh (53)*
Director – Quality Leadership

Qualifications:
BPharm, MSc (Med), Eng D
Joined in 2011

Lynelle Bagwandeem (40)*
Group Company Secretary and General Counsel

Qualifications:
BSc, LLB (summa cum laude), LLM, FCIS
Joined in 2011

Travis Dewing (42)
Chief Information Officer

Qualifications:
NDip IT
Joined in 1997

Peter Warrener (54)*
Group Human Resources Director

Qualifications:
BSocSci, Dip Fin Man
Joined in 2007

Melanie Da Costa (43)*
Director – Strategy and Health Policy

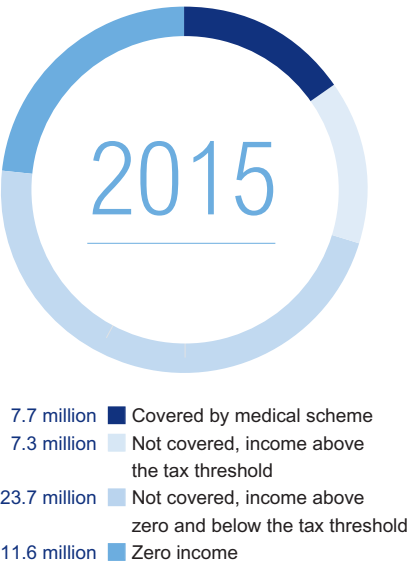
Qualifications:
MCom, CFA
Joined in 2006

* Executives with SA and UK responsibilities.

SA: OUR OPERATING ENVIRONMENT

While there is growing demand for healthcare SA as a result of an increasing burden of disease and an ageing population, the provision of healthcare faces a number of challenges, including a chronic shortage of medical professionals and an inflexible regulatory regime. Due to failings in the public healthcare system, private healthcare is increasingly important in addressing national healthcare requirements.

Opportunity for employed people earning above the tax threshold (>15 million)



Source: Stats SA, Income & Expenditure Survey 2010/2011, counting lives in households, judging by the highest income in the household.

SA in 2015

Macroeconomic environment worsened and
MEDICAL AID MEMBERSHIP

contracted by 0.6% in H1 2015

Competitive landscape
INTENSIFIED

across all business units

OPERATING ENVIRONMENT
deteriorated with increased power outages

The Competition Commission continued its
Market Inquiry into the private healthcare sector

requiring extensive data submissions

Private healthcare in SA

SA has a well-established medical scheme industry, which provides cover to around 8.8 million beneficiaries, representing approximately 16.6% of the population¹. This covered population relies almost exclusively on the private sector for healthcare. Out-of-pocket payments for primary healthcare and medication is also fairly significant and it is estimated that almost a third of the SA population receive some care in the private healthcare sector².

The macroeconomic environment in SA continues to weaken, with corresponding rises in interest rates and sluggish consumer confidence. Private medical scheme membership has historically been resilient in economic downturns given the quality of public healthcare access in SA. In the first nine months of 2015, the economy created 508 000³ jobs, mostly in the informal sector. Surprisingly, the number of lives covered by medical schemes contracted by 0.6% in the first six months of 2015, from 8.81 million at 31 December to 8.76 million at 30 June.

The growth of primary members has increased at a premium to dependants and total beneficiaries for over a decade.

Primary member numbers have continued to increase; however the average number of dependants per primary member has decreased from 1.57 in 2001 to 1.25 in 2014, a compound annual growth rate of -1.8%. These broader trends could be a function of dual-income households and families, where each adult is a member of their own medical insurance scheme, as well as smaller households.

Since 2011, there have been no increases in the subsidy government employees receive on GEMS, driving significant real premium increases for members. It is hoped that the re-basing of subsidies from mid-2015 will arrest further declines in GEMS beneficiaries.

Regulatory changes

In 2015, the Certificate of Need provisions of the National Health Act were retracted and regulators turned their attention to stimulating medical scheme membership growth through developing a framework for low-cost medical scheme benefit options. The framework and principles allowing for the introduction of low-cost benefit options were approved by the Council for Medical Schemes in September 2015. However, it was retracted a few weeks later due to push back relating to the benefit inclusions being slanted towards primary care, with no or very limited private hospitalisation benefit.

Discussions around the implementation of National Health Insurance (NHI) have remained low key in 2015 but a White Paper and Finance Paper are expected to be published this year. The NHI policy remains the most contentious item on the healthcare regulatory agenda given the lack of detail on its scope, timelines and likely impact.

The Private Healthcare Market Inquiry started in 2014. Following an extensive call for submissions and data, it has seen delays in the publication of position papers and oral submissions. In the revised timetable published in October 2015, the Competition Commission has

indicated that the Inquiry will be completed in December 2016. A total of 68 parties have made submissions to the Inquiry panel and non-confidential versions were made public in February 2015.

A key objective of the Inquiry is to explore the drivers of healthcare costs with the fundamental notion being that "Prices in the private sector are at levels which only a minority of South Africans can afford, evidenced by the (small) share of the population with access to private healthcare".

Past commentary attributes the increase in the prices of healthcare services as the driver of increased healthcare cost. In effect, the starting point of the debate is that healthcare cost has increased by 4% above the Consumer Price Index (CPI) since 2008. This was considered unusual enough to call for an inquiry into the competitive functioning of the market. However, the reality is that SA's real healthcare cost increases are below the global average healthcare cost increases of 6.2%⁴. Among BRICS (Brazil, Russia, India, China and South Africa) countries, only India has experienced lower real healthcare cost increases.

1. Insight Actuaries and Consultants Report. Figure 3.
2. Econex: The South African Private Healthcare Sector. Role and Contribution to the Economy. Page 6. December 2013. This includes medical scheme beneficiaries as well as people who use their own funds to pay for visits to GPs or who purchase medicines from pharmacies.
3. Stanlib, SA Unemployment Q3 2013.
4. Source: Towers Watson 2012 Global Medical Trends Survey.

The upside of the Inquiry, which aims to procure detailed and verifiable substantiation of all positions tabled, is that conclusions are based on factual submissions with no place for surmise. According to the submissions of two large medical scheme administrators, Discovery and Medscheme, real healthcare price increases have played a rather insignificant role in the contribution to total increases in healthcare cost. Instead, the submissions confirm that utilisation has driven healthcare cost increases by between 40% and 50%.

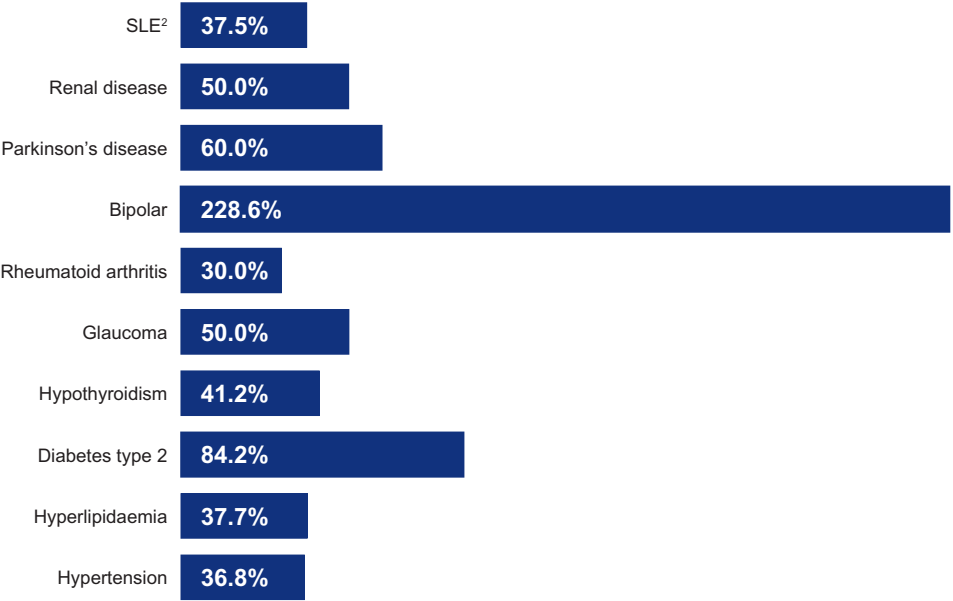
In addition, a number of submissions to the Inquiry panel reflect that the current regulatory framework may also be a contributor to certain increases in the cost of medical scheme cover, including:

- + The Medical Schemes Act, which allows for open enrolment without risk equalisation across schemes or mandatory cover. This means that anyone can join an open medical scheme and pay the same contribution irrespective of age or risk profile. As more high risk and sicker individuals join medical schemes while young and healthy people opt out, this leads to a deteriorating risk profile within medical schemes that drives healthcare cost;
- + Failure to increase the number of medical schools and regulatory interventions that prohibit the private sector from training doctors is negatively impacting the supply of doctors and other healthcare professionals. This is further exacerbated by regulatory restrictions on the registration of foreign doctors, limitations arising from the Nursing Act and the decision of the Nursing Council to cap the number of nurse enrolments in the private sector;

- + The demanding requirements of the hospital licensing regime, which mean that healthcare providers have had to increase their resource utilisation from a time and cost perspective to secure new operating licences;
- + Regulations that preclude hospitals from employing doctors and from participating in multi-disciplinary entities (doctor practices), restricting the development of new and innovative ways to deliver healthcare; and
- + The Health Amendment Act, which requires significant resources to comply with the norms, standards and building regulations relating to private hospitals, inhibiting innovation in low-cost builds and adding to national and per capita healthcare spend.

Governments globally are grappling with increasing healthcare costs, a systemic issue that has largely resulted from global incomes having risen at unprecedented rates. As income increases, people not only utilise more healthcare but actually increase the portion of their income spent on healthcare. In addition, they demand palpably better healthcare services, all of which lead to greater healthcare expenditure. Rising incomes also result in increased life expectancy rates, increasing the burden of chronic disease. The SA private healthcare sector is not unique and healthcare expenditure is bound to continue rising as populations age and the burden of chronic illnesses increase.

Increased prevalence of chronic diseases (2006 – 2011) per 1 000 beneficiaries¹



A chronic member, regardless of age, claims 2.3 x more than a member without a chronic condition³

1. Source: Council for Medical Schemes, Annual Report 2012-2013.
2. Systemic Lupus Erythematosus.
3. Discovery Health Competition Commission submission, 2014.

There is an encouraging shift in the spirit of collaboration between stakeholders with regard to health policy, and it is apparent that there is a desire to increase access to Private Medical Insurance as attested by the number of submissions made to the Inquiry. It is hoped that the outcomes of the Inquiry will allow for:

- + A review of prescribed minimum benefits (PMBs) to facilitate innovation in the low-income medical scheme segment;
- + The inclusion of primary healthcare in PMBs, as opposed to savings, to encourage preventative care;
- + The introduction of mandatory cover for formally employed individuals that will address the deteriorating risk profile;
- + The implementation of risk equalisation measures; and
- + Private funding of medical schools to address the shortage of healthcare professionals.



OUR FULL SUBMISSION TO THE COMPETITION INQUIRY CAN BE ACCESSED AT
www.compcom.co.za/netcare-response-to-submissions/

SA: 2015 PROGRESS

AGAINST STRATEGIC PRIORITIES

2015 progress

ORGANISATIONAL GROWTH

- + Added 584 beds to the hospital network, positioning us well for future growth. Of these, 256 were new beds added at existing hospital facilities.
- + Opened two greenfield hospitals in Polokwane (Limpopo) and Pinehaven (West Rand, Gauteng), comprising a combined 300 new beds.
- + Acquired the 28-bed Ceres Hospital in the Western Cape.
- + Added 68 new beds in Phase 2 of the Netcare Waterfall Hospital build.
- + Converted 94 (2014: 65) underutilised beds to in-demand disciplines.
- + Netcare 911 awarded a new capitated medical aid contract within the energy sector in SA and a mining contract in Mozambique.
- + Opened the Carnival Mall Medicross in Brakpan.
- + Opened three new National Renal Care chronic units.

OPERATIONAL EXCELLENCE

- + Added further resources to accelerate the delivery of Group projects to automate and improve processes.
- + Total energy usage for 2015 was 240 gigawatt hours (GWh) (2014: 245 GWh) costing R259 million (2014: R246 million). Electricity costs would have risen to around R293 million if our sustainability projects had not been implemented.
- + Implemented the new automated ward planning tool in 455 hospital wards to manage direct nursing costs and nursing acuities.
- + Netcare 911 completed the change to a diesel operated fleet.
- + Converted the reverse osmosis plants of two National Renal Care units to re-use filter flush water as grey water to flush toilets, reducing water demand by 3 044 kilolitres a year.

PHYSICIAN PARTNERSHIPS

- + Secured net growth of 154 medical practitioners with treatment privileges at our hospitals.
- + Increased the number of doctors and dentists in Primary Care by 20.
- + Invested R640 million (2014: R735 million) in the refurbishment of hospital facilities, and the replacement and upgrade of medical equipment.
- + Undertook marketing visits to 4 266 (2014: 3 735) general practitioners.
- + Held 80 (2014: 86) continuous professional development events for healthcare professionals.

Looking forward

- + In 2016, add at least 44 new beds to existing Hospital facilities and convert approximately 50 underutilised beds to disciplines with a higher demand.
- + Open the new 248-bed Netcare Christiaan Barnard Memorial Hospital in Cape Town in early December 2016.
- + Roll out Netcare 911's critical care transportation services in Cape Town.
- + Expand the Medicross day theatre network.

- + Reduce energy consumption across the SA operation by 35% by 2024.
- + Complete the roll out of the new automated theatre labour planning tool.
- + Netcare 911 will incorporate audit tools and a paperless web-based claims tool for service providers as part of the integrated IT platform.
- + Over the medium-term, Primary Care will implement a more integrated IT platform across its network.
- + Outsource and integrate a fully certified technical team tasked with managing and maintaining National Renal Care's fleet of dialysis machines.

- + Grow our base of highly skilled specialists.
- + Hold key forums in specialised disciplines in SA hospitals.
- + Ongoing upgrades to facilities and investment in leading technology across our portfolio with major projects including:
 - Netcare Christiaan Barnard Memorial Hospital; and
 - Netcare Milpark Hospital.
- + Maintain benchmarking of best practice and medical innovation internationally.
- + Support ongoing collaboration and innovation in infection control and antibiotic stewardship.

2015 progress

BEST AND SAFEST PATIENT CARE

- + Implemented an antibiotic tracking tool in the Hospital division. This provides real-time tracking and early detection of areas for concern with respect to possible increases in infection rates.
- + Improved the overall National Core Standards score for the Hospital division to 88% (2014: 81%).
- + Achieved 8.62 rating (out of 10) of Netcare SA hospital services by patients.
- + Completed quality assurance audits for all SA hospitals, achieving an overall compliance score of 88.2%.
- + Netcare 911 entered into a new partnership to operate two Bell 222UT helicopters, enabling it to dispatch emergency services 24 hours a day.
- + Netcare 911 launched a revised Netcare application (app) with enhanced functionality such as geolocation technology.
- + Medicross achieved a 'definitely recommend' score of 81.3%.
- + National Renal Care started a shared care dialysis programme, where haemodialysis takes place at home.
- + Continued to install water tanks at hospital facilities, providing water supply back-up.

GROWING WITH PASSIONATE PEOPLE

- + 85% of the SA workforce completed the Employee Engagement Index (2014: 87%) and the overall engagement score improved to 65.09 (2014: 62.16).
- + The **Leading the Netcare Way** programme has delivered improved levels of emotional resilience among our managers in the Hospital division.
- + R41 million spent on training and development interventions, reaching 11 143 employees (2014: R45 million reaching 12 021 employees).
- + 4 482 (2014: 4 251) registered students at Netcare Education. The number of participants that graduated from Netcare Education was:
 - 1 501 (2014: 1 531) nursing graduates;
 - 355 (2014: 91) paramedics; and
 - 227 (2014: 273) employees on management development programmes.
- + A total of 36 (2014: 72) employees enrolled in undergraduate and postgraduate studies.
- + Invested over R2.5 million in promoting health awareness and undertaking health risk screens for employees.

ACCELERATING TRANSFORMATION

- + Distributed R211 million to more than 11 650 Netcare employees through our Health Partners for Life Trust (2014: R154 million to 10 400 employees).
- + Scored 63.3 points out of a possible 109 points in the revised dti Codes of Good Practice and achieved a Level 8 B-BBEE rating.
- + Finalised a new five-year employment equity plan.
- + Improved black representation to 74% (2014: 73%) of the workforce and across junior, middle and senior management.
- + Of our workforce, 2.6% (2014: 2.4%) were employees with disabilities against the national target of 2%.
- + 84% (2014: 84%) of skills development spend was on black people.
- + A total of 35 learners and interns were registered on the Sinako graduate programme, a skills development programme for people with disabilities.
- + Of our total procurement spend, 81% was measurable under the dti scorecard.
- + R25 million invested in healthcare-related corporate social investment (CSI) initiatives with approximately 86% of the beneficiaries being black people.

Looking forward

- + Achieve SA multi-divisional ISO9001 quality certification for our quality management system.
- + Invest R50 million to R60 million in water storage tanks.
- + In 2016, National Renal Care will implement integrated electronic systems to monitor and measure efficiencies, resource allocation, clinical outcomes and patient satisfaction.
- + National Renal Care will report back on the clinical benefits accrued from the shared care dialysis programme and will investigate the feasibility of adding shared care dialysis units to its network.
- + Provide ongoing support through the employee wellness programme.
- + Build on an improved employee engagement score.
- + Extend our focused approach to training and bursaries.
- + Embed our targeted interventions to support employee communication with a focus on the Employee Lead Communication forums, our talent development strategy and the **Caring the Netcare Way** and **Leading the Netcare Way** initiatives.
- + We will continue our efforts towards normalising our staff profile and aim to have 4% of our employees being people with disabilities by 2020.

- + As men remain under-represented at junior management level, our 2020 employment equity plan places particular focus on driving greater male representation across all races.
- + Continue to train our Transformation Committee members to ensure they have the capability to engage on critical issues relating to race, gender, disability, sexuality, religion, nationality and culture.

SA: ENSURING QUALITY OUTCOMES

Our goal is to build a dynamic system of interacting and interdependent relationships that are aligned to a common vision for quality in healthcare.

Quality and clinical governance

Netcare is committed to delivering value in healthcare against the objectives of the **Triple Aim**, which combines cost-effective, and patient and family-centred care with the best clinical outcomes. In 2015, we strengthened the fourth dimension of healthcare value creation further. This is to ensure that our people practices support the objectives of the **Triple Aim**, and are understood and implemented by the healthcare professionals who are central to the care we deliver. Measures in quality leadership are critical to track and inform our quality programmes, and are increasingly used to communicate a shared quality vision where goals are aligned across all participants in our healthcare delivery system. This is facilitated through the Netcare Group quality leadership management framework. Our IT platforms enable sharing of robust data, which in turn helps us identify opportunities for learning and change within individual units and across the Group. Building deep improvement capability through a science- and evidence-based approach has continued across all our divisions in 2015.

We use internal and external measures to inform our quality improvement initiatives, and we use international benchmarks as a further measure of performance and to track global trends in healthcare measures. We prioritise continuous improvement of the accuracy of our data and processes, where possible.

Elements of the Netcare Group quality leadership management framework



OUR PROGRESS AGAINST EACH ELEMENT OF THE FRAMEWORK IS SET OUT IN OUR SA: QUALITY AND CLINICAL GOVERNANCE REPORT.

Quality assurance and innovation

All divisions conduct annual self-assessments against comprehensive quality and risk management criteria. Verification audits are undertaken by independent subject matter experts. In 2015, we reached our highest level of performance against the Department of Health's National Core Standards, as well as our own specific standards of care. Pleasingly, there has been a narrowing of the gap between the highest and lowest performing facilities over the past three years, demonstrating greater consistency of quality care across facilities. We have taken the strategic decision to embark on a SA multi-divisional ISO9001 quality certification for our quality management system. This will provide further external assurance.

Our investment in technology focuses on bringing new tools to assist frontline functions with their quality measures. These are discussed in the operational reviews.

Patient care

In 2015, we completed the roll out of the multimodal patient feedback system to all Netcare divisions. The system provides reliable feedback on a daily basis to help us improve our responsiveness, understand changes required to meet patient needs, and improve patient-centred care. Together with patient-specific comments, system reports are delivered to frontline staff and senior management.

Our patient feedback questions are based on the United States' (US) Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS), which measures 'top box' performance and reflects the percentage of patients that score the most positive response. The system also records scheme-specific results that are shared with funders, giving them insight into their members' experience in a Netcare facility. Compared to 2014, scheme-specific data for 2015 shows improvement across all medical schemes. We have achieved improvements in patient satisfaction on our 2015 focus areas, including discharge information

received, pain management while in hospital and medication information received.

All Netcare divisions have implemented a risk-based approach to infection prevention and control, which focuses on sustained outcomes improvement and compliance to best practice care for infection risk areas. We have achieved year-on-year improvement in all four infection risks, namely central line bloodstream infections, ventilator associated pneumonia, catheter associated urinary tract infections and surgical site infections. A total of 32 hospitals reached zero infections for central line bloodstream infections and 18 hospitals reached zero rate for ventilator associated pneumonia in 2015.

We collaborate closely with experts locally and internationally to develop our policies and standard operating procedures to manage the growing global risk of multidrug-resistant infections, including the increasing risk of Carbapenem-resistant Enterobacteriaceae (CRE). Our preventative measures include pre-admission risk reviews, screening of long-stay intensive care unit (ICU) patients, enhanced cleaning programmes, hand hygiene compliance and our Group-wide antimicrobial stewardship programme.

Quality improvement and capability

Our multi-dimensional Group-level quality balanced scorecard is used to track progress against the goals set at Group level for each division and at each facility. Quality leadership accounts for up to 35% of executive management's balanced scorecard. Quality outcomes and process measures are a significant percentage of performance management measures for all senior and frontline managers. **the Netcare Way of Improvement** uses internationally recognised methodology to train employees and our newly established quality leadership intranet portal, available across all divisions, encourages collaboration and knowledge building. In 2015, over 70 000 downloads of patient feedback information were completed from the portal.

In 2015, we achieved a record level of employee participation in Netcare's quality leadership improvement initiatives. A total of 261 (2014: 163) improvement projects were submitted as abstracts to international and national professional academic events. Of these, 150 projects were submitted to the Netcare Quality Leadership Awards that recognise individuals and teams who have positively impacted patients' lives.

Clinician leadership

We continuously invest in our clinical governance structures and forums to support employee, doctor and patient engagement, which enables the identification of risks and supports continuous quality improvement initiatives. Engaging with doctors is key to our quality improvement programmes, and specific doctor engagement forums bring relevant medical expertise and clinical leadership to our quality initiatives. These forums include the Physicians Advisory Boards in hospitals, the Clinical Practice Committee and Clinical Ethics Committee, as well as Group-wide educational and review structures, such as morbidity and mortality meetings and continuous medical education events.

Healthcare in SA

We participate in learning collaborations aimed at sharing ideas to achieve best care delivery. At the Best Care Always (BCA) Quality Improvement Summit, held in collaboration with the Hospital Association of South Africa, Netcare was represented by teams from a number of divisions, bearing testimony to the spread of quality improvement skill throughout the Group. A total of 34 abstracts were accepted for display after independent peer-review by national quality improvement experts.



OUR AWARDS RECEIVED IN 2015 CAN BE FOUND ON PAGE 46.

Our people

The impact of our staff on the level of care provided to patients and how patients experience our facilities is critical, and directly linked to our core value of ‘Care’. Taking care of our staff supports and motivates them to deliver the highest quality of care. We focus on providing staff with a working environment that supports their wellbeing, and providing opportunities for career progression and continuous professional learning and development. During 2015, our SA workforce decreased by 2.5% to a total of 20 094 employees compared to 2014.

 DETAILED STATISTICS ON OUR EMPLOYEES ARE SET OUT IN OUR SA: PEOPLE REPORT.

In 2015, the Employee Engagement Index showed positive employee perception with regard to sense of achievement and organisational diversity. Care and concern, fairness at work and trust in employees remain identified areas for improvement. Initiatives were implemented at a Group level and through targeted interventions at a facility level to improve our employee engagement. Some 85% of the SA workforce completed the survey in 2015 (2014: 87%) and the overall engagement index score improved to 65.09 from 62.16 in 2014.

The **Leading the Netcare Way** programme focuses on building a culture of care in the workplace. It aims to develop an ethos of personal accountability and resilience in a constantly changing and demanding work environment. In 2015, this initiative focused on the nursing and human resources management teams in the Hospital division. It supported tangible growth in their emotional intelligence, which enables our unit managers to guide staff through change programmes more effectively, and drive quality and care at an individual level. The outcomes of the **Leading the Netcare Way** programme have demonstrated that our managers feel more valued and more valuable in leading strategic initiatives that build a culture of care across the organisation. Ensuring that these efforts translate into sustainable people practices requires constant awareness and reinforcement on the part of management, and we continue to invest in these important engagement programmes. A total of 227 (2014: 273) employees graduated from leadership development programmes in 2015. A further 483 (2014: 294) employees were registered on leadership development programmes, of which 84% were enrolled on the **Leading the Netcare Way** programme.

Our Netcare Education initiatives deliver formal nursing and emergency services programmes and qualifications to clinical and technical staff. At March 2015, 1 856 participants graduated from a Netcare Education nursing or emergency programme, with a further 3 999 registered on a programme. Our advanced life support paramedics are kept up-to-date on best practice in the field of critical care through the streaming of our mortality and morbidity meetings to all Netcare 911 sites nationally. Independent medical experts also review our handling of critical care cases and the key learnings are shared across the organisation. In addition, a total of 36 (2014: 72) employees were enrolled on undergraduate and postgraduate studies in 2015 at various universities in the fields of nursing, pharmacy and emergency services.

Training statistics

Our training spend in SA is reported using a March year-end (1 April to 31 March of the following year) to align to the Health and Welfare Sector Education and Training Authority reporting period.

	2015	2014	2013
Spend (Rm) (March year-end)			
Planned skills development spend per the HWSETA	32	36	35
Actual skills development spend	41	45	46
Learning and development interventions			
Number of interventions delivered	27 607	35 548	40 994
Total number of employees trained	11 143	12 021	18 689
% of employees trained that were women	83	84	83
Netcare Education¹			
Number of graduates for 2015	2 083	1 895	Not comparable
Number of employees registered in 2015	4 482	4 251	Not comparable

1. Includes nursing, emergency services and management development programme participants.

 OUR FULL SA: PEOPLE REPORT AND SA: TRANSFORMATION REPORT SET OUT OUR PEOPLE PRACTICES IN GREATER DETAIL.



QUALITY LEADERSHIP

SCORECARD HIGHLIGHTS

IMPROVING PATIENT EXPERIENCE

276 697

patient feedback surveys completed for hospital admissions

78%

of patients would “**definitely recommend**” Netcare facilities (US HCAHPS average = 71%)

94%

of oncology patients

89%

of Netcare 911 patients

would “**definitely recommend**” our services

OVERALL ACHIEVEMENTS IN QUALITY

307 SA quality measures

74% had a year-on-year improvement

85%

of Hospital division quality measures showed year-on-year improvement

Netcare teams won 14 of 30 awards at the 2015 BCA Quality Improvement Summit, held in collaboration with the Hospital Association of South Africa

QUALITY ASSURANCE AND AUDIT

45%

improvement in Medicross clinics with control self-assessment scores at or above 85% compliance for quality audits

89%

compliance of Netcare 911 quality assurance audits to regulatory emergency services standards

12345

+ − × ÷

2014 **86%** 2015 **88%**

quality assurance audit score in Hospital division

2014 **78%** 2015 **86%**

achieved by National Renal Care in National Core Standards audits

PREVENTING HARM – HEALTH AND SAFETY

5 488

frontline staff trained in medication safety for high-alert medicines

3.5

minutes average response time for Rapid Response Team across all hospitals

87%

compliance to emergency preparedness fire, education and hospital-specific emergency plans

IMPROVING CLINICAL OUTCOMES



0.09

central line infection rate per 1 000 line days (down from 0.23 in 2014 and 2.25 in 2011)



32

facilities achieved zero central line bloodstream infection rate in 2015



5.38%

acute myocardial infarction in-hospital mortality per 100 cases across 17 hospitals (down from 5.50% in 2014 and 7.68% in 2011)

CLINICIAN LEADERSHIP

93%

Physician Advisory Boards at hospitals actively review data on quality outcomes

86%

antibiotic stewardship committees have clinician champions

22

clinician leaders co-authored scientific improvement abstracts that were submitted to professional conferences

CONTRIBUTION TO HEALTHCARE IN SA

4 winners in BCA Quality Improvement Summit 2015 Awards – Science of Improvement

10 Quality Excellence Awards for BCA Quality Improvement Summit 2015 Awards

46 poster and podium presentations at national conferences on Netcare antimicrobial stewardship initiatives

GROWING WITH PASSIONATE PEOPLE

91% average score on audit of **the Netcare Way** behaviours in Hospital division

261 improvement projects submitted by staff as scientific abstracts to Netcare Quality Leadership Awards and professional academic events

97% patient feedback scores (up from 85% in 2014) on **the Netcare Way** behaviours by staff in frontline of care in Medicross

56

owned and managed
hospitals (2014: 54)

9 996

registered beds (2014: 9 424)
including 1 711
(2014: 1 601) intensive
care and high care beds

50

retail pharmacies (2014: 47)

35

hybrid theatres, catheterisation
and electro physiology
laboratories (2014: 29)

352

theatres (2014: 343)

43

emergency centres
(2014: 44)

8.62

out of 10 overall rating
of Netcare SA hospital
services by patients;
sample size = 276 696

HOSPITAL DIVISION

Strategic focus

Our Hospital division executes our strategic objective of providing best-quality patient care in the most effective and efficient manner, consistently achieving the best quality outcomes for our patients.

Our hospitals comprise a mix of technologically advanced multi-disciplinary tertiary institutions and specialist centres of excellence. Our centres of excellence are highly respected and used by patients from all across SA, neighbouring countries and further afield in Africa. These include the only accredited level 1 and 2 trauma units in SA. All Netcare SA hospitals are benchmarked against the Department of Health's National Core Standards.

Our hospitals support dedicated, passionate and committed specialists and employees who make a positive difference in the lives of our patients. We continue to establish and maintain strategic partnerships with doctors, funders, suppliers and government.

Through our PPPs in SA and Lesotho, we contribute to national healthcare by utilising our operational experience and intellectual capital in targeted high-need areas. In SA, our four PPPs represent 323 beds in our hospital portfolio. When concessions reach their end, the beds managed by Netcare will be handed back to the respective provincial departments of health, enabling them to utilise the improved facilities for state patients. The Lesotho PPP is an 18-year concession and represents 425 tertiary hospital beds and a gateway clinic at the hospital, as well as three primary care clinics.

Socially beneficial outcomes

Through partnerships we have extended free access to healthcare to over 140 000 patients over 10 years through the following initiatives:

- + Emergency assistance and stabilisation;
- + 37 Netcare Sexual Assault Centres nationally;
- + Hear for Life programme (cochlear implants);
- + Johannesburg Craniofacial programme;
- + Netcare Cataract programme; and
- + Netcare Cleft Lip and Palate programme.

We have supported efforts to curb the high infant mortality rate in the Eastern Cape through our PPP with the Provincial Department of Health. The South African Breastmilk Reserve (SABR) co-ordinates the collection and redistribution of life-saving donated breastmilk to critically ill babies. SABR began distributing donated breastmilk collected at Uitenhage's Netcare Cuyler Hospital in 2007 in a pilot facility.

HOSPITAL GOVERNANCE STRUCTURE

NETCARE LIMITED BOARD

EXECUTIVE COMMITTEE

HOSPITAL DIVISION
EXECUTIVE COMMITTEE

EXECUTIVE COMMITTEE
(CORPORATE/CLINICAL GOVERNANCE)

PHYSICIAN ADVISORY BOARD
(CLINICAL
GOVERNANCE)

UNIT MANAGEMENT &
HEADS OF DEPARTMENT
COMMITTEE

RISK COMMITTEE
(CORPORATE
GOVERNANCE)

EMERGENCY
SERVICES
MEETINGS

MORTALITY &
MORBIDITY MEETINGS

DEPARTMENTAL
MEETINGS

QUALITY
COMMITTEE¹

INTENSIVE CARE
UNIT FORUM

CAPITAL
EXPENDITURE
AND WORKING
CAPITAL MEETINGS

OCCUPATIONAL
HEALTH & SAFETY
COMMITTEE²

THERAPEUTIC
MEETINGS

WASTE CONTROL
COMMITTEE

INFECTION CONTROL

TRANSFORMATION
COMMITTEE²

RESUSCITATION &
EMERGENCY COMMITTEE

Includes where relevant theatre, radiology and key stakeholder sub-committees.
1. Deals with infection prevention, customer satisfaction, compliments and complaints.
2. Unions attend these meetings.



THE GROUP GOVERNANCE STRUCTURE
IS SET OUT ON PAGE 87.

Key figures

	2015	2014
Patient day growth	0.2%	2.6%
Occupancy	67.8%	68.9%
Revenue (Rm)	16 119	15 171
EBITDA ¹ margin	23.8%	23.1%

1. Earnings before interest, tax, depreciation, and amortisation.

Operating performance Up to and including the third quarter of 2015, the Hospital division recorded an increase in patient days of 1.7% compared to the same period in 2014.

However, the fourth quarter was characterised by reduced patient day growth as a function of increased competition. In this financial year, six greenfield acute hospitals opened in competition to Netcare hospitals during the 2015 financial year.

Hospitals and Emergency services achieved a 6.2% increase in revenue in 2015, largely due to tariff revisions, marginal growth in patient days and a slightly lower case mix. Capital expenditure was dominated by expansion projects, including the completion of two greenfield hospitals.

The low patient day growth of 0.2% for 2015, together with the addition of 584 new beds to the hospital portfolio, resulted in marginal decreases to full-week and week-day occupancy to 67.8% (2014: 68.9%) and 73.8% (2014: 75.0%) respectively. The average length of stay increased 2.8% compared to 2014. An analysis of paid patient days indicates a slight change in caseload mix, with higher growth in medical admissions and improved utilisation of ICUs, offset by lower maternity ward utilisation. As a percentage of inpatient admissions, surgical cases contributed over 60% of admissions.

Net revenue per patient day increased by 6.0%. Price inflation related to tariff increases and the increased cost of drugs and surgical supplies. The cost of consumables was well contained as a result of our efforts to standardise product lines. The balance of the price per patient day inflation increase was attributable to changes in caseload mix.

Despite the marginal improvement in patient days, overhead expenses were well controlled, with Hospital and Emergency services posting EBITDA of R3 837 million. This represents growth of 9.7%, at an improved margin of 70 basis points from 23.1% in 2014 to 23.8%, attributed to operational leverage and business process improvements.

Outstanding debtor days were at 28.4 days in 2015 despite slow payments from the Compensation for Occupational Injuries and Diseases (COID) fund, which had fallen behind during the year due to their implementation of new systems. However, significant progress has been made on collections from COID during September 2015 and subsequent to year-end. Debtors' days outstanding excluding COID remained unchanged from 2014 at 20.4 days. The quality of the medical scheme debtors' book has again improved.

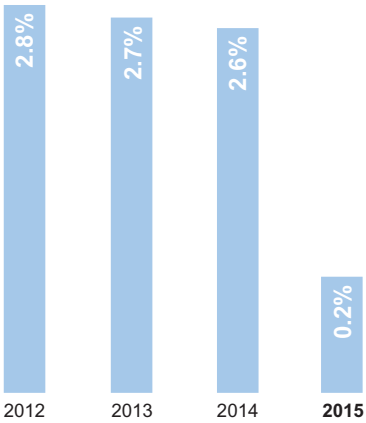
Organisational growth

We strive to ensure that our business is agile enough to take advantage of changes in private healthcare demand and to evolve how healthcare is delivered in SA. In 2015, we added 584 beds to our network, bringing the total number of registered beds to 9 996, a 6.1% increase compared to 2014. This positions us well for future growth.

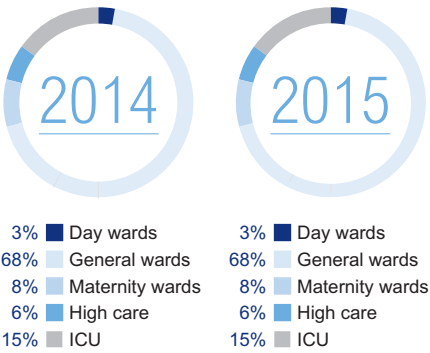
Our investment in expanding the hospital network is based on a scientific, demographic, demand-driven model, supported by full financial viability models with internal hurdle rate targets. We look at areas where we are not represented or are under-represented, or where there is high demand for beds. In 2015, we enhanced our geographical spread with the opening of a newly built hospital in Polokwane, Limpopo, a province in which we were not previously represented. We now provide healthcare in the region through our 200-bed facility with treating privileges extended to 69 doctors. The Netcare Pholoso Hospital was developed in conjunction with the Pholoso Hospital Group and provides non-invasive and minimally invasive cardiac catheterisation and vascular procedures, as well as paediatric pulmonology, paediatric surgery and ophthalmology. The second greenfield development, a 100-bed hospital in Pinehaven, Gauteng west, has extended our footprint in this high-growth area.

Netcare Pinehaven Hospital is our second partnership with Phelang Bonolo and Rubispan Proprietary Limited, and provides gynaecological, obstetric and paediatric services, as well as specialised orthopaedics.

Growth in patient days (%)



Patient days by ward type



Increasing our competitive advantage

The Netcare Milpark Hospital expansion project will enhance the flow and functionality of the hospital, providing for better service and increasing our competitive edge through new services. Netcare Milpark Hospital currently has eight centres of excellence including a one-of-a-kind trauma and burns unit. The expansion project will add three new centres of excellence, being a cancer centre, a cardiothoracic centre with a dedicated ICU, and a transplant centre. We have applied for licences for additional beds for the cardiology, trauma and medical ICU to align with increasing demand. The full isolation ICU will be utilised in day-to-day management of high-risk infectious patients. A new surgical high care unit will also increase services offered at the hospital. The new 760-bay parking deck has been completed, and additional future capacity will be available in the top two floors.

The Netcare Christiaan Barnard Memorial Hospital is being relocated to a new purpose-built building located on the Cape Town foreshore. The new hospital will include a Level 1 emergency department with heli-pad access and decontamination area, a radiology department, and 7 000m² of consulting suites for doctors. The hospital will cater for 16 disciplines, including cardiology, cardiothoracic surgery, transplants, trauma, general surgery, a breast care centre of excellence and urology, including robotic assisted surgical programmes. A number of green design principles have been used in the construction of the hospital, from elevators with energy-saving regenerative drives to a double skin façade to provide efficient insulation. The heating, ventilation and air conditioning systems are energy efficient and the hot water generation system utilises waste heat recovered from the hospital's chillers. The hospital has also been designed with risk and infection control in mind, with air filtration systems in theatres and ICU, as well as isolation rooms.

We acquired the 28-bed Ceres Hospital in the Western Cape and 68 beds were added in the Phase 2 build of our Netcare Waterfall Hospital in Midrand. Of the 256 brownfield beds added at existing facilities, 216 were in hospital wards trading at 80% to 90% occupancy where demand exceeds current capacity. New beds added in 2015 will only contribute to the Hospital division's performance from 2016 as most were opened towards the end of the 2015 financial year.

We continually optimise capacity across the portfolio, converting beds from low occupancy disciplines to higher demand units, either in the same hospital or another hospital in the surrounding area, according to demand trends. However, converting beds depends on our ability to secure hospital bed licences from provincial departments of health, which can sometimes be challenging. In 2015, we converted 94 (2014: 65) underutilised beds, mainly to disciplines such as adult medical and surgical beds, as well as paediatric and maternity beds. We also look for additional opportunities to drive capacity utilisation, by ensuring that specific facilities are multi-purpose. A good example is our hybrid theatres, which can accommodate a range of surgical procedures. In October 2014, we disposed of our 50% shareholding in the 12-bed Optimed Ophthalmology Hospital located in Alberton, Gauteng.

For 2016 and 2017, we will focus on growing into the capacity in our new facilities. We also have at least 44 additional beds planned for existing facilities. The construction of the new 248-bed Netcare Christiaan Barnard Memorial Hospital in Cape Town is on track and scheduled to open in early December 2016. Major extensions to our flagship trauma 1 hospital in Milpark are progressing well. There are still opportunities for further greenfield investment in SA and we will continue to apply for licences based on our assessments of demand for various disciplines. We will also convert approximately 50 underutilised beds during 2016 to disciplines with higher demand.

 A FULL LISTING OF HOSPITALS AND REGISTERED BEDS CAN BE FOUND ONLINE AT www.netcareinvestor.co.za.

The weakness of the Rand against major currencies continues to impact capital costs, as most equipment and technology is only available from advanced economies. While the Group manages this impact where possible, escalating costs, constraints on medical innovation and long lead times remain a reality in procuring advanced medical technology.

Operational excellence

Streamlined processes and containing costs

During 2015, we added further resources to accelerate the digitalisation of the Hospital division as part of our process improvement projects, which are improving data collection and supporting the objectives of the *Triple Aim*.

In a maturing market, top-line growth increases are unlikely to be as high as in the past. This requires that we continually focus on our cost base to achieve continuous growth. Our investment in SAP is expected to provide substantial efficiencies over the next five years. We are using this robust enterprise resource system to control fixed costs and standardise our protocols and processes. Optimal management of procurement, stock levels and issuing pharmacy items leads to better cost management, accurate invoicing and sound clinical practice.

During 2015, we added further resources to accelerate the digitalisation of the organisation as part of our process improvement projects, which are improving data collection and supporting the objectives of the *Triple Aim*.

As a hospital operator, we operate 24 hours a day, 365 days of the year. As occupancy levels fluctuate, especially with lower occupancies over weekends and holidays, we must be agile in matching our staffing levels to the number of patients. In addition, we are using scarce skills and must ensure that we have the right people in the right place providing the right level of care at any given time. We have implemented an automated ward planning tool to manage our direct nursing costs and nursing

acuties. Staff scheduling takes place twice a day across 455 wards in SA. The tool has generated margin efficiencies from better utilisation of nursing staff and improved the balance in staff complement between permanent and agency staff. In 2015, we started rolling out this tool to our theatres.

Our optimisation projects facilitate automatic billing for stock used in theatre or in the ward. Nurses simply scan the script and medication, and the stock tool automatically updates a patient's bill. The system also ensures that the correct drugs are administered to patients. This reduces the burden of manual administration, reducing cost and the risk of human error while freeing up nurses to focus on providing care. The system is also reducing paper consumption and supporting our efforts to eliminate stock wastage. Stock days were well managed in 2015. We are also streamlining our admission procedure to reduce the length of time a patient spends on completing administration forms, with some processes already in place and further implementation expected in 2016.

We have completed the outsourcing of our catering services, with catering being highlighted by patients as key to their comfort and recovery. Cost savings have been achieved and patient satisfaction on quality and presentation of food has increased to 73.4% (2014: 71.6%) as measured by HCAHPS, an international survey instrument and data collection methodology for measuring patients' perceptions of their hospital experience.

Asset and utilities management
Our top specialists provide highly specialised treatments and require costly and advanced medical technology. To support quality outcomes, we need to ensure these assets are maintained for optimal operation.

We have strengthened our technical services departments and started the asset management programme mentioned in last year's report. This five-year plan encompasses a more strategic role in managing these assets and requires the listing of all our assets on SAP, including a maintenance schedule for each. Maintenance plans cover both preventative and routine maintenance, in a

proactive approach that mitigates the risk of assets not being available when required and increasing the lifespan of assets. The asset maintenance plan also drills down to a component level, adding a further layer of maintenance not available in the traditional asset register.

Our asset management programme aligns to our environmental sustainability programme, with more efficient use of resources also improving the bottom line. In 2013, we implemented a five-year strategy and execution plan, covering Group operations in SA, to achieve a targeted 35% real reduction in energy consumption over 10 years. To date, 42 projects have been completed in our journey to achieving this projected saving. To date, the Sustainability Committee has approved energy efficient and renewable energy projects to the value of R320 million, with completed projects having effectively avoided energy costs by around R64 million over the past two years. Green principles have been applied to the building design of the new hospitals in Pinehaven and Polokwane, and should collectively avoid an energy impact of 1.8 GWh annually, an approximate annual avoidance of 1 800 tonnes of carbon emissions.

Meters are being installed in all hospitals to establish accurate baselines for measuring, verifying and reporting energy reductions. Our current projects include a national project to upgrade lighting systems in our hospital facilities, with estimated cost savings of R14 million a year at current tariffs. A total of R16 million has been approved for solar photovoltaic (PV) installations. Our rooftop solar PV projects will produce approximately 6 GWh of electricity a year by the end of 2016. Our first rooftop solar PV installation was switched on in September 2015.

We are auditing our water and waste management and use principles. Completion is expected in the second quarter of 2016. Based on the audit findings, we will develop strategies to manage risks related to water shortage and waste management.

Interruptions to water supply impact business operations and potentially the ability to provide quality healthcare, which in turn could have a negative financial impact on the business. As part of our water strategy, we are installing water meters to monitor our optimisation

- Notable accolades during the year included:
- + First in the Hospital Management category for the sixth consecutive year in the 2015 Top 500 Companies Awards.
 - + Netcare Pretoria East Hospital voted best hospital in Pretoria by readers of the Rekord for the third consecutive year.
 - + Netcare St Augustine's Hospital voted first in the hospital category of The Daily News 'Your Choice 2015' Awards for the seventh year.
 - + Netcare St Augustine's and Netcare Christiaan Barnard Memorial hospitals each won a PMR.africa Diamond Arrow Award in the category private hospitals/clinics in KwaZulu-Natal and City of Cape Town/Cape Peninsula respectively.
 - + Netcare Umhlanga Hospital won a Golden Arrow Award and Netcare Parklands Hospital received a Silver Arrow Award from PMR.africa, in the category private hospitals/clinics in KwaZulu-Natal.
 - + Netcare Garden City Hospital was voted the best private hospital in the 2015 The Star Readers' Choice Awards.
 - + Netcare Montana Hospital won a silver award in the hospital category of the 2015 Beeld Your Choice Awards.

initiatives. We are investigating water efficient alternatives such as boreholes, filtering, re-use of water and rain water harvesting. The Netcare Femina Hospital in Pretoria and Netcare Alberlito Hospital near Durban will be the first facilities to benefit from these feasibility studies.

Where the quality of water supplied to certain facilities requires additional treatment before distribution, we build on-site water recycling systems to limit our dependency on treated water from municipal utilities. For the last five years, we have spent R72 million on backup water storage. Over the next two years, R50 million to R60 million has been budgeted for further initiatives.

In 2015, we completed Phase 2 of the nationwide low-flow shower upgrade. We have also converted the reverse osmosis plants at the National Renal Care units of Netcare Sunninghill and Netcare Alberlito hospitals to re-use filter flush water as grey water to flush toilets. Combined, these conversions will reduce fresh water demand by 3 044 kilolitres (kL) a year. A water-wise grey water laundry design was implemented in the new hospital in Polokwane, reducing the facility's potable water requirements by 1 931 kL. Similarly, we are investigating ground water as a potential water supply alternative for our central laundry in Gauteng.

The recycling initiative, started in 2013, ensures accurate and robust medical waste management practices and data. Following the waste management audit, we will implement a more integrated waste management process to optimise the waste value stream. This will be rolled out to all hospital facilities over a 24-month period.



MORE INFORMATION CAN BE FOUND IN THE SA: ENVIRONMENTAL REPORT ONLINE.

Physician partnerships
At 30 September 2015, the total number of specialists with privileges at Netcare facilities was 2 432 (2014: 2 278).

As established doctors with existing client bases are in short supply, they are highly sought after in the highly competitive healthcare environment. In 2015, 51 seasoned specialists terminated their privileges with Netcare, of which 21 took

up permanent privileges in competitor facilities. However, 129 specialists (excluding the 76 specialists practising in the two new greenfield hospitals) were granted privileges in Netcare facilities, although many of them are young doctors who are still building their practices. In addition, there is an increasing trend of specialists choosing to divide their time between competing healthcare providers, known as 'splitting', which can reduce patient volumes at facilities.

The factors that attract specialists to a healthcare provider include the premises and medical equipment, quality of nursing care and more recently equity participation. To date, Netcare has not offered shareholding incentives to physicians. It is testament to our doctor-centric approach that we have managed to retain leading specialists, despite not offering this incentive in the past.

We continue to invest in medical technology that provides quality care and supports our specialists. During the year, we invested around R640 million in the refurbishment of facilities, as well as replacement and upgrade of medical equipment.

The Physician Advisory Boards work well as an engagement platform between doctors and Netcare, and support our efforts to continually improve services to patients and doctors. A total of 4 266 (2014: 3 735) GP visits were undertaken in 2015. We are committed to supporting and developing the skills of our healthcare professional partners in rapidly developing clinical fields. In 2015, we held 80 (2014: 86) continuous professional development events.

Best and safest patient care

A number of interventions support our ability to provide quality care, ranging from embedding *the Netcare Way* and our quality leadership scorecard through to our infection prevention and antibiotic stewardship programme. In 2015, we implemented an electronic laboratory system that integrates with antibiotic usage and patient-specific data. The system has enabled more effective risk management of infections and ensured consistent antibiotic stewardship standards and interventions across all Netcare hospitals. We also use the Therapeutic Intervention Scoring System (TISS), an internationally accredited

scorecard, to assess intensity of care administered in the ICU. Based on the number of interventions a patient requires, this helps us understand whether a patient is in the correct level of care or whether they can be stepped down to a lower level of care.

We have incorporated the National Core Standards into our quality assurance audits and we track performance against these standards, as well as additional Netcare-specific standards and outcomes. Quality assurance audits were completed for all hospitals and the Hospital division achieved an overall compliance score of 88.2%. The Hospital division's quality leadership scorecard monitors over 70 measures and showed year-on-year improvement in 85% of these measures.

We use internal and external data sources on patient feedback to inform our programmes that focus on improving the experience we provide for patients. Against the HCAHPS benchmark, we achieved scores higher than those of the US hospital national average in all ratings, barring one for the supply of sufficient discharge information, where 78% of patients said we always provide information about what to do during their recovery at home (US survey: 85%). Going forward, we intend to make better use of electronic communication to stay in touch with patients after their discharge. This will enable us to provide additional discharge and medication information to aid recovery.

In response to patient feedback with regards to noise levels at night we are testing an 'electronic ear', a device that tracks the decibel level of the ambient noise and provides teams and management with information to monitor progress.



ENSURING QUALITY OUTCOMES THROUGH THE QUALITY LEADERSHIP SCORECARD AND OUR PEOPLE PRACTICES CAN BE FOUND ON PAGE 44 TO PAGE 46 OF THIS REPORT AND IN THE ONLINE SA: QUALITY AND CLINICAL OUTCOMES AND SA: OUR PEOPLE REPORTS.



85

emergency bases (2014: 86)

214

vehicles (2014: 209)

1 084

paramedics (2014: 1 078)

2

helicopters (2014: 2)

2

seconds
average time to answer calls

1

jetair ambulance (2014: 1)

88.2%

Netcare 911 patients
'definitely recommend' score

EMERGENCY SERVICES

EMERGENCY SERVICES

Strategic focus

Netcare 911 is the leading pre-hospital risk management and emergency services provider in Southern Africa. Our core competency is emergency medical assistance, evacuation by road or air transportation, medical advisory services through a world-class emergency operations call centre and medical management services at commercial, industrial, construction and mining sites.

Remote site clinic solutions include on-site ambulances, clinics, laboratories, counselling and education, as well as health risk management and pre- and post-deployment medical examinations.

Our air ambulance service caters for short- and long-range flights and we service clients such as medical assistance companies, international insurers and the mining industry.

Socially beneficial outcomes

Netcare 911 responds to any life-threatening emergency, irrespective of whether the patient is medically insured or able to pay for the service. In the last two years, Netcare 911 has cared for nearly 9 000 indigent patients needing emergency care at a cost of R30 million.

Operating performance

Netcare 911's fee-for-service activity increased during the 2015 financial year, despite a challenging competitive environment with a proliferation of independent emergency medical service (EMS) providers entering the market. In SA, we renewed or extended a number of existing contracts and were awarded a new capitated contract within the energy sector that commenced in June 2015. Helicopter EMS activity and fixed wing transfers in Africa and surrounding islands increased in 2015. In the last quarter of the 2015 financial year, our helicopter EMS achieved its best financial performance in its 10-year history.

Netcare 911 experienced sustained demand in the Southern African Development Community (SADC) region in 2015, despite reduced commodity prices slowing down mining project activity. In Mozambique, we won a contract in the oil and gas sector. A number of existing sites also increased their scope of services, particularly in the construction sector.

Our focus on operational efficiencies resulted in better utilisation of resources from a human capital perspective, as well as better allocation of vehicles and the way we dispatch emergency services. We have grown revenue and attended more incidents, while operating a smaller fleet of response vehicles, maintaining our headcount and reducing staff overtime. Capex has been confined to cyclical replacements, and investments in IT and life-saving technology in ambulances.

Organisational growth
Netcare 911 is the only provider of ICU transportation in SA. In 2016, we will further establish our brand as the provider of choice in moving critically ill patients by expanding this service to Cape Town.

We are one of only three providers in SA that offer risk-based capitated contracts to medical scheme clients. This is a difficult product to manage given the unpredictable nature of emergency services demand. As such, we are focusing on growth in other service lines

including the fee-for-service client base, the industrial sites business, as well as fixed wing and helicopter emergency services. Progress has been made in all focus areas.

In our Industrial division we have focused on the mining sector and are now looking to diversify into less cyclical sectors. Our competitive advantage is our ability to provide services beyond a pure emergency medical service product. For example, we are able to provide resources, both human capital and equipment, to deal with fire prevention and outbreak, as well as primary care services. This enables our clients to focus on their core business, meet occupational health and safety regulations and reduce cost in terms of set-up and training.

The implementation of our integrated IT platform has improved our competitive advantage. We are now able to link our system with certain security companies so that when an emergency call is received by the security company to assist a client requiring medical assistance, they are quickly able to determine whether a Netcare 911 vehicle is in the vicinity.

Our focus in Mozambique has mostly been to maintain and expand existing contracts given the slowdown in economic activity. The liquefied natural gas (LNG) project is expected to provide further opportunities for growth when the project comes online. The impact of commodity prices on prospective clients remain the biggest challenge to growth in Mozambique. Beyond Mozambique, we are looking to increase our operational footprint in the SADC region and are undertaking situational analyses to identify opportunities.

While our strategic focus is on acquiring a greater share of the market that is able to pay for private services, we continue to service those that are in life-threatening situations, irrespective of their ability to pay.

Operational excellence
Our integrated IT platform is improving our control over the business, allowing us to commit the right resources in the right place at the right time.

This allows for improved allocation of human and manufactured capital resources, and supports investment decisions and our contribution to society.

Our three largest cost drivers are car leases, fuel and staff. The business has benefited from the reduction in fuel costs and the conversion of our road vehicle fleet to diesel. We have implemented blue technology in our response vehicles, which switches off a vehicle's engine while it is stationary. These initiatives save costs while lowering our carbon footprint. More strategic use of our fixed wing service has also contributed to cost savings in our fleet.

By its nature, providing emergency services requires being prepared for the unknown, making the efficient allocation of resources difficult to achieve. Improvements in our systems are providing better data informing trends and planning accordingly. For example, in 2015 we integrated the industrial sites business, which used to be a separate division, into Netcare 911 operations. This has provided a better operational view and increased our understanding of the medical incidents likely to be associated with certain types of mining projects. Our ability to efficiently project which resources are required depends on our ability to leverage our data. As such, our capital investment has remained focused on an integrated IT platform that supports our progress towards meeting the objectives of the *Triple Aim*.

In 2015, we completed the national roll out of the IT platform across all services offered by Netcare 911. Our patient reporting tool is the foundation for all business processes, automating data capturing tasks and managing information electronically from calls received and dispatch of services, through to incident and transfer services. The benefits of the system include less time spent by attending paramedics on manual record-keeping, which allows them to focus on patient interaction and care without compromising the quality of patient data collected. It allows for the

efficient dispatch of emergency services and enables quicker response times as the geolocation technology is able to locate ambulances and determine the estimated time of arrival. This provides patients with greater peace of mind.

Best and safest patient care

Our fleet of emergency vehicles are strategically placed throughout all nine provinces in SA, and are supported by emergency care practitioners trained to the appropriate level of care specific to a patient's condition. For example, our rapid response vehicles are crewed by advanced life support paramedics for immediate dispatch to any acute trauma or medical emergency.

Our dedicated ICU ambulances, operating in Gauteng, are specially configured and equipped to provide inter-hospital transfers for ventilated adults through to neonatal ICU patients. Our rotary and fixed wing units have the same ICU-level capabilities, utilising the latest technology to ensure highly effective patient care.

Given the cost of rotary and fixed wing medical services, we have partnership arrangements with aeromedical service providers in four provinces in SA to secure our ability to provide aeromedical evacuation. We have entered into a new partnership to operate two Bell 222UT helicopters, which are faster, larger and have a longer range. This partnership, which has tripled the number of flights undertaken monthly, ensures an emergency care practitioner-based helicopter service is available for immediate dispatch to life-threatening emergencies 24 hours a day. This is made possible through a single-source, end-to-end dedicated flight operations centre based in the Netcare 911 national emergency operations centre in Midrand, Gauteng. The service is also available to expedite inter-facility transfers.

Through these integrated services we minimise medical risk for our patients while staying true to the intent of our "Saving Time Saves Lives" initiative. Through this initiative, we analyse key links in the EMS value chain to find efficiencies and incorporate quality and clinical guidelines into our processes.

We have continued to maintain the 22% reduction in time from receiving a call to the arrival of an appropriate medical practitioner at a scene, achieved in 2014. This 20-minute saving has doubled our capacity to provide emergency services and deliver better clinical outcomes as we are able to arrive at a scene, treat the patient and transport them to the right facility within a shorter period of time, while containing costs.

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Key relationships

One of our bigger challenges in managing our capitation contracts is balancing our own, more efficient, resources with the cost of using third-party or outsourced service providers when we are unable to attend to an incident, particularly given the higher relative cost of service providers. Furthermore, the use of service providers can impact on our reputation in terms of their ability to provide good quality paramedic services. Our service provider agreements are therefore centred on minimum standards.

The National Health Act has been promulgated to standardise the quality of care provided by emergency service providers. We have provided comment and are working to ensure that we comply with the requirements of the Act within the stipulated timeframes. We are also active in emergency medical services forums.

Terminology

Capitated contracts are contracts where a client is charged a fixed fee calculated per member per month for a suite of services. **Capitated payment systems** are therefore based on a payment per person rather than a payment per service provided.

Fee-for-service refers to services provided to non-capitated clients who are generally covered by a medical aid fund.



88

Medicross centres and Prime
Cure clinics (2014: 87)

13

Medicross day
theatres (2014: 13)

36

retail pharmacies (2014: 36)

81.3%

Medicross patients
'definitely recommend' score

PRIMARY CARE

PRIMARY CARE

Strategic focus

Netcare's Primary Care division provides a national network of comprehensive family medical and dental centres, for the group practices of private doctors, dentists and allied health professionals.

Our comprehensive suite of services includes practice management, finance and administration, support services, human resources management, facilities management, retail pharmacies and day theatres. We manage the logistical demands that accompany the professional practices of around 650 medical and dental practitioners, which allows them to focus on delivering primary healthcare outpatient services. Our day theatre network provides patients with access to same-day specialist surgical procedures for minor surgical cases.

Our Medicross network offers insured and self-pay patients convenient access to primary healthcare services, providing curative and preventative services that promote wellness. These include pharmacies, radiology services, pathology services and allied health professional services such as audiology and physiotherapy.

Our occupational health services and workplace employee wellness programmes provide employer groups with a value proposition that allows them to mitigate and proactively manage their occupational health and safety-related risks. We assist employers to meet the regulated occupational health needs of their employees while ensuring that their organisations' productivity is not adversely affected by poor employee health and absenteeism. These services, which include travel medicine and advisory services from our travel clinic network, are provided directly at the workplace or through appointed providers to small, medium and large employer groups across various sectors nationally.

We provide a well-established system of managed care for various funders across a range of options, including specialised managed care for dental treatment, HIV disease management, hospital utilisation, chronic disease management, drug utilisation and provider network management.

Key figures

	2015	2014
Visits to Primary Care facilities	3.2 million	3.2 million
Scripts dispensed	2.0 million	2.0 million
Revenue (Rm)	1 170	1 102
EBITDA ¹ margin	9.5%	8.9%

1. Earnings before interest, tax, depreciation and amortisation.

Operating performance

Primary Care grew revenue 6.2% to R1 170 million. Across the Medicross network, the number of visits remained steady notwithstanding the mild winter in SA. We have continued to focus on optimising our operational costs, which were contained below general inflation despite notably higher increases in utility and staff costs. Working capital was again well managed with debtor days at 19.8 days compared to 19.4 days in 2014.

EBITDA increased 13.3% to R111 million (2014: R98 million) and the EBITDA margin improved from 8.9% in 2014 to 9.5% as a result of structural and operational refinements to the business model.

Organisational growth

Our investment in primary care is strategic as healthcare models focused on early detection and access to care, at the right level of care or intervention, are more efficient. Our strategic priority is to add capacity and maximise the capacity utilisation of our existing day clinics and theatres. A new facility, the Carnival Mall Medicross in Brakpan, was opened in August 2015. We continue to look for opportunities to extend our range of services to give us exposure to more of the health services value chain, and to grow our current transitional care offering where patients are moved out of an acute hospital setting into a sub-acute facility if they are not yet ready for discharge into the home environment.

This aligns to the increasing international trend of funders promoting the use of day theatres and sub-acute facilities, particularly as these facilities deliver more affordable services at the appropriate level of care. In addition, they offer patients an easier clinical

pathway to access minor health cases and dental work.

While discussions around the implementation of NHI remained low key in 2015 and there is uncertainty still in terms of the systems the funder may require, we are confident that we have the infrastructure and systems in place to meet the NHI's data requirements, particularly the ability to validate users across multiple facilities. The changes made to advance our business model will likely be to our advantage should we become a service provider to the NHI. For example, we may become more attractive to a wider base of practitioners as the national funder may require conformance to a set of facility and information management standards, which practitioners may not be able to achieve on their own.

Operational excellence
The Prime Cure Wellness occupational health services unit received a best practice commendation from external auditors, Deutsche Gesellschaft zur Zertifizierung von Management Systems, which undertook an OHSAS 18001 and ISO14001 audit on one of our clients in the steel industry that employs over 7 000 people.

To further improve our operations, Primary Care is implementing IT systems that will help us achieve optimal process efficiencies and improve patient management and communication. We are re-engineering our processes to remove duplication of data capturing between front office (practice-facing) and the back office (financial head office). Our

medium-term objective is to implement a more standardised IT platform across our network that better accommodates a group practice environment rather than to individual practices.

Physician partnerships

Funders are becoming increasingly interested in treatment outcomes, whether at primary care or hospital level. They are moving towards profiling tools, based on favourable clinical outcomes achieved and preventative measures applied, to reimburse practitioners. We are cognisant of the need to implement a relevant clinical management system to support our physician partners in better managing and monitoring clinical data so that they are able to participate in these medical funder driven initiatives.

To effectively measure and report on these outcomes requires the implementation of standardised technology systems. We have made progress in evaluating clinical management systems and have prioritised identifying an appropriate system in 2016. However, this is a complex undertaking with a number of associated challenges. These range from changing the ways in which physicians work through to balancing administrative proficiency against the cost of implementation, and ensuring a reasonable level of return.

Best and safest patient care

We are bedding down standard operating procedures and processes to create consistency across our business. Our quality improvement programmes ensure we provide an industry-leading customer experience, as well as compliance with the National Core Standards set by the Department of Health. While these standards have been designed for public hospitals, we have voluntarily adopted them as they reinforce our strong management of aspects such as infection management and control, waste management and occupational health and safety.

Our balanced scorecard includes targets for continuous quality improvement across our operating platforms, and we continue to emphasise that quality must be a

service guarantee. This is helping us move towards consistent application of the standards.

We have increased engagement with our staff to drive **the Netcare Way** culture throughout the network. The benefits of this culture initiative have been reported by some practitioners and we will continue our efforts to drive consistency throughout all group practices.

We have also rolled out a patient feedback system to measure patient experience across all touch points, from pharmacies and GP practices to the dental practices, nursing stations and interactions at front desks. Feedback is received electronically through a simple questionnaire, which enables us to identify trends and areas of improvement, such as long queues in certain pharmacies or items that are repeatedly out of stock. Feedback informs how management time and resources are allocated to address problems timeously and drive patient utilisation of our facilities. The survey also includes a question on whether or not the patient observed **the Netcare Way** in their interaction with our staff. In 2015, the Medicross patient satisfaction survey was measured for the first time across a full year, reporting a 'definitely recommend' score of 81.3%.

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Notable accolade during the year included:
+ 2015 Bloemfontein Courant Best of Bloemfontein Readers' Choice Awards:
Medicross is the winner of the healthcare category for "providing efficient and competent care" at its medical and dental centres in the city.



NATIONAL RENAL CARE

59
National Renal
Care units (2014: 58)

740
dialysis stations
(2014: 668)

88.0%
National Renal Care patients
'definitely recommend' score

NATIONAL RENAL CARE

Strategic focus

National Renal Care is committed to optimising healthcare and improving quality of life for patients with compromised renal function. We drive this by providing convenient access to affordable, quality and integrated care.

Our strategy to remain at the forefront of renal support therapies is underpinned by the pillars of operational excellence, growth, optimisation and sustainability. This is enhanced by establishing and maintaining long-term strategic partnerships with the public healthcare sector, hospital groups, medical professionals and suppliers.

National Renal Care's key focus areas are:

- + Employee engagement;
- + Operational efficiencies;
- + Patient experience; and
- + Brand consistency.

Socially beneficial outcomes

We help improve the quality of life for patients with compromised renal function. In building relationships with the public healthcare sector and increasing capacity through our 12 PPPs, we broaden access to treatment for public sector patients. As part of our CSI, we performed 906 discounted or free dialysis sessions in 2015 and provided transport assistance to 29 patients.

Organisational growth
In May 2015, we opened our newly expanded Queenstown dialysis unit. This state-of-the-art facility has 16 dialysis stations, with the capacity to provide dialysis to 80 patients with chronic kidney failure, three times a week for four hours at a time.

In the 2015 financial year, we increased the number of National Renal Care chronic units to 55 (2014: 53), expanded seven existing units and grew the number of dialysis stations by 72 to 740. New units were opened in Waterfall (Gauteng), Mdantsane township and Pelonomi Private Hospital. Two units were closed (Midlands and Plettenberg Bay) and the Isipingo unit was moved to Athlone to accommodate demand. With this increased capacity, we anticipate patient growth over the next two years. When making investment decisions we look at demand and proximity to a medical facility.

Scientific evidence is demonstrating that self-care and enhanced patient engagement can deliver superior patient outcomes. To ensure we remain 'future fit', we are looking to implement new delivery mechanisms for providing renal care. In 2015, we started our shared care dialysis programme, where haemodialysis takes place at home and the patient self-cannulates (places a cannula inside a vein to provide venous access). Sixteen patients are participating in the pilot programme after having received self-cannulation training and assessments. Establishing a renal unit at a patient's home allows patients to dialyse in comfort and at their convenience. Our intention is to adapt our business model to include home dialysis as a service offering delivered at the same cost as in-centre treatment. In 2016, we will continue to drive shared care dialysis therapies that will include investigating the feasibility of opening shared care dialysis units as part of our facilities network and as an alternative to standard in-centre treatment.

Operational excellence
We focus on creating greater efficiencies in our basic operational processes including clinical targets, pump speeds, increased fistula ratios and our bundles of care. Our bundles of care are focused practice guidelines based on our clinical pathways and have been established using evidence-based medicine on outcome management. Added to this, in 2015 we started bringing specific technical support services in-house. Our aim is to integrate a fully certified technical team tasked with managing and maintaining National Renal Care's fleet of dialysis machines.

In 2015, we refined the process to capture treatment data using mobile devices and enhanced employee performance measurement tools. We are piloting a clinical system in two units that integrates our patient database, providing one source of patient data for treatment sessions, medications and prescriptions. The system takes into account the requirements of the Protection of Personal Information Act.

Haemodialysis is a resource-intense procedure, requiring between 400 to 500 litres of water and 10 kilowatt hours of electricity per session. Medical waste is also generated as an output of the procedure. We are achieving water savings by re-routing reject water back into our reverse osmosis systems, recycling waste water for general use and routing reject water to machine drains. For example, our new building in Umhlanga recycles 60% of its grey water back to the remainder of the building. We are close to completing the upgrade of our fixed reverse osmosis systems to ensure consistency in the quality of water used during dialysis. To mitigate against the risk of no water supply, we cultivate relationships with nearby utilities such as firehouses in the event of a water disruption in an area.

Physician partnerships
Forming collaborative partnerships with our doctors and benefiting from their expertise is an important enabler of continuously improving service levels. The trend of nephrologists working with more than one renal care service provider continues, but our footprint of dialysis units, designated service provider agreements with funders and brand reputation enables us to maintain our position as the provider of choice. Our doctor satisfaction score for 2015 improved to 93.4% (2014: 92.0%).

Best and safest patient care
Quality assurance standards
Some 80% of all National Renal Care units achieved a quality score of greater than 85% in the 2015 self-assessment exercise. Our total quality score improved from 91% in 2014 to 92% in 2015, with a 4% and 8% improvement achieved for infection control and medical waste management respectively.

In June 2015, we completed verification audits across a diverse sample of 20 units with at least two units from each province being included in the exercise. A score greater than 85% was achieved by 83% of the units included in the sample.

We voluntarily implement the South African National Core Standards. This year marks the second year of implementation with our acute teams achieving 100% compliance in the 'extreme' measures and 97% in the 'vital' measures. Across the National Renal Care network, 88% of our units achieved a score greater than 85%. In 2015, we implemented an interactive reporting tool in our acute departments, nationally. The tool, which will be operational in 2016, runs on a mobile platform and will track efficiencies, resource allocation, clinical outcomes and patient satisfaction.

Patient satisfaction
Our patient satisfaction questionnaire is aligned to the HCAHPS survey. Our patient satisfaction score for 2015 was 87%, a 1% improvement on 2014. Feedback is analysed and used to inform initiatives to address specific patient concerns.

Patient experience is mostly driven by comfort and the standards of service (such as television viewing and meals) as opposed to clinical outcomes. While it is primarily demand factors that drive our decisions on which units to invest in, our management team is set on delivering brand consistency across all National Renal Care facilities. Bringing technical teams in-house and standardising service levels will support our progress against this objective.

Contribution to improving kidney disease management
Our efforts towards kidney disease management include in-house research programmes in partnership with external research teams. In 2015, we presented seven papers at the World Congress of Nephrology and published an article in the South African Medical Journal.



ENSURING QUALITY OUTCOMES THROUGH THE QUALITY LEADERSHIP SCORECARD AND OUR PEOPLE PRACTICES CAN BE FOUND ON PAGES 44 AND 46 OF THIS REPORT AND IN THE ONLINE SA: QUALITY AND CLINICAL OUTCOMES AND SA: OUR PEOPLE REPORTS.

Key relationships
We are a founding member of the Dialysis Service Providers of South Africa, an association formed to promote the interests of the private dialysis industry in SA and to encourage the setting of appropriate standards in the provision of dialysis services. Our nephrologist consultants have formed the South African Renal Consortium to co-ordinate and promote the interests of nephrology in the private healthcare sector.



LEADERSHIP

OVERVIEW

UK
left to right

Catherine Vickery (40)

General Counsel and Company Secretary

Qualifications: Solicitor, BA (Hons) Jurisprudence and PGDip Legal Practice
Joined in 2005

Sally Sykes (53)

National Director of Public Relations and Marketing

Qualifications: MSc, BA (Hons), Chart. PR, IoD Diploma in Company Direction
Joined in 2015

Jill Watts (57)

Chief Executive Officer – GHG

Qualifications: MBA, Graduate Diploma in Health Administration and Information Systems, Wharton J&J Leadership Programme
Joined in 2014

Robin Copeland (53)

National Director, People, Performance and Quality

Qualifications: BSpThy, MBA
Joined in 2015

Liz Sharp (56)

National Director of Clinical Services

Qualifications: MA Healthcare Ethics and Law, Registered Nurse
Joined in 1991

Henry Davies (47)

Chief Financial Officer

Qualifications: ACA ICAEW
Joined in 2015

UK: OUR OPERATING ENVIRONMENT

UK in 2015

Economy continues to IMPROVE

but Private Medical Insurance remains under pressure

Employment levels at the HIGHEST

since comparable records began in 1971

NHS expected to remain under significant pressure due to growing demand for healthcare services and funding constraints

Despite a recovery in the UK economy and rise in employment rates, the Private Medical Insurance (PMI) market remains under pressure. However, BMI Healthcare continues to experience strong growth in NHS business but we remain cautious on how financial pressures and recent actions by the NHS and governing bodies may impact on our growth.

Economic recovery and political certainty

According to the Office for National Statistics (ONS), the UK's GDP has experienced continuous growth since the beginning of 2013. GDP increased by 2.3% between the third quarter of 2014 and the same period of 2015, and growth between the second and third quarter of 2015 was 0.5%. Aggregate output is estimated to be 13.3% above its lowest point in the second quarter of 2009¹.

Employment levels are a primary driver of demand for PMI. For July to September 2015, 73.7% of people aged from 16 to 64 were employed, up from 73.0% for the same period in 2014. The unemployment rate for July to September 2015 was 5.3% down from 6.0% a year earlier².

Compared to the first quarter of 2015, household spending (adjusted for inflation) grew by 0.8% to £2.3 billion in

the second quarter. Compared to the second quarter of 2014, household spending was 3.1% higher in the same period of 2015. The main contribution to growth was recreation and culture, with the minimum contribution from the healthcare sector³.

The return of the Conservative Party, following the election early in 2015, reduces the likelihood of major changes to the NHS and related structure policies for the foreseeable future. The Party has pledged a real increase of £8.4 billion in NHS spending by 2020/21, significantly frontloaded with £3.8 billion pledged for next year. Given the current financial pressures faced by the NHS, the phasing of this increase is important to address current challenges while achieving greater stability in the medium term.

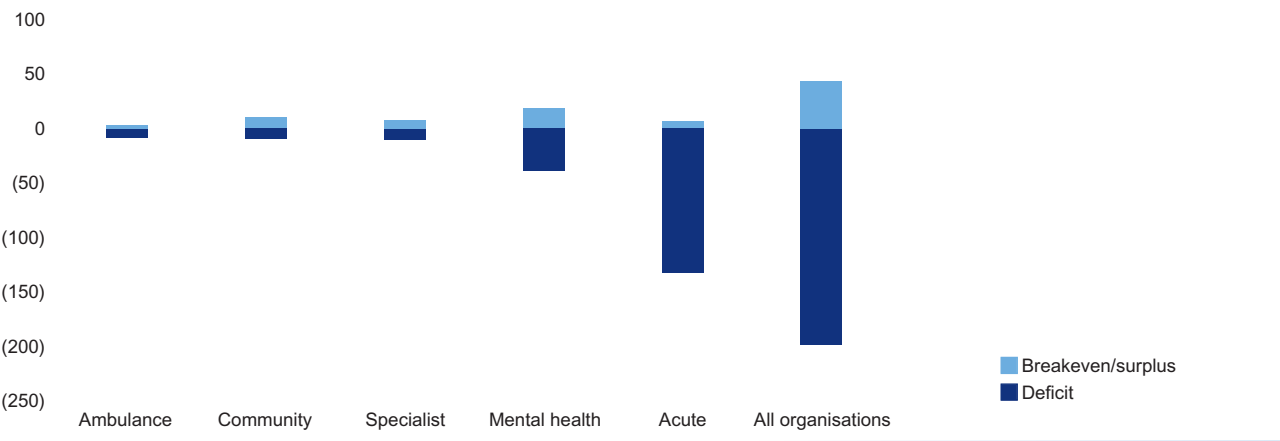
The UK health environment⁴

Current indications are that the NHS continues to be in an overall operating deficit, with numerous high profile trusts experiencing financial difficulties. The funding gap is expected to be well over £35 billion by 2021.

A survey of NHS trust finance directors by the King's Fund shows that 198 out of 241 NHS providers ended the first quarter of 2015/16 in deficit with a collective net overspend of more than £930 million. In addition, 64% of all provider organisations are forecasting a deficit by the end of 2015/16 (see chart alongside) with 88% of acute trusts expecting to overspend.

Estimates, prior to the capital injections committed to in November 2015, indicate that overspending by trusts could collectively amount to more than £2 billion by April 2016 (Wintour and Campbell, 2015). Nearly 90% of NHS trusts reported that financial pressures on local authorities are adversely affecting healthcare services in their local area⁵.

NHS provider organisations: Q1 2015 financial position



Source: Kings Fund Quarterly Monitoring Report for July 2015.

In addition, the NHS continues to face service pressures. As reported in the Quarterly Monitoring Report for July 2015: "Concerns about waiting times follow the worst year for breaches of the national 18-week target for admitted patients since it was introduced". The report goes on to note that continued increases in the total number of patients on the waiting list, estimated at 3.4 million (around one in 20 people in the whole of the UK), is at its highest level since 2008. Data indicates that the waiting list is growing by around 60 000 people per month. Furthermore, the four-hour target for A&E (accident and emergency) was missed in the first quarter of 2015/16, being the first time

this has happened at the start of a year for more than a decade. Despite these breaches, Monitor⁶ has suspended a number of fines and penalties relating to waiting lists and targets.

UK private healthcare

Independent acute medical hospitals and clinics generated revenue of £4.6 billion in 2014, up 1.8% on 2013 in real terms, taking inflation into account. This is below projected real growth of 3% for 2014. Excluding London, revenue generated from the use of independent facilities to treat NHS patients was up 6.5% in 2014 with NHS accounting for £1.3 billion of revenue.

Demand for UK PMI has remained flat since 2012. The volume of subscribers is currently 9% lower than the peak of 4.3 million subscribers at the end of 2013. However, some growth has been reported within a younger corporate demographic. Despite a year of improved economic growth and employment levels, this is yet to impact employer demand for private healthcare. However, sector analysts LaingBuisson project that good economic performance will likely start to benefit the PMI market which traditionally trails other sectors, and that a stable economic growth forecast of between 2% and 3% per annum in the medium term should see employers start to spend more on healthcare benefits⁷.

1. ONS: Quarterly National Accounts, Quarter 3 (July to Sept) 2015.
2. ONS: Labour Market Statistics, September 2015.
3. Consumer Trends, Quarter 2 (April to June) 2015. Quarter 3 data for household spending were not available at the time of going to print.
4. Quarterly Monitoring Report, The King's Fund, October 2015.
<http://qmr.kingsfund.org.uk/2015/17/>

5. LaingBuisson Private ACit.
6. Monitor is the sector regulator for health services in England.
7. LaingBuisson Health Cover UK Market Report, 12th Edition.

Competition and Markets Authority

In April 2014, the Competition and Markets Authority (CMA) published its final report following a two-year enquiry into the private healthcare market. The report did not find evidence that provider concentration outside central London led to higher prices for insured patients. In October 2014, the CMA issued an order intended to remedy certain findings of the private healthcare investigation⁸, including:

- + Power to review arrangements for private hospitals to operate private patient units in NHS hospitals in their local areas;
- + Patient access to better information on the performance of consultants and hospitals; and
- + Scrutiny of benefits and incentive schemes provided to referring clinicians by private hospital operators.

BMI Healthcare is working with the Private Healthcare Information Network (PHIN) to provide accurate and up-to-date information relating to patient outcomes, at hospital and consultant level. It is also assisting consultants with the publishing of their fees. This information is required by April 2017 and will be published on an independent public website.

As of April 2015, all private hospital operators are required to publish the details of all referring clinicians who have a share or financial interest in the hospital, as well as details of payments made to all referring clinicians who hold a part-time position. In addition, all 'higher-value

services', including consulting rooms and medical secretary support, are to be charged at fair market value and published on the facility's website. 'Lower-value services' including in-house training, basic workplace amenities and general marketing or hospitality must also be disclosed. However, the identity or cost of a clinician is not disclosed, as this is not a requirement.

Applications have been made to the Competition Appeal Tribunal (CAT) by hospital group HCA, health insurer AXA PPP and FIPO, a consultant representative organisation, contesting its recommendations⁹. The CAT has agreed to remit part of the final report into the private healthcare market back to the CMA for reconsideration. This decision specifically relates to the finding that there was an adverse effect on competition leading to higher prices being charged by HCA to private medical insurers across the range of treatments for insured patients in central London. This resulted in HCA being required to divest one or two of their hospitals. The CMA has since published a working paper on the revised insured pricing analysis and consultation¹⁰, with the intention of publishing their final report in January 2016. This is not expected to impact BMI Healthcare.

8. https://assets.digital.cabinet-office.gov.uk/media/542c1543e5274a1314000c56/Non-Divestment_Order_amended.pdf
9. https://assets.digital.cabinet-office.gov.uk/media/540dcc5040f0b612d3000009/Notice_of_further_consultation_on_draft_order.pdf
10. https://assets.digital.cabinet-office.gov.uk/media/55799385ed915d15be000034/Private_healthcare_remittal_-_Insured_price_analysis.pdf



UK: 2015 PROGRESS

AGAINST THE EIGHT-POINT PLAN

2015 progress

GOVERNANCE FRAMEWORK

- + New Chief Executive Officer and Chief Financial Officer appointed.
- + Established a revised Executive Board, as well as national committees, with defined terms of reference and key performance indicators.

SUPERIOR PATIENT CARE

- + Written patient complaints across hospitals decreased from 0.75 complaints per 100 admissions in September 2014 to 0.66 complaints in September 2015. For the 2015 reporting period, written patient complaints were 0.735 per 100 admissions (2014: 0.759 per 100 admissions).
- + Between October 2014 and September 2015, the unplanned returns to theatre rate dropped to 0.127 per 100 theatre cases (2014: 0.155 per 100 theatre cases).
- + No cases of MRSA Bacteraemia reported at any BMI Healthcare hospital during 2015.
- + Self-assessment tool implemented and a team of specialists established to prepare BMI Healthcare hospitals for the stringent Care Quality Commission hospital inspections.
- + At 30 September 2015, there were 5 703 practising physicians of which 600 were new to BMI Healthcare facilities (2014: 5 128 of which 773 were new).

PEOPLE, PERFORMANCE AND CULTURE

- + Focused on increasing our leadership capability through a number of development programmes, reaching 450 leaders and hospital managers.
- + Published a 90-day National Induction framework to support new staff and speed up the time required for them to become effective in their roles within BMI Healthcare.
- + Introduced a theatre development programme for registered nurses wanting to become theatre practitioners.
- + During 2015, 132 206 (2014: 110 290) e-learning modules were successfully completed, 9 653 employees received some form of training and 44 470 training workshops (2014: 43 244 workshops) were delivered.
- + A total of 984 clinical staff joined BMI Healthcare as part of our national recruitment drive to improve our skills mix and staffing profiles.
- + Made progress in standardising our people management practices, by introducing a new set of employment conditions for all contracted staff.
- + Undertook staff engagement surveys to determine how our leaders and managers understood their roles in delivering change.

Looking forward

- + Appoint a National Director of Business Development.
- + Review the national committee structure annually.
- + Make patient reported outcomes for all patients who have had surgery for total hip or knee replacements, groin hernias and cataracts available.

- + Actively partner with organisations in the UK and European Union (EU) to facilitate the 2016 intake of the theatre development programme.
- + Implement a national framework to direct staff development to meet future needs.
- + Undertake the business-wide staff survey, BMI Say, in February 2016.

2015 progress

BUSINESS GROWTH

- + Grew overall caseload activity, including outpatient cases, by 4.0% in the 2015 reporting period.
- + 13.5% growth in NHS caseload for the year, increasing NHS volumes to 39% (2014: 35%) of the caseload mix.
- + The self-pay caseload experienced steady growth, up 3.5% on the prior year.
- + Invested in our hospital facilities and medical equipment and as discussed in Facilities and Sustainability below.

MAXIMISING EFFICIENCY AND COST MANAGEMENT

- + Addressed the cost base through the introduction of the eight-point plan, with the aim of driving operational improvement and efficiencies to compensate for the shift in business to a larger NHS caseload with lower associated tariffs.

FACILITIES AND SUSTAINABILITY

- + Invested capital expenditure of £39 million (2014: £42 million) in the BMI Healthcare portfolio (including maintaining or replacing medical equipment), refurbishments and IT platforms.
- + Continued with the roll out of endoscopy upgrades and full-field digital mammography and ultrasound imaging technology across the portfolio.
- + Ratified and implemented revised waste and environmental policies approved in 2014.
- + Implemented updated e-learning training for employees with environmental and waste responsibilities.
- + 47% of re-lamping cost was spent on energy efficient light-emitting diode (LED) lamps.
- + Increased the general waste recycling rate to 53% from 49% in 2014.

INTERNAL AND EXTERNAL COMMUNICATIONS

- + Tasked the new Executive Board with reinforcing BMI Healthcare's position as the largest healthcare provider in the independent sector.
- + Refreshed our recruitment strategy to make better use of technology and social media to increase awareness around our corporate brand.

INFORMATION MANAGEMENT

- + Established an Information Management Committee to oversee the information management strategy. The committee consists of representatives from across the organisation to ensure that information management and IT decisions are led by strategy and business need.
- + Continued to roll out the improved appointment booking systems that increase patient access to consultants.

Looking forward

- + Investing in day theatres and outpatient services.
- + Grow revenue from acute medical services.
- + The strengthening of the UK economy is expected to provide growth opportunities for BMI Healthcare in the medium term. However, in the short term, the market is expected to remain challenging given the stagnant PMI market and stringent claims management processes by insurers.
- + Focus on ways to effectively re-engineer and streamline patient pathways.
- + Drive greater operational efficiency throughout the business.
- + Planned investment of £40 million to maintain hospital facilities and medical equipment.
- + Complete the environmental risk management framework in the first quarter of 2016.
- + Implement energy efficiency measures in 10 BMI Healthcare clinical sites by 2017.
- + This includes a 20% reduction.
- + Roll out the non-infectious healthcare waste programme in 2016.
- + Implement the 2016 Operational Plan that focuses on enhancing corporate reputation, stakeholder engagement and communications.
- + Launch new BMI Healthcare website.
- + Full roll out of the time and attendance system across BMI Healthcare in 2016, enabling staff to log in and out of work using an electronic finger scanner. This system will interface with payroll.

UK: ENSURING QUALITY OUTCOMES

We aspire to be the leader in private healthcare providing the highest quality of clinical care while exceeding our patients’ expectations. Our by-line “serious about health, passionate about care” reflects the core behaviours we expect of our managers and staff to provide competent and compassionate care.

Superior patient care

Quality leadership scorecard

	2015	2014
Improving patient experience		
Overall quality of care rated as either excellent or very good	98.6%	97.3%
Met or exceeded patient expectations	99.1%	98.4%
Extremely likely or likely to recommend the hospital to friends and family	99.0%	97.8%
Improving clinical outcomes		
Rate of unplanned re-admissions to hospital care per 100 discharges within 28 days of discharge	0.15	0.16
Reduction in the average length of stay for a primary knee replacement since 2011	31%	34%
Reduction in the average length of stay for a primary hip replacement since 2011	33%	33%
Rate of unplanned re-admissions to theatre per 100 cases	0.127	0.155

1. Latest available statistics: Public Health England; April 2014 – March 2015.

Patient experience

All admitted patients are asked to complete a detailed questionnaire on aspects of their experience, with 422 032 completed questionnaires received in 2015 (2014: 62 500). Feedback is analysed by an independent third party and reported at hospital and group level. Each hospital is then required to develop and implement appropriate actions to address highlighted issues. Written patient complaints were down to 0.735 per 100 admissions in 2015 (2014: 0.759 per 100 admissions). Complaints are used to improve the patient experience, from hospitality considerations to clinical care and aftercare.

Clinical outcomes

Unplanned returns to the operating theatre within the same admission is used as an indication of the quality of surgical

teams and effectiveness of clinical pathways. Our hospitals have shown further improvement, with the unplanned returns to theatre rate dropping to 0.127 per 100 theatre cases (2014: 0.155 per 100 theatre cases).

A low MRSA Bacteraemia rate and a low Clostridium difficile rate indicate good overall infection control practices. No cases of MRSA Bacteraemia were reported at any of our hospitals for the 2015 reporting period. While BMI Healthcare’s Clostridium difficile rate increased to 4.87 per 100 000 bed days (2014: 1.6 per 100 000 bed days), it is significantly lower (recognising the different case mix) than the NHS of 26.3 per 100 000 bed days. The increase is attributable to higher medical and complex patient admissions. Where possible, we pre-screen all admissions and we have increased our number of isolation units from three to nine.

Our falls prevention programme is based on risk assessment and specific action plans for high-risk patients. Between October 2014 and September 2015, patient falls remained constant at 0.83 falls per 1 000 bed days, marginally up from 0.82 in 2014. Falls that led to patients sustaining an injury occurred at a rate of 0.30 per 1 000 bed days (2014: 0.32 per 1 000 bed days), meaning that two out of three incidents did not cause any harm to patients.

Best practice pathways and processes

Ongoing review and improvement of our core processes is an important component of improving outcomes. Our enhanced recovery clinical pathways implemented across all of our hospitals ensure the consistent application of evidence-based processes, which improve patient outcomes and speed up

recovery time after surgery. Changes have been made to peri-operative care including epidural or regional anaesthesia, minimally invasive techniques, optimal pain control and aggressive post-operative rehabilitation, as well as pre-operative management of surgical patients. Information and patient education gives patients the opportunity to ensure that all of their questions and concerns are addressed, and pre-assessments ensure that the hospital has the right teams and equipment in the right place at the right time.

Care Quality Commission

The Care Quality Commission hospital inspections have been adapted to assess each hospital's performance against the requirements to be safe, caring, responsive, effective and well led. The inspections offer us an additional opportunity to use the feedback to make improvements to patient care, as well as providing us with a benchmark for our performance against our peers, both public and private, across the UK. We introduced a self-assessment tool across all of our hospitals in 2015, which assesses the performance of all aspects of hospital operations from theatre practice and governance to environmental management. Assessments are then audited and appropriate improvement action plans implemented with an internal team of special advisors supporting, guiding and educating our hospital staff. Since the team's inception in October 2014, special advisors have visited close to 20 sites, including hospitals preparing for an inspection and those identified as requiring specialist assistance.

OUR FULL QUALITY AND CLINICAL GOVERNANCE DISCLOSURE IS SET OUT IN OUR UK: SUPERIOR PATIENT CARE REPORT.

People, performance and culture

Recruitment

A total of 984 clinical staff joined BMI Healthcare in 2015 as part of our national recruitment drive to improve our skills mix and staffing profiles. Our development programmes add to our attractiveness and ability to recruit specialised staff, and our refreshed recruitment strategy, which makes better use of technology and social media, aims to increase awareness of our corporate brand. At 30 September 2015 we employed 7 439 people in the UK (2014: 7 805) and our annual employee turnover for the year was 26.9% compared to 18.1% in 2014. This includes exceptional headcount redundancies related to our business efficiency project and the transfer of staff due to the outsourcing of the catering function.

Leadership and talent

We develop the skills of our leaders at all levels of the organisation, including hospital managers who are pivotal to the quality of healthcare we deliver to our patients and to our staff satisfaction levels. A total of 450 leaders and hospital managers received development training in 2015, 400 of whom attended Transformation Influencer workshops designed to develop the practical skills required to implement complex change and to engage effectively with stakeholders. All hospital managers undertook personal and team resilience development and were given access to executive coaching.

We have published a 90-day National Induction framework to support new staff and speed up the time required for them to become effective in their roles within BMI Healthcare. We also implemented a National Care Certificate for all new

BMI Healthcare assistants and further upskilled our existing assistants. A bespoke 12-week theatre development programme has been introduced for registered nurses who want to become theatre practitioners.

During 2015, 132 206 (2014: 110 290) e-learning modules were successfully completed, 9 653 employees received some form of training, and 44 470 training workshops (2014: 43 244 workshops) were delivered.

Engaging with our employees

Employee engagement surveys at management level undertaken in 2015 indicate that our leadership development programmes are increasing understanding around the changes being implemented and are assisting our managers to successfully facilitate crucial conversations. Two change-focused surveys also allowed participants to articulate lessons learned, highlighting where communication, planning and engagement had been used effectively. The BMI Say business-wide staff survey is scheduled to take place in February 2016.

OUR FULL UK: PEOPLE, PERFORMANCE AND CULTURE REPORT SETS OUT OUR PEOPLE PRACTICES IN GREATER DETAIL.

56

acute care private patient
hospitals (2014: 57)

2 785

acute and critical care
beds (2014: 2 788)

196

operating theatres
(2014: 195)

10

catheterisation and
electrophysiology
laboratories (2014: 8)

5

urgent care centres
(2014: 5) and 8 level III
critical care centres (2014: 8)

98.1%

BMI Healthcare patient
satisfaction score;
sample size = 44 496

HOSPITAL DIVISION

Strategic focus

BMI Healthcare operates the largest high-acuity private network of hospitals in the UK, offering the latest medical technology and treatment protocols. Our continued focus on behavioural and process changes enables us to deliver excellent patient care.

Transforming our business

The transformation programme implemented in the UK during 2015 started with understanding BMI Healthcare's vision for the next five years and putting in place the plans required to enable this change. A comprehensive eight-point plan has been developed that touches all aspects of the business, across superior patient care, human capital, business growth, maximising efficiency and cost management, facilities, governance, communications and information management.

Our vision is to grow the BMI Healthcare business utilising the capacity that already exists. This means re-engineering how care is delivered and investing in new models of care in both day theatres and outpatient services. An ageing population means that demand for healthcare is growing and placing pressure on the NHS, which also has to contend with funding constraints. This presents us with the opportunity to deliver quality healthcare to the NHS, as well as to patients covered by PMI and those able to pay for healthcare services. Our services to the NHS are facilitated through 'choose and book' (now rebranded as NHS e-booking), where NHS patients may choose a BMI Healthcare hospital for their healthcare needs, and 'spot' contracts with the NHS when it does not have capacity to deliver on specific procedures. The majority of these spot contracts cover orthopaedic procedures. Our objective is to expand this into more complex surgical and medical cases.

Our competitive advantage lies in our ability to deliver healthcare more immediately and efficiently than the NHS. Key to achieving this goal is building BMI Healthcare's reputation and developing strong relationships that instil confidence with GPs and drive greater referrals to our hospitals.

Key figures

	2015	2014
Caseload mix		
• Private Medical Insurance	49.7%	53.7%
• National Health Service	39.2%	35.3%
• Self-pay	11.1%	11.0%
Inpatient and day caseload growth	2.3%	0.1%
Total	100%	100%
Revenue (£m)	886.0	886.2
Revenue (Rm)	16 422	15 510
EBITDA ¹ margin	6.2%	5.2%

1. Earnings before interest, tax, depreciation, and amortisation.

HOSPITAL GOVERNANCE
STRUCTURE



Operating performance
90% of the PMI population
live within 60 minutes of a
BMI Healthcare facility.

BMI Healthcare delivered an improved trading performance despite lower PMI volumes and lower NHS tariffs. Revenue of £886.0 million was in line with the prior year, reflecting the continued shift in funder mix from private to NHS patients. EBITDA before non-recurring costs improved by 22.6% to £64.0 million (2014: £52.2 million). Net non-recurring costs amounted to £8.8 million comprising a fair value gain of £3.1 million arising on acquisition of control of a former associate, offset by costs of £11.9 million incurred on restructuring the business during the year in terms of the initiatives under the eight-point plan. The benefits of this project were evident in the improved EBITDA margin, before non-recurring costs, of 7.2% (2014: 5.9%). EBITDA including non-recurring costs rose 20.3% to £55.2 million (2014: £45.9 million) and operating profit improved to £16.7 million (2014: £8.0 million).

Business growth
NHS caseload continues to
provide strong volume growth at
13.5%, mainly driven by growth
in NHS patients utilising the NHS
e-booking option, as well as NHS
waiting list pressures driving
further spot contracts.

Our overall caseload activity was up 2.3% compared to 2014 for inpatient and day cases. Outpatient activity continued to grow, supported by the increasing range of services provided in an outpatient environment. Including outpatient visits, overall caseload activity increased 4.0%.

All regions achieved good growth in NHS caseload, with London experiencing the greatest growth at 35%. While this growth is encouraging, the lower tariff associated with this business continues to put pressure on margins. NHS accounted for 39.2% (2014: 35.3%) of total caseload, compensating for the decline in PMI cases.

The self-pay caseload, although a small portion of BMI Healthcare's caseload activity, experienced steady growth in the latter half of the year, up 3.5% on 2014. Across the healthcare market, PMI subscribers contracted by 1.4% in 2014 (according to the latest LaingBuisson report) and total private medical cover subscribers, including self-insured, contracted by 0.7%. As such, our PMI caseload remained under pressure in 2015, with a 4.7% year-on-year decline.

Maximising efficiency and
cost management

We continue to address our cost base, through the eight-point plan, to drive operational improvements and efficiencies to compensate for the shift in business to a higher NHS caseload. We are focusing on ways to effectively re-engineer and streamline patient pathways and drive greater operational efficiency throughout the business.

General and specialist nursing and qualified clinical staff shortages continued to be significant operational challenges in 2015, placing substantial pressure on salary costs and an increasing reliance on agency staff. Recruitment of suitable staff is expected to remain a challenge into 2016; however, the UK Government has temporarily simplified the recruitment of nurses from outside of Europe. We are working with international agencies to recruit nurses from the Philippines and India. In September 2015, 24 nursing graduates from Cyprus joined the Group and are currently participating in the theatre development programme. Over 80 healthcare assistants have been recruited and have started the National Care Certificate training programme.

INFORMATION ON OUR PEOPLE PRACTICES CAN BE FOUND ONLINE IN THE UK: PEOPLE, PERFORMANCE AND CULTURE REPORT AND ON PAGE 77 OF THIS REPORT.

Superior patient care
Feedback from patients in 2015
showed that 99.0% (2014:
97.8%) of our patients would
recommend BMI Healthcare to
friends and family and 98.2%
(2014: 97.3%) rate the overall
quality of care provided as very
good or excellent.

Our primary goal is to provide the best care for our patients in the most convenient locations, and with the highest quality outcomes. We work closely with consultants and local GPs to support the delivery of high-quality care to our patients. Besides our day-to-day interactions, we formally engage with consultants and GPs through forums, local presentations and clinical conferences where we share information and give participants the opportunity to feedback to BMI Healthcare's management on areas where improvements can be made. Our digital magazine, Consultant Connect, provides consultants and GPs with regular information on developments at BMI Healthcare.

OUR DRIVE TO PROVIDE CLINICAL EXPERTISE AND CARING SUPPORT FOR OUR PATIENTS IS SET OUT ON PAGE 76 AND IN THE UK: SUPERIOR PATIENT CARE REPORT.

Facilities and sustainability
Capital expenditure

Our capital expenditure for 2015 amounted to £39 million (2014: £42 million), funded through a combination of cash generated from operations and finance leases at favourable interest rates. This was allocated to our ongoing investment in BMI Healthcare's portfolio, refurbishments and IT platforms, including:

- The installation of the latest full field digital mammography scanners in eight hospitals;
- New C-Arm imaging equipment at four hospitals;

- + The latest time-lapse imaging fertility equipment at three of our fertility centres;
- + Continuing the endoscopy equipment upgrade across the portfolio, with an additional £4.5 million spent on upgrades to three sites. This will ensure Joint Advisory Group (JAG) accreditation and full compliance with leading practice;
- + Continuing the roll out of new ultrasound imaging technology across the BMI Healthcare portfolio; and
- + Other maintenance and upgrades on facilities and equipment.

 INFORMATION ON OUR ENVIRONMENTAL PERFORMANCE CAN BE FOUND IN OUR UK: ENVIRONMENTAL REPORT.

Utilities

Key environmental performance indicators have been agreed for 2016 and a risk management framework, currently under development, is due for completion in the first quarter of next year. Together, these improvements will assist us in identifying key environmental risks and developing the resources and competencies required to manage and mitigate them.

In 2015, our carbon emissions reported to the government for the first year of the second phase of the Carbon Reduction Commitment (CRC) Energy Efficiency Scheme were 46 372 tonnes of carbon dioxide (CO₂) (2014: 48 091 tonnes of CO₂), a 3.6% decrease. However, the cost to purchase carbon allowances increased from £12/tonne of CO₂ in 2014 to

£16.40/tonne of CO₂ in 2015. Our cost to cover regulated emissions in 2015, therefore, amounted to £0.8 million (2014: £0.6 million), higher than our reported estimate of £0.7 million. We are securing an energy services agreement with a commercial energy service company to implement energy efficiency measures in 10 BMI Healthcare clinical sites by 2017. At current energy prices, achievable energy savings across these 10 sites are estimated at £0.6 million a year. This includes a 20% reduction in energy consumption and 37% reduction in CO₂ emissions.

Our general waste recycling rate has increased to 53% from 49% in 2014. In 2014, we undertook two pilot trials to test our revised policy and guidance for the segregation of non-infectious healthcare waste. This has informed our non-infectious healthcare waste programme to be rolled out in 2016. The benefits of the programme include cost savings of up to £0.3 million annually and reduced carbon emissions from eliminating unnecessary disposal treatment.

Information management

During 2015, we continued to roll out the improved appointment booking system, which increases patient access to consultants. The time and attendance system, @Work, successfully piloted at BMI Chaucer Hospital in July 2015, will be rolled out across BMI Healthcare over the next year. This system enables staff to log in and out electronically, removing the need for time-consuming manual timesheets. The system also links attendance to payroll output.

 A FULL LISTING OF HOSPITALS AND REGISTERED BEDS CAN BE FOUND ONLINE AT www.netcareinvestor.co.za.



GOVERNANCE



PARTICIPATION

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ABRIDGED
CORPORATE
GOVERNANCE
REPORT

Netcare is committed to and fully endorses the principles of good corporate governance as recommended in the Code of Corporate Practices and Conduct set out in the King Report on Corporate Governance for South Africa (King III) and the JSE Limited (JSE) Listings Requirements.

We also consider other voluntary codes when reviewing our governance framework, including the principles of the United Nations (UN) Global Compact, Organisation for Economic Co-operation and Development (OECD) recommendations and the Millennium Development Goals, which have been replaced by the 17 Sustainable Development Goals.

Our commitment

Corporate governance provides the foundation upon which the Group is managed in accordance with the highest standards of ethics and in a manner that is efficient and accountable. Transparency and accountability are strictly applied, along with adherence to the Group’s values, as the key principles that guide all the Group’s business activities.

We are leveraging governance to constantly improve the way the business is managed, information is shared and protocols are established, guided by the **Triple Aim** framework. We consistently improve our governance framework and related policies to ensure they accurately reflect best practice. Our internal controls promote an awareness of risk, compliance and good governance in every area of the business.

Greater integration of governance into operational management leads to the creation of value for all stakeholders. This supports a sustainable business with sustainable returns, which, in turn, attracts essential investment into the healthcare sector.

OUR FULL CORPORATE GOVERNANCE REPORT, FROM WHICH THIS REPORT HAS BEEN EXTRACTED, AND OUR KING III COMPLIANCE CHECKLIST ARE AVAILABLE ONLINE.

Board of directors

Board responsibilities and charter

The Board is accountable to shareholders and other stakeholders for the Group’s performance. It is responsible for Netcare’s strategic direction and primary objective of creating and building sustainable value for all its stakeholders.

The Board functions within the ambit of an annually reviewed charter, and instructs and oversees the management and control structure that directs and executes all functions within the organisation.

THE BOARD CHARTER IS AVAILABLE ONLINE.

The directors embrace these responsibilities and endeavour to ensure that Group strategy, risk, performance and sustainability are managed in an integrated way that supports value creation for the Group. The Board provides effective leadership based on an ethical foundation of responsibility, accountability, fairness and transparency.

Board structure and composition

Netcare has a unitary Board structure and directors have a wide range of expertise and experience in strategic, financial, commercial and healthcare activities. At 23 November 2015, the Board comprised 11 directors.

The Board is led by the newly appointed Chairman, JM Kahn, an independent non-executive director.

Independence



Gender



Race



THE BIOGRAPHICAL DETAILS OF DIRECTORS CAN BE FOUND AT www.netcareinvestor.co.za/over_board.php.

Rotation

Generally, directors have no fixed term of appointment and retire by rotation every three years. If available, they are considered for re-appointment at the annual general meeting.

Evaluation

The Board is assessed at least once a year through an internal process overseen by the Chairman’s Forum that deals with individual directors, as well as the Board and its various committees. The Chairman’s Forum has been supplemented by a questionnaire-based review to facilitate further discussion on Board effectiveness and director

development. The recommendations made by the forum in 2014 were fully implemented. The 2016 evaluation process will be reviewed under the stewardship of the new Chairman.

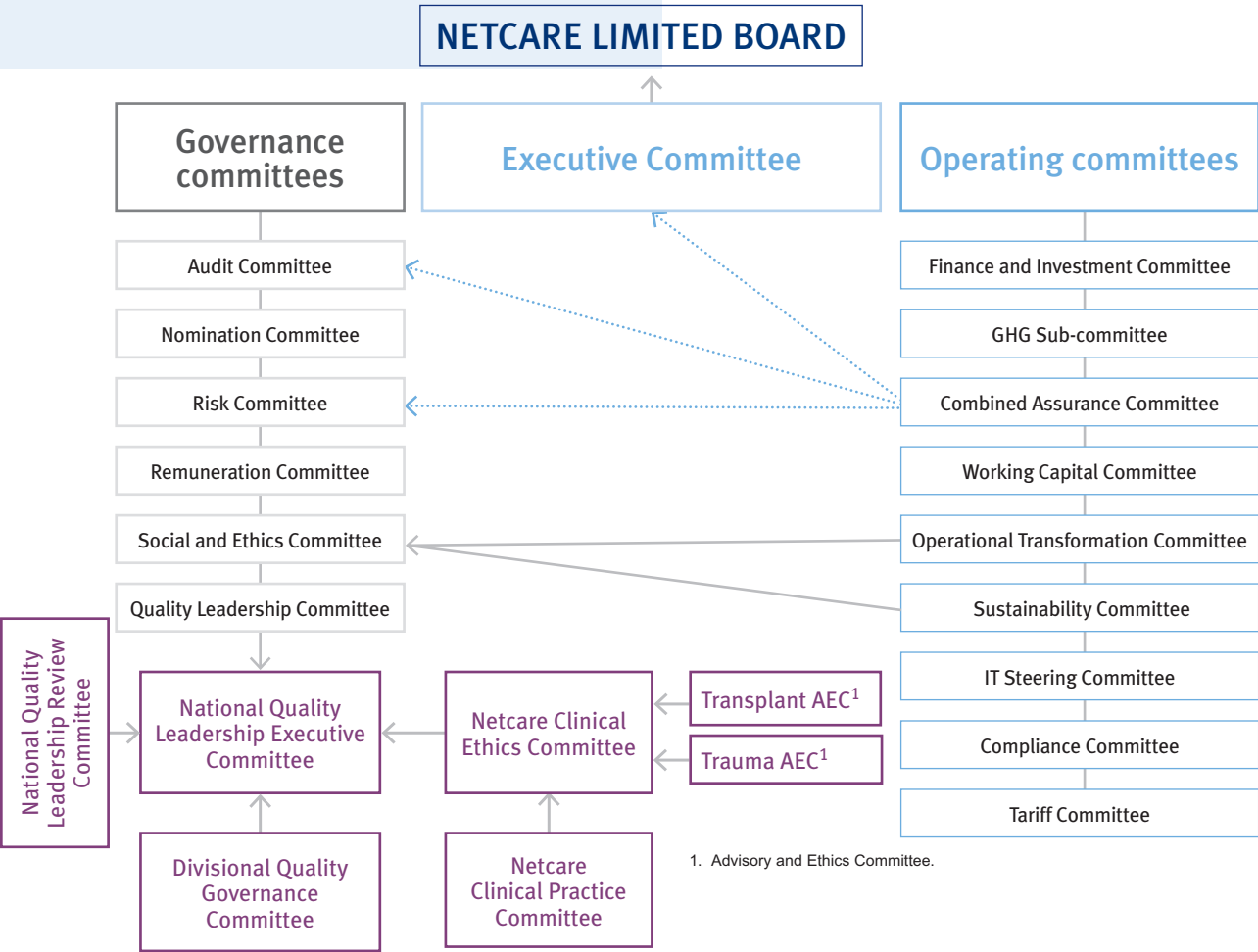
The continued independence of independent non-executive directors that have served for a period of nine years is also evaluated, taking into account the factors that may impair their independence. Following the 2015 review, the Board is satisfied that there are no relationships or circumstances likely to affect, or which appear to affect, the judgement of Messrs JM Kahn and APH Jammine, and Adv KD Moroka as directors. The Board is also satisfied that the Chairman of the Board, JM Kahn, is independent and free from any conflicts of interest. The independence of this role will be further enhanced by the appointment of T Brewer as Deputy Chair and lead independent non-executive director. Two independent non-executive directors, M Bower and B Buló, were appointed to the Board effective 23 November 2015, further bolstering the independence of the Board and its governance committees.

Governance framework

In accordance with the established principles of delegation of authority, the Board has delegated specific duties to Board governance committees that are responsible for assisting the Board in discharging its responsibilities. These committees provide an in-depth focus on specific areas in accordance with the Group’s governance structure and are supplemented with nine operating committees. Committee terms of reference are reviewed annually to ensure that each committee’s conduct and oversight accords with the various recommendations of King III, the Companies Act, applicable legislation and, where appropriate, international best practice. Both the Board and its committees materially complied with their terms of reference in 2015.

BMI HEALTHCARE ALSO HAS A CORPORATE GOVERNANCE FRAMEWORK THAT FEEDS INTO THE GROUP’S FRAMEWORK. THIS IS DISCUSSED IN THE FULL CORPORATE GOVERNANCE REPORT ONLINE.

GOVERNANCE STRUCTURE



THE TERMS OF REFERENCE OF EACH COMMITTEE ARE AVAILABLE AT www.netcareinvestor.co.za UNDER THE GOVERNANCE TAB AND JSE SRI LINK.

The Chairman of the Board continued in his role as Chairman of the respective committees he serves on to ensure continuity while he acted as Chairman from 1 June 2015 until 23 November 2015. Following JM Kahn’s formal appointment as Chairman, the Chairmanship of various board governance committees has been revised and committee membership supplemented with the newly appointed non-executive directors as shown in the table below. JM Kahn retains his role as Chairman of the Nomination Committee, which he has held since 1 June 2015.

Committee	Changes
Audit Committee	New independent non-executive: M Bower
Risk Committee	Chair: JM Kahn to N Weltman New independent non-executives: M Bower and B Buló
Nomination Committee	Chair: J Vilakazi to JM Kahn Supplemented: T Brewer
Remuneration Committee	Chair: JM Kahn to APH Jammine
Quality Leadership Committee	New independent non-executive: B Buló

The Netcare Board’s key focus areas in 2015

The key themes managed at board and management meetings during 2015 centred on the slowdown in the South African (SA) economy and the resultant impact on medical aid membership growth. Along with a changing competitive landscape and tougher tariff negotiations with funders, this has resulted in a decline in the rate of growth in patient days. Also of importance were the issues of power outages in SA, the weakening Rand and the changing regulatory environment, with particular focus placed on the requirements of the Competition Commission’s Private Healthcare Market Inquiry. International expansion, compliance issues, patient satisfaction scores and our internal focus on quality are standing items on the Board’s agenda.

 THE FOCUS AREAS OF THE INDIVIDUAL SUB-COMMITTEES CAN BE FOUND ON PAGE 90.

Succession planning

To ensure the Board retains sufficient skills over time, the Nomination Committee constantly reviews new candidates to supplement the Board and to ensure succession plans are in place. Consideration is given to candidates who will maintain a balance of skills, diversity and experience, and who will continue to promote rigorous debate. An induction programme assists newly appointed directors to understand their fiduciary duties and the responsibilities of executive management.

Professional advice

Directors are entitled, at the Group’s expense, to seek professional advice about the affairs of the Group.

Share dealings

Directors’ dealings in the securities of Netcare Limited are subject to the directors’ dealing policy that is based on regulatory requirements and governance best practice. During 2015, the policy was supplemented with additional information on the management of price sensitive information and the appropriate cautionary conduct required during a closed period. Directors and directors of major subsidiaries, as well as the Company Secretary and company secretaries of major subsidiaries, require the written approval of the Chairman prior to buying or selling Netcare shares.

Conflict of interest

Where conflicts exist in respect of directors, they are requested to recuse themselves from meetings. Procedures relating to managing conflict of interest are reviewed and revised on an ongoing basis.

Board and governance committee meetings and attendance

at 30 September 2015

Director	Netcare Board	Audit	Risk	Nomination ²	Remuneration	Quality Leadership	Social and Ethics
T Brewer	✓ : 4/4	Chair : 4/4		✓ : 1/2	✓ : 2/2		
RH Friedland	✓ : 4/4	*	✓ : 2/2	*	*	✓ : 1/2	✓ : 2/2
KN Gibson	✓ : 4/4	*	✓ : 2/2				
APH Jammie	✓ : 4/4	✓ : 4/4		✓ : 2/2	✓ : 2/2		
JM Kahn	✓ : 4/4		Chair : 2/2	Chair : 2/2	Chair : 2/2		✓ : 1/2
MJ Kuscus	✓ : 4/4		✓ : 2/2			Chair : 2/2	✓ : 2/2
KD Moroka	✓ : 4/4						Chair : 1/2
SJ Vilakazi ¹	✓ : 2/4	*	✓ : 1/2		✓ : 2/2	*	*
D van den Bergh						✓ : 2/2	
J Watts	✓ : 3/4						
N Weltman	✓ : 4/4	✓ : 4/4	✓ : 2/2			✓ : 2/2	

✓ Member.
* Invitation.
1. Retired on 31 May 2015.
2. The formal meetings held by the Nomination Committee were supplemented by a series of ad hoc informal meetings throughout the year, and T Brewer was appointed to the committee effective 31 May 2015.

Compliance

For the period under review, the Board is satisfied that the Group complied with the JSE Listings Requirements and the substance of the principles embodied in King III. The Board is committed to complying with all applicable legislation and regulations, and is kept informed of changes to standards, codes and relevant sector developments that could potentially affect the Group and its operations. Through the Compliance Committee, the compliance function assesses the impact of all significant new laws and amendments on the Group and provides ongoing monitoring of the legislative landscape. Ongoing training takes place on key health sector regulations and, in 2015, included awareness training on the requirements of the Protection of Personal Information Act (POPI).

In 2015, Netcare complied with all relevant legislation and was not subject to any material penalties, fines or criminal prosecutions. Our internal reviews have

not identified any contravention that could expose the Company to any actual risk or liability.

 THE COMPLIANCE COMMITTEE’S TERMS OF REFERENCE CAN BE FOUND ONLINE.

Sustainability

Sustainability information has undergone stringent internal review and was independently assured by Global Carbon Exchange SA Proprietary Limited (GCX). The verification, at a limited level of assurance, was performed in accordance with the principles of the WBCSD/WRI GHG Protocol Corporate Accounting Standard, 2nd Edition, 2004 (the GHG Protocol Corporate Standard).

While our direct impact on the environment is limited, we focus on minimising our carbon footprint and enhancing our sustainability initiatives. Energy and water efficiency considerations inform decision-making

and we implement mechanisms to efficiently manage the Group’s utilities where applicable. Our environmental policy and management plan have defined action plans and targets to reduce energy and water usage, and increase recycling and control of waste. We consistently participate in the Carbon Development Project’s (CDP) Carbon and Water Disclosure Projects, and in 2015 participated in the Global Green and Healthy Hospitals Network for the first time.

 OUR INITIATIVES ARE SET OUT IN THE SA: ENVIRONMENTAL AND UK: ENVIRONMENTAL REPORTS.

Netcare’s Broad-based Black Economic Empowerment (B-BBEE) scorecard, applicable to the SA operation only, has been independently verified.

 OUR SA: TRANSFORMATION REPORT CAN BE FOUND ONLINE.



Board committees’ purpose and focus areas for 2015

Committee	Purpose	Key focus in 2015
Audit	Assists the Board in monitoring the integrity of the Group and Company's financial statements, accounting policies and internal control functions, as well as statutory functions.	Reviewed the planning and implementation of the combined assurance framework by internal audit. Oversight of external audit function and related audit fees.
	AUDIT COMMITTEE REPORT ONLINE.	
Risk	Ensures adequate risk management processes are in place to identify and monitor the management of key risks and the suitability of risk mitigation plans.	Reviewed the reporting mechanisms to ensure that top risks received prioritised attention. Reviewed the management of control self-assessments, and the process applicable to managing and oversight of legal and compliance risk as proposed by the Company Secretary and General Counsel.
	OUR RISK MANAGEMENT REPORT CAN BE FOUND ON PAGE 94.	
Nomination	Assists with appointing directors, evaluating the leadership requirements of the Group and Board succession planning.	Ensured ongoing compliance with Paragraph 3.84 of the JSE Listings Requirements. Revised the committee's chairmanship.
Remuneration	Determines directors' and senior executives' remuneration, and levels of remuneration of all employees, as well as adjustment of remuneration where required. Reviews bonuses, incentives and the implementation of the Forfeitable Share Plan (FSP).	Supplemented the performance metrics used to evaluate executives and senior management. Extensively reviewed the remuneration policy. OUR REMUNERATION REPORT CAN BE FOUND ON PAGE 114.
Quality Leadership	Reviews the availability of transparent and accountable systems for the provision of patient-centred, safe, high-quality care. Identifies areas of clinical risk and standardised clinical practice.	Reviewed systems to enhance measurable improvements in quality outcomes. Focused on improving clinician engagement in quality improvement through enhanced governance structures.
Social and Ethics	Monitors Netcare's activities in compliance with the Companies Act, Regulation 43(5). Provides oversight of social and economic development, and good corporate citizenship.	Approved the submission of the UN Global Compact assessment tool and endorsed Netcare's commitment to comply with the Global Compact Principles¹.

1. Netcare has submitted its communication on progress and all related submissions which outline the Group's commitment to the UN Global Compact Principles.

The JSE FTSE Responsible Investment Index assesses performance in terms of corporate governance and the environmental, economic and social sustainability practices of listed companies. From 2016 assessment will take place in collaboration with FTSE Russell and Netcare has been included in this new index in 2015, scoring a total of 2.8 points out of five. Netcare has been included in the Dow Jones World and Emerging Markets Indices for the second consecutive year.

We are a member of the UN Global Compact and support its 10 principles on human rights, labour, environment and anti-corruption.

Company Secretary

All directors have access to the advice and services of the Company Secretary, L Bagwandeen, who acts as a conduit between the Board and the Group. The Company Secretary is also responsible for the flow of information to the Board and its committees, and for ensuring compliance with Board procedures. The Board has empowered the Company Secretary with the responsibility for advising the Board, through the Chairman, on all governance matters including the duties set out in Section 88 of the Companies Act.

The qualifications and experience of the Company Secretary were formally evaluated by the Nomination Committee and subsequently ratified by the Board. The committee specifically evaluated the objective nature of the role of the Company Secretary, confirming that she has no affiliation or association to any single board member, holds no directorship and provides independent advice to the Board as a whole. Based on this process and the review of the quality of governance outputs, it was found that the Company Secretary is suitably qualified, experienced and fit and proper to perform the function of Company Secretary and it was confirmed that she maintains an arms-length relationship with the Board.

Stakeholder relationships

A stakeholder communication strategy is in place to ensure enhanced and comprehensive stakeholder communications. Proactive and constructive stakeholder engagement is delegated to management. We understand the important role our stakeholders play in supporting value creation for the Group and we have implemented governance mechanisms to enhance implementation of the King III stakeholder engagement principles and to support our own principle of values-based engagement.



OUR KEY RELATIONSHIPS AND
STAKEHOLDER CONCERNS ARE SET
OUT ON PAGE 18.

Accountability and control
Financial reporting

The Board, on recommendation from the Audit Committee, is responsible for overseeing the preparation of the Group annual financial statements and other information presented in reports to shareholders in a manner that fairly presents the state of affairs and results of the Group's business operations. The Board is satisfied that the Group annual financial statements fairly present the state of affairs of the Group at the end of the 2015 financial year.

Internal control and
internal audit

The Netcare Board is responsible for ensuring that an appropriate system of internal control is maintained to safeguard and manage Netcare's assets, minimise losses arising from fraud and/or other illegal acts, and fairly present financial and operating information. The Audit Committee meets regularly with management, external audit and Group Internal Audit in discharging its mandate.

Group Internal Audit, which functions at a Group level, is an independent, objective assurance and consulting activity. It assists Netcare to accomplish its objectives by bringing a systematic, disciplined approach to evaluate and improve the effectiveness of risk management, control and governance processes. The Group Internal Audit Charter is prepared in accordance with the recommendations of King III and the standards set by the Institute of Internal Auditors. The Audit Charter and the risk-based annual audit plan are presented annually to the Audit Committee for approval.

Based on the scope of their assignments, Group Internal Audit has concluded that “nothing has come to the attention of Group Internal Audit to suggest that the

system of internal financial controls does not form a sound basis for the preparation of reliable financial statements”.



THE AUDIT COMMITTEE'S
RESPONSIBILITY WITH REGARD TO
GROUP INTERNAL AUDIT IS REPORTED
IN THE AUDIT COMMITTEE REPORT IN
THE GROUP ANNUAL FINANCIAL
STATEMENTS, AVAILABLE ONLINE.

Combined assurance

A combined assurance model aims to optimise the assurance coverage obtained from management, and internal and external assurance providers on the risk areas affecting the company. We have compiled a combined assurance framework supported by a combined assurance matrix depicted in the diagram alongside.



THE COMBINED ASSURANCE MATRIX



Governance of information technology

A strategic pillar for Information Technology (IT) is to add value to the business and shareholders by integrating technical requirements with good governance, thereby ensuring sustainable practice. The IT Steering Committee is responsible for managing IT risk and IT governance in terms of a defined strategy to improve business outcomes.

The Control Objectives for Information and Related Technology (COBIT) framework provides a foundation for decisions and investments in the governance and management of enterprise IT. The IT department is responsible for the IT governance strategy, which includes defining the information architecture, acquiring the necessary hardware and software to execute the strategy, managing projects, ensuring continuous service, and monitoring the performance of the IT system.

Ethics

In 2015, a total of 294 incidents relating to alleged misconduct were received, with 274 reported in SA and the balance from the United Kingdom. A total of 278 incidents related to fraud with the remainder relating to unethical behaviour. In SA, 235 incidents have been closed with the balance still under investigation.

All our divisions are committed to a policy of fair dealing and integrity in the conduct of their business. This commitment is actively endorsed by the Board of directors and is based on a fundamental belief that business should be conducted honestly, fairly and legally. We expect all our employees to share our commitment to high moral, ethical and legal standards.

The Group's Code of Ethics (the Code) articulates our policy regarding conflicts of interest, gifts, confidentiality, fair dealings and the protection and

appropriate utilisation of Netcare's assets. We entrench the Code's various principles in a number of ways, including training interventions and an annual survey.

Our whistle-blowing mechanism facilitates anonymous reporting of alleged theft, or fraudulent, corrupt or unethical behaviour, including unethical medical behaviour. The Fraud and Ethics Hotline is available to all Netcare employees, and ensures the anonymity of all reports and the protection of anyone reporting these incidents. It can also be utilised by the public, including suppliers and patients.

We take a zero tolerance approach to theft, fraud and corruption. All identified cases are reported to the South African Police Services and, where appropriate, to the applicable registered bodies such as the Health Professions Council of South Africa.

In addition to the Fraud and Ethics Hotline, all internal and external parties can contact Group Forensics by telephone, email or meeting request. Group Forensics resides within Group Risk, Audit and Forensic Services.

UK: BMI Healthcare

BMI Healthcare's Code of Business Conduct sets out standards for all employees that define and govern illegal and unethical behaviour. The code is supplemented by BMI Healthcare's anti-bribery and corruption policy, and associated training, which provides further guidance on appropriate behaviour. BMI Healthcare's basic values are honesty, directness and openness in dealing with others. These values encompass our relationships with employees, shareholders, customers, suppliers and local communities. Information on the use of our whistle-blowing mechanism is provided in our whistle-blowing policy. Doctors working in BMI Healthcare hospitals are able to raise concerns either with hospital management or regional and corporate directors, including the BMI Healthcare Group Medical Director. Patient concerns can be directed to hospital management or anonymously through our patient survey, which is administered by an independent third party.

SA

The Fraud and Ethics Hotline details are:

**0860FRAUD1
(0860 372 831)**

If anonymity is not a concern, the email address fraud@netcare.co.za can be used.

RISK MANAGEMENT REPORT

Netcare's risk management strategy and processes are fundamental to achieving our strategic objectives in a sustainable manner. Understanding our top risks forms the basis of improved decision-making and effective management of our business within the parameters of the Group's risk appetite.

THE GOVERNANCE OF RISK

NETCARE BOARD

- + Ultimate responsibility for the management of risk.
- + Defines the level of risk that the Group is willing to accept in pursuit of its vision and in creating sustainable value for stakeholders.
- + Considers the economic, social and environmental requirements of stakeholders in defining risk appetite.

RISK COMMITTEE

- + As a sub-committee of the Board, assists the Board in discharging its risk management responsibilities.
- + Sets the strategic direction for the process and system of risk management by authorising the risk management policy and plan.

GROUP RISK MANAGEMENT FUNCTION

- + The custodian of the risk management policy and plan.
- + Co-ordinates risk management activities throughout the Group.
- + Benchmarks the process and system of risk management against local and international standards and best practices.



THE RISK COMMITTEE'S TERMS OF REFERENCE CAN BE FOUND AT <http://www.netcareinvestor.co.za> UNDER THE GOVERNANCE TAB AND JSE SRI LINKS.



Risk management process

Risk management is embedded in business activities and decision-making processes at all levels of the Group, within a common and approved risk management framework. Management is accountable to the Board for designing, implementing and monitoring the system and process of risk management. Top business risks are systematically identified, assessed, evaluated and managed in accordance with the agreed risk appetite. These inter-related risks include matters over which we exert limited influence.

Our top business risks are managed at an executive level in relation to our strategy to mitigate negative impact and optimise competitive advantage. They are also considered in our stakeholder engagement processes. Our top business risks are formally reported to the Group Risk Committee, which meets twice a year, and reviewed and approved annually by the Audit Committee.

The system and process of managing risk takes the following into account:

+ Strategic direction and objectives of the business;

+ Nature and extent of risks facing the business;

+ Extent and categories of risk regarded as acceptable;

+ Likelihood of identified risks materialising and their impacts;

+ Ability of the business to reduce the incidence and impact on the business if risks materialise;

+ Effectiveness of the implemented risk response plans; and

+ Cost of risk response plans and processes relative to the exposure and benefit obtained.





EFFECTIVENESS OF RISK MANAGEMENT

AUDIT COMMITTEE

The Audit Committee, a sub-committee of the Board, is responsible for providing independent and objective assurance on the effectiveness of our internal control, governance and risk management systems. It oversees Netcare's internal audit function, financial risk management, compliance and the IT internal control environment.

GROUP INTERNAL AUDIT

The Group internal audit function is an integral component of the risk management process and provides independent and objective assurance to the Board, through the Audit Committee, on the effectiveness of the systems of internal control and risk management. It also provides recommendations for improvement where appropriate. Our internal policies and control procedures provide reasonable assurance that risks are mitigated and that the attainment of our business objectives are not compromised.

SELF-ASSESSMENTS

All major divisions and business units perform management self-assessments, with results reported to the Risk and Audit committees. Management is responsible for identifying and assessing risks, and for developing, implementing and maintaining control activities to manage those risks. The management self-assessment process enhances overall risk management practices and supports a culture of ownership over internal control processes. During 2015, the management self-assessment process reviewed more than 3 000 control activities across the organisation and achieved an average compliance rating in excess of 90%. In addition, management submits quarterly statements of assurance to the Netcare Executive Committee on the adequacy of the design and the effective operation of their systems of internal control.

The Board is satisfied that Netcare's risk funding strategy and existing cover are adequate and appropriate in relation to the exposures identified. The Board, through the Audit Committee, has also considered the effectiveness and efficiency of the process and system of risk management and found it to be effective; a determination that has been endorsed by relevant compliance reports. Furthermore, in the event of a disastrous incident there is a documented and tested major incident plan and disaster recovery programme to support continuity of critical business processes.

The Board is confident that:

- + The system and process of risk management in place is appropriate for Netcare's business model and strategy;
- + The risk appetite is appropriate;
- + An appropriate risk culture has been embedded within the Group; and

- + The system and process of risk management operates appropriately to inform the Board of major risks facing the Group.

An ongoing process for identifying, evaluating and managing top risks has been in place for the year under review and up to the date of approval of the integrated report.

Identifying top risks

Our risk appetite varies depending on the specific category of risk. Top business risks are identified based on the attention they require from the Board and executive teams, the views of operational management and concerns raised by key stakeholders. In SA, the Group Risk Management function engages with key management from the major divisions and business units locally and in Lesotho to identify key risks, and it monitors the plans and processes put in place to manage these risks. The key risks are consolidated to determine the top

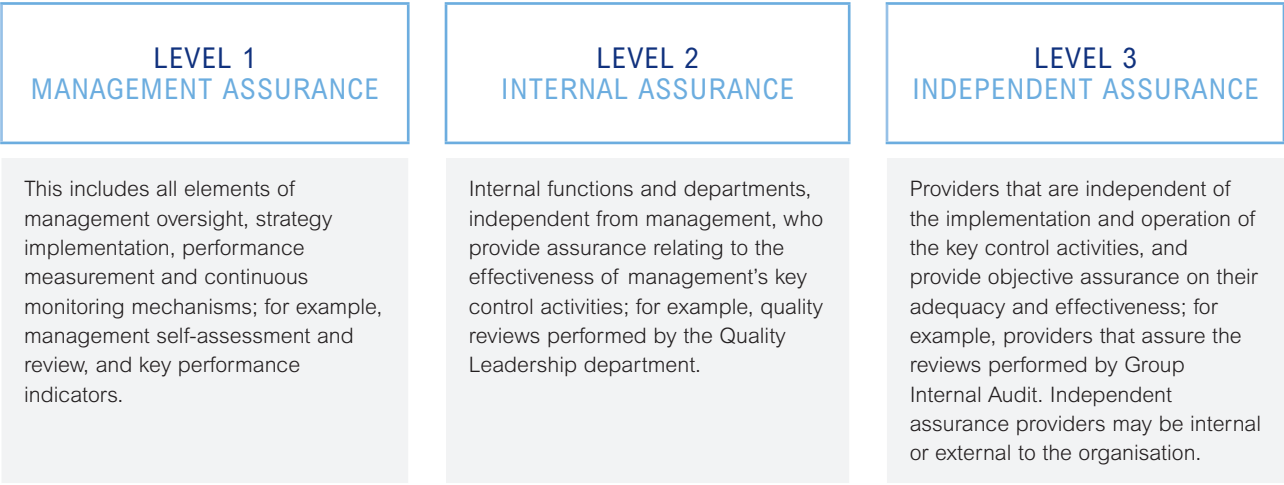
business risks affecting the organisation. Risks are assessed on their potential impact (low, medium, high and significant) on the Group achieving its strategic and business objectives. The top business risks discussed in this section have been assessed as either high or significant based on the severity of their potential impact on the main intangible assets of the business, which are management, brand and reputation.

BMI Healthcare's executive management team identifies the risks pertaining to the United Kingdom (UK) operations through its committee structure and particularly the Governance Committee and its three sub-committees. These are the Clinical Governance, Financial Governance, and Safety, Health and Environment committees. A consolidated risk register, formally ratified twice a year, is reported to the General Healthcare Group (GHG) Board. The top business risks are also considered by the GHG Audit, and Quality and Risk committees and are presented to the Netcare Group Risk Committee.

Combined assurance in SA

The combined assurance model, which governs management of top risks affecting the Southern African operations, was further developed in 2015. The Combined Assurance Committee is governed by formal terms of reference approved by the Chairpersons of the Audit Committee and the Combined Assurance Committee. The committee comprises Executive Committee members, audit (internal and external) and key business unit managers. Through its terms of reference, the committee endeavours to co-ordinate the efforts of all assurance providers in the Group to avoid duplication of assurance services, optimisation of assurance costs and a better understanding of the business requirements by all participants in the committee.

Our combined assurance framework is based on the application of three levels of assurance:



Our combined assurance matrix continuously evolves as it maps our identified top business risks to the relevant assurance providers and reflects the actions that management have implemented to mitigate these risks.

The Combined Assurance Committee considers the skills and experience of the assurance providers, and the nature and extent of the assurance work provided. It has agreed to work towards independent assurance of the top business risks over a period of time, taking into consideration the financial implications, mitigations that are outside Netcare's control and where it is practical to do so.

 MORE INFORMATION ON OUR COMBINED ASSURANCE MATRIX CAN BE FOUND ON PAGE 92 OF THE ABRIDGED CORPORATE GOVERNANCE REPORT.

Financial risk management

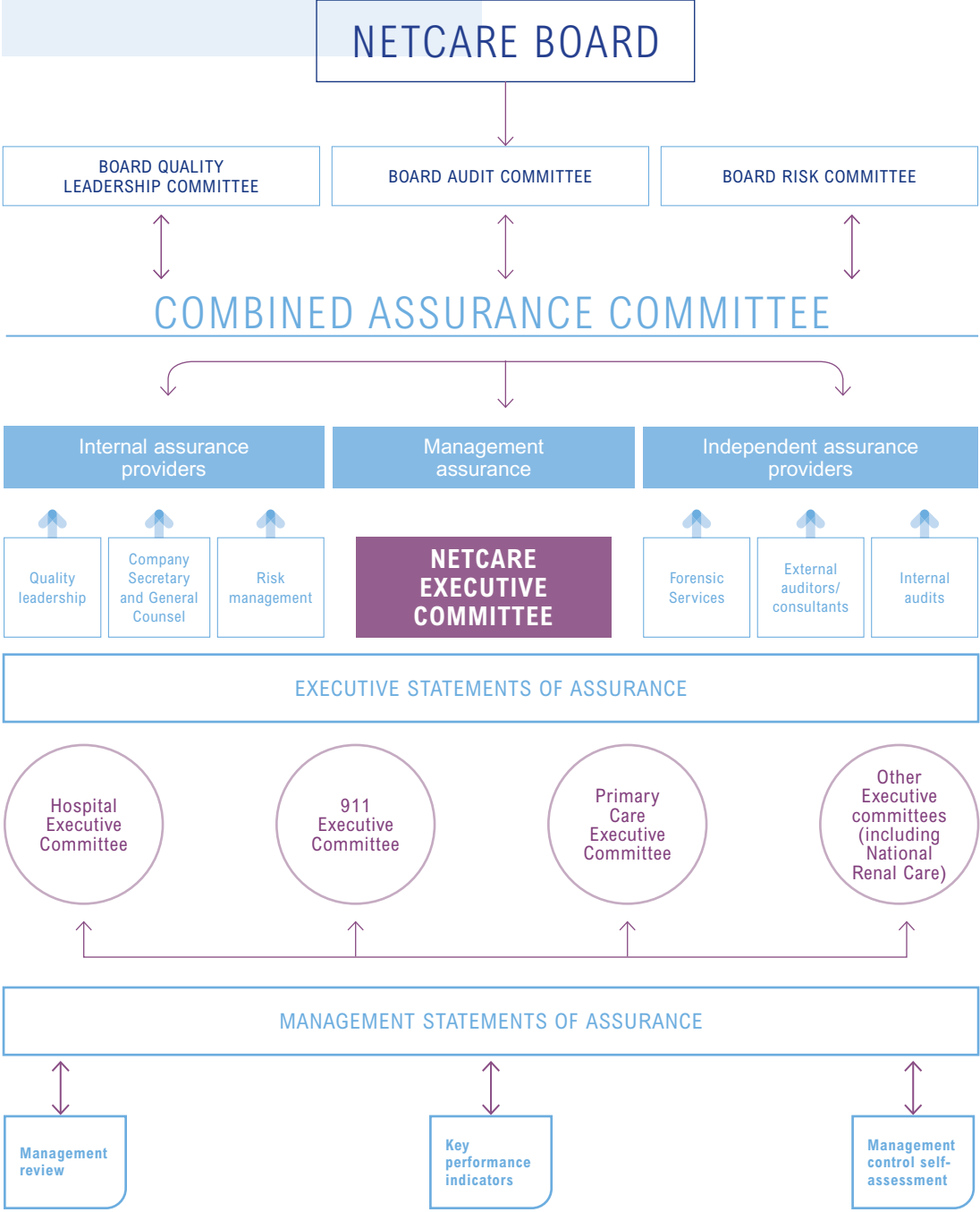
 DETAILS ON NETCARE'S FINANCIAL RISK MANAGEMENT ARE INCLUDED IN NOTE 33 TO THE GROUP ANNUAL FINANCIAL STATEMENTS.

Looking ahead

Key priorities and focus areas for 2016 include:

- + Review and update our risk management policy and methodology, and where appropriate take into account the principles and best practices of the fourth King Report and Code of Governance in SA (when it becomes available), as well as best risk management practice set out by major listed companies in SA.
- + Expand the combined assurance framework beyond top business risks to include key operational risks affecting individual divisions and business units as identified by the operational risk assessments undertaken in 2015.
- + Mature the management self-assessment process that will be supported by the implementation of an electronic solution.

FLOW OF ASSURANCE OF INFORMATION



This diagram does not depict the governance structures within Netcare, it merely attempts to illustrate the flow of assurance information between the various assurance providers and current governance structures.

TOP BUSINESS RISKS IN SOUTHERN AFRICA

The overall risk profile of the Southern African operations have not changed significantly during 2015 and the top business risks remain unchanged. Our integrated report now includes disclosure on the level and change in risk exposure for each identified top risk.

CHANGE IN RISK EXPOSURE

-  DECREASE IN RISK EXPOSURE
-  RISK EXPOSURE REMAINED CONSTANT
-  INCREASE IN RISK EXPOSURE

OVERALL RISK EXPOSURE

-  Adequate risk mitigation is being applied to minimise the potential risk exposure.
-  The risk is not fully mitigated due to mitigation measures not being entirely within Netcare's control.
-  Risk mitigation is being explored or implemented by management to minimise the potential risk exposure that is largely within our control.

QUALITY PATIENT CARE (CLINICAL QUALITY)

Risk description The ability to consistently deliver quality care could be compromised by the growing resistance to antibiotics and the spread of Carbapenemase-producing Enterobacteriaceae (CPE) and Carbapenem-resistant Enterobacteriaceae (CRE). Outbreaks of this nature remain one of the biggest threats to the global and local healthcare system. Poor control over the prescription of antibiotics, together with the decline in the development of new antibiotic therapies, means that the threat of multidrug-resistant infections is an ongoing challenge to quality healthcare outcomes.	
Risk exposure 	Potential impact Failure to consistently provide the best and safest patient care could adversely affect the quality of clinical outcomes, brand and reputation, and long-term sustainability. In addition, a CPE/CRE outbreak may require one or multiple hospital wards to be quarantined, which may be closed until appropriate infection prevention procedures have rendered the ward safe for use. This would disrupt normal hospital operations and impact the delivery of healthcare services.
Strategic priority + Best and safest patient care	Performance A total of 32 hospitals are using our new electronic infection surveillance and antibiotic stewardship system. Adherence to process and outcome measures is tracked monthly.  OUR QUALITY LEADERSHIP PERFORMANCE IS OUTLINED ON PAGE 46 OF THIS REPORT AND IN DETAIL IN THE QUALITY AND CLINICAL GOVERNANCE REPORT ONLINE. 
Risk mitigation measures An adequate solution to the growing resistance to antibiotics globally is currently not within the control of Netcare or the private hospital sector. To address this risk within our facilities, we undertake the following measures: + A multidrug-resistant outbreak response team to assist hospital teams with the control of outbreaks. + Increased focus on hand-hygiene compliance and environmental and equipment cleaning protocols. + The antibiotic stewardship programme, which improves clinical outcomes by using appropriate antimicrobial treatment regimes, reducing overall exposure to antibiotics, preventing antimicrobial resistance and decreasing the use of antibiotics and their associated costs.	

QUALITY PATIENT CARE (CLINICAL QUALITY) CONTINUED

Additional quality improvement measures include: + Quality leadership that is governed and monitored across all divisions by the Netcare Quality Leadership Committee (a sub-committee of the Board), quality governance structures and multi-dimensional quality leadership scorecards. The scorecards track 307 quality measures and progress against targets monthly, and are formally reviewed quarterly at business unit and executive level. + The quality management system, which ensures accredited quality standards in specialist areas and clinical risk management focus areas. Quality standards are measured across all divisions through the annual quality review process. + The National Quality Leadership Review Committee, which reviews trends for adverse events and medico legal matters, and agrees on specific interventions and reviews how the interventions are progressing. + Patient feedback, which improves our understanding of patients' needs and is used to direct resources appropriately to improve the overall patient experience.	
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AVAILABILITY AND QUALITY OF SKILLS

Risk description The healthcare sector in Southern Africa is experiencing a shortage of specialist doctors and registered nurses. In SA, the number of doctors being trained has remained stagnant for the last 40 years while demand for healthcare has increased significantly. Competition among healthcare providers for available specialist skills will therefore continue to intensify. In addition, the current economic climate may see specialists leaving SA in search of opportunities abroad.	
Risk exposure 	Potential impact The shortage of skilled healthcare professionals may impact the quality of clinical outcomes, Netcare's ability to implement expansion opportunities, access to healthcare in SA and the sustainability of healthcare access.
Strategic priority + Organisational growth + Physician partnerships + Best and safest patient care + Growing with passionate people	Performance The Hospital division attracted 205 new specialists in 2015. A total of 51 specialists left our network, mainly due to emigration, retirement, death or the decision to take up practising privileges at other healthcare facilities.  INITIATIVES TO ATTRACT AND RETAIN PHYSICIANS CAN BE FOUND ON PAGE 22.  OUR PEOPLE PRACTICES ARE SUMMARISED ON PAGE 44.  REFER TO THE SA: OUR PEOPLE REPORT FOR A FULL REVIEW OF OUR PEOPLE PRACTICES.
Risk mitigation measures An adequate solution to the shortage of specialist skills in SA is not within the control of Netcare or the private hospital sector. To address this risk within our business, we undertake the following measures: + The Hospital division's senior management regularly attends Physician Advisory Board meetings and we keep track of the number of healthcare practitioners that join and leave our facilities on a monthly basis. + Where appropriate, we source qualified nurses from outside SA. + We encourage relationship building between specialists and hospital staff, from nurses through to hospital management, to ensure a team effort in delivering and advancing quality healthcare. + Development opportunities available to staff range from technical and clinical courses to management and leadership development programmes. On-site career management committees identify individuals for accelerated development interventions. These initiatives contribute to healthcare skills development in SA.	

INDUSTRY REGULATIONS AND FUNDER REGIME

Risk description The most significant regulatory issues faced by the Group in SA are: Competition Commission’s Private Healthcare Market Inquiry The Competition Commission is continuing its Inquiry into the functioning of the private healthcare sector across medical aid schemes, private and independent hospitals, medical specialists, general practitioners (GPs), pharmaceutical companies and medical device manufacturers. In September 2015, the commission published the Profitability Analysis Methodology document. Written submissions regarding the proposed methodology were required by 2 November 2015. In their revised timetable published in October 2015, the Competition Commission indicated that the Inquiry will be completed in December 2016. Medical scheme consolidation and membership growth The consolidation of smaller medical schemes into larger administrators strengthens the negotiating position of larger schemes. Four entities (i.e. three administrators and one scheme) are already negotiating on behalf of 70% of medical scheme lives in SA. An additional concern is the decline in growth of medical aid membership. Proposed amendments to the Medical Schemes Act In July 2015, the Minister of Health published proposed amendments to the Medical Schemes Act that relate to: + Draft Regulation 5 requires that hospital accounts must be accompanied by a discharge summary prepared and provided by the attending healthcare provider. + Draft Regulation 8 holds medical schemes liable for payment of healthcare professionals in accordance with the billing rules and tariff codes of the 2006 National Health Reference Price List tariffs (adjusted annually in line with consumer price inflation). Medical schemes may negotiate alternative tariffs with healthcare service providers for which no co-payment or deductible will be payable by a member. If implemented in its current form, this amendment will make consumers responsible for the shortfall in healthcare professionals’ fees not settled in full by medical schemes. In the current challenging economic environment, this may impact specialist demand and ultimately hospital demand.	
Risk exposure 	Potential impact Changes in healthcare regulation and funder regime may impact the industry landscape and competitive environment.
Strategic priority + Organisational growth + Operational excellence	Performance In October 2014, Netcare submitted comprehensive submissions to the Competition Commission. Further submissions were made in 2015, and we continue to engage with the authorities as required.  MORE INFORMATION ON THE HEALTHCARE INDUSTRY AND FUNDER REGIME CAN BE FOUND ON PAGE 23.
Risk mitigation measures + Dedicated internal and external resources continuously monitor the regulatory environment. + Engagement with regulators on policy decisions takes place where appropriate and allows for the proactive amendment of our strategy and business model when required.	

IT SYSTEM AVAILABILITY AND IT-ENABLED BUSINESS CHANGE

Risk description To remain ‘future fit’ we must transform our operational and administrative systems and processes. Our newly implemented enterprise resource platform enables accelerated service delivery, productivity, efficiency and innovation. However, the realisation of these objectives are dependent on the ongoing availability of our IT systems and on our ability to rapidly restore system functionality, prevent or minimise data loss and re-establish normal business operations in the event of a major IT system failure.	
Risk exposure 	Potential impact Failure to implement and maintain appropriate IT systems, infrastructure and resources will inhibit the level of business change required to meet operational challenges and create a platform for sustainable growth, quality improvement and innovation.
Strategic priority + Operational excellence	Performance In 2015, we successfully completed a SAP technical upgrade which will allow us to implement new functionality and evolve our front and back office IT systems. To deliver strategic business improvement solutions that result in efficiencies and improved patient care, we also employed two general managers responsible for business process improvement. The planning for Phase 2 of the IT governance improvement programme is underway following the successful implementation of Phase 1 during the year.
Risk mitigation measures + The IT Steering Committee convenes quarterly and has overall responsibility for recommendations and decisions regarding IT priorities, funding and other IT and security requirements. It provides strategic and governance direction for IT throughout the business. The IT Management Committee advises the Netcare Board and executive management on current and future IT-related issues. + The IT strategy allocates resources to maintain an appropriate balance between sustaining the current IT infrastructure (day-to-day operations, IT governance and security) and driving technological advancement and innovation. + Capital expenditure projects, resourcing of appropriately skilled staff and development of our IT intellectual capital are carefully planned to support the long-term IT strategy. IT spend is monitored within a set of benchmarks. + The Information Systems division manages the performance of the IT environment and service delivery through Sigma, Netcare’s IT helpdesk system. Performance is presented at the quarterly meetings of the IT Steering Committee. + Disaster recovery plans are in place as part of IT risk management. + Proactive monitoring of third-party service providers is undertaken, given their role in the performance of our IT systems.	

APPROPRIATELY MAINTAINED PLANT AND EQUIPMENT

Risk description The investment we make in plant and equipment, which includes medical equipment, is an integral part of our value proposition and supports our competitive advantage.	
Risk exposure 	Potential impact Improper maintenance of plant and equipment poses a risk to the safety of patients and employees. It also impacts on the quality of patient care and our ability to attract and retain healthcare specialists.
Strategic priority + Physician partnerships + Best and safest patient care	Performance Netcare continues to invest in maintaining existing facilities and equipment. For 2015, our capital expenditure in SA was R1.9 billion, with replacement capital expenditure accounting for 46% of this spend. Following the review by the Property and Technical Services division, multiple sites will be allocated additional capital expenditure to ensure the security of water and power supply (see 'security of utilities' on page 27).
Risk mitigation measures + Preventative maintenance programmes are evaluated in all our facilities and are tracked monthly by management. + Compliance to preventative maintenance programmes is assessed annually as part of the quality review process and informs our repairs and maintenance expenditure. + The quality management system ensures accredited quality standards are adhered to in preventative maintenance and technical risk management focus areas.	

SECURITY OF UTILITIES (INCLUDING ELECTRICITY AND WATER)

Risk description As an organisation that operates 24 hours a day, 365 days a year to care for patients, our operations depend on a secure and stable national electricity grid and water supply. Netcare continues to face significant potential threats to the sustainability of our operations as a result of the fragile and unstable national electricity grid and water infrastructure capability. A prolonged shut-down of the national grid will impact on the provision of clean water, adequate sewerage, catering services, staffing and adequate security at facilities.	
Risk exposure 	Potential impact Electricity and water supply interruptions may impact business operations and the quality of patient care. In addition, power surges resulting from the unstable electricity grid and frequent electricity interruptions can affect the performance, uptime and sustainability of our plant and equipment.
Strategic priority + Physician partnerships + Best and safest patient care	Performance In 2015, we extended our major incident plan to cover disruptions relating to electricity cuts, and in extreme cases, a total blackout. 2015 marks the third year of Netcare's five-year environmental sustainability strategy that aims to ensure our sustainability and efficient use of energy. A number of energy efficiency and renewable energy projects are currently being implemented. We have spent approximately R68 million of the sustainability loan from the French Development Agency during 2015, which has yielded R30 million in energy savings so far. We have started developing a sustainable water strategy to direct our water saving initiatives, water installations and risk mitigation strategies in the event of water supply disruptions. Smart water meters are being installed in our hospitals. All hospitals are equipped with UPS (uninterrupted power supply) systems and emergency electricity generation capacity. In 2015, the Property and Technical Services division surveyed the capacity of generators and water tanks at our hospitals. Capacity upgrades will be undertaken where required.  OUR ENVIRONMENTAL REPORT PROVIDES FURTHER DETAILS ON THESE INITIATIVES.
Risk mitigation measures + The Sustainability Committee, a sub-committee of the Social and Ethics Committee, considers the impact of climate change on current and future operations. It also reviews compliance with applicable environmental legislation and the CDP. + Strategies are in place to secure the supply of power and water, and sustainability targets are included in executive balanced scorecards. Our target is to reduce our energy consumption by 35% over five years. + The major incident plan defines the managerial and administrative actions and processes to be implemented at all Netcare facilities in the event of electricity cuts and, in extreme cases, a total blackout. This aims to ensure a co-ordinated response to incidents. Under this plan, 11 hospitals will be able to remain operational for up to two weeks during a blackout and will have the ability to support critical areas including communication, medical supplies, security, transport, sewerage and staffing. The major incident plan is available on the Group intranet. + Emergency preparedness and compliance to emergency policies are evaluated as part of the annual quality review process.	

INTERNATIONAL INVESTMENTS – BMI HEALTHCARE IN THE UNITED KINGDOM

Risk description BMI Healthcare is becoming increasingly dependent on caseload from the National Health Service (NHS). The NHS represented more than 39% of BMI Healthcare's total caseload during 2015, growing by approximately 13.5% from 2014. Changes in NHS policy or reductions in NHS tariffs may reduce the caseload referred to BMI Healthcare or the related revenues, impacting its future business growth and profit margins.	
Risk exposure 	Potential impact The success of BMI Healthcare is critical to Netcare's brand and reputation, and may create future growth and expansion opportunities through improved collaboration between private and public healthcare providers.
Strategic priority + Organisational growth	Performance The growth in NHS caseload reflects the success of BMI Healthcare's targeted initiatives and the solid national and local partnerships built with commissioning bodies. A business-wide transformation programme was implemented at the beginning of 2015. The eight-point plan touches all aspects of the business including governance, superior patient care, human capital, business growth, maximising efficiency and cost management, facilities, communications and information management. The restructuring of the non-recourse GHG PropCo 1 debt facility of £1.5 billion was successfully concluded in May 2015. Consequently, Netcare no longer holds an equity interest in GHG PropCo 1, which is now the external landlord to BMI Healthcare.  BMI HEALTHCARE'S OPERATIONAL REVIEW CAN BE FOUND ON PAGES 68 TO 83.
Risk mitigation measures BMI Healthcare continues to focus on attracting higher complexity work. The organisational restructure and refreshed strategy will contribute to the effective management of BMI Healthcare's cost base. Performance against approved budgets is measured and reported monthly.	

FIRE AND ELECTRICAL SAFETY

Risk description The appropriate operation of the fire safety measures incorporated in Netcare facilities, including the safety of electrical installations.	
Risk exposure 	Potential impact The appropriate operation of fire safety measures is essential to maintain business continuity and ensure the safety of patients, healthcare practitioners, employees and members of the public.
Strategic priority + Physician partnerships + Best and safest patient care	Performance In 2015, we engaged with professional fire engineers to ensure that current facilities complied with relevant regulations and standards relating to fire safety, and that updated fire compliance certificates were obtained where required.
Risk mitigation measures + Comprehensive insurance cover is maintained to mitigate the financial impact of physical damage and interruption to business operations. + Emergency preparedness measures are evaluated in all facilities and tracked monthly as part of the Netcare quality leadership scorecard. Progress against targets is reviewed quarterly at business unit and executive level. + Compliance to emergency preparedness policies is evaluated as part of the annual quality review process. Emergency preparedness reviews include hospital-specific evacuation plans, training for disaster management teams and fire marshals, annual evacuation drills and inspection of fire equipment. + The major incident plan defines the managerial and administrative actions and processes to be implemented at all Netcare facilities in the event of a major incident such as a fire. The plan is published on the Group intranet. + Electrical design reviews ensure that all certificates of compliance are up to date and updated where required. + All facilities are required to have a valid fire compliance certificate issued by the relevant municipal authority.	

PANDEMIC OR INFECTIOUS OUTBREAK

Risk description Emerging and re-emerging epidemic diseases, including viral haemorrhagic fevers (VHFs), pose an ongoing threat to global health security. VHFs are a group of acute diseases that are highly contagious and include Ebola Virus Disease (EVD), Marburg, Lassa and Crimean Congo Fever. Following the EVD outbreak in West Africa in July 2014, the threat of EVD spreading globally has largely abated. However, until such time as the EVD outbreak has been completely contained, a level of risk exposure remains. At 30 September 2015 there were no confirmed cases of EVD reported in SA.	
Risk exposure	Potential impact A pandemic or widespread infection outbreak, affecting the wider population as well as healthcare professionals, may result in the quarantine or closure of healthcare facilities, a breakdown in healthcare services and loss of life.
Strategic priority Best and safest patient care	Performance We have assessed more than 9 300 patients since the EVD outbreak. Ten cases were formally tested by the National Institute for Communicable Diseases with our Response Team co-ordinating and managing the isolation and care of nine patients. All cases were confirmed as due to other causes.
Risk mitigation measures - Precautionary protocols and screening guidelines govern the management of all at-risk patients. - The 24-hour Netcare VHF Protocols Call Line enables immediate communication when VHF is suspected or confirmed. - A WhatsApp group of key internal and external stakeholders is provided with real-time information when at-risk VHF cases are identified. Related screening results and decisions taken are also communicated to the WhatsApp group. - VHF personal protective equipment is available at every Netcare hospital and at identified Netcare 911 and Primary Care sites. - One mobile and two fixed special negative pressure isolation chambers fully isolate, contain and transport potential VHF patients. - A documented and tested major incident plan, based on best practice, sets out the activities and procedures to be adhered to in the event of a major incident. The pandemic preparedness plan outlines the management of a potential pandemic or infection outbreak. Both plans are published on the Group intranet. - Training and the reinforcement of our protocols and guidelines is ongoing. More than 800 employees received training since the EVD outbreak in 2014 on initial isolation procedures and the use of personal protective equipment.	

TOP BUSINESS RISKS IN THE UK

BMI Healthcare’s executive management team identifies the risks pertaining to the UK operations through its committee structure and particularly the Governance Committee and its three sub-committees.

CHANGE IN RISK EXPOSURE

- DECREASE IN RISK EXPOSURE
- RISK EXPOSURE REMAINED CONSTANT
- INCREASE IN RISK EXPOSURE

OVERALL RISK EXPOSURE

- Adequate risk mitigation is being applied to minimise the potential risk exposure.
- The risk is not fully mitigated due to mitigation measures not being entirely within BMI Healthcare's control.
- Risk mitigation is being explored or implemented by management to minimise the potential risk exposure that is largely within our control.

COMPETITOR ACTIVITIES

Risk description Well-capitalised competitors opening facilities within the vicinity of BMI Healthcare hospitals.	
Risk exposure	Potential impact Demand for private hospitals in localities may be insufficient to support multiple hospitals and competitors may attract patients and specialists away from BMI Healthcare.
Strategic priority - Operational excellence - Best and safest patient care	Risk mitigation measures - We monitor local and national market changes and plan strategically for the short and medium term. - Capital investment plans are developed to counter competitor activities and improve local communication with consultants and GPs.

RECRUITMENT AND RETENTION OF KEY STAFF

Risk description Ensuring we recruit and retain highly skilled and qualified personnel.	
Risk exposure	Potential impact Failure to attract or retain skilled staff places over-reliance on agency and locum workers to deliver core services, which could negatively impact patient satisfaction scores.
Strategic priority Growing with passionate people	Risk mitigation measures - Clinical skills mix and vacancies are monitored weekly. - Agency expenditure is closely monitored and agency use is governed by a robust approval process. - Specialist recruiters and employment strategies are used to attract staff. Our talent management and development programmes recognise and nurture potential. THE UK: PEOPLE, PERFORMANCE AND CULTURE REPORT SETS OUT OUR INITIATIVES TO BE AN EMPLOYER OF CHOICE. A SUMMARY OF OUR PEOPLE INITIATIVES IS ON PAGE 77.

INVESTMENT IN FACILITIES AND CRITICAL EQUIPMENT

Risk description	
Ensuring appropriate investment in facilities and critical equipment.	
Risk exposure 	Potential impact Insufficient investment increases the risk of equipment failure, and facilities that are not fit for purpose or which do not meet funder or regulatory requirements. In addition, should harm occur, there is potential risk of prosecution and closure of a hospital service, adversely impacting BMI Healthcare's reputation.
Strategic priority Operational excellence Best and safest patient care	Risk mitigation measures Capital expenditure investment is monitored by a number of committees, including the Capital Expenditure Committee, and Finance and Investment Committee. Each BMI Healthcare hospital has engineer support. A maintenance management system manages planned maintenance activities ensuring that assets are kept in good condition and repairs are logged and prioritised. A capital investment prioritisation process, standard operating procedures, site management plans, auditing and reporting are in place for all critical maintenance activities.  THE UK: SUPERIOR PATIENT CARE REPORT SETS OUT OUR INITIATIVES TO ENSURE QUALITY OUTCOMES.  A SUMMARY OF OUR QUALITY INITIATIVES IS ON PAGE 76.

REPUTATIONAL ISSUES

Risk description	
Negative media attention.	
Risk exposure 	Potential impact Negative media attention can impact a particular service or hospital, as well as BMI Healthcare as a brand. This may lead to loss of stakeholder confidence.
Strategic priority Operational excellence Best and safest patient care	Risk mitigation measures Media is monitored daily. Adverse content is managed by key individuals internally and monitored by the Public Relations and Marketing Committee and BMI Healthcare's Executive Board.

NEGOTIATIONS WITH HEALTH FUNDS

Risk description	
Ensuring commercial and competitive contracts are agreed with health funders.	
Risk exposure 	Potential impact Sub-optimal funder contracts may lead to health fund members experiencing difficulties in accessing BMI Healthcare facilities as the contract terms may restrict what members can and cannot access at the facility. This may create business uncertainty that negatively impacts stakeholder and patient confidence, staff morale and ultimately cash flow.
Strategic priority Operational excellence Best and safest patient care	Risk mitigation measures A dedicated and experienced team manages negotiations with health funders. Our health fund negotiation strategy is developed using analytical and shareholder support, and is monitored by the Executive Board.

CHANGE IN PAYOR AND CASE MIX, AS WELL AS DECLINING TARIFFS

Risk description	
A continuing shift from Private Medical Insurance and direct patient payment to state-funded patients, a reduction in length of patient stay with a move towards day and outpatient care, and lower tariffs from funders reducing revenues.	
Risk exposure 	Potential impact Reduced profit margins would hinder BMI Healthcare's ability to both invest in capital expenditure for future growth and innovate in key clinical areas to drive quality and choice for patients.
Strategic priority Organisational growth Operational excellence	Risk mitigation measures The transformation programme implemented in the UK aims to ensure an agile business model that can take advantage of the opportunities presented by a changing caseload mix by re-engineering how care is delivered and moving into new models of care delivery, such as day theatres and outpatient business. Tariff changes and their impact on business are regularly analysed. A comprehensive action-focused programme is in place to optimise revenue across the business, including control of administrative and discretionary costs. This is monitored by the Executive Board.  THE UK: HOSPITAL DIVISION REPORT ON PAGE 78 PROVIDES FURTHER DETAILS ON INITIATIVES TO OPTIMISE REVENUE.

LIQUIDITY

Risk description Liquidity constraints.	
Risk exposure 	Potential impact Insufficient cash flow or banking facilities hinders BMI Healthcare's ability to meet current and future financial obligations.
Strategic priority + Organisational growth + Operational excellence	Risk mitigation measures + Liquidity is reviewed regularly and timely cash forecasts used to manage the business. Policies to ensure appropriate management of cash are also in place. + Strong relationships exist with lenders and outstanding debt is regularly reviewed. + Robust reconciliation processes are in place for NHS work, including data quality reports, to facilitate seamless collection of amounts due. + In September 2015, the revolving credit facility was refinanced increasing the facility from £22.3 million to £36.0 million and extending the maturity date to March 2017.

QUALITY OF PATIENT CARE

Risk description Providing safe and clinically effective patient care ensuring that preventable injury or death does not occur.	
Risk exposure 	Potential impact Failure to provide safe and high-quality patient care adversely affects BMI Healthcare's operations, patient experience, staff morale, brand and reputation.
Strategic priority + Best and safest patient care	Risk mitigation measures + Our comprehensive national clinical governance framework ensures the highest standards of patient outcomes are achieved. The framework consists of clinical policies, a national Clinical Governance Committee that reviews clinical trends, and a national Medical Advisory Committee that engages with doctors working at BMI Healthcare facilities. In addition, clinical governance and medical advisory committees are operational at each hospital. + All staff participate in regular performance appraisals and mandatory training, and undertake other ongoing training. + Any concern relating to staff or consultants is promptly and thoroughly investigated. Where an adverse incident has occurred, this is reviewed by the Clinical Governance Committee with suspension and reporting to regulators taking place, where appropriate. Lessons learned from adverse incidents are cascaded throughout the organisation to minimise the risk of recurrence.  THE UK: SUPERIOR PATIENT CARE REPORT SETS OUT OUR INITIATIVES TO ENSURE QUALITY OUTCOMES.  A SUMMARY OF OUR QUALITY INITIATIVES IS ON PAGE 76.

REGULATORY COMPLIANCE

Risk description Meeting regulatory requirements.	
Risk exposure 	Potential impact Failure to comply with healthcare regulation and legislation could result in prosecution and a risk to BMI Healthcare's ability to continue operating certain services or one or more of its hospitals. BMI Healthcare's reputation would also be negatively impacted.
Strategic priority + Operational excellence + Best and safest patient care	Risk mitigation measures + The regulatory environment is monitored continuously and regulatory compliance is reviewed by the Clinical Governance Committee. Any concerns identified are escalated to the Governance Committee and Executive Board. Policies and an internal team of legal and specialist advisors provide additional support. + Hospitals undergo internal audits and each facility has a registered manager responsible for regulatory compliance. + Regular training is provided to staff, including on regulatory matters.

INABILITY TO ACHIEVE BUSINESS GROWTH OBJECTIVES

Risk description Ability to grow the BMI Healthcare business.	
Risk exposure 	Potential impact Static or declining levels of activity negatively impacts profit and hinders BMI Healthcare's ability to invest in the business.
Strategic priority + Organisational growth	Risk mitigation measures + A recently appointed National Director of Business Development will oversee BMI Healthcare's national and local development plans. + Where appropriate, strategic leads for service line development and relationships with joint venture partners are considered. + Growth across all patient groups (private and state insured, as well as self-pay) are included in performance delivery plans locally and nationally. These plans are reviewed by the Executive Board and the Operational Delivery Committee.

REMUNERATION REPORT

During 2015, we engaged shareholders to obtain their views on the Group’s remuneration structures. We extend our appreciation for their time and we have endeavoured to include responses to their views in this remuneration report and policy review.

As authorised by the Board, the Remuneration Committee is pleased to present Netcare’s Remuneration report for the financial year ended 30 September 2015. This report sets out the Group’s remuneration policy and philosophy, and the principles that underpin Netcare’s remuneration strategy to attract and retain talent. It also endeavours to set out how our incentive schemes support Netcare’s business strategy and sustainable value creation over the long term.

Netcare’s remuneration policy guides decision-making by setting the principles the Group uses to ensure competitive remuneration within regulatory requirements and with due regard to the evolving macroeconomic environment. It covers executive directors, prescribed officers¹ and non-executive directors in SA, as well as the actual payments, accruals and awards for the year ended 30 September 2015. It also sets out the remuneration structure in the UK.

JM Kahn retained the chairmanship of the Remuneration Committee² while acting as the Chairman of the Board for purposes of continuity. This was duly communicated to the Continuing Obligations Division of the JSE. However, following the decision of the Board and the Nomination Committee to ratify his position as the non-executive Chairman, APH Jammie has been appointed as the new Chairman of the Remuneration Committee, effective 25 November 2015. JM Kahn will remain a member of the Remuneration Committee.

The committee is satisfied that its terms of reference have been met and that the principles advocated by King III, the Companies Act and the JSE Listings Requirements have been adhered to, including the level of disclosure provided and the revised composition of the Remuneration Committee, which consists only of independent non-executive directors.



BOARD COMMITTEE TERMS OF REFERENCE ARE AVAILABLE AT www.netcareinvestor.co.za/jse_sri.php.

- In reviewing and finalising the remuneration policy, the committee has sought to ensure that:
- + Salary structures and short-term incentives motivate superior performance, and are linked to realistic and appropriately articulated performance objectives that support long-term sustainable growth and prevent irresponsible risk-taking;
 - + Stakeholders are able to readily review the governance processes and reward practices; and
 - + The policy complies with all applicable laws and codes.

The annual non-binding advisory vote being sought from shareholders at the annual general meeting on 5 February 2016 pertains only to the remuneration policy.

During 2015, we engaged shareholders to obtain their views on the Group’s remuneration structures. We extend our appreciation for their time and we have endeavoured to include responses to their views in this Remuneration report and policy review. The main areas of concern identified by shareholders relate to the disclosure of bonus outcomes, coupled with disclosure of detailed performance metrics in respect of the Forfeitable Share Plan. Changes have been incorporated in the remuneration policy to facilitate additional disclosure relating to the performance measures used to determine the award of short- and long-term incentives.

Forfeitable Share Plan for the period ending 30 September 2015

PERFORMANCE PARAMETER		TARGET
Target 1: 50%	Return on capital employed (ROCE) ³	Weighted average cost of capital (WACC) ⁴ + 6%
Target 2: 50%	Headline earnings per share (HEPS)	Compound annual growth rate of the average consumer price index (CPI) + 4% for the performance period

Taking into account the performance of the Group and the value created for shareholders during the year, the committee is of the view that the remuneration policy and its implementation reflect appropriate alignment of the Group’s strategic imperatives to the interests of shareholders.



SHAREHOLDERS CAN ACCESS THE VALUE-ADDED STATEMENT IN THE FINANCIAL SECTION OF OUR ANNUAL INTEGRATED REPORT.

A core component of the Group’s executive incentive scheme is rewarding individual and team performance, based on personal effort and success in meeting performance objectives that are aligned to the Group’s strategic objectives. The performance-based remuneration principle is a foundational element of our remuneration philosophy and is coupled with sound governance and management principles.

The committee ensures that the remuneration policy and practices target and support Netcare’s business drivers, and corporate and strategic priorities. Performance conditions are designed to ensure remuneration practices are equitable, align the interests of executives with those of shareholders, and encourage longer-term business sustainability. Executives are compensated according to their performance, which is measured in terms of financial and strategic delivery, as well as the achievement of non-financial objectives.

Netcare’s long-term sustainability is an underlying principle in determining remuneration. The committee and Board are satisfied that the financial targets do not encourage an inappropriate level of risk-taking to achieve the performance targets set.

For the 2015 financial year, the committee did not exercise its right to appoint external consultants to obtain salary survey information or assist in conducting reviews. The Group’s remuneration practices were, however, competitively benchmarked in relation to performance attained within an agreeable level of risk appetite. In addition, through the offices of the Group Human Resources Director and Company Secretary, the committee receives regular reviews against relevant market and peer data. The committee is satisfied that appropriate structures exist both at and below Board level to recognise and retain our top talent.

The committee invites stakeholders to submit comments on the Group’s remuneration policy to the Company Secretary at lynelle.bagwandeem@netcare.co.za as we seek to constantly improve oversight of Netcare’s processes, policies and reporting mechanisms.

1. The methodology for determining prescribed officers was reviewed by the Nomination Committee in September 2015 and no changes were made for the period under review.

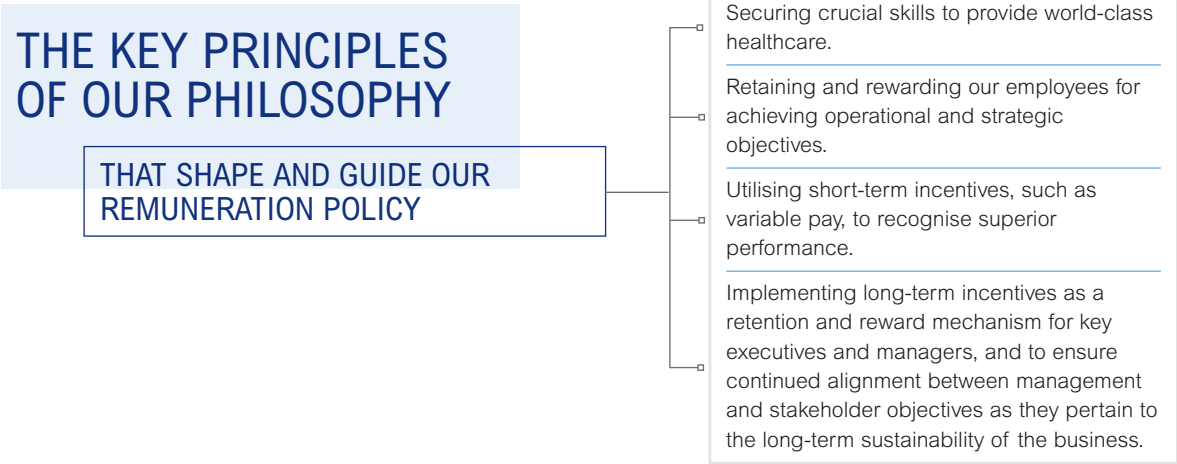
2. The Chairman of the committee attends the annual general meeting and is available to address shareholders’ questions regarding the remuneration policy, its application and the committee’s activities. The Group Chief Executive Officer (CEO) and the Group Human Resources Director attend the Remuneration Committee meetings by invitation and are not present when matters relating to their own remuneration are discussed. The Group Company Secretary acts as the secretary for the committee and is also not present when matters relating to her remuneration are discussed. Detailed information on attendance of members at committee meetings can be found in the online annual integrated report at www.netcareinvestor.co.za/reports/ar_2015/gov-board-of-directors.php.

3. ROCE is defined as operating profit and income from associates and joint ventures expressed as a percentage of average shareholders’ equity and net debt.

4. The WACC is the average WACC (prepared by external consultants and ratified annually by the Finance Committee) that is applicable during the relevant performance period.

Remuneration philosophy

Our remuneration philosophy is guided by the principles of fairness and affordability, and is designed to ensure that our employees are reasonably and responsibly rewarded for their contribution to the Group's operating and financial performance. It is Netcare's policy to increase the annual salary of executives and managers by a lower percentage than that of supervisors and staff. It should be noted that Netcare pays its staff the highest minimum wage in the healthcare sector. In excess of 80% of Netcare staff members belong to the Netcare Medical Scheme. There is substantial cross-subsidisation of contributions making membership of the company medical scheme widely accessible, particularly to lower earning members of staff.



The main objectives of our holistic remuneration policy



Benchmarking

All elements of remuneration are subject to periodic review. Benefits offered by the Group are reviewed to determine appropriateness and competitiveness given the industry, the Group's financial position, legislative requirements, and market benchmarks and trends.

The Remuneration Committee endeavours to ensure that each director and executive is remunerated fairly and responsibly, and that the disclosure of director remuneration is accurate, complete and transparent.

Remuneration policy

At the annual general meeting held on 6 February 2015, shareholders approved the Group's remuneration policy and the fees payable to independent non-executive directors for the 2015 calendar year. The effectiveness of the policy is reviewed annually and forms the basis of developing the Remuneration Committee's annual work plan.

Remuneration structure of executives

A core element of executive remuneration is variable remuneration that aims to maximise performance, promote a culture of excellence, and provide rewards that attract and retain executives. It also seeks to achieve a suitable balance between fixed and variable remuneration. Remuneration decisions are linked to individual performance and a balanced scorecard, together with values and behaviours that promote the delivery of sustainable and measurable business performance.



Guaranteed package

Objective	Basis for determination	Delivery method
Reflects individual contribution and market value relative to role, and recognises the individual's skill and experience.	Based on the complexity of the role, market value, and the ongoing review of the employee's personal performance and contribution to Netcare's overall performance and values. Guaranteed remuneration is reviewed annually and increases take effect in March. Annual increases are performance and market related, taking into account factors such as prevailing economic conditions, inflation, Group performance and affordability, change in responsibilities, internal and external benchmarks, and average salary increases. During the period under review the increase to the guaranteed package of executives was linked to CPI at 5.5%. Executive increases are intentionally pitched at a lower percentage than managers, supervisors and general staff increases, which ranged from 6% to 7% for 2015. A similar approach will be adopted in 2016.	Monthly payment after deducting contributions to retirement funding and medical scheme. The Group also makes group life cover, funeral cover and disability insurance contributions.

Short-term incentives

Objective	Basis for determination	Delivery method
Recognises the achievement of performance metrics aligned to the Group's strategic pillars and identified areas of focus.	Minimum financial gateway targets, which demonstrate annual improved financial performance at a Group level, must be achieved before payment is considered. Individuals must score a minimum of 60% on their personal scorecard, which documents key performance areas, to be eligible for participation in the annual short-term incentive plan. A weighting linked to Group-based targets exists to ensure alignment across team members in individual and Group balanced scorecards. Performance in relation to the Group's annual financial performance, as approved by the Board, was met in 2015, although certain targets below the overall target were not met.	Entitlement and quantum is determined and remains discretionary, subject to the fulfilment of the key performance areas. The maximum amount payable is outlined on page 119.

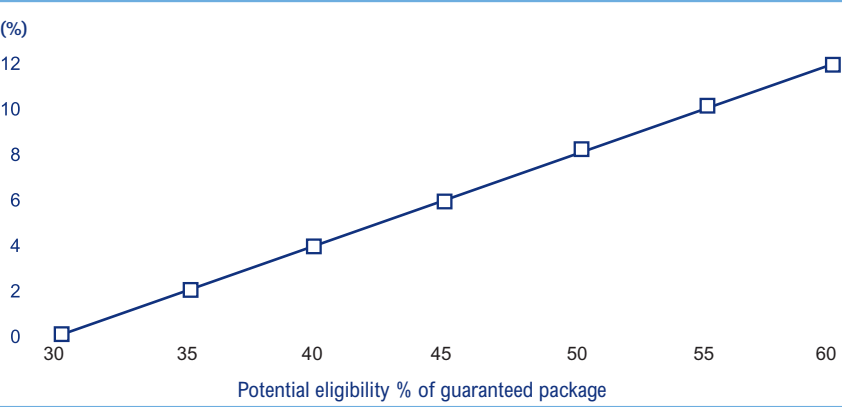
Executives and managers participate in an annual short-term incentive plan that delivers a bonus if certain targets are met. Participating members have a detailed balanced scorecard which contains divisional, functional and individual performance metrics aligned to the Group's strategic pillars and identified areas of focus.

Executive Committee members participate in a committee-based balanced scorecard to ensure alignment across the operating divisions and support functions. The Executive Committee scorecard carries a 40% team performance weighting, measured against detailed deliverables and targets for the Group. The remaining 60% of the scorecard focuses on individual and divisional responsibilities.

The short-term incentive plan has a gateway of a minimum annual improvement to SA HEPS, approved on an annual basis by the Remuneration Committee but linked to the entry level of prevailing CPI. If this gateway is achieved, the defined incentive targets with measurable performance metrics apply.

A broad range of specific strategic and operational targets aimed at providing the appropriate focal points to achieve sustainable growth are included in the individual, divisional and Executive Committee balanced scorecards. The weighting and targets vary between executives depending on their function, although specific financial performance has to be met for there to be any incentive payment.

SA HEPS increase above inflation



The graph above illustrates the potential percentage participation for an Executive Committee member with a maximum incentive eligibility of 60% of guaranteed package. The potential participation level is determined by the incremental increase of SA HEPS above the inflation rate. This is then factored against the executive's individual and divisional scorecards, as well as the Executive Committee scorecard, to calculate the actual proposed incentive value.

BONUS PAID
IF TARGETS MET

=

GUARANTEED PACKAGE

X

POTENTIAL ELIGIBILITY

X

WEIGHTED AVERAGE OF BALANCED SCORECARD

The allocation of short-term incentives is based on a detailed analysis of executive and senior management performance against balanced scorecard targets. These targets are formulated with the aim of achieving the Group's budget and selectively weighted non-financial indicators. These targets are reviewed annually by the Remuneration Committee, with input from management, to ensure they are appropriately aligned to value creation for the Group's stakeholders.

The key financial gateways which are linked to the budget include:

- + SA earnings before interest, tax, depreciation and amortisation (EBITDA) measured against the prior year's performance and targets;
- + SA adjusted HEPS; and
- + Non-financial parameters and targets which differ per division but place overarching focus on the following core deliverables:
 - Quality metrics and outcomes with a key focus on patient satisfaction and clinical outcomes;
 - Staff engagement survey;
 - Transformation targets;
 - Internal control framework compliance;

- Sustainability initiatives; and
- Strategic imperatives such as reducing energy and water consumption, as well as the Group's carbon footprint.

The maximum levels of potential short-term incentives as a percentage of guaranteed remuneration package (total cost to company excluding company contributions to retirement funding, medical aid and cellular phone allowances) as defined in the rules of the short-term incentive plan are detailed as follows:

Position	Maximum bonus
Group CEO ¹	75%
Executive Committee members	60%
Other executives/senior management	50%

1. Chief Executive Officer.

The Remuneration Committee has the discretion to approve incentive payments outside of these levels should it deem such a decision to be appropriate in the circumstances.



Long-term incentives: Netcare Share Incentive Scheme

Objective	Basis for determination	Delivery method
Attract and retain executives and senior managers.	An equity-based scheme with share options vesting in equal amounts over five years, commencing on the second anniversary of the grant date. The scheme rewards improved, sustainable business performance that aligns with shareholder interest over the longer term. Share options are granted at the discretion of the Remuneration Committee. No awards were made in 2015 and we do not intend to make any further awards in terms of this scheme. As such, we will no longer report on this scheme going forward.	Delivered in Netcare shares over the vesting period. The last vesting period expired on 30 September 2015.

No changes were made to the long-term incentive scheme’s rules in 2015, nor are any changes contemplated going forward. There is no claw back policy but the Remuneration Committee reserves the right to implement this if deemed necessary.

The Remuneration Committee is of the view that the short-term incentive metrics coupled with the long-term incentive metrics are appropriately and responsibly linked to value drivers, are easily quantified and measured, and remain relevant to the core business and strategic priorities outlined on page 13.



DETAILS OF THE NETCARE SHARE INCENTIVE SCHEME CAN BE FOUND IN NOTE 36, AND DETAILS OF THE EXECUTIVE DIRECTORS' AND PRESCRIBED OFFICERS' SHARE OPTIONS IN TERMS OF THE SCHEME CAN BE FOUND IN NOTE 35 TO THE GROUP ANNUAL FINANCIAL STATEMENTS.



Long-term incentives: Forfeitable Share Plan (FSP)

Objective	Basis for determination	Delivery method
Attract and retain executives and senior managers.	A combination of performance-based share awards that are fixed to clearly defined performance targets (which, if not met, result in the forfeiture of shares) and a retention-based award that serves to incentivise the senior manager or executive to remain in the Group’s employ. As per the rules of the plan and the decision of the Remuneration Committee, the percentage split in shares awarded for performance and retention depends on the seniority of the participant. Senior manager awards are equally split between performance and retention, while CEO, Chief Financial Officer (CFO) and Executive Committee members’ awards are weighted 75% toward performance conditions and 25% toward retention awards. If the performance conditions are not met, the performance portion is forfeited. The reasonableness of the performance conditions is reviewed annually to ensure that they remain a realistic stretch for participants. Two grants of forfeitable share awards have been issued to participants to date, including executives and prescribed officers. The Remuneration Committee decided on 1 December 2015 that the performance targets for 2015, namely ROCE and HEPS targets, were achieved and therefore the performance shares vested.	Delivered in Netcare shares over the vesting period, providing dividends but not voting rights.

The FSP provides benefits that align with recommended governance practice, the most significant benefit being the provision of dividends, which addresses immediate retention risk. The FSP is also characterised by strictly monitored performance targets. Although the participants are predominantly executives and senior management, other employees may be invited to participate.

FSP allocation levels

CEO	2.5 x annual guaranteed package
CFO	2.0 x annual guaranteed package
Executive Committee members	1.5 to 1.75 x annual guaranteed package
Nominated senior management	0.75 to 1.25 x annual guaranteed package

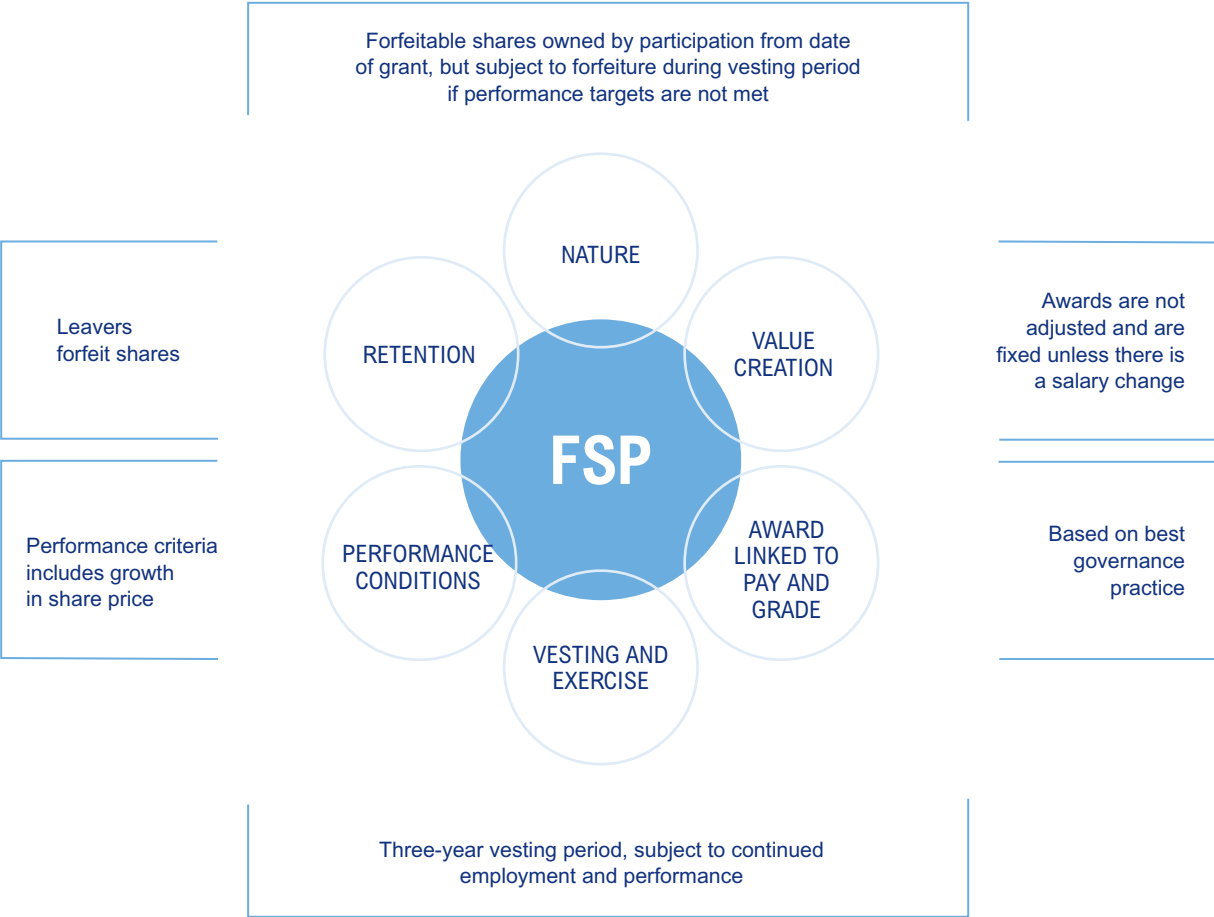
Note: Annual guaranteed packages of participants are defined in the table titled Guaranteed package on page 117.

The number of forfeitable shares subject to an FSP award and the ratio between performance and retention shares is primarily based on the employee’s total annual guaranteed package, grade, performance, retention requirements and market benchmarks as determined by the Remuneration Committee.

The principles relating to the performance conditions ensure that the targets are:

- + Linked to HEPS and take into account a minimum return over prevailing interest rates; and
- + Based on suitable stretch targets for executives that are linked to financial targets, which are compatible with those cited under the short-term incentives.

The underpinning tenets of the FSP are creating sustainable value in the business that is aligned to increasing shareholder value.



 FURTHER DETAILS ON THE FSP CAN BE FOUND IN NOTE 36 TO THE GROUP ANNUAL FINANCIAL STATEMENTS.

Service contracts

Executive directors are not employed on fixed-term contracts and have standard employment service agreements with notice periods of three months. RH Friedland is restrained from competing with Netcare for a six-month period should he terminate his employment with the Group.

Executive directors’ and prescribed officers’ remuneration

The executive directors’ and prescribed officers’ emoluments are disclosed in the table below:

R’000	Guaranteed packages	Bonuses	Total
2015			
Executive directors			
RH Friedland	8 052	6 000	14 052
KN Gibson	4 157	2 500	6 657
Prescribed officers			
C Pailman	3 189	1 500	4 689
J du Plessis	3 609	2 000	5 609
N Phillipson	2 898	1 500	4 398
2014			
Executive directors			
RH Friedland	7 623	5 500	13 123
KN Gibson	3 944	2 000	5 944
Prescribed officers			
C Pailman	3 026	1 400	4 426
J du Plessis	3 424	1 700	5 124
N Phillipson	2 603	1 100	3 703

The short-term incentives paid to the executive directors and prescribed officers in December 2015, which will be detailed in the 2016 Annual Integrated Report, totalled R12.4 million compared to those paid in December 2014 of R13.5 million, which constitutes a reduction of 8%.

The gains on share options exercised by executive directors and prescribed officers during the year are reflected in the table below.

	Exercise price (cents)	Share options exercised	Market price at exercise date (cents)	Gain arising on exercise (R’000)
Netcare Share Incentive Scheme share options				
Executive directors				
RH Friedland	838	1 300 000	3 680	36 946
KN Gibson	838	100 000	3 957	3 119
Prescribed officers				
C Pailman	838	640 000	3 809	19 015
J du Plessis	838	160 000	4 000	5 059
Health Partners for Life share options				
Executive directors				
RH Friedland		200	4 101	5
KN Gibson		1 041	4 101	15
Prescribed officers				
J du Plessis		2 000	3 272	34
Forfeitable Share Plan share options				
Executive directors				
RH Friedland		72 843	3 609	2 629
KN Gibson		28 434	3 609	1 026
Prescribed officers				
C Pailman		17 784	3 609	642
J du Plessis		22 833	3 609	824
N Phillipson		12 688	3 609	458

 FURTHER DETAILS OF THE EXECUTIVE DIRECTORS’ AND PRESCRIBED OFFICERS’ REMUNERATION AND SHARE OPTIONS CAN BE FOUND IN NOTE 35, AND RETENTION AND PERFORMANCE SHARES RELATING TO THE FSP WHICH VESTED IN RESPECT OF EXECUTIVE DIRECTORS AND PRESCRIBED OFFICERS DURING THE YEAR IS DISCLOSED IN NOTE 36 OF THE GROUP ANNUAL FINANCIAL STATEMENTS.

Non-executive directors’ remuneration

Non-executive directors are appointed to the Netcare Board based on their competence, insight, experience, and ability to assist the Group in setting and achieving its objectives. Fees are therefore set at levels that will attract and retain the calibre of directors necessary to contribute to a highly effective Board.

Non-executive directors receive a fixed level of remuneration for their services. King III recommends that non-executive directors are paid an attendance fee and a base fee. Netcare has elected to pay non-executive directors a fixed fee for services rendered, on the basis that the services of directors extend beyond the boardroom and are therefore not confined to attendance at meetings only.

Non-executive directors do not qualify for participation in any share or incentive scheme.

The remuneration of non-executive directors is reviewed annually by the Remuneration Committee and the Board, and recommendations for increases are made to shareholders at the annual general meeting for consideration and approval.

The non-executive directors’ fees paid for the year ended 30 September 2015 and the proposed fees for the year ending 30 September 2016 are shown below. An increase of approximately 6%, which is linked to inflation and consistent with the increasing demands faced by non-executive directors in respect of personal liability and ongoing regulatory requirements, was proposed by the Remuneration Committee and remains subject to shareholder approval on 5 February 2016.

The 6% increase was not applied to the attendance fee applicable to ad hoc committees.

With the newly created role of Deputy Chair, the Remuneration Committee resolved to introduce a fee commensurate with the increase in time and responsibility for the role.

Fees paid to non-executive directors

Fees paid to non-executive directors for 2015 and 2014 were as follows:

R'000	2015	2014
T Brewer	1 312	1 054
APH Jammine	1 095	1 019
JM Kahn	1 238	1 047
MJ Kuscus	931	912
HR Levin ¹	–	461
KD Moroka	691	652
SJ Vilakazi ²	725	1 401
N Weltman	1 008	1 053
Total	7 000	7 599

1. Retired on 28 February 2014.
2. Retired on 31 May 2015.

The total amount paid to non-executive directors for the period under review in respect of their Board, committee and ad hoc committee attendance is detailed as follows:

1 October 2014 – 30 September 2015

R'000	Board	GHG ¹	Audit	Risk	QL ²	Rem ³	Social & Ethics	Finance & invest ⁵	Nom ⁴	Tariff ⁶	Total
T Brewer	548	180	179			102		252	51		1 312
APH Jammine	548	180	143			102			122		1 095
JM Kahn	548	180		143		143	102		122		1 238
MJ Kuscus	548			102	179		102				931
K Moroka	548						143				691
SJ Vilakazi	536	36		51		51		51			725
N Weltman	548		143	102	143					72	1 008
Total	3 824	576	465	398	322	398	347	346	252	72	7 000

1. GHG (operating sub-committee).
2. Quality Leadership.
3. Remuneration.
4. Nomination.
5. Finance and Investment (operating committee).
6. Tariff (operating committee).

The table below reflects the annual fees paid to non-executive directors based on their chair or member status:

R'000	Proposed 2016	Actual 2015	Actual 2014
Board			
Chairman	1 135	1 072	1 011
Deputy Chair	750	–	–
Member	581	548	517
Audit Committee			
Chair	190	179	169
Member	152	143	135
Remuneration Committee			
Chair	152	143	135
Member	109	102	96
Risk Committee			
Chair	152	143	135
Member	107	102	96
Nomination Committee			
Chair	152	143	135
Member	107	102	96
Social and Ethics Committee			
Chair	152	143	135
Member	107	102	96
Quality Leadership Committee			
Chair	190	179	169
Member	152	143	135
Payable per meeting			
Ad hoc committees	36	36	34

Summary of UK remuneration structure

The UK Remuneration Committee, chaired by P Warrener, reviews and sets BMI Healthcare's remuneration strategy, and salary and benefit levels to ensure that remuneration of our employees remains competitive. The maximum bonuses that can be earned by executives and management as a percentage of total guaranteed package, excluding company contributions to retirement funding and medical insurance, are as follows:

Position	Maximum bonus
CEO	60%
CFO and Executive Board	45% – 50%



The remuneration elements in the UK consist of:

Guaranteed package

BMI Healthcare aims to remunerate its employees at a fair market rate taking into account individual responsibilities and performance. Basic remuneration packages are periodically benchmarked against the market, including against those offered by the NHS. Basic remuneration includes salary, employee benefits (such as car allowances, pension contributions and private health cover), life cover, and critical illness cover.

Basic remuneration is reviewed annually and increases take effect in October. Annual increases are based on performance and the market, taking into account factors such as prevailing economic conditions, inflation, company performance and affordability.

Short-term incentives

Executives and senior management participate in an annual short-term incentive plan that delivers a cash bonus based on BMI Healthcare's achievement of financial targets and on team and personal performance objectives set annually. This discretionary incentive plan is activated when certain budgeted financial targets are achieved and payment levels are determined by the achievement of team and personal objectives for the year. Team and personal targets vary across individuals and teams.

Once the EBITDA gateway is passed, the bonus is calculated with a 50% weighting allocated to each of the team and individual targets, 30% weighted towards specified objectives ('The What') and 20% towards how these objectives were met, based on BMI Healthcare's defined behaviours ('The How').

'The What' objectives are set and scored centrally for 10 hospital-based roles. Other hospital-level roles are also included in the management bonus scheme where 'The What' objectives are set and scored by the local Executive Director or Head of Department. 'The How' objectives are the same for all participants. To ensure consistent scoring with regard to 'The How' objectives, each director is individually engaged and given the opportunity to agree or challenge their score.

The UK Remuneration Committee approves the overall payment level of short-term incentives.

Long-term incentives

The Long-term Incentive Plan runs on a rolling three-year basis and started at the beginning of October 2015. The scheme is designed to retain key employees by rewarding achievement of certain targets over each three-year period. Amounts are accrued into the scheme over the three-year period if financial performance targets are met under the scheme rules. These amounts are then payable in cash to the members of the scheme at the end of each three-year period provided they are still an employee. The payments are broadly based on the remuneration of the individual and their period of employment during each three-year scheme.

Annual guaranteed remuneration and bonus payments for the 2014 and 2015 financial years

1 October 2014 to 30 September 2015

Name £	Basic salary	Car allowance	Company pension contributions	Bonus paid Dec 2014	Long-term incentive plan	Other
S Collier ¹	60 393	3 000	6 667	133 699	490 328	274 046
H Davies ²	25 000	1 250	2 500	–	–	–
C Lovelace ³	156 800	8 865	15 680	99 871	327 719	–
J Watts ⁴	479 487	8 718	33 333	–	–	–

1. Resigned on 15 November 2014.
2. Appointed on 1 September 2015.
3. Resigned on 30 April 2015.
4. Appointed on 17 November 2014.

1 October 2013 to 30 September 2014

Name £	Basic salary	Car allowance	Broadband allowance	Private medical plan value estimated	Company pension contributions	Bonus paid Dec 2013
S Collier	362 355	18 000	420	1 000	37 361	137 445
C Lovelace	260 100	15 000	–	400	26 010	100 202



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CHIEF
FINANCIAL
OFFICER'S
REVIEW

Capital
expenditure
R2.7 billion
(2014: R1.9 billion)

Cash
generated
from operations
R5.0 billion
(2014: R4.4 billion)

Netcare delivered a solid set of financial results for the year ended 30 September 2015. In South Africa (SA), our business units improved operating margins through embedded long-term efficiency projects, despite a deterioration in the broader economic environment. In the United Kingdom (UK), BMI Healthcare completed a large-scale restructuring exercise and improved operating margins, delivering a strong performance in a persistently challenging market.

Netcare's core business is its hospital operations, which are complemented in SA by ancillary offerings relating to primary care and emergency medical services. The financial performance of each individual business unit within the Group is influenced by specific risk and opportunity factors. However, as discussed on page 130, a number of common value drivers impact each operation in a similar manner.

Revenue and cost drivers

The table below sets out the key revenue and cost drivers for the Netcare Group.

Revenue drivers	Impact on performance	Material issue component
Patient days	Primary driver of revenue: Higher activity and growth in patient days. Established doctors and specialists with practising privileges at Netcare facilities are an important contribution to patients.	+ Economic conditions + Rapidly changing competitor environment + Ability to compete for specialist healthcare providers
Case mix	Important driver of revenue: The mix of caseload between surgical versus medical admissions. Given our extensive network of trauma facilities and operating theatre capacity, Netcare tends to have a higher proportion of surgical procedures.	+ Economic conditions + Rapidly changing competitor environment
Contracts (specific to Primary Care and Emergency services)	Steady source of revenue: Contracts to provide emergency medical assistance and occupational wellness services to corporate and industrial clients.	+ Economic conditions + Rapidly changing competitor environment
Tariff	Important driver of revenue: The tariff applicable to a particular clinical service or product. Tariffs are generally governed by negotiations with various medical schemes. In the UK, tariffs applicable to procedures funded by the National Health Service (NHS) are set by the regulatory authorities. Aligning tariff uplifts with increases in key input costs, while at the same time ensuring that the cost of patient care remains affordable, is critical.	+ Economic conditions + Changes in healthcare industry regulation and funder regime
Consumable items (specific to SA)	No margin earned: Medical consumable items are charged at net acquisition cost. Pharmacy dispensing prices for drugs and medicines are set at cost by the Single Exit Pricing dispensation.	+ Changes in healthcare industry regulation and funder regime
New capacity added	Important element in growing Group revenues: The addition of new beds and the construction of new hospitals in areas of demand.	+ Rapidly changing competitor environment
Cost drivers	Impact on performance	Material issue component
People	Our employee costs are our largest cost driver. The shortage of qualified nurses and pharmacists, both in SA and the UK, is a market-wide challenge.	+ Managing costs + Shortage of healthcare professionals
Utility costs	In SA, increases in utility costs, well in excess of inflation, are the result of consumer demand for electricity being higher than supply. Furthermore, the prevalence of load shedding in SA during 2015 resulted in increased consumption of diesel to run generators when the national grid was unavailable. In the UK, the cost of purchasing carbon allowances is determined by our carbon footprint, a component of which is our energy usage.	+ Security of utilities including water and electricity

While we are able to influence many of our revenue and cost drivers, there are a number of external factors that are outside our control. In 2015, we invested significantly in new bed capacity in the SA business, growing the portfolio by 6.1% to 9 996 beds. A net addition of 78 doctors were granted practising rights in the SA Hospital and Emergency services division, with a further 76 doctors granted privileges at our two newly opened greenfield hospitals.

To support active management of our cost base, our established long-term efficiency programmes are driving operational leverage and improving business processes. The nursing ward labour tool has been successful in optimising and managing nursing acuity at the appropriate level of clinical care. We have taken steps to insulate our operations from power disruptions and have equipped our facilities to ensure continuity of care and patient outcomes. To mitigate the impact of ongoing power interruptions and rising utility costs, a number of energy optimisation and sustainability projects are underway across the entire network.



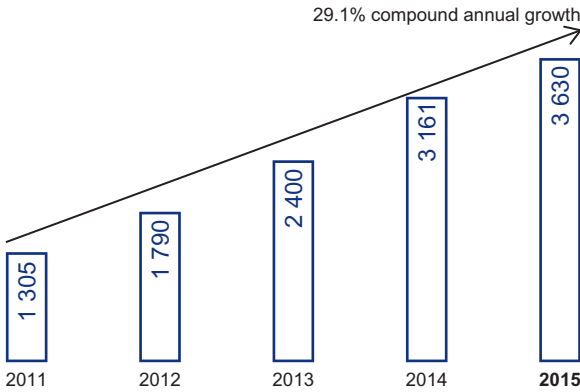
OUR OPTIMISATION AND SUSTAINABILITY PROJECTS ARE DISCLOSED IN THE SA: ENVIRONMENTAL REPORT.

Shareholders' returns

Earnings attributable to shareholders for the year ended 30 September 2015 rose 14.5% to R2 412 million (2014: R2 107 million). Headline earnings per share (HEPS) grew 10.1% to 174.1 cents (2014: 158.2 cents). Adjusted HEPS, which we believe to be a better indicator of sustainable performance, increased 12.6% to 189.0 cents (2014: 167.8 cents).

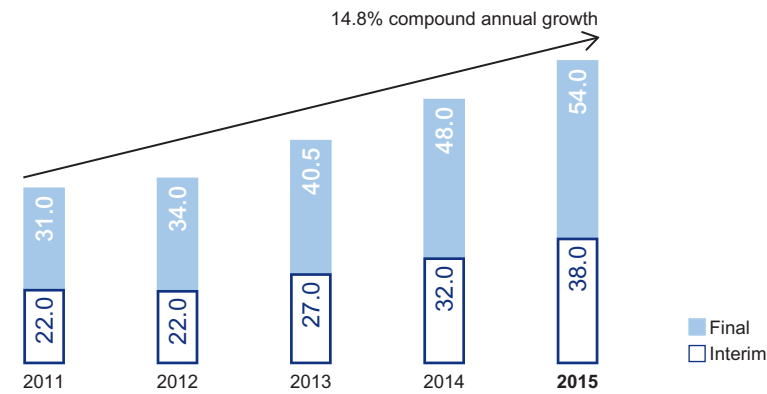
Netcare creates value for its shareholders through share price appreciation and dividends. The Netcare share price performed well, with a closing share price of R36.30 per share at 30 September 2015, 14.8% higher than the closing price of R31.61 in 2014. Over the past five years, the compound annual growth in the value of Netcare's share price was 29.1%.

Share price performance (cents)



A total dividend of 92.0 cents per ordinary share was declared for 2015 (2014: 80.0 cents), comprising the interim dividend of 38.0 cents (2014: 32.0 cents) per share and a final dividend of 54.0 cents (2014: 48.0 cents) per share. A compound annual growth of 14.8% in distributions to shareholders has been achieved over the past five years.

Distribution performance (cents)



Summarised Group income statement

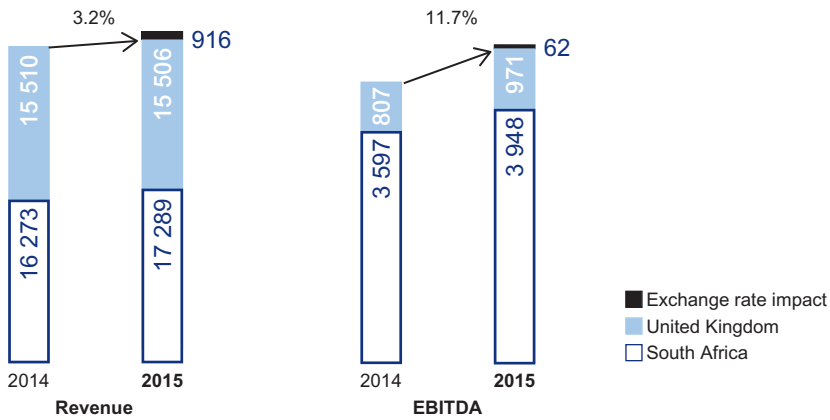
Rm	2015	2014	Change %
Revenue	33 711	31 783	6.1
EBITDA ¹	4 981	4 404	13.1
Operating profit	3 728	3 253	14.6
Net financial expenses	(467)	(431)	
Attributable earnings of associates and joint ventures	114	75	
Taxation	(936)	(801)	
Profit for the year	2 439	2 096	16.4
Ratios			
EBITDA margin (%)	14.8	13.9	
Operating profit margin (%)	11.1	10.2	
Interest cover (times)	11.2	9.2	
Effective tax rate (%)	27.7	27.6	

1. Earnings before interest, tax, depreciation, and amortisation.

At R18.55 to the Pound Sterling, the average exchange rate used to convert offshore income and expenditure was 6.1% weaker in 2015 (2014: R17.49). The weakening of the Rand against the Pound added R916 million to revenue and R62 million to EBITDA. Notwithstanding currency impacts, our optimisation projects have resulted in strong operating leverage, converting a constant currency increase in revenue of 3.2% into a constant currency increase in EBITDA of 11.7%.



Constant currency performance (R million)



Operational performance

2015	South Africa			United Kingdom	
	Hospitals & Emergency Services Rm	Primary Care Rm	Total Rm	BMI Healthcare Rm	BMI Healthcare £m
Revenue	16 119	1 170	17 289	16 422	886.0
EBITDA	3 837	111	3 948	1 033	55.2
Operating profit	3 335	76	3 411	317	16.7
EBITDA margin (%)	23.8	9.5	22.8	6.2	6.2
Operating profit margin (%)	20.7	6.5	19.7	1.9	1.9
2014	South Africa			United Kingdom	
	Hospitals & Emergency Services Rm	Primary Care Rm	Total Rm	BMI Healthcare Rm	BMI Healthcare £m
Revenue	15 171	1 102	16 273	15 510	886.2
EBITDA	3 499	98	3 597	807	45.9
Operating profit	3 045	65	3 110	143	8.0
EBITDA margin (%)	23.1	8.9	22.1	5.2	5.2
Operating profit margin (%)	20.1	5.9	19.1	0.9	0.9

South Africa

The SA business delivered a solid performance in a difficult economic environment, specifically in the second half of the financial year. Strict cost management and focused optimisation initiatives enabled further enhancements in EBITDA and operating profit margins.

Revenue grew by 6.2% to R17 289 million (2014: R16 273 million), while EBITDA increased 9.8% to R3 948 million (2014: R3 597 million) and operating profit rose by 9.7% to R3 411 million (2014: R3 110 million). Capital expenditure, including intangible assets, amounted to R1 895 million (2014: R1 195 million) due to our investment in growing the SA portfolio with the addition of 584 new beds. Our asset replacement and renovation plan accounted for approximately R900 million of total capital expenditure. This equates to just over 5% of revenue, which is in line with prior years.

Hospitals and Emergency services

Demand for private healthcare remained resilient, notwithstanding low economic growth and a 0.6% decline in total medical scheme beneficiaries to 8.76 million (as reported by the Council for Medical Schemes at 30 June 2015). The impact of these factors, together with intensified competition from six new competitor hospitals and a mild winter, resulted in lower activity levels. This was particularly the case for the last financial quarter, which is traditionally a busy period. Patient days grew 0.2% compared to the 2014 financial year.

Revenue grew 6.2% to R16 119 million and EBITDA increased by 9.7% to R3 837 million (2014: R3 499 million), with the EBITDA margin up 70 basis points to 23.8% in 2015 from 23.1% in 2014. Operational excellence initiatives, including tight management of nursing acuity and staffing, energy optimisation and procurement, underpinned the margin improvement, bolstering the division's contribution to Group performance.

The 6.1% increase in bed capacity includes the:

- + 200-bed Netcare Polokwane Hospital in Limpopo province (opened on 21 September 2015);
- + 100-bed Netcare Pinehaven Hospital in west Gauteng (opened on 30 September 2015);
- + 28-bed Netcare Ceres Private Hospital in the Western Cape (acquired with effect from 1 November 2014); and
- + 256 beds opened at various Netcare facilities.

New beds will only contribute to the division's performance from 2016 as most were opened towards the end of the 2015 financial year. Earlier in the year, we disposed of our interest in the 12-bed Optimed Clinic.

Primary Care

Our national network of Medicross family medical and dental centres experienced resilient demand, with slower activity in the second half of the year due to the mild winter experienced across SA. A new facility, the Carnival Mall Medicross in Brakpan, Gauteng, opened in August 2015. The Prime Cure business performed solidly and optimised its operational costs further. The division achieved revenue of R1 170 million, up 6.2% on 2014, and EBITDA rose 13.3% to R111 million (2014: R98 million). The EBITDA margin expanded from 8.9% to 9.5% due to structural and operational refinements to the business model.

United Kingdom

The recovery in the UK economy has not translated into Private Medical Insurance (PMI) growth, which continues to face the challenges of declining subscriber numbers, stringent claims management processes and directional products. The strong growth trend in NHS activity continued, with caseload increasing by 13.5%, driven by waiting list pressure and patient choice. NHS accounted for 39.2% (2014: 35.3%) of total caseload, compensating for the decline in PMI cases. Self-pay caseload grew by 3.5%, enjoying a sustained period of growth in the second half of the year. Outpatient activity continued to grow, supported by the increasing range of services we provide in the outpatient environment.

In total, inpatient and day caseload rose by 2.3%.

Revenue of £886.0 million remained flat year-on-year, reflecting the continued shift in funder mix from private patients to the NHS. EBITDA before non-recurring costs improved 22.6% to £64.0 million (2014: £52.2 million). Net non-recurring costs of £8.8 million comprise a fair value gain of £3.1 million arising on acquisition of control of a former associate, offset by costs of £11.9 million incurred on restructuring the business. Restructuring costs included re-engineering patient pathways and driving greater process efficiency in response to the changing business payor mix. The benefits of this exercise are evident in the widened EBITDA margin, before non-recurring costs, of 7.2% (2014: 5.9%). EBITDA inclusive of non-recurring costs rose 20.3% to £55.2 million (2014: £45.9 million) and operating profit improved to £16.7 million (2014: £8.0 million).

Net financial expenses include a non-cash fair value accounting charge of £6.0 million (R109 million) relating to a mark-to-market revaluation of the Retail Price Index (RPI) swaps related to some of BMI Healthcare's property leases. The RPI swap valuation was driven by lower inflation forecasts, influenced by low oil prices and European Central Bank stimulus actions.

Attributable earnings of associates and joint ventures

The Group's earnings from equity accounted investments were up by 52.0% to R114 million (2014: R75 million). Enhanced performance was achieved by various SA investments, while the positive performance of the UK investments was negatively impacted by the non-recurring cost of swap cancellations upon completion of the refinancing of GHG PropCo 2.

Taxation

Profit before tax amounted to R3 375 million (2014: R2 897 million) for the Group. The Group taxation expense of R936 million (2014: R801 million) represents an effective tax rate of 27.7% (2014: 27.6%).

Statement of financial position

Rm	30 Sep 2014	Forex effect	Other movement	30 Sep 2015
Assets				
Property, plant and equipment, goodwill and intangible assets	15 820	1 078	1 603	18 501
Other non-current assets	3 479	337	399	4 215
Current assets	7 418	572	958	8 948
Total assets	26 717	1 987	2 960	31 664
Equity and liabilities				
Total shareholders' equity	12 172	850	1 259	14 281
Borrowings	6 678	459	1 129	8 266
Other liabilities	7 867	678	572	9 117
Total equity and liabilities	26 717	1 987	2 960	31 664

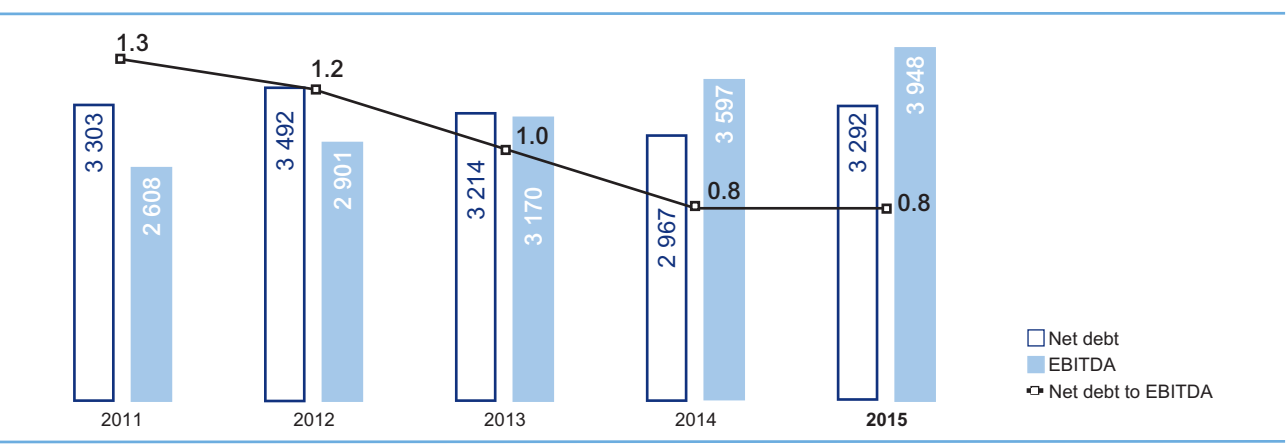
The Group's total assets at 30 September 2015 amounted to R31.7 billion (2014: R26.7 billion). The closing exchange rate, at which we convert assets and liabilities, weakened by 14.5% to R20.94 at the end of September 2015 (2014: R18.29). As a result, currency conversion grew the asset base by nearly R2.0 billion.

Our 2015 capital projects relate to our new hospital builds and brownfield expansion projects as we invest for future growth, as well as the upgrade and maintenance of our existing equipment and facilities. Property, plant and equipment increased to R13 622 million (2014: R11 504 million) due to higher capital expenditure of R2 641 million (2014: R1 902 million), and a foreign currency translation impact relating to the weakening of the Rand against the Pound of R590 million. This was partly offset by depreciation of R1 135 million (2014: R1 046 million). We will pursue a strategy of targeted investment for future growth and have the opportunity to leverage from the existing capacity already in place.

Capital projects are funded through a combination of internal resources and external debt. The Group's net debt was R5 790 million at 30 September 2015 (2014: R4 972 million), with the Group net debt to EBITDA ratio remaining comfortable at 1.2 times (2014: 1.1 times). Interest cover strengthened to 11.2 times (2014: 9.2 times).

SA net debt increased by R325 million to R3 292 million at 30 September 2015. Cash generated from operations rose 17.8% at an excellent cash conversion ratio of 105.1%. With strong cash flow, the business contained the overall increase in net borrowings, notwithstanding a combined cash outflow on capital investment, tax and dividends of R4.4 billion in the year, which represents a year-on-year increase in cash outflow of R1.2 billion. Furthermore, as reflected by the net debt to EBITDA ratio, the leverage of the business has remained steady at 0.8 times. Interest cover remains very healthy at 47.4 times, improving from the already strong levels evident in September 2014.

SA: Net debt: Leverage improvement (R million)



In the UK, net debt rose to £119.3 million (2014: £109.6 million). However, the leverage ratio strengthened and the business remains comfortably geared with a net debt to EBITDA ratio of 2.2 times (2014: 2.4 times). In October 2014, a maturing debt tranche of £24.1 million was repaid by the business. In October 2015, post the financial year-end, a further maturing debt tranche of £23.1 million was repaid from existing resources. The revolving credit facility was successfully refinanced in September 2015 through an 'amend and extend' arrangement, which increased the facility from £22.3 million to £36.0 million and extended the maturity date to March 2017.

GHG PropCo 1 debt

GHG PropCo 1 comprises 35 hospital properties acquired in 2006. Arrangements for the restructure of the £1.5 billion GHG PropCo 1 debt facility, with an original maturity date of October 2013, were finally completed in May 2015. Following completion of the restructure, Netcare no longer holds any equity interest in GHG PropCo 1. In terms of the existing long-term leases, which remain intact through to 2031 with a 10-year renewal option, the relationship with GHG PropCo 1 is now that of an external landlord for 35 BMI Healthcare hospitals. As Netcare deconsolidated its equity interest in GHG PropCo 1 from 16 November 2012, the restructure has had no impact on Netcare's accounts.

Netcare's interest in GHG PropCo 2, consisting of six hospital properties acquired in 2008, has not been affected and these entities are equity accounted in the Group results.

Health Partners for Life restructure

Netcare implemented this Broad-based Black Economic Empowerment (B-BBEE) scheme in 2005, which was originally funded by way of preference shares from Netcare and third-party funding. In July 2015, the Health Partners for Life trusts were restructured through a specific repurchase of the Netcare ordinary shares held by the B-BBEE financing companies. The proceeds of the repurchase were used to settle the outstanding debt funding and subscribe directly for ordinary shares in Netcare. The benefits of the restructure include an increase in value for future beneficiaries as the scheme is now debt-free, and a simplified structure requiring less administration. The restructure did not impact the Group's results, but did result in a reclassification of balances between reserves, ordinary share capital and treasury shares within the statement of financial position.

Working capital

Optimising working capital, which is managed and monitored by local working capital committees, remains a key focus for both the SA and UK operations.

The SA investment in working capital decreased by a net R137 million. Debtor collections remained strong across all categories of receivables. Significant progress has been made on collections from the SA Compensation for Occupational Injuries and Diseases (COID) office, which had fallen behind during the year due to their implementation of new systems. Working capital in the UK continued to be tightly controlled. Just before the year-end, the business made a large once-off 'true up' payment on an outsourcing contract. The costs under the contract had been fully accrued and consequently did not affect the income statement results, but the actual cash settlement of the account had been deferred subject to finalisation.

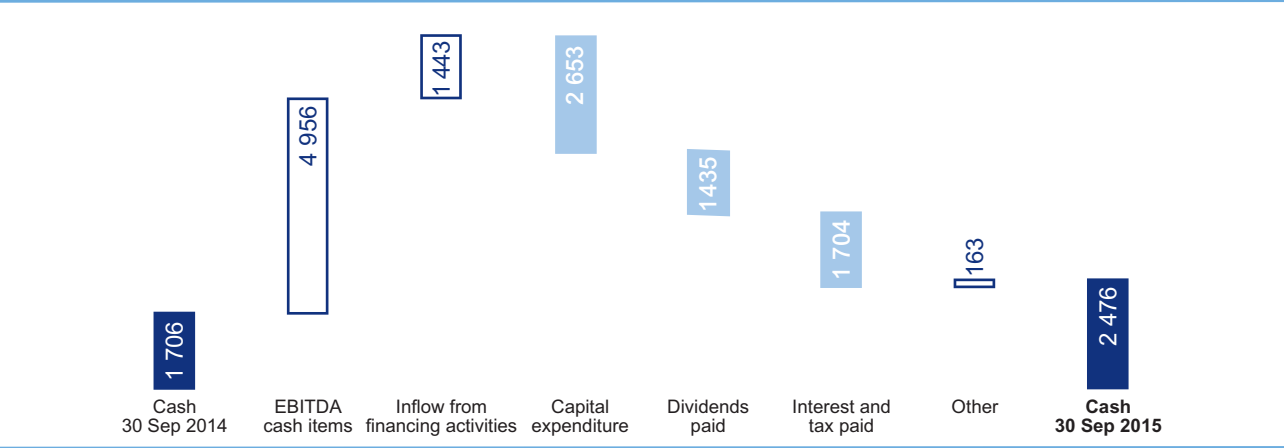
Statement of cash flows

Summarised Group statement of cash flows

Rm	2015	2014
Cash generated from operations	4 956	4 382
Interest paid	(600)	(545)
Taxation paid	(1 104)	(822)
Ordinary dividends paid by subsidiaries	(9)	(3)
Ordinary dividends paid	(1 166)	(973)
Preference dividends paid	(49)	(46)
Distributions to beneficiaries of the HPFL Trusts	(211)	(154)
Net cash from operating activities	1 817	1 839
Net cash from investing activities	(2 647)	(1 827)
Net cash from financing activities	1 443	66

The Group's cash generated from operations increased by 13.1% to R4 956 million, and cash conversion remained consistently strong at 99.5%. A total of R2 653 million was invested in property, plant and equipment, including intangible assets. In addition, R1 435 million (2014: R1 176 million) was returned to shareholders in dividends and distributions paid. The Group's cash and cash equivalents at 30 September 2015 amounted to R2 476 million (2014: R1 706 million).

Analysis of cash movements for the year (R million)



Future outlook

The demand for private healthcare services in SA is expected to remain resilient despite persistent weakness in the economy. We are well positioned in the market to provide a full suite of services to our patients through our core and ancillary operations. We will continue to focus on ongoing business projects and initiatives to drive operational excellence and quality improvement. Planned capital expenditure is expected to remain at approximately R2 billion to cover refurbishments and further brownfield expansion projects. The increase in capital investment above the level of normal sustainable spend is attributed to the expansion of Netcare Milpark Hospital and relocation of Netcare Christiaan Barnard Memorial Hospital.

We will also continue to evaluate potential international opportunities. Based on our knowledge and experience as a hospital operator, we look for high-quality assets that fall within our core business and have the potential to provide scalable growth. We consider both emerging and developed markets, provided there is a demand for private hospital care, a well-regulated healthcare market and secure funding mechanisms.

In the UK, BMI Healthcare has a large footprint and spare capacity to support the growing supply gap. Projects initiated in 2015 will be further entrenched in the business to mitigate the margin impact of the change in payor mix to the NHS. BMI Healthcare is also actively investing in projects to enhance revenue generation, specifically on imaging equipment and hospital infrastructure, and is expected to spend approximately £40 million on capital expenditure projects in 2016.

Appreciation

I would like to thank all our financial personnel across the Group for their ongoing support and commitment, which has enabled us to consistently deliver quality financial information to our stakeholders.

Keith Gibson
Chief Financial Officer

FIVE-YEAR REVIEW

Rm	2015	2014	Restated ¹ 2013	2012	2011
Summarised statement of financial position					
Assets					
Property, plant and equipment	13 622	11 504	10 401	27 678	26 416
Goodwill and intangible assets	4 879	4 316	3 855	5 426	15 400
Deferred taxation	1 597	1 419	1 218	2 730	2 165
Other non-current assets	2 618	2 060	1 718	1 132	497
Total non-current assets	22 716	19 299	17 192	36 966	44 478
Total current assets²	8 948	7 418	6 616	7 256	6 174
Total assets	31 664	26 717	23 808	44 222	50 652
Equity and liabilities					
Total shareholders' equity	14 281	12 172	10 415	(1 020)	7 685
Long-term debt	6 104	4 939	5 290	27 015	25 106
Financial liability – Derivative financial instruments	224	97	8	7 433	5 319
Deferred taxation	1 633	1 360	1 129	3 530	5 178
Other non-current liabilities	668	472	396	337	339
Total non-current liabilities	8 629	6 868	6 823	38 315	35 942
Total current liabilities	8 754	7 677	6 570	6 927	7 025
Total equity and liabilities	31 664	26 717	23 808	44 222	50 652
Summarised statement of cash flows					
Cash generated from operations before working capital changes	4 968	4 483	4 056	5 193	4 668
Working capital changes	(12)	(101)	(266)		904
Cash generated from operations	4 956	4 382	3 790	5 193	5 572
Interest paid	(600)	(545)	(812)	(1 976)	(1 836)
Taxation paid	(1 104)	(822)	(725)	(740)	(674)
Ordinary dividends paid by subsidiaries	(9)	(3)	(3)	(4)	(3)
Capital reductions and ordinary dividends paid	(1 166)	(973)	(788)	(694)	(636)
Preference dividends paid	(49)	(46)	(47)	(46)	(47)
Distributions to beneficiaries of the HPFL ³ Trusts	(211)	(154)	(66)	(43)	(47)
Net cash from operating activities	1 817	1 839	1 349	1 690	2 329
Net cash from investing activities	(2 647)	(1 827)	(955)	(1 426)	(1 139)
Net cash from financing activities	1 443	66	(1 352)	296	(880)
Increase/(decrease) in cash and cash equivalents	613	78	(958)	560	310
Translation effects on cash and cash equivalents of foreign entities	157	125	148	131	210
Cash and cash equivalents at beginning of year	1 706	1 503	2 411	1 805	1 285
Cash and cash equivalents of businesses deconsolidated/disposed			(98)	(27)	
Cash and cash equivalents at end of year	2 476	1 706	1 503	2 469	1 805

1. Restated for the adoption of IFRS 10: Consolidated Financial Statements, IFRS 11: Joint Arrangements and IAS 19 (Revised): Employee Benefits. Years prior to 2013 have not been adjusted.
2. Includes discontinued operations and assets held for sale.
3. Health Partners for Life.

	Compound growth % ¹	2015	2014	Restated ² 2013	Normalised 2012 ^{3,4}	Reported 2012 ⁴	2011
Summarised income statement							
Continuing operations							
Revenue	10.5	33 711	31 783	27 382	25 174	25 174	22 584
Operating profit before items listed below		3 728	3 253	2 997	3 812	3 812	3 644
Impairment of goodwill						(10 773)	
Profit on deconsolidation				3 257			
Operating profit/(loss)⁵	0.6	3 728	3 253	6 254	3 812	(6 961)	3 644
Financial income and expenses		(467)	(431)	(653)	(1 835)	(4 795)	(1 736)
Attributable earnings of associates and joint ventures		114	75	89	27	27	23
Profit/(loss) before taxation	15.0	3 375	2 897	5 690	2 004	(11 729)	1 931
Taxation		(936)	(801)	(640)	(289)	2 016	(95)
Profit/(loss) for the year from continuing operations	7.4	2 439	2 096	5 050	1 715	(9 713)	1 836
Discontinued operations							
Profit for the year from discontinued operations					413	413	19
Profit/(loss) for the year	7.1	2 439	2 096	5 050	2 128	(9 300)	1 855
Attributable to:							
Owners of the parent	11.3	2 412	2 107	5 044	1 825	(4 235)	1 570
Preference shareholders		49	46	47	46	46	47
Non-controlling interest		(22)	(57)	(41)	257	(5 111)	238
		2 439	2 096	5 050	2 128	(9 300)	1 855
Divisional analysis							
Revenue							
South Africa	6.7	17 289	16 273	15 147	14 607	14 607	13 361
Hospitals and Emergency services	7.5	16 119	15 171	13 984	13 219	13 219	12 089
Primary Care	(2.1)	1 170	1 102	1 163	1 388	1 388	1 272
United Kingdom	15.5	16 422	15 510	12 235	10 567	10 567	9 223
BMI Healthcare		16 422	15 510	12 235	10 567	10 567	9 223
GHG Property Businesses					1 699	1 699	1 465
Eliminations					(1 699)	(1 699)	(1 465)
		33 711	31 783	27 382	25 174	25 174	22 584
Operating profit							
South Africa	11.5	3 411	3 110	2 697	2 468	2 468	2 206
Hospitals and Emergency services	11.4	3 335	3 045	2 648	2 416	2 416	2 168
Primary Care	18.9	76	65	49	52	52	38
United Kingdom⁶	(31.5)	317	143	3 557	1 344	(9 429)	1 438
UK before items listed below		317	143	300	1 344	1 344	1 438
BMI Healthcare		317	143	(27)	(113)	(113)	22
GHG Property Businesses				227	1 133	1 133	1 133
Adjustments and eliminations				100	324	324	283
Impairment of goodwill						(10 773)	
Profit on deconsolidation				3 257			
		3 728	3 253	6 254	3 812	(6 961)	3 644

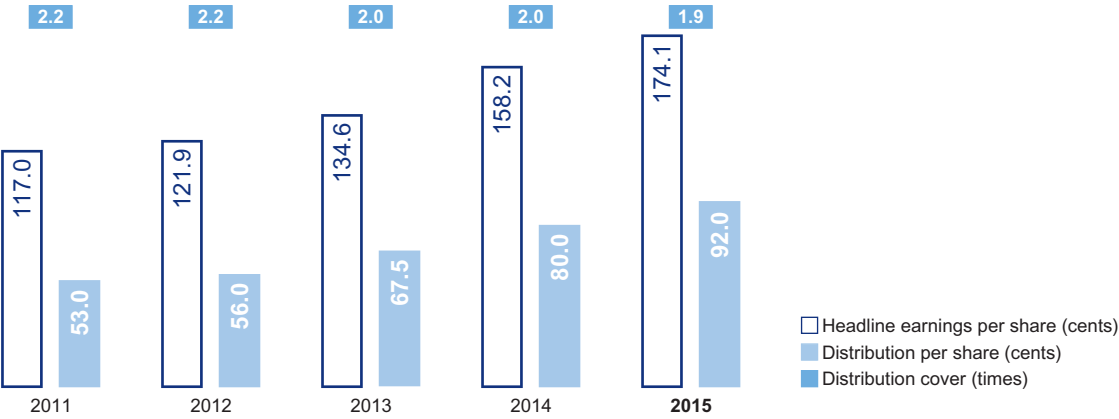
1. Compound annual growth rate for the period 2011 to 2015.
2. Restated for the adoption of IFRS 10: Consolidated Financial Statements, IFRS 11: Joint Arrangements and IAS 19 (Revised): Employee Benefits. Years prior to 2013 have not been adjusted.
3. Adjusted to exclude the non-cash exceptional items relating to GHG PropCo 1.
4. The 2012 and 2011 results of the Group and UK were adjusted to exclude discontinued operations.
5. Operating profit has normalised in 2014 post the deconsolidation of the GHG Property Businesses. Prior years have not been adjusted. However, net profit before tax is comparable.
6. The UK operating segment has been expanded to separately disclose BMI Healthcare and the GHG Property Businesses.

FIVE-YEAR REVIEWCONTINUED

		Compound growth % ¹	2015	2014	Restated ² 2013	Normalised 2012 ³	Reported 2012	2011
Key performance								
Exchange rates								
Closing rate at 30 September	R:£		20.94	18.29	16.22	13.42	13.42	12.54
Average rate for the year	R:£		18.55	17.49	14.43	12.68	12.68	11.09
Ratios								
Operating profit margin ⁴	%		11.1	10.2	10.9 ⁵	15.1	(27.7)	16.1
Interest cover ⁴	times		11.2	9.2	6.4 ⁵	2.2	(4.0)	2.1
Effective tax rate ⁴	%		27.7	27.6	26.3 ⁵	14.4	17.2	4.9
Current ratio	:1		1.0	1.0	1.0	1.0	1.0	0.9
Shareholder returns								
Attributable earnings/(loss) per share	cents	10.0	178.9	157.5	381.2	139.5	(323.8)	122.1
Continuing operations	cents		178.9	157.5	381.2	122.8	(340.5)	121.3
Discontinued operations	cents					16.7	16.7	0.8
Headline earnings per share	cents	10.4	174.1	158.2	134.6	121.9	95.3	117.0
Continuing operations	cents		174.1	158.2	134.6	121.8	95.2	116.2
Discontinued operations	cents					0.1	0.1	0.8
Dividends per share	cents	14.8	92.0	80.0	67.5	56.0	56.0	53.0
Distribution cover	times		1.9	2.0	2.0	2.2	1.7	2.2

1. Compound annual growth rate for the period 2011 to 2015.
2. Restated for the adoption of IFRS 10: Consolidated Financial Statements, IFRS 11: Joint Arrangements and IAS 19 (Revised): Employee Benefits. Years prior to 2013 have not been adjusted.
3. Adjusted to exclude the non-cash exceptional items relating to GHG PropCo 1.
4. Based on continuing operations.
5. Excluding profit on deconsolidation of the GHG Property Businesses.

Distribution per share



	2015	2014	2013	2012	2011
Key performance indicators					
Operational performance indicators					
South African hospitals					
Number of hospitals ¹	56	54	54	55	55
Registered beds	9 996	9 424	9 289	9 262	9 052
Increase in patient days	% 0.2	2.6	2.7	2.8	2.2
Increase/(decrease) in patient admissions	% (2.2)	(1.5)	3.4	1.6	0.7
Average length of stay	days 3.69	3.64	3.56	3.53	3.51
Primary Care					
Medicross centres	73	70	68	66	68
Prime Cure clinics	11	17	19	20	20
Total number of visits – R millions	3.2	3.2	3.2	3.2	3.2
Total number of managed care beneficiaries (end of period) – R millions	1.8	1.9	1.9	0.1	0.1
United Kingdom hospitals					
Number of hospitals ¹	56	57	61	61	64
Registered beds	2 785	2 788	2 889	2 979	3 038
Patient admissions (total cases) ²	287 576	281 129	280 781	285 969	280 060
Outpatient cases	1 589 352	1 523 382	1 515 732	1 544 671	1 485 838
Social performance indicators					
Total employees	28 763	28 421	28 618	28 374	28 199
South Africa	21 324 ³	20 616	20 857	20 583	20 165
United Kingdom	7 439	7 805	7 761	7 791	8 034
Employee turnover					
South Africa	% 18.7	13.7	13.7	14.6	15.6
United Kingdom	% 26.9	18.1	16.3	22.5	19.0
Black (African, Coloured and Indian) employee representation ⁴	% 73.9	72.6	72.1	70.0	67.8
Unionised employees ⁴	% 51.2	53.4	53.0	52.7	50.6
Numbers of nurses registered for training ⁴	3 534	3 470	3 331	3 294	3 186
Corporate social investment ⁴	Rm 38 ⁵	47	58	36	30
Environmental performance indicators					
South Africa					
Energy usage	gigajoules 1 091 125	1 118 169	1 038 540 ⁷	945 489	719 727
Water usage ⁶	kilolitres 1 917 058	1 757 397 ⁷	1 786 844 ⁷	1 522 426	1 725 153
Carbon dioxide equivalent (CO ₂ e) emissions	tonnes 300 829	319 213	311 765 ⁷	257 943	193 006
Total CO ₂ e per R1 million revenue	15.56	17.49	20.09 ⁷	17.66	14.45
United Kingdom					
Energy usage	megawatt hours 149 504	140 999	154 388	147 188	142 560
CO ₂ e emissions ⁶	tonnes 51 154	50 959 ⁷	48 665 ⁷	49 206	50 830

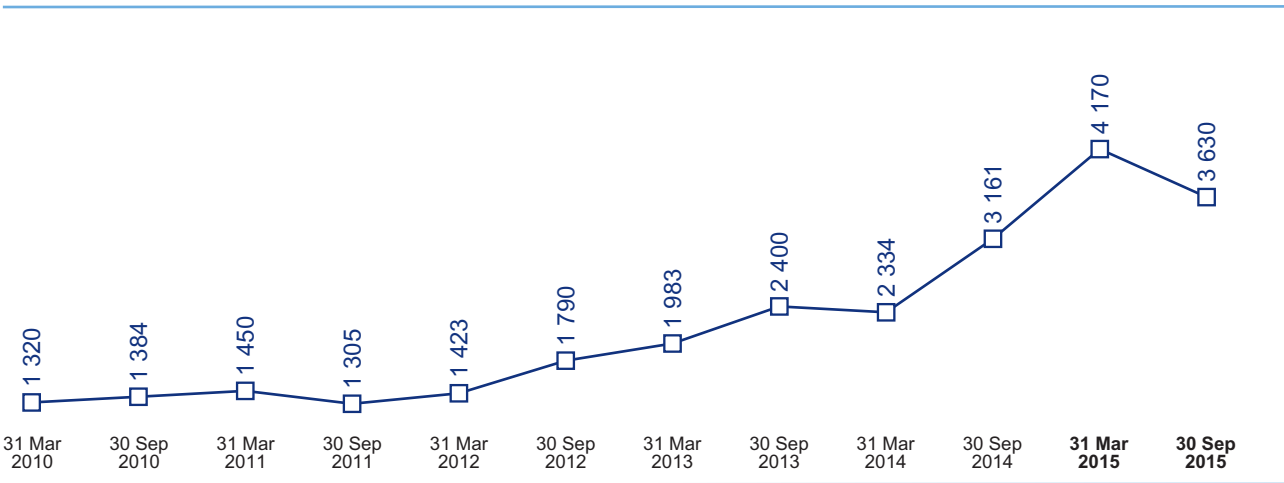
1. Owned and managed hospitals.
2. The 2012 and 2011 figures exclude discontinued operations.
3. Includes the five PPPs.
4. SA operations only.
5. Inclusive of bursaries.
6. Hospital division only.
7. Restated.

FIVE-YEAR REVIEW CONTINUED

		2015	2014	Restated ¹ 2013	2012	2011
Key performance indicators continued						
Ordinary share statistics						
Shares in issue	million	1 456	1 478	1 475	1 458	1 446
Shares in issue net of treasury shares	million	1 349	1 337	1 329	1 317	1 295
Weighted average number of shares	million	1 345	1 334	1 322	1 308	1 286
Diluted weighted average number of shares	million	1 377	1 363	1 354	1 332	1 317
Market capitalisation ²	R million	52 853	46 720	35 400	26 098	18 870
JSE statistics						
Market price per share						
at 30 September	cents	3 630	3 161	2 400	1 790	1 305
highest	cents	4 438	3 444	2 471	1 919	1 643
lowest	cents	2 962	2 076	1 710	1 275	1 285
weighted average	cents	3 834	2 651	2 052	1 503	1 438
Number of share transactions		777 692	370 593	236 805	138 679	141 063
Value of share transactions	R million	36 241	20 394	16 909	11 030	10 261
Volume of shares traded	million	945.3	769.4	823.6	733.6	713.4
Volume traded to issued	%	65.0	52.1	62.5	56.2	55.0
Market performance ratios						
Earnings yield ³	%	4.8	5.0	5.6	5.3	8.9
Distribution yield ³	%	2.5	2.5	2.8	3.1	4.1
Price:earnings ratio ³	times	20.9	20.0	17.8	18.8	11.2

1. Restated for the adoption of IFRS 10: Consolidated Financial Statements, IFRS 11: Joint Arrangements and IAS 19 (Revised): Employee Benefits. Years prior to 2013 have not been adjusted.
2. Based on shares in issue.
3. Based on continuing operations.

Netcare share price performance on the JSE (cents)

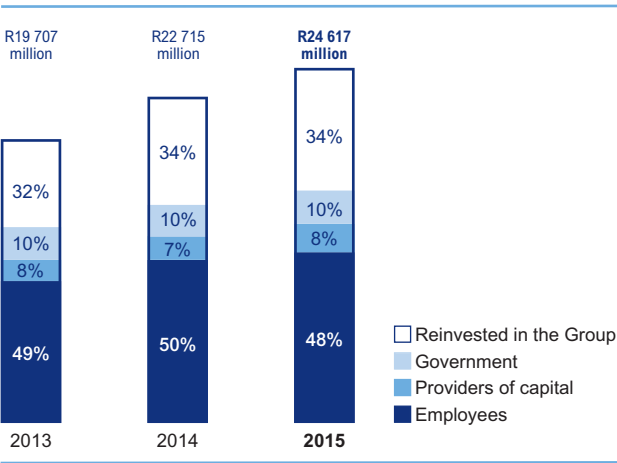


VALUE-ADDED STATEMENT

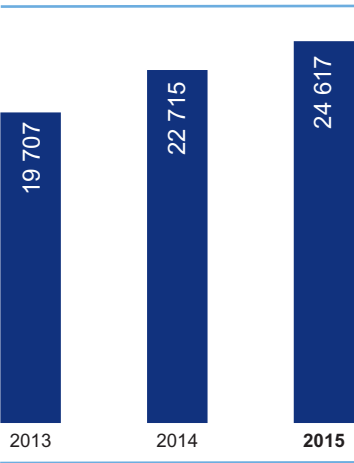
Rm	2015	%	2014	%	2013	%
Revenue	33 711		31 783		27 382	
Payments to suppliers of materials and services	(9 575)		(9 356)		(8 052)	
Income from investments ¹	24 136		22 427		19 330	
Wealth created	481		288		377	
Wealth created	24 617	8.4	22 715	15.3	19 707	
Distributed as follows:						
Employees						
Salaries, wages and other benefits	11 654	47.3	11 113	48.9	9 686	49.2
Distributions to beneficiaries of the HPFL Trusts	211	0.9	154	0.7	66	0.3
Providers of capital						
Finance costs ²	700	2.8	564	2.5	754	3.8
Preference dividends paid	49	0.2	46	0.2	47	0.2
Distributions paid	1 175	4.8	976	4.3	816	4.1
Government						
Direct taxes	902	3.7	776	3.4	752	3.8
Indirect taxes ³	1 517	6.2	1 417	6.2	1 291	6.6
Reinvested in the Group to maintain and develop operations						
Retained earnings	7 156	29.1	6 519	28.7	5 206	26.4
Depreciation and amortisation	1 253	5.1	1 151	5.1	1 089	5.5
Wealth distributed	24 617	100.0	22 715	100.0	19 707	100.0

1. Includes interest received and share of associates' and joint ventures' earnings.
2. Includes interest paid.
3. Included indirect taxes relevant to VAT, which were not previously included.

Wealth distributed (R million)



Wealth created (R million)





ABRIDGED GROUP ANNUAL FINANCIAL STATEMENTS FOR THE YEAR ENDED 30 SEPTEMBER 2015

These abridged Group annual financial statements comprise a summary of the complete audited Group annual financial statements for the year ended 30 September 2015 that were approved by the Netcare Board on 19 November 2015. The abridged Group annual financial statements do not contain sufficient information to allow for a complete understanding of the results of the Group, as would be provided in the complete audited Group annual financial statements. The audited Group annual financial statements have been prepared under the supervision of KN Gibson CA(SA), Chief Financial Officer of Netcare Limited.



THE COMPLETE AUDITED GROUP ANNUAL FINANCIAL STATEMENTS IS AVAILABLE AT www.netcareinvestor.co.za.

The abridged Group annual financial statements comprise of:

- + Group statement of profit and loss;
- + Group statement of comprehensive income;
- + Group statement of financial position;
- + Group statement of cash flows;
- + Group statement of changes in equity;
- + Condensed segment report; and
- + Condensed notes to the abridged Group annual financial statements.

Basis of preparation and accounting policies

The annual financial statements from which these abridged financial statements have been derived, have been prepared in accordance with International Financial Reporting Standards (IFRS), including all interpretations applicable to companies reporting under IFRS, as issued by the International Accounting Standards Board (IASB), the SAICA Financial Reporting Guides as issued by the Accounting Practices Committee, the requirements of the South African Companies Act No 71 of 2008 and the JSE Listings Requirements. These abridged financial statements have also been prepared in compliance with the requirements of the International Accounting Standards (IAS) 34: *Interim Financial Reporting*.

The accounting policies adopted are consistent in all material respects with those applied for the year ended 30 September 2014, with the exception of the adoption of Amendment to IAS 19: *Employee Benefits*, Amendment to IAS 36: *Impairment of Assets*, Amendment to IAS 39: *Financial Instruments: Recognition and Measurement* and Amendment to IAS 32: *Offsetting Financial Assets and Financial Liabilities*. No standards were adopted before the effective date during the financial reporting period ended 30 September 2015.

The financial statements are presented in South African Rand (ZAR), the functional currency of the Group and Company and all amounts are rounded to the nearest million, except when otherwise indicated. They are prepared on the historical cost basis, except for the following material items included in the statement of financial position that are measured as described below:

- + Derivative financial instruments and financial assets at fair value through profit or loss are measured at fair value; and
- + Post-retirement benefit obligations are measured in terms of the projected unit credit method.

The directors consider it appropriate to adopt the going concern basis in preparing the Group annual financial statements.

Independent report of the auditors

These abridged Group annual financial statements for the year ended 30 September 2015 have been extracted from the complete audited Group annual financial statements on which the auditors, Grant Thornton Johannesburg Partnership, have expressed an unqualified audit opinion.

GROUP STATEMENT OF PROFIT AND LOSS
FOR THE YEAR ENDED 30 SEPTEMBER

Rm	Notes	2015	2014
Revenue		33 711	31 783
Cost of sales		(18 948)	(18 227)
Gross profit		14 763	13 556
Other income		498	350
Administrative and other expenses		(11 533)	(10 653)
Operating profit	1	3 728	3 253
Investment income	2	367	213
Financial expenses	3	(700)	(564)
Other financial losses – net	4	(134)	(80)
Attributable earnings of associates		66	39
Attributable earnings of joint ventures		48	36
Profit before taxation		3 375	2 897
Taxation	5	(936)	(801)
Profit for the year		2 439	2 096
Attributable to:			
Owners of the parent		2 412	2 107
Preference shareholders		49	46
Profit attributable to shareholders		2 461	2 153
Non-controlling interest		(22)	(57)
		2 439	2 096
Earnings per share (cents)			
Basic	6	178.9	157.5
Diluted	6	174.8	154.2

GROUP STATEMENT OF COMPREHENSIVE INCOME
FOR THE YEAR ENDED 30 SEPTEMBER

Rm	2015	2014
Profit for the year	2 439	2 096
Items that may not subsequently be reclassified to profit or loss	(88)	(13)
Remeasurement of defined benefit obligation	(123)	(18)
Actuarial losses on defined benefit obligations	(75)	(131)
Actuarial gains relating to plan assets	239	201
Unrecognised pension surplus	(298)	(97)
Future defined benefit pension scheme provision	11	9
Taxation on items that may not subsequently be reclassified to profit or loss	35	5
Items that may subsequently be reclassified to profit or loss	912	694
Effect of cash flow hedge accounting	44	(39)
Change in the fair value of cash flow hedges	7	(39)
Reclassification of cash flow hedge accounting reserve	37	–
Effect of translation of foreign entities	878	732
Taxation on items that may subsequently be reclassified to profit or loss	(10)	1
Other comprehensive income for the year	824	681
Total comprehensive income for the year	3 263	2 777
Attributable to:		
Owners of the parent	2 814	2 469
Preference shareholders	49	46
Non-controlling interest	400	262
	3 263	2 777

GROUP STATEMENT OF FINANCIAL POSITION
AT 30 SEPTEMBER

Rm	Notes	2015	2014
ASSETS			
Non-current assets			
Property, plant and equipment		13 622	11 504
Goodwill		4 482	3 879
Intangible assets		397	437
Investment in joint ventures	7	197	76
Investment in associates	7	668	602
Loans and receivables	7	1 680	1 337
Financial assets	8	57	45
Deferred lease assets		16	–
Deferred taxation		1 597	1 419
Total non-current assets		22 716	19 299
Current assets			
Loans and receivables	7	71	26
Inventories		1 107	987
Trade and other receivables		5 192	4 688
Taxation receivable		19	5
Cash and cash equivalents		2 551	1 712
		8 940	7 418
Asset classified as held for sale		8	–
Total current assets		8 948	7 418
Total assets		31 664	26 717
EQUITY AND LIABILITIES			
Capital and reserves			
Ordinary share capital and premium		4 033	962
Treasury shares		(3 713)	(735)
Other reserves		3 090	2 560
Retained earnings		6 902	5 859
Equity attributable to owners of the parent		10 312	8 646
Preference share capital and premium		644	644
Non-controlling interest		3 325	2 882
Total shareholders' equity		14 281	12 172
Non-current liabilities			
Long-term debt	9	6 104	4 939
Financial liabilities	8	224	97
Post-retirement benefit obligations		400	260
Deferred lease liabilities		118	74
Deferred taxation		1 633	1 360
Provisions		150	138
Total non-current liabilities		8 629	6 868
Current liabilities			
Trade and other payables		6 403	5 726
Short-term debt	9	2 162	1 739
Financial liabilities	8	4	3
Taxation payable		110	203
Bank overdrafts		75	6
Total current liabilities		8 754	7 677
Total equity and liabilities		31 664	26 717

GROUP STATEMENT OF CASH FLOWS
FOR THE YEAR ENDED 30 SEPTEMBER

Rm	2015	2014
Cash flows from operating activities		
Cash received from customers	33 523	31 456
Cash paid to suppliers and employees	(28 567)	(27 074)
Cash generated from operations	4 956	4 382
Interest paid	(600)	(545)
Taxation paid	(1 104)	(822)
Ordinary dividends paid by subsidiaries	(9)	(3)
Ordinary dividends paid	(1 166)	(973)
Preference dividends paid	(49)	(46)
Distributions to beneficiaries of the HPFL Trusts	(211)	(154)
Net cash from operating activities	1 817	1 839
Cash flows from investing activities		
Acquisition of businesses	(35)	(19)
Purchase of property, plant and equipment	(2 641)	(1 902)
Additions to intangible assets	(12)	(43)
Proceeds on disposal of property, plant and equipment and intangible assets	68	80
Proceeds from disposal of businesses	3	46
Increase in other loans and investments	(145)	(103)
Interest received	152	96
Dividends received	12	18
Increase in equity interest in subsidiaries	(49)	–
Net cash from investing activities	(2 647)	(1 827)
Cash flows from financing activities		
Proceeds on disposal of treasury shares	300	121
Proceeds from issue of ordinary shares	37	28
Long-term debt raised/(repaid)	828	(614)
Short-term debt raised	278	535
Acquisition of non-controlling interests	–	(4)
Net cash from financing activities	1 443	66
Net increase in cash and cash equivalents	613	78
Translation effects on cash and cash equivalents of foreign entities	157	125
Cash and cash equivalents at the beginning of the year	1 706	1 503
Cash and cash equivalents at the end of the year	2 476	1 706

GROUP STATEMENT OF CHANGES IN EQUITY
FOR THE YEAR ENDED 30 SEPTEMBER

Rm	Ordinary share capital	Ordinary share premium	Treasury shares	Cash flow hedge accounting reserve	Employee share trust reserve	Foreign currency translation reserve	Investment fair value reserve	Share-based payment reserve	Retained earnings	Equity attributable to owners of the parent	Preference share capital and premium	Non- controlling interest	Total shareholders' equity
Balance at 1 October 2013 (restated)¹	15	919	(766)	–	32	1 778	90	246	4 846	7 160	644	2 611	10 415
Shares issued during the year	–	28	–	–	–	–	–	–	–	28	–	–	28
Sale of treasury shares	–	–	31	–	–	–	–	–	69	100	–	–	100
Share-based payment reserve movements	–	–	–	–	–	–	–	37	–	37	–	–	37
Income tax recognised in equity	–	–	–	–	–	–	–	2	17	19	–	–	19
Deferred tax recognised in equity	–	–	–	–	–	–	–	–	(1)	(1)	–	–	(1)
Dividend withholding tax	–	–	–	–	–	–	–	–	(14)	(14)	–	–	(14)
Preference dividends paid	–	–	–	–	–	–	–	–	–	–	(46)	–	(46)
Dividends paid	–	–	–	–	–	–	–	–	(973)	(973)	–	(3)	(976)
Distributions to beneficiaries of the HPFL trusts	–	–	–	–	–	–	–	–	(154)	(154)	–	–	(154)
Change in shareholding of subsidiary	–	–	–	–	–	–	–	–	(25)	(25)	–	12	(13)
Total comprehensive income for the year	–	–	–	(19)	–	394	–	–	2 094	2 469	46	262	2 777
Balance at 30 September 2014	15	947	(735)	(19)	32	2 172	90	285	5 859	8 646	644	2 882	12 172
Shares issued during the year	–	37	–	–	–	–	–	–	–	37	–	–	37
Sale of treasury shares	–	–	56	–	–	–	–	–	244	300	–	–	300
Restructure of HPFL B-BBEE Trusts	–	3 034	(3 034)	–	–	–	–	–	(53)	(53)	–	–	(53)
Share-based payment reserve movements	–	–	–	–	–	–	–	39	–	39	–	–	39
Tax recognised in equity	–	–	–	–	–	–	–	–	(90)	(90)	–	–	(90)
Preference dividends paid	–	–	–	–	–	–	–	–	–	–	(49)	–	(49)
Dividends paid	–	–	–	–	–	–	–	–	(1 166)	(1 166)	–	(9)	(1 175)
Distributions to beneficiaries of the HPFL trusts	–	–	–	–	–	–	–	–	(211)	(211)	–	–	(211)
Increase in equity interest in subsidiaries	–	–	–	–	–	–	–	–	(4)	(4)	–	52	48
Total comprehensive income for the year	–	–	–	22	–	469	–	–	2 323	2 814	49	400	3 263
Balance at 30 September 2015	15	4 018	(3 713)	3	32	2 641	90	324	6 902	10 312	644	3 325	14 281

1. Restated for the adoption of IFRS 10: Consolidated Financial Statements, IFRS 11: Joint Arrangements and IAS 19 (Revised): Employee Benefits.

CONDENSED SEGMENT REPORT
FOR THE YEAR ENDED 30 SEPTEMBER

Segment report – 2015

Rm	South Africa		United Kingdom		
	Hospital and emergency services	Primary Care	Total	BMI Healthcare	Group
Income statement					
Revenue	16 119	1 170	17 289	16 422	33 711
EBITDA*	3 837	111	3 948	1 033	4 981
Depreciation and amortisation	(502)	(35)	(537)	(716)	(1 253)
Depreciation	(492)	(35)	(527)	(608)	(1 135)
Amortisation of intangible assets	(10)	–	(10)	(108)	(118)
Operating profit	3 335	76	3 411	317	3 728
Investment income			280	87	367
Financial expenses			(352)	(348)	(700)
Other financial losses – net			–	(134)	(134)
Attributable earnings of joint ventures and associates			67	47	114
Profit/(loss) before taxation			3 406	(31)	3 375
Taxation			(908)	(28)	(936)
Profit/(loss) for the year			2 498	(59)	2 439
Segment assets and liabilities					
Total assets			16 788	14 876	31 664
Total liabilities			(8 384)	(8 999)	(17 383)
Debt net of cash			(3 292)	(2 498)	(5 790)
Other segment information					
Additions to property, plant and equipment			1 893	748	2 641

* Earnings before interest, tax, depreciation and amortisation.

Segment report – 2014

Rm	South Africa		Total	United Kingdom	
	Hospital and emergency services	Primary Care		BMI Healthcare	Group
Income statement					
Revenue	15 171	1 102	16 273	15 510	31 783
EBITDA*	3 499	98	3 597	807	4 404
Depreciation and amortisation	(454)	(33)	(487)	(664)	(1 151)
Depreciation	(444)	(33)	(477)	(569)	(1 046)
Amortisation of intangible assets	(10)	–	(10)	(95)	(105)
Operating profit	3 045	65	3 110	143	3 253
Investment income			201	12	213
Financial expenses			(328)	(236)	(564)
Other financial losses – net			(2)	(78)	(80)
Attributable earnings of joint ventures and associates			35	40	75
Profit/(loss) before taxation			3 016	(119)	2 897
Taxation			(841)	40	(801)
Profit/(loss) for the year			2 175	(79)	2 096
Segment assets and liabilities					
Total assets			13 694	13 023	26 717
Total liabilities			(6 710)	(7 835)	(14 545)
Debt net of cash			(2 967)	(2 005)	(4 972)
Other segment information					
Additions to property, plant and equipment			1 195	707	1 902

* Earnings before interest, tax, depreciation and amortisation.

CONDENSED NOTES TO THE ABRIDGED GROUP ANNUAL FINANCIAL STATEMENTS FOR THE YEAR ENDED 30 SEPTEMBER

Rm	2015	2014
1. Operating profit		
After including:		
Amortisation of intangible assets	118	105
Depreciation – property, plant and equipment	1 135	1 046
Operating lease charges	3 625	3 070
Land and buildings	3 583	3 024
GHG Property Businesses	2 683	2 464
Other	900	560
Motor vehicles	42	46
2. Investment income		
Expected return on retirement benefit plan assets	77	70
Interest on bank accounts and other	290	143
	367	213
3. Financial expenses		
Amortisation of arrangement fee	7	6
Interest on bank loans and other	333	206
Interest on promissory notes	259	262
Retirement benefit plan interest cost	101	90
	700	564
4. Other financial losses – net		
Amount reclassified from the cash flow hedge accounting reserve	(25)	–
Fair value losses on inflation rate swaps	(109)	(78)
Fair value gains on interest rate swaps	–	1
Fair value losses on other financial assets	–	(3)
	(134)	(80)
5. Taxation		
South African normal taxation		
Current year	(884)	(807)
Prior years	1	(5)
Capital gains tax	–	(6)
	(883)	(818)
Dividend tax	–	(1)
Foreign taxation		
Current year	(19)	(14)
Prior years	–	57
	(19)	43
Income tax	(902)	(776)
South African deferred taxation		
Current year	(7)	(12)
Prior years	(1)	1
	(8)	(11)
Foreign deferred taxation		
Current year	(11)	(2)
Prior years	(15)	(12)
	(26)	(14)
Deferred taxation	(34)	(25)
Total taxation per the income statement	(936)	(801)

Cents	2015	2014
6. Earnings per share		
Basic earnings per share	178.9	157.5
Diluted earnings per share	174.8	154.2
Headline earnings per share	174.1	158.2
Diluted headline earnings per share	170.0	154.9
Adjusted headline earnings per share	189.0	167.8
Million		
Weighted average number of ordinary shares		
The weighted average number of ordinary shares used in the calculations is as follows:		
Weighted average number of shares	1 345	1 334
Potential dilutive effect of employee share options and HPFL trust units	32	29
Diluted weighted average number of shares	1 377	1 363
Potential dilutive effect of employee share options and HPFL Trust units		
The dilutive effect is arrived as follows:		
Netcare Share Incentive Scheme	3	5
Forfeitable Share Plan	6	5
HPFL Trust units	23	19
	32	29
Rm		
Basic earnings per share		
The earnings used in the calculation of basic earnings per share is as follows:		
Profit for the year	2 439	2 096
Less:		
Dividends paid on shares attributable to the Forfeitable Share Plan	(6)	(5)
Preference shareholders	(49)	(46)
Non-controlling interest	22	57
Profit attributable to owners of the parent	2 406	2 102
Headline earnings		
Headline earnings are determined as follows:		
Earnings used in the calculation of basic earnings per share	2 406	2 102
Adjusted for:		
Bargain purchase on acquisition of subsidiary	(1)	–
Fair value gains on investments on acquisition of control	(77)	–
Recognition of impairment of property, plant and equipment	–	1
(Profit)/loss on disposal of property, plant and equipment	(30)	27
Loss/(profit) on disposal of investments (net)	1	(10)
Tax effect of headline adjusting items	–	(5)
Non-controlling share of headline adjusting items	42	(4)
Headline earnings	2 341	2 111
Adjusted headline earnings		
Adjusted headline earnings are determined as follows:		
Headline earnings	2 341	2 111
Adjusted for:		
Amount reclassified from the cash flow hedge accounting reserve	36	–
Fair value losses on derivative financial instruments	109	77
Fair value losses on inflation rate swaps	109	78
Fair value gains on interest rate swaps	–	(1)
Recognition/(reversal) of loan impairment	4	(4)
Competition Commission costs	42	145
Restructure costs	223	–
Site closure costs	–	31
Tax effect of adjusting items	(87)	(56)
Non-controlling share of adjusting items	(126)	(66)
Adjusted headline earnings	2 542	2 238

CONDENSED NOTES TO THE ABRIDGED GROUP
ANNUAL FINANCIAL STATEMENTS CONTINUED
FOR THE YEAR ENDED 30 SEPTEMBER

Rm	2015	2014
7. Equity accounted companies, loans and receivables		
Non-current		
Associated companies	668	602
Joint ventures	197	76
Loans and receivables	1 680	1 337
	2 545	2 015
Current		
Loans and receivables	71	26
	2 616	2 041
Included in loans and receivables is an investment of R1 398 million (2014: R1 087 million) relating to a contractual economic interest in the debt of BMI Healthcare.		
8. Derivative financial instruments		
Derivative financial assets		
Interest rate swaps		
South African Rand	38	23
Inflation rate swaps		
South African Rand	–	2
Non-derivative financial asset		
Investment in Cell Captive	19	20
	57	45
Derivative financial liabilities		
Interest rate swaps		
South African Rand	(7)	(8)
Inflation rate swaps		
South African Rand	(13)	(7)
Foreign currency	(208)	(85)
	(228)	(100)
Included under non-current liabilities	(224)	(97)
Included under current liabilities	(4)	(3)
	(228)	(100)

Fair value hierarchy

Financial instruments measured at fair value are grouped into the following levels based on the significance of the inputs used in determining fair value:

Level 1: Fair value is derived from quoted prices (unadjusted) in active markets for identical instruments.

Level 2: Fair value is derived through the use of valuation techniques based on observable inputs, either directly or indirectly.

Level 3: Fair value is derived through the use of valuation techniques using inputs not based on observable market data.

8. Derivative financial instruments continued

The table below analyses the level applicable to financial instruments measured at fair value:

Rm	Level 2	Level 3	Total
2015			
Non-derivative financial asset			
Cell Captive	19	–	19
Derivative financial assets			
Interest rate swaps	38	–	38
	57	–	57
Derivative financial liabilities			
Interest rate swaps	(7)	–	(7)
Inflation rate swaps	(13)	(208)	(221)
	(20)	(208)	(228)
2014			
Non-derivative financial asset			
Cell Captive	20	–	20
Derivative financial assets			
Interest rate swaps	23	–	23
Inflation rate swaps	2	–	2
	45	–	45
Derivative financial liabilities			
Interest rate swaps	(8)	–	(8)
Inflation rate swaps	(7)	(85)	(92)
	(15)	(85)	(100)

The Group has no financial instruments categorised as Level 1.

The reconciliation of the movements in the derivative financial liabilities categorised in Level 3 is presented below:

Rm	2015	2014
Inflation rate swaps:		
Balance at beginning of the year	(85)	25
Fair value movement recognised in the cash flow hedge accounting reserve	37	(32)
Fair value movement recognised in the income statement	(134)	(76)
Translation of foreign entities	(26)	(2)
Balance at the end of the year	(208)	(85)

CONDENSED NOTES TO THE ABRIDGED GROUP
ANNUAL FINANCIAL STATEMENTS CONTINUED
FOR THE YEAR ENDED 30 SEPTEMBER

Rm	2015	2014
9. Debt		
Long-term debt	6 104	4 939
Short-term debt	2 162	1 739
Total debt	8 266	6 678
Comprising:		
South African Rand		
Secured liabilities	2	–
Finance leases	29	23
Promissory notes	4 000	3 567
Unsecured debt	606	–
	4 637	3 590
Foreign currency		
Secured debt	3 193	2 743
Finance leases	308	292
Accrued interest	138	67
Less: Arrangement fees	(10)	(14)
	3 629	3 088
	8 266	6 678

Maturity profile

Rm	Total	< 1 year	1 – 2 years	2 – 3 years	3 – 4 years	> 4 years
2015						
Debt in South African Rand	4 637	1 016	265	1 609	560	1 187
Debt in foreign currency	3 629	1 146	485	493	1 428	77
	8 266	2 162	750	2 102	1 988	1 264
2014						
Debt in South African Rand	3 590	1 178	992	258	602	560
Debt in foreign currency	3 088	561	467	418	423	1 219
	6 678	1 739	1 459	676	1 025	1 779

Rm	2015	2014
10. Commitments		
Capital commitments	2 012	2 600
Operating lease commitments	57 653	55 542
11. Contingent liabilities		
South Africa	99	171

12. Events after the reporting period

The directors are not aware of any matters or circumstances arising since the end of the financial year, not otherwise dealt with in the Group's annual financial statements, which significantly affect the financial position at 30 September 2015 or the results of its operations or cash flows for the year ended.

GLOSSARY

AN EXPLANATION OF SOME OF THE TERMS AND ABBREVIATIONS USED IN THIS INTEGRATED REPORT IS SHOWN BELOW.

Financial definitions

Capital items

Capital items include items such as the impairment of goodwill, impairment of investments and loans, impairment of property, plant and equipment, profit/loss on disposal of property, plant and equipment, and profit/loss on disposal of subsidiaries.

EBITDA

Earnings before interest, taxation, depreciation and amortisation.

EBITDA margin

EBITDA expressed as a percentage of revenue.

Effective tax rate

Taxation expressed as a percentage of profit before taxation.

Headline earnings

This comprises the earnings attributable to owners of the parent after adjusting for specific re-measurements as defined in Circular 2/2013 issued by the South African Institute of Chartered Accountants.

Interest cover

Operating profit divided by net interest paid.

Net debt

Long-term debt, short-term debt and bank overdrafts net of cash and cash equivalents.

Net debt to EBITDA

Net debt divided by EBITDA.

Acronyms and non-financial definitions

B-BBEE

Broad-based Black Economic Empowerment

BMI Healthcare

Operating business forming part of General Healthcare Group in the United Kingdom

CDP

Carbon Disclosure Project

CMS

Council for Medical Schemes

CSI

Corporate social investment

EMS

Emergency medical services

FSP

Forfeitable Share Plan

GEMS

Government Employees Medical Scheme

GHG

General Healthcare Group Limited, a subsidiary in the United Kingdom

GHG PropCo 1

Portfolio of 35 UK hospital properties initially acquired as part of the General Healthcare Group acquisition in 2006

GHG PropCo 2

Six properties acquired from Nuffield in 2008 and incorporated as part of General Healthcare Group in the United Kingdom

GP

General practitioner

GRAFS

Group Risk, Audit and Forensic Services

HASA

Hospital Association of South Africa

HCAHPS

Hospital Consumer Assessment of Healthcare Providers and Systems

HIV/Aids

Human Immunodeficiency Virus/Acquired immune deficiency syndrome

HPFL

Health Partners for Life

ICU

Intensive care unit

IFRS

International Financial Reporting Standards

IT

Information Technology

JSE

JSE Limited (previously the Johannesburg Stock Exchange)

NHI

National Health Insurance (South Africa)

NHS

National Health Service (United Kingdom)

PMI

Private Medical Insurance

PPP

Public Private Partnership

SA

South Africa

UK

United Kingdom

CORPORATE INFORMATION

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1996/008242/06

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www.primecure.co.za
www.nrc.co.za
www.ghg.co.uk
www.bmihealthcare.co.uk

JSE information

JSE share code: NTC (ordinary shares)
ISIN code: ZAE000011953
JSE share code: NTCP (preference shares)
ISIN code: ZAE000081121

Sponsor

Deutsche Securities (SA) Proprietary Limited
A non-bank member of the Deutsche Bank Group
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Transfer secretaries

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Auditors

Grant Thornton Johannesburg Partnership

Principal bankers

Nedbank Limited

SHAREHOLDERS' DIARY

Annual general meeting

5 February 2016

Reports

Interim results announcement
Final results announcement

May
November

Dividends

Ordinary dividend

Interim
Final

Declared

May
November

Paid

July
February

Preference dividend

Interim
Final

April
October

May
November

Disclaimer

Certain statements in this Notice of Annual General Meeting constitute 'forward-looking statements'. Forward-looking statements may be identified by words such as 'believe', 'anticipate', 'expect', 'plan', 'estimate', 'intend', 'project', 'target', 'predict' and 'hope'. By their nature, forward-looking statements are inherently predictive, speculative and involve risk and uncertainty because they relate to events and depend on circumstances that will occur in the future, involve known and unknown risks, uncertainties and other facts or factors which may cause the actual results, performance or achievements of the Group, or the healthcare sector to be materially different from any results, performance or achievement expressed or implied by such forward-looking statements. Forward-looking statements are not guarantees of future performance and are based on assumptions regarding the Group's present and future business strategies and the environments in which it operates now and in the future. No assurance can be given that forward-looking statements will prove to be correct and undue reliance should not be placed on such statements.

Any forward-looking information contained in this announcement/presentation has not been reviewed or reported on by the Company's external auditors.

Forward-looking statements apply only as of the date on which they are made, and Netcare does not undertake, other than in terms of the Listings Requirements of the JSE Limited, to update or revise any statement, whether as a result of new information, future events or otherwise.



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www.netcare.co.za

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