National Health Sector Summit

Strategic Outcomes & Proceedings Report

Youth at the Heart of Healthcare Transformation

4 July 2026 | EmpowaWorx, Ferndale, Randburg | Johannesburg, South Africa

Prepared by NEXEC Advisory and the NEXEC Health Subcouncil

The National Executive Economic Collective (NEXEC) Group

www.nexec.co.za | @nexecsouthafrica | health@nexec.co.za

Winnie Mandela Dr &, Leslie Ave, Magaliessig, Sandton, 2067

Design Quarter

Publication Details

This report documents the proceedings, strategic insights and implementation priorities emerging from the NEXEC National Health Sector Summit 2026. More than a record of the day, it serves as a foundation for continued collaboration across government, business, healthcare and civil society.

NEXEC National Health Sector Summit 2026 — Strategic Outcomes & Proceedings Report.

First published: July 2026.

Prepared by: NEXEC Advisory, in association with the NEXEC Health Subcouncil.

Division Head, NEXEC Health Subcouncil: Tshenolo Moeti.

Group President & Chief Executive Officer, NEXEC: Matoti Buthelezi.

This report is based on proceedings, addresses, panel discussions, delegate registers and programme documentation from the NEXEC National Health Sector Summit held on 4 July 2026 at EmpowaWorx, Ferndale, Randburg. Figures cited from public addresses reflect the statements of speakers in their individual or institutional capacities and are attributed accordingly; they are not independently verified by NEXEC unless otherwise stated.

Enquiries: health@nexec.co.za (NEXEC Health Subcouncil) | events@nexec.co.za (Projects & Events).

Table of Contents

FOREWORD

Mr Matoti Buthelezi
Group President & CEO

NEXEC turned two years old in the week that followed this Summit. We began, as most youth-facing institutions do, in the language of advocacy - naming what was wrong, insisting on redress, asking to be let into rooms that had not been built with us in mind. What became clear as the organisation matured is that the gap in South Africa's youth economy was never a shortage of external agitators but rather a shortage of internal development partners: institutions capable of sitting inside government and industry processes, with the technical seriousness to be useful there, while remaining accountable to the young people on whose behalf we claim to speak.

The National Health Sector Summit was convened to test that model against one of the country's hardest problems. Healthcare in South Africa is not short of diagnoses. Every stakeholder in this room — from the Deputy Minister of Women, Youth and Persons with Disabilities, to the dental therapist, from the Treasury economist to the medical student who has never set foot inside a public hospital boardroom — can describe with precision what is broken. What is rarer is a platform that seats them at the same table, on the same day, working from the same set of facts.

This report does not pretend that one Summit resolves the distance between the Missing Chair and the Missing Link, to use the Deputy Minister's own framing. It records what was said, tests it against evidence, and sets out what NEXEC and its partners are accountable for delivering in the months that follow. We have made this commitment before, in other sectors, and we intend to be judged by it again here: not by whether the analysis was persuasive, but by whether a young professional found a place to serve, a community gained access to better care, and an enterprise entered a value chain it had previously been shut out of.

I want to thank Tshenolo Moeti and the NEXEC Health Subcouncil for building this platform from the ground up; the **Ministry of Women, Youth and Persons with Disabilities and the National Department of Health** for their partnership; **Aspen Pharmacare**, **Haleon, the Progressive Business Forum, the South African Private Practitioners Forum, the South African Medical Research Council, the Teddy Bear Foundation, the Public Oral Health Forum: and BMW Bryanston** for lending their institutional weight to this agenda; and every young delegate who arrived not to be spoken about, but to speak.

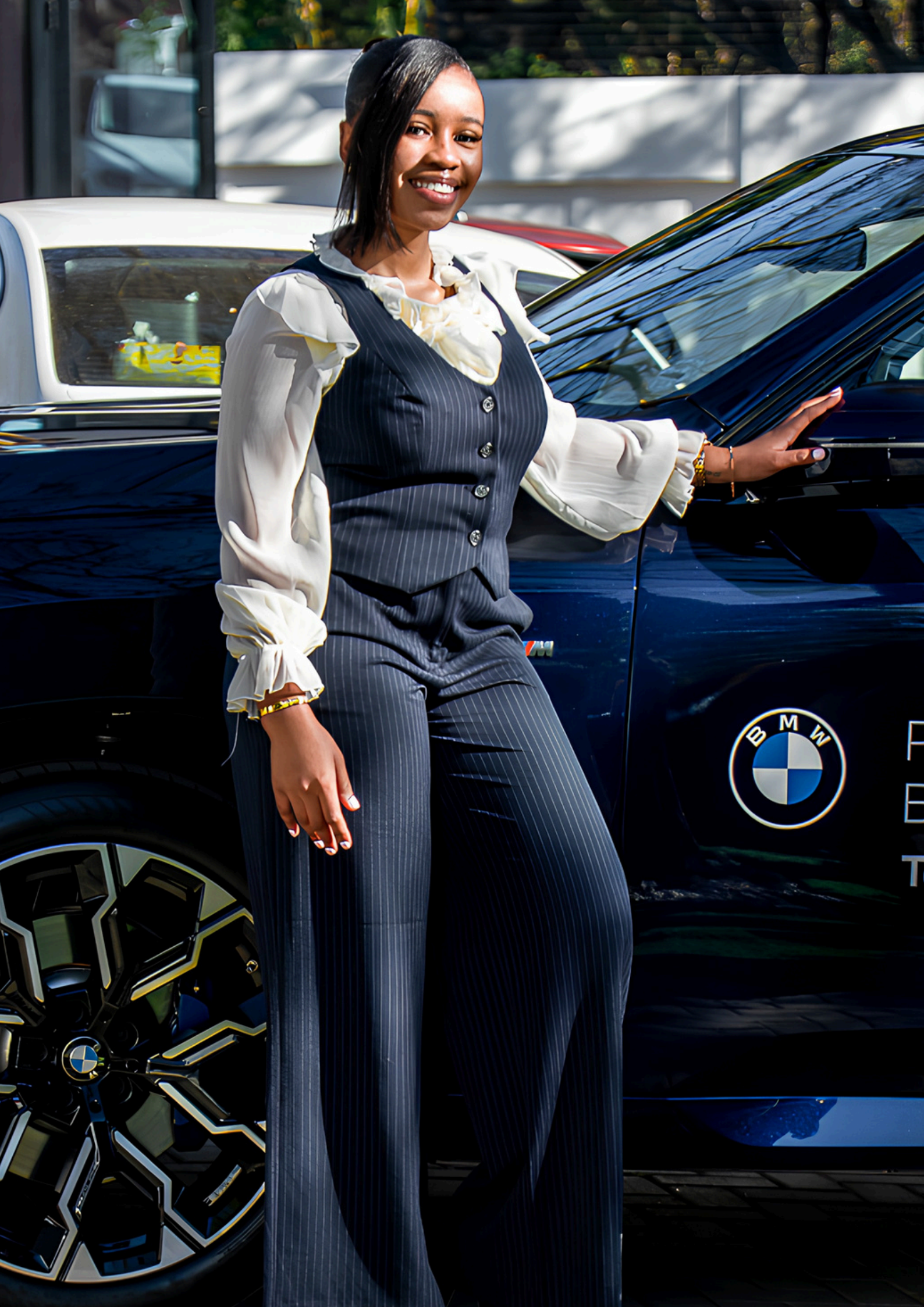
Leadership Message
Ms. Tshenolo Moeti
Division Head: NEXEC Health

When preparations began for the NEXEC National Health Sector Summit 2026, our ambitions were deliberately practical. We did not set out to produce another conference, another declaration, or another collection of well-intentioned speeches. Our working assumption was modest: that if government, industry, academia, healthcare practitioners and young professionals could be brought into the same room for a single day, under a shared commitment to honest dialogue, something more valuable than another set of recommendations might emerge. By the time registration closed, many delegates had confirmed their participation, including fifteen speakers and panellists representing the Presidency, the National Department of Health, National Treasury, three of South Africa's largest pharmaceutical and healthcare companies, statutory councils, universities, hospital leadership, professional bodies, entrepreneurs and a new generation of healthcare practitioners committed to shaping the future of the sector.

What emerged throughout the Summit was not simply agreement on the challenges confronting South Africa's healthcare system, but a shared recognition that many of those challenges are institutional rather than individual. We heard repeatedly that the country does not lack capable graduates, committed practitioners or innovative ideas. Instead, it continues to struggle with the spaces between institutions: between education and employment, policy and implementation, innovation and procurement, public need and institutional capacity. Those gaps have profound consequences for both the healthcare workforce and the communities it seeks to serve. The Summit was built on one central proposition: that young healthcare professionals should not be regarded merely as future contributors to the health system, but as current partners in its design, delivery and improvement. That distinction runs throughout this report. Where barriers are identified, they are described as structural rather than personal. Unfunded posts, fragmented accreditation pathways, procurement systems inaccessible to emerging enterprises, uneven professional transition, and institutional fragmentation are challenges that require systemic solutions. They should not be interpreted as deficiencies in the young professionals who continue to demonstrate extraordinary capability despite them.

Equally important was the Summit's commitment to expanding our understanding of healthcare itself. Healthcare is not confined to hospitals and clinics. It is supported by manufacturing, research, education, technology, logistics, finance, infrastructure, entrepreneurship, regulation and public policy. The conversations captured in these pages reflect a growing consensus that strengthening South Africa's healthcare system will require collaboration across this entire ecosystem. The responsibility for healthcare transformation cannot rest with government alone, nor with the private sector alone. It must become a genuinely shared national project. This report has therefore been structured to serve multiple audiences. Whether you are a Director-General seeking implementation priorities, a hospital executive exploring partnership opportunities, a policymaker examining workforce challenges, an academic contributing new evidence, or a young entrepreneur navigating the health economy, our hope is that you will find practical insight and meaningful direction within these pages. More importantly, we hope the report demonstrates that the value of the Summit lies not in the conversations themselves, but in the partnerships, commitments and implementation they continue to inspire.

Finally, I extend my sincere appreciation to every speaker, delegate, partner and member of the organising team who placed their trust in this platform and contributed openly to the national conversation. Your willingness to engage honestly, challenge assumptions and share your expertise has produced far more than a successful Summit. It has strengthened a growing community committed to building a healthcare system that is more collaborative, more inclusive and more responsive to the needs of all South Africans. The Summit has concluded. The responsibility it created remains. It is now our collective task to ensure that the conversations documented in this report continue to shape policy, partnerships and implementation in the months and years ahead


BMW

Strategic Partner Spotlight
BMW Bryanston
Driving Leadership, Innovation and Access

Healthcare transformation depends on more than hospitals, medicines and clinical expertise. It relies equally on the mobility, infrastructure, technology and partnerships that connect healthcare professionals, institutions and communities. As South Africa continues to strengthen its healthcare system, organisations operating beyond the traditional health sector have an increasingly important role to play in enabling access, supporting innovation and contributing to broader social development.

The BMW Group has long demonstrated a commitment to advancing health and wellbeing through corporate social investment, employee wellness, road safety initiatives, emergency response partnerships and support for healthcare and community development programmes. Alongside its leadership in advanced manufacturing, skills development and sustainable mobility, these investments reflect an understanding that healthy societies are fundamental to sustainable economic growth.

These principles closely align with the vision of the NEXEC National Health Sector Summit 2026, which explored healthcare as a complete ecosystem extending beyond clinical care to include manufacturing, logistics, infrastructure, technology, education, entrepreneurship and cross-sector collaboration. The Summit recognised that improving health outcomes requires partnerships across industries, with mobility serving as a critical enabler of healthcare access, service delivery and institutional connectivity.

Through its support of the Summit, BMW Bryanston enabled a platform where senior leaders from government, healthcare, business, academia and civil society could engage on the future of South Africa's healthcare system. The partnership reflects a shared belief that meaningful progress is achieved when institutions invest not only in their own sectors, but in the broader national conversations that shape South Africa's future.

NEXEC extends its sincere appreciation to BMW Bryanston for its valued partnership and contribution to the National Health Sector Summit 2026. Their support exemplifies how corporate leadership can extend beyond commercial success to help foster dialogue, collaboration and innovation in pursuit of a healthier and more prosperous South Africa.

About NEXEC

The National Executive Economic Collective (NEXEC) is South Africa's largest youth-led economic advisory, research and implementation firm dedicated to advancing inclusive economic development through strategic convening, policy research, institutional partnerships and programme delivery. Operating at the intersection of government, business, academia and civil society, NEXEC exists to bridge the gap between policy formulation and practical implementation by bringing together decision-makers, industry leaders, researchers and emerging professionals around shared national priorities.

Founded on the belief that sustainable development requires coordinated action rather than isolated interventions, NEXEC convenes sector-specific platforms that generate evidence-based dialogue, strengthen institutional collaboration and support the implementation of solutions across key areas of the South African economy. Its work spans strategic advisory, policy development, stakeholder engagement, thought leadership, research and the design and delivery of high-impact programmes.

Through its specialised internal subcouncils—including Health, Infrastructure, Agriculture, Mining and Energy, Arts and the Creative Economy, Transport and Tourism, Women's Advocacy and Sport—NEXEC cultivates sectoral expertise while creating opportunities for meaningful collaboration between the public and private sectors. These platforms enable government, industry, professional bodies, entrepreneurs and young professionals to engage constructively on policy, innovation and implementation.

NEXEC's approach is underpinned by a simple principle: South Africa's most complex challenges cannot be solved by individual institutions acting alone. By convening diverse stakeholders, generating strategic intelligence and supporting implementation, the organisation seeks to reduce institutional fragmentation, strengthen partnerships and contribute to more responsive, inclusive and sustainable development outcomes.

As a trusted convenor and strategic partner, NEXEC continues to position young professionals not merely as beneficiaries of development, but as active participants in shaping South Africa's economic, social and institutional future.

NEXEC's stated comparative advantage is not advocacy in the conventional sense of external pressure applied to government and industry from outside. It is convening: the ability to place government, business, healthcare institutions, academia, civil society and young professionals inside the same structured process, and to translate the resulting dialogue into implementation. In the words used to close this Summit, the organisation's founders describe this as a shift from being "the new kid on the block adding to the discourse around young people" toward functioning as an internal development partner with sufficient technical depth to be useful inside government and industry processes, rather than only outside them.

NEXEC's public positioning during this Summit rejected two competing premises. The first is that young people lack the readiness to participate meaningfully in institutional reform; the Summit's proceedings, and this report, treat readiness as a shared institutional obligation rather than a deficit to be corrected in young people alone. The second is that engagement itself constitutes delivery; NEXEC's leadership was explicit, in both the Summit's design and its closing remarks, that dialogue divorced from measurable follow-through is a pattern the organisation intends to break rather than repeat.

Executive Summary

On 4 July 2026, the National Executive Economic Collective (NEXEC), through its Health Subcouncil, convened the NEXEC National Health Sector Summit at EmpowaWorx in Ferndale, Randburg, under the theme “Youth at the Heart of Healthcare Transformation.” The Summit brought together government leadership from the Presidency and the National Department of Health, private-sector executives from South Africa's pharmaceutical and consumer-health industries, statutory and professional councils, academic institutions, multilateral development agencies, and a cohort of youth-led health enterprises, for a single day of structured dialogue, panel scrutiny and institutional commitment-making.

Hundreds of delegates registered to attend, fifteen of them as confirmed speakers or panellists. The day comprised two government keynote addresses, a private-sector keynote from Aspen Pharmacare, two panel discussions, a business and transformation address from the Progressive Business Forum, a research capacity presentation from the South African Medical Research Council, and closing remarks from the Acting Director-General of Health and the NEXEC Group President & CEO. A third panel, NEXEC: Youth Speaks, was displaced from the programme by time constraints on the day — a scheduling reality this report treats as a delivery risk in its own right, addressed later in this document.

The Summit was established to fill a specific institutional gap: the absence of a dedicated, structured platform bringing government, healthcare institutions, private providers, funders and youth actors together to co-design practical solutions to two problems that are conventionally treated as separate — a healthcare workforce and infrastructure crisis, and a youth unemployment crisis — but which this Summit's proceedings repeatedly demonstrated to be a single crisis of institutional connection.

Across the government keynotes, the private-sector address, both panels and the open floor, a consistent set of structural themes recurred: a health workforce pipeline broken not by a shortage of trained people but by unfunded posts and fragmented accreditation; a procurement system that is, in practice, closed to new and youth-owned suppliers regardless of formal transformation targets; a financing debate about National Health Insurance that is more constrained by implementation capability than by the availability of money; a local pharmaceutical and medical-device manufacturing base that has shrunk over the past two decades to a fraction of its historical output; and a persistent disconnect between research evidence, policy formulation and frontline implementation.

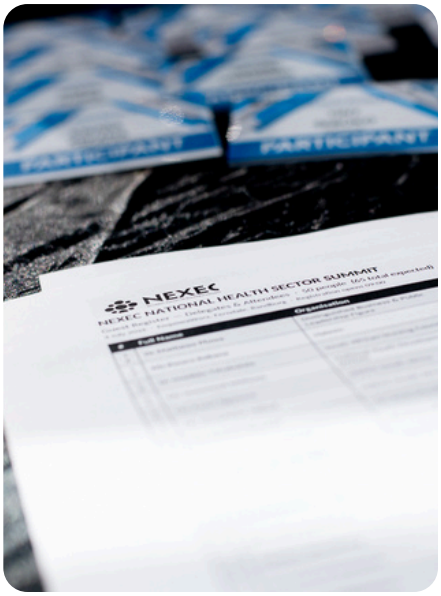
The Summit's proceedings support a central strategic conclusion: youth inclusion in healthcare is not a parallel employment programme to be layered onto health system reform. It is a precondition for the delivery capacity that reform depends on. National Health Insurance, provincial budget allocations, and industrial policy for local manufacturing will each succeed or fail depending on whether the institutions responsible for training, accrediting, employing and financing young health professionals and health enterprises can be made to operate as a single coherent pathway rather than as separate, mutually unaccountable mandates.

This report translates the day's proceedings into ten strategic national findings, stakeholder-specific recommendations for government, the private sector, hospital groups, professional councils, universities, development agencies, funders, NEXEC itself and young professionals, a phased implementation roadmap from the immediate term to three years, and a NEXEC Implementation Programme intended to carry this agenda forward as a recurring national platform rather than a single event.

About The Summit

Strategic Objectives

- Surface practical barriers limiting youth access to health-sector employment, training and procurement.
- Showcase scalable models already working in community-based care, health entrepreneurship and workforce readiness.
- Enable direct dialogue between youth leaders, public hospitals, private providers and state-owned entities.
- Identify specific delivery opportunities where youth can be integrated into mainstream and alternative health infrastructure.
- Reinforce the Department of Women, Youth and Persons with Disabilities' role as a connector between youth policy, service delivery and national sectors



South Africa's healthcare system is under sustained pressure from workforce shortages, deteriorating infrastructure, uneven provincial performance, a rising and shifting disease burden, and constrained public finances. At the same time, thousands of young people trained in health-related fields remain unemployed, underemployed, or excluded from formal healthcare delivery systems, and youth-led health enterprises struggle to access procurement channels, accreditation pathways and institutional partnerships. Despite growing national commitment to health system reform, no dedicated, structured platform existed to bring government, institutions, private providers, funders and youth actors together to co-design practical solutions to these problems jointly. The 2026 National Health Sector Summit was established to fill that gap.

The theme, “Youth at the Heart of Healthcare Transformation,” was deliberately positioned by government and NEXEC speakers alike as a rejection of a narrower reading of youth inclusion — one confined to bringing young people into a room or placing them on a panel. As the Deputy Minister framed it in the Government Keynote Address, the theme was intended to mean placing young people within the design, delivery, governance and ownership of the health system itself. The Summit's convening rationale rests on the same logic that underpins NEXEC's institutional model more broadly: that the distance between commitments made and lives changed is an institutional-coordination problem, and that a platform capable of holding government, industry and youth accountable to the same set of facts on the same day is a precondition for closing it.

The Summit took place at a moment of live national debate on National Health Insurance implementation, phased financing models, and the 2026 Budget's provincial health allocations — a timing that shaped much of the day's content, particularly the government keynotes and the NHI/financial panel discussion

South Africa's health system pressures, as they were described across this Summit's proceedings, are no longer purely clinical. They are simultaneously economic, institutional, governance, industrial, educational, technological, financial and employment challenges — a framing this report adopts throughout, treating healthcare as a complete economic ecosystem rather than a clinical service sector alone.

The 2026 Budget allocates R310.4 billion to the national health function, of which approximately R200 billion is directed toward compensation of employees — a figure the Deputy Minister cited as reflecting the centrality of health professionals to care delivery. Provinces have been allocated a further R21.3 billion over the medium term specifically for health-sector compensation and the employment of doctors, alongside R5.9 billion for the Human Resources and Training Grant in 2026/27. The Budget documentation explicitly recognises the need to absorb unemployed doctors and address service-delivery shortages. As the Deputy Minister noted, however, an allocation is not the final measure of progress: its value depends on whether it becomes a funded and filled post, whether appointments are made transparently, and whether professionals are equitably distributed between provinces and between urban and rural facilities.

Multiple speakers — from the Deputy Minister through to hospital and professional-council representatives described the same paradox from different vantage points: newly qualified doctors, nurses, oral health professionals, podiatrists and rehabilitation graduates unable to find funded posts, alongside facilities reporting severe pressure on existing personnel. This is not, on the evidence presented, a talent-supply problem. It is a distribution and absorption problem, compounded by fragmented institutional accountability — universities and colleges train, professional councils regulate, SETAs support workplace development, provincial departments appoint, hospitals supervise, and Treasury funds posts, with no single institution accountable for the journey between these stages as experienced by an individual graduate.

The private-sector keynote from Aspen Pharmacare's Dr Stavros Nicolaou characterised the country, and the continent, as carrying a disproportionate share of global disease burden relative to population, while simultaneously undergoing a rapid epidemiological shift. Where the historic "triple burden of disease" was framed around HIV, tuberculosis and a smaller set of infectious conditions, panellists and the keynote address described the emergence of a fourth, less visible burden: a cardio-metabolic-renal complex of non-communicable disease, including rising diabetes, chronic kidney disease and obesity, increasingly presenting in children as well as adults. HIV, TB and vaccine-preventable diseases such as cervical cancer (addressed through HPV vaccination) remain significant, but were repeatedly described as being addressed alongside, rather than instead of, this newer and less well-resourced burden.

Several speakers rejected the framing of public and private healthcare as two distinct systems, arguing instead for a single population served by two differently resourced delivery channels. The private sector was described as holding affordability and infrastructure capacity that the public sector lacks, while the public sector carries reach and volume that the private sector does not attempt to replicate. The ratio of private-to-public health expenditure was cited in the region of five to one, a disparity multiple speakers linked directly to the urgency of National Health Insurance reform, while cautioning that reform's success depends on facility functionality, ethical leadership, medicine supply reliability, referral pathways and public trust — not on legislation and financing architecture alone.

Local pharmaceutical and medical-device manufacturing capacity emerged as a distinct and recurring concern. South Africa's local production of antiretroviral medicines was cited as having declined from approximately 92% in 2008 to approximately 22% at present, and the country was described as having lost significant industrial capacity and employment in the pharmaceutical-equivalent manufacturing sector over the past year alone. COVID-era supply disruptions — including instances where South African manufacturers were approached by other governments for medicines that domestic and international supply chains could not otherwise secure — were cited as evidence that local and regional manufacturing capability is a health-security as well as an industrial-policy issue.

Government and civil-society speakers alike emphasised that clinical intervention arrives too late in the causal chain to be sufficient on its own. Points raised included the shift away from health promotion and prevention toward an overwhelmingly curative system, the persistence of preventable late-stage presentation for conditions such as breast and cervical cancer, and the intersection of poverty, trauma, gender-based violence and family dysfunction with clinical presentation — particularly in child health, where a multidisciplinary and intersectoral response was described as largely absent from current training and service models.

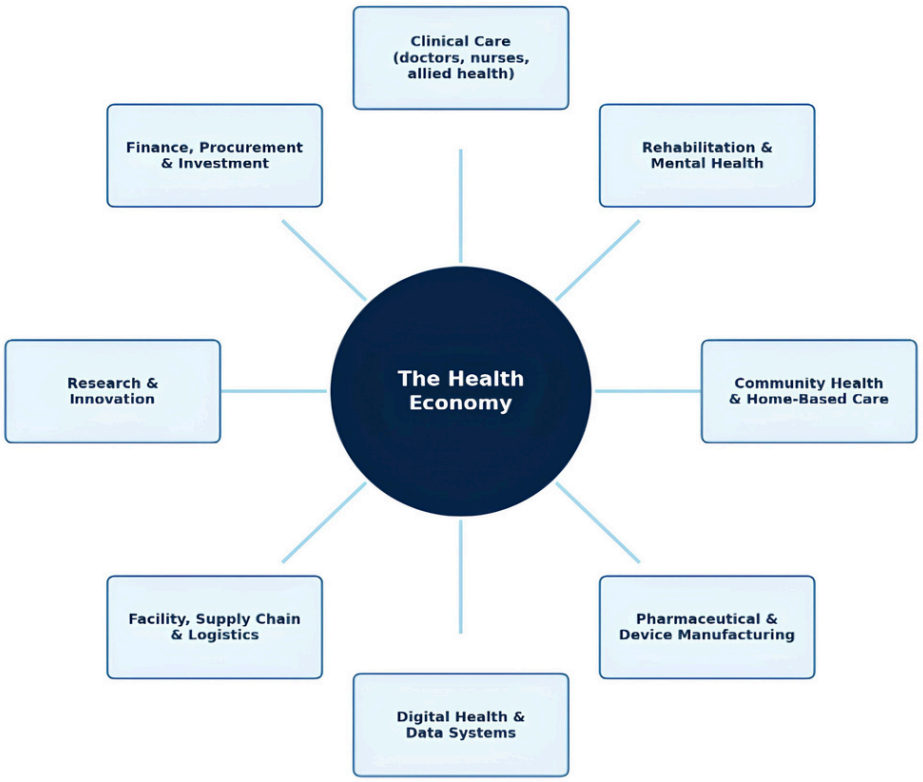


Figure — Healthcare as a complete economic ecosystem: the framing this report applies throughout, consistent with the Summit's own proceedings.

A Summit is, on its own, an unremarkable format. What distinguished this one, on the evidence of its proceedings, was less its structure than four specific choices in its design and execution.

The Summit deliberately placed a sitting Deputy Minister, a Ministerial Advisor, an Acting Director-General of Health, a National Treasury analyst, hospital chief executives, pharmaceutical industry executives, statutory council representatives and unfunded, newly qualified health professionals inside the same panel structures rather than in sequential, separated sessions. Panel One placed a medical student alongside three young health entrepreneurs; Panel Two placed a private-sector CEO, a public hospital CEO, a child-protection NGO director and a Treasury analyst on the same stage answering the same audience questions.

Every young speaker on the programme — in podiatry, dentistry, telehealth, medicine and public health advocacy — appeared as the operator of a functioning enterprise, platform or clinical practice, not as a recipient of a proposed intervention. This distinction was made explicitly and repeatedly from the floor: young professionals at this Summit described what they had already built despite the system, not what they would need in order to begin.

Both the opening framing and the closing remarks explicitly rejected a declaratory outcome. The Deputy Minister set a 90-day accountability marker for the Summit's proposed pilots — placement numbers, funded posts, procurement access and outstanding commitments — and NEXEC's closing remarks were explicit that the organisation intends to be judged on delivery rather than on the quality of the day's dialogue.

Health Framed as an Economic, Not Only Social, Sector

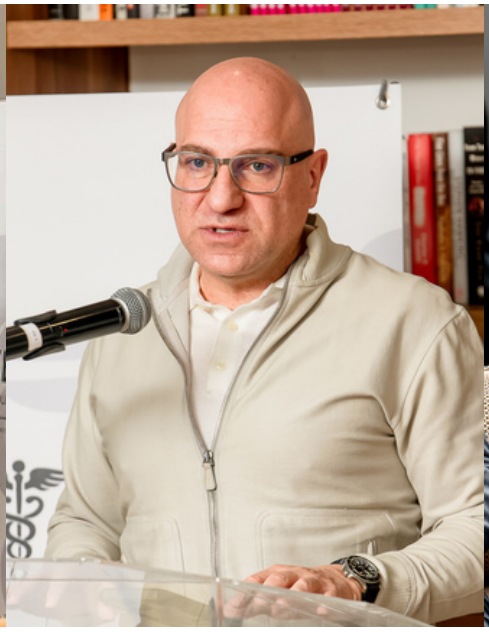
A recurring and, on the evidence of the transcript, unresolved tension ran through the day: whether healthcare is treated by government and financing institutions as an economic sector on par with mining, energy or infrastructure, or as a social cost to be subsidised. Multiple speakers — from the private sector, from academia and from young entrepreneurs — argued that this classification has direct financing consequences, since dedicated capital-market and development-finance instruments exist for infrastructure and mining in a way they do not yet exist for health enterprise.

Speakers Profiles

Dr Nono Simelela
Advisor to Minister of Health

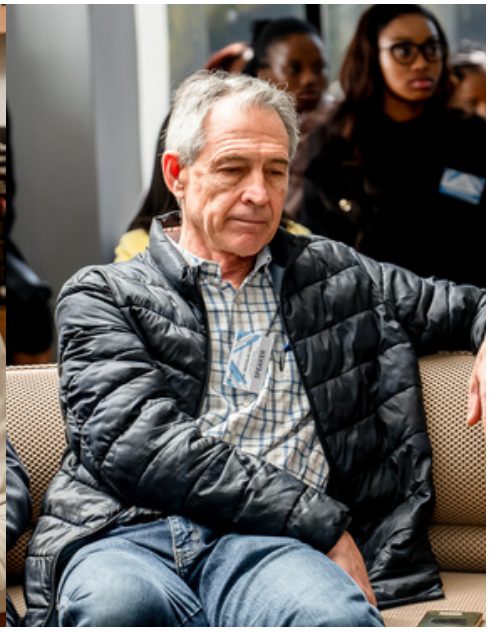
Dr Princess Nono Simelela is one of South Africa's most accomplished public health leaders and a globally respected authority in women's health and health systems strengthening. After qualifying as South Africa's first Black female gynaecologist, she joined the National Department of Health, where she has played a pivotal role in shaping national health policy and advancing equitable access to healthcare. Her career spans senior leadership roles in government and international health, with a longstanding commitment to sexual and reproductive health, maternal health, gender equity and Universal Health Coverage. As Advisor to the Minister of Health, Dr Simelela continues to provide strategic guidance on strengthening South Africa's healthcare system and advancing national health priorities.

Dr Stavros Nicolaou
Group Senior Executive: Aspen Pharmacare



Dr Stavros Nicolaou is one of Africa's leading pharmaceutical executives and a recognised authority on healthcare policy, industrial development and pharmaceutical manufacturing. As Group Senior Executive: Strategic Trade at Aspen Pharmacare, Africa's largest pharmaceutical manufacturer, he has been a leading voice in promoting local medicine production, health security, industrialisation and strategic public-private collaboration. A passionate advocate for positioning healthcare as both a social imperative and an economic growth sector, Dr Nicolaou has contributed extensively to policy dialogue on pharmaceutical resilience, supply chain security and Africa's capacity to manufacture medicines, vaccines and other essential health technologies. His leadership continues to influence healthcare policy and industrial strategy across South Africa and the continent.

Prof. Nicholas Crisp
Acting Director-General: Department of Health



Prof Nicholas Crisp is one of South Africa's most respected public health leaders, with decades of experience spanning clinical medicine, health policy and health systems management. As Acting Director-General of the National Department of Health, he provides strategic leadership on strengthening the country's health system, advancing health workforce development and overseeing the implementation of National Health Insurance (NHI). Renowned for his evidence-based approach to healthcare reform, Prof Crisp has played a central role in shaping policies that promote equitable access, institutional collaboration and a more integrated, sustainable healthcare system for all South Africans.

Hon.Mmapaseka Steve Letsike

Deputy Minister: Women, Youth and Persons with Disabilities

Deputy Minister Steve Letsike is a distinguished social justice advocate and public leader committed to advancing the rights, empowerment and inclusion of women, young people and persons with disabilities. As Deputy Minister in the Presidency, she provides strategic leadership on policies that promote equality, social cohesion and youth development, while championing inclusive governance and equitable access to opportunities across South Africa. Her work continues to strengthen the intersection between social development, economic participation and national transformation.

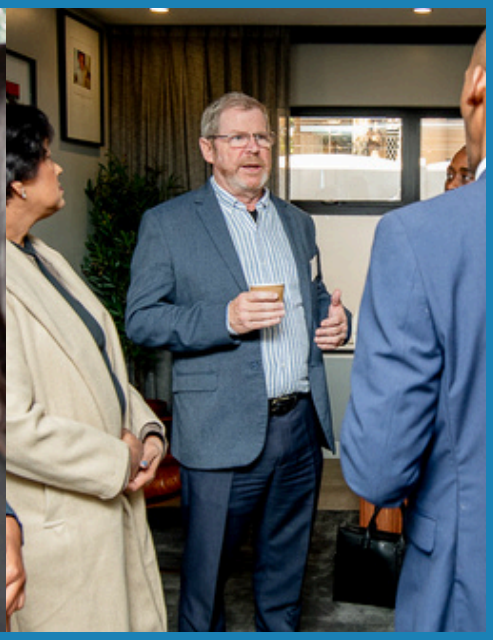
Ms Onicca Kwakwa

Group Chief Executive Officer: Progressive Business Forum (PBF)

Ms Onicca Kwakwa is the Group Chief Executive Officer of the Progressive Business Forum (PBF), where she leads initiatives that strengthen collaboration between business, government and society to drive inclusive economic growth and transformation. With extensive experience in stakeholder engagement, enterprise development and strategic partnerships, she is a recognised advocate for creating a more inclusive economy through meaningful private sector participation, investment and leadership.

Dr Simon Strachan

Chief Executive Officer: South African Private Practitioners Forum (SAPPF)



Dr Simon Strachan is a practising paediatrician and Chief Executive Officer of the South African Private Practitioners Forum (SAPPF), representing more than 4,500 specialist private practitioners nationwide. In addition to his clinical expertise in paediatrics, vaccinology, pulmonology, allergy and ADHD, he is a respected leader in healthcare policy and system reform. Through his leadership of SAPPF and his work with the Universal Healthcare Access Coalition, Dr Strachan champions constructive public-private collaboration and practical solutions to strengthen universal access to quality healthcare in South Africa.

Public, Private & Professional Leadership

KEYNOTE ANALYSIS

This chapter analyses the Summit's three keynote addresses not as speeches to be summarised, but as strategic positions to be tested: what problem each speaker identified, what solution each proposed, and what that implies for institutions beyond the speaker's own mandate.

Government Vision: Hon. Mmapaseka Steve Letsike, MP
Deputy Minister in the Presidency for Women, Youth and Persons with Disabilities, addressing the Summit virtually.

The Deputy Minister's address built on a framing she had used at a previous NEXEC engagement — the "Missing Chair," the empty seat at the table for a young person, a woman, a person with a disability, or someone excluded from the productive economy — and extended it to a second, more specific diagnosis for the health sector: the "Missing Link" between the human capability South Africa has developed and the needs its health system is struggling to meet. Her central claim was that health workforce shortage and youth unemployment are not two separate crises but one crisis of institutional connection, viewed from opposite ends of the same discussion: unemployed doctors, nursing, pharmacy, rehabilitation and oral health graduates on one side; unfilled posts, understaffed facilities and under-recognised community health workers on the other.

The address grounded this diagnosis in the 2026 Budget: R310.4 billion allocated to the national health function, of which approximately R200 billion is compensation of employees; a further R21.3 billion allocated to provinces over the medium term specifically for health-sector compensation and the employment of doctors; and R5.9 billion for the Human Resources and Training Grant in 2026/27. The Deputy Minister was explicit that this allocation is necessary but not sufficient — its value depends on whether it converts into funded, filled and equitably distributed posts.

The Solutions Proposed

- A Youth Health Enterprise Procurement Accelerator, using public and private health-sector purchasing power to develop credible youth-owned suppliers.
- A Community Health Worker Formalisation Pipeline, converting precarious community health labour into recognised, remunerated, supervised roles with a development pathway.
- A Youth Health Workforce Readiness Programme, explicitly reframed as a dual obligation — preparing young people for the system, while preparing the system to receive them.
- A Cross-Sector Working Circle, intended to be properly authorised, resourced and held to measurable outcomes.
- Structured engagement with the National Youth Development Agency to align these initiatives with its legislated mandate — an invitation this report notes was not visibly reciprocated in the delegate register (see Delegate Profile and Risks).

The Deputy Minister set an explicit 90-day accountability window: how many placement opportunities were identified, how many young professionals entered funded work, how many community health workers were placed on stronger pathways, how many youth enterprises gained procurement access, and which commitments remain outstanding. This report adopts that marker as the first checkpoint in the Implementation Roadmap.

"The young person must not only be seated in the meeting. They must be connected to the clinic, the laboratory, the research institution, the community-health programme, the supply chain and the ownership structures of the health economy."
— Hon. Mmapaseka Steve Letsike, MP

KEYNOTE ANALYSIS cont.

Diagnosing the System: Dr Princess Nono Simelela

Advisor to the Minister of Health, addressing the Summit on the theme of diagnosing the healthcare sector.

Dr Simelela situated South Africa's health system within its constitutional, democratic and global context: a three-sphere government structure in which national policy commitments do not automatically bind provincial implementation, a country whose health outcomes are frequently benchmarked favourably against continental averages while individual young people continue to experience daily frustration and lack of progress. She drew a direct line from South Africa's medical education history — including the historical shortage of admission places relative to demand for medical training — to the present-day paradox of unemployed doctors coexisting with unmet clinical need, and argued that technology-enabled distance and blended learning models remain underused as a means of expanding training capacity.

Her address returned repeatedly to the balance between curative and preventive spending, arguing that the health system has moved too far toward a curative orientation at the expense of health promotion and prevention, particularly around reproductive health information for adolescent women, nutrition-related non-communicable disease, and mental health. She also addressed the financing debate directly, characterising the core question for the NHI not as “is there enough money in the system,” but as how existing resources — already partially subsidised through employer and taxpayer contributions to medical schemes and public financing alike — are more equitably mobilised and distributed.

Dr Simelela's contribution reinforces this report's central thesis from a policy-diagnostic angle: South Africa's constitutional commitment to progressive realisation of the right to healthcare is not in question; the country's capacity to translate resourced national policy into consistent provincial execution is. She explicitly welcomed continued dialogue of the kind this Summit convened as a mechanism for surfacing that provincial-national execution gap.

KEYNOTE ANALYSIS cont.

Industry as Partner: Dr Stavros Nicolaou
Group Executive, Aspen Pharmacare

Dr Nicolaou opened from a continental vantage point: Africa carries a disproportionate share of global disease burden relative to its share of the world's population, while consuming a comparatively small share of global health resources. He argued that this disparity has direct investment-case consequences — an unhealthy, unproductive population depresses the socio-economic development indicators international investors increasingly weight alongside financial return — and that health spending should therefore be understood by government and investors alike as an investment in productive capacity, not a welfare cost.

A Six-Point Private-Sector Agenda

- Public-private convergence: framing South Africa's population as a single patient base served by two differently resourced channels, rather than as two distinct sectors, with a private-to-public spending ratio he placed at roughly five to one.
- Health literacy and lifestyle education: addressing the rise of a non-communicable, cardio-metabolic-renal disease burden — describing it as a fourth epidemiological "highway" alongside the historical triple burden of HIV, TB and other infectious disease — through public education on diet, substance use and sedentary lifestyle, comparable in urgency to the country's historical HIV response.
- Screening and early detection: expanding mobile clinic infrastructure, funded partly through corporate social-investment channels, to catch conditions such as cervical, breast and skin cancer before late-stage, high-cost presentation.
- A "one health" approach: treating zoonotic disease emergence, climate-linked epidemiological shifts, and antimicrobial resistance as cross-departmental problems requiring coordination between health, agriculture, environment and other portfolios, not health-department problems alone.
- Digitalisation of patient records: arguing that a shared, verified digital health record — checked against professional council registration — would materially reduce clinical administrative time, reduce diagnostic and medication errors, and free capacity for direct patient care, while acknowledging the scale of connectivity investment required across thousands of public facilities.
- Local and regional pharmaceutical manufacturing: citing the decline of South Africa's local antiretroviral manufacturing share from approximately 92% in 2008 to approximately 22% at present, and the loss of jobs in the local pharmaceutical-equivalent manufacturing sector, as evidence of an eroded industrial base with direct implications for health security, referencing COVID-era episodes in which South African manufacturers were approached by other governments' health systems for medicines that global supply chains could not otherwise secure.

A Four-Point Manufacturing Policy Ask

- Regulatory harmonisation across African markets, with priority and parallel review pathways referencing WHO prequalification, to reduce the multi-year lag between production readiness and market access.
- Public procurement policy that scores value for money on multiplier economic impact, not unit price alone, to make space for local industrial suppliers against lower-cost imports.
- Export incentives — citing South Africa's existing General Export Incentive Scheme as a shelved but available policy instrument — to reorient local manufacturing toward continental export.
- Reform of international donor and multilateral procurement practice (citing bodies such as the Global Fund) to direct a share of donor-funded medicine and commodity procurement toward African manufacturers rather than exclusively toward established Asian suppliers.

SPEAKER ANALYSIS

Business as a Partner in Healthcare Transformation: Ms Onicca Kwakwa
Group Chief Executive Officer, Progressive Business Forum

Kwakwa opened with what she called a confession: after twenty-five years as an investment practitioner, listening to Panel One's young entrepreneurs describe the equipment and infrastructure required to open their first practice, she realised she had never actually asked who funds that first purchase — a dentist's chair, a diagnostic device — once a graduate is ready to practise. That question led her to check whether South Africa's National Empowerment Fund, the state vehicle intended to support exactly this kind of early-stage capital need, has a dedicated health-industry vertical. She could not find one, despite the fund covering sectors such as tourism, trade and investment. Her conclusion was structural rather than anecdotal: health has not been elevated to the same industrial status as mining, energy, infrastructure or ICT in South Africa's development-finance architecture, and is instead treated as a social cost to be subsidised rather than a sector to be capitalised.

She was explicit that this is not a capital-scarcity problem. In her account, meetings with investors and development finance institutions across the continent — the IDC, the African Development Bank, the BRICS-aligned New Development Bank among them — consistently produce the same message: money is not the constraint. Yet the same investors and funders are, in her words, never in the room with the young innovators actually solving health problems on the ground. She also raised the Public Procurement Act's requirement that a share of government's roughly R1.7 trillion in annual procurement — commonly cited at 40% — go to previously disadvantaged groups, including women, youth and persons with disabilities, and asked directly where that requirement is being tracked or enforced in health-equipment procurement specifically. She extended the same challenge to the President's annual investment conference, where pledges have run into the hundreds of billions of rand: her question was how much of that capital is reaching young people, and how much is reaching health specifically, and she argued the NYDA should be raising that question publicly every year rather than leaving it unasked.

Kwakwa's central proposal was business matchmaking: pairing international investors and companies committing capital to Africa with credible South African health innovators and enterprises, structured deliberately around mentorship and skills transfer rather than one-off transactional investment, so that transformation is built into the capital relationship rather than treated as a compliance afterthought.

Her contribution supplies the clearest institutional diagnosis, from the finance side, of a gap this report identifies repeatedly from the youth-enterprise side in Panel One: credible, delivery-proven health innovators exist, and capital exists, but no mechanism currently connects them. This reinforces the case for the Youth Health Enterprise Procurement Accelerator and for a dedicated health-sector vertical within existing development finance and enterprise-support funds.

SPEAKER ANALYSIS cont.

Research Capacity Development: Dr Mongezi Mdhluli
Chief Research Operations Officer, South African Medical Research Council

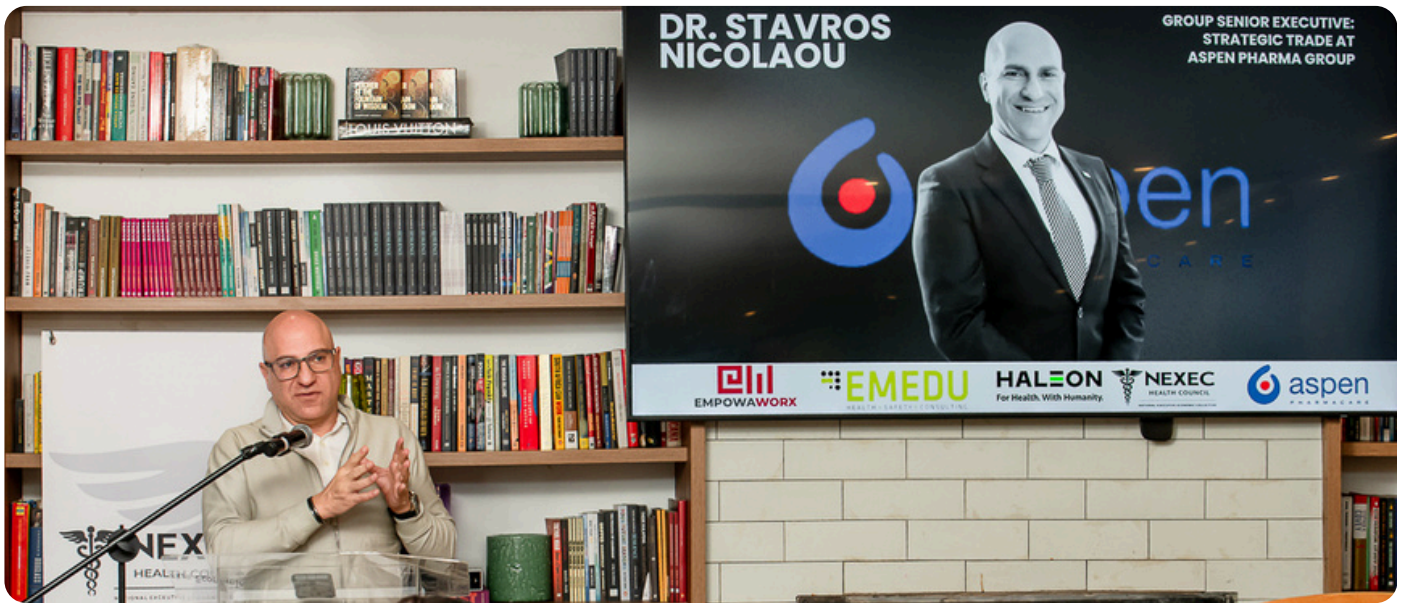
Dr Mdhluli's presentation was the Summit's most candid account of where evidence-based health reform currently breaks down. He set out the SAMRC's mandate across five pillars — resource mobilisation, generation of new knowledge, science and technology innovation, capacity development of the next generation of researchers, and translation of research into policy and practice — and was direct that the last of these, translation, is the weakest link in the chain. Research findings, he said, do not automatically reach the officials formulating policy or the frontline staff implementing it, because researchers, policymakers and implementers are frequently not in structured conversation with one another at all.

He grounded the SAMRC's focus areas in the same epidemiological shift raised elsewhere in the day: research is increasingly directed at the intersection of non-communicable and infectious disease — diabetes alongside HIV and TB, rather than treated as separate research silos — alongside interpersonal violence, digital health and precision medicine. A long-standing genomic sequencing partnership with the Beijing Genomics Institute, running since 2018, and work on indigenous knowledge systems and associated intellectual-property benefit-sharing frameworks, were cited as evidence of a broader innovation pipeline than public perception of the SAMRC typically credits it with. He was also candid about a funding risk: reduced international research collaboration funding from a major bilateral partner has already affected the scale of joint work the SAMRC can sustain, with direct implications for ongoing surveillance and vaccine-development capacity.

The Solutions Proposed

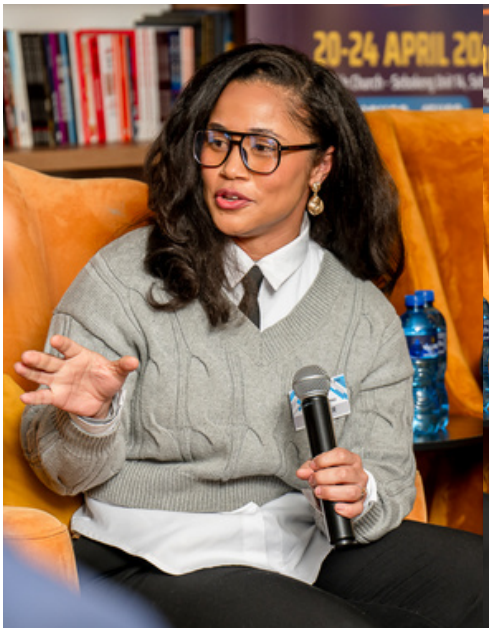
- A structured pathway allowing medical doctors to pause their clinical degree partway through to complete a PhD, graduating with both qualifications and moving directly into a research career track — a direct, practical response to the same workforce-pipeline fragmentation raised throughout the day, aimed specifically at building local research capacity rather than losing clinically trained talent to practice alone.
- Continued investment in historically disadvantaged institutions through scholarship and hands-on laboratory training programmes, several delivered in partnership with private funders, designed to address the basic infrastructure gap — several cohorts, he noted, arrive at university having never physically used a laboratory.
- A technology transfer function managing intellectual property arising from publicly funded research, intended to ensure innovation funded by the state does not lose its public benefit as it moves toward commercialisation.
- Ongoing youth science outreach, including bringing school learners into MRC facilities directly, as a long-horizon investment in the same pipeline this report addresses throughout.

Mdhluli's presentation supplies the research-evidence chapter's own admission that sits underneath many of this report's other findings: South Africa is not short of relevant research. It is short of a functioning bridge between that research and the policy decisions and implementation choices it should be informing — the same institutional-coordination diagnosis this report applies to workforce, procurement and financing elsewhere.



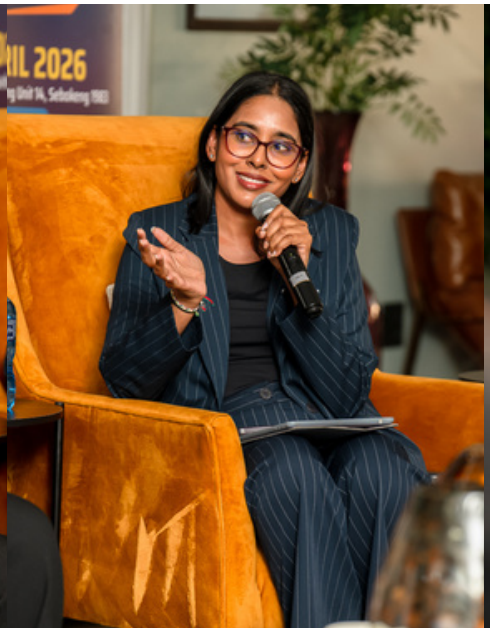
"Healthcare experience is one of the wisest investments you can make in human capital. We've got to be clear that when you spend on healthcare, it's an investment — it's not an expense."
— Dr Stavros Nicolaou, Group Executive, Aspen Pharmacare

Dr.Taz Emeran-Thomas
Founder: Khaya Doc



Dr Taz Emeran-Thomas is a medical doctor and healthcare entrepreneur committed to delivering compassionate, patient-centred care. As Founder of Khaya Doc, she champions equitable access to quality healthcare through innovative, community-focused solutions that integrate physical, emotional and psychological wellbeing. Her work advocates for a healthcare system where dignity, empathy and access are fundamental to every patient's experience.

Ms. Alisha Lalbeharie
Founder & Director, Foot Motion Podiatry and FMP Wellness



Alisha Lalbeharie is an award-winning podiatrist, entrepreneur and corporate wellness leader dedicated to advancing preventive healthcare and improving quality of life. As Founder of Foot Motion Podiatry and FMP Wellness, she has pioneered innovative podiatry services, workplace wellness programmes and strategic partnerships that promote accessible, preventative and patient-centred healthcare across South Africa.

Ms. Kelebogile Mothupi
Board Member, Public Oral Health Forum

Kelebogile Mothupi is a Board Member of the Public Oral Health Forum and an advocate for advancing oral health within South Africa's public healthcare system. Her work focuses on improving equitable access to oral healthcare, promoting preventative interventions and strengthening the integration of oral health into broader health policy and Universal Health Coverage initiatives.

Panel Analysis

The Summit's two convened panels, together with the open floor discussion each generated, form the richest evidentiary base in this report. Each is analysed below for its purpose, its consensus, its points of tension, and its institutional and policy implications.

Panel One: Evidence of Exclusion

Moderator: Tshenolo Moeti. Panellists: Dr Taz Emeran-Thomas (Founder, Khaya Doc); Miss Alisha Lalbeharie (Founder & Director, Foot Motion Podiatry); Nonhlanhla Siwela (Medical Student, Author & Public Health Advocate); Kelebogile Mothupi (Dental Therapist, Public Oral Health Forum).

The panel's brief was to test the theme's central claim — that young professionals are already delivering healthcare, in spite of the system, not because of it — against the direct testimony of practitioners who had built functioning clinical or advocacy platforms without institutional support.

Dr Emeran-Thomas described Khaya Doc, a telehealth platform launched before the Summit, already reaching roughly 500 households, offering clinical services at approximately half of traditional cost to underserved communities, and designed to plug modularly into any point of the public-sector value chain. Miss Lalbeharie described building what she positioned as Africa's first national podiatry brand, citing a ratio of one podiatrist to roughly twelve million people in the public system she trained in, an in-house 3D printing capability for orthotics, and a proactive-care cost argument — a podiatry consultation costing a fraction of a diabetic amputation. Ms Mothupi, a dental therapist, lecturer and Public Oral Health Forum and HPCSA board member, described an oral health workforce of roughly 8,500 professionals for a population exceeding 60 million, of whom the large majority practise privately, alongside a national child dental caries burden and roughly 1,000 new oral cancer diagnoses a year, frequently detected too late for effective treatment. Ms Siwela, a Wits medical student and SRC member, described building a digital health-education platform exceeding 100,000 followers, with individual videos on HPV vaccination and antimicrobial-resistant sexually transmitted infection reaching over a million views, alongside rural community health-worker collaboration on adolescent pregnancy in Mpumalanga.

Points of Tension

An audience question from a reproductive-health NGO coordinator surfaced an unresolved tension the panel did not fully answer: whether promoting youth entrepreneurship as the primary route to health-sector inclusion risks becoming, in the questioner's words, “a sophisticated way of teaching people how to remain excluded” when market access itself remains structurally closed. Panellists responded pragmatically — necessity, not preference, drives innovation, and innovation does not require large capital to begin — without resolving the underlying policy question of whether government job creation or enterprise facilitation is the more appropriate lever.

Panel Analysis cont.

Policy and Institutional Implications

- Procurement reform aimed specifically at youth-owned health suppliers (see the Youth Health Enterprise Procurement Accelerator, Keynote Analysis) has a ready pipeline of credible, delivery-proven candidates, on this panel's evidence.
- Oral health and podiatry, both historically peripheral to health workforce planning, present quantifiable economic cases — cost-avoidance through prevention — that this report carries into its Thematic Analysis and National Findings.
- Digital health advocacy by practitioners themselves, reaching audiences at a scale conventional public health communication rarely achieves, is an underused and effectively free public health asset.

Panel Two: Building a Sustainable Healthcare System

Panellists: Dr Simon Strachan (CEO, South African Private Practitioners Forum); Dr Shaheda Omar (Director, Teddy Bear Foundation); Dr Lehlogonolo Majake-Mogoba (Chief Executive Officer, Steve Biko Academic Hospital); Mr Sivuyise Ngwane (Analyst, National Treasury, in a personal capacity).

Where Panel One tested exclusion from the perspective of individual practitioners, Panel Two examined system sustainability from the perspective of the institutions responsible for financing, delivering and safeguarding care at scale.

Dr Strachan described the Universal Healthcare Access Coalition, a 34-member coalition of private healthcare providers and hospital groups that has developed a proposed strategic reform model, and argued from experience that public-private partnerships in South African healthcare have shown mediocre to exceptional benefit but have rarely been sustained — a failure he attributed to inconsistent accountability and governance rather than to a shortage of private-sector willingness, citing existing collaborations on postgraduate specialist training between public registrars and private academic hospitals as evidence the model can work when well governed. Dr Majake-Mogoba offered a tertiary-hospital perspective, cautioning that specialist-level institutions are a poor proxy for the health system as a whole, and that under-investment in primary healthcare produces the late-stage, high-cost complications — including preventable amputation — that tertiary facilities then absorb; she also noted that compensation of employees consumes the majority of a large academic hospital's budget, leaving limited room for anything else. Dr Omar, drawing on decades in child protection and forensic child-abuse services, argued that healthcare graduates are technically competent but insufficiently prepared for the poverty, trauma, gender-based violence and family dysfunction that shape the health outcomes of the patients in front of them, citing case examples in which repeat child abuse went undetected because no intersectoral, multidisciplinary response connected a treating clinician to a social worker's or child-protection unit's information. Mr Ngwane, representing a Treasury analyst's personal perspective, argued that health spending is persistently under-analysed as an aggregate budget line rather than disaggregated by function, and that NHI financing debates about affordability are frequently conducted without reference to alternative instruments — such as risk-adjusted social insurance contributions or outcomes-linked social financing — that could change the affordability calculus.

Panel Analysis cont.

An audience member from the Lady of Peace Community Foundation pressed Mr Ngwane directly on whether Treasury would commit to a dedicated, ring-fenced epidemic-preparedness budget line, citing the country's exposure to emerging infectious and zoonotic disease threats. His response — candid rather than evasive — acknowledged that health-related shocks are increasingly funded reactively through Treasury's general contingency reserve rather than through a dedicated instrument, and that more granular budget classification would be needed before such a commitment could be responsibly made. A University of Johannesburg delegate then reframed the panel's entire premise from the floor, arguing that healthcare continues to be treated politically and fiscally as a social cost rather than as an economic sector on the same footing as skills development — a intervention that received visible support from the panel moderator and was carried into the day's closing remarks.

Consensus

- **Money is not, on this panel's shared assessment, the primary constraint on health system sustainability; accountable leadership, governance discipline and intersectoral coordination are.**
- **Primary healthcare under-investment is a false economy, generating higher-cost complications at tertiary level that could have been avoided through earlier, cheaper intervention.**
- **Health workforce training curricula do not adequately prepare graduates for the social and structural context in which they will practise.**

Policy and Institutional Implications

- A formal, resourced intersectoral training standard — bringing health, social development and justice-sector competencies into a single curriculum requirement — has a strong evidentiary case from this panel and should be a specific, named recommendation (see Recommendations: Universities and Professional Councils).
- Treasury's own representative identified budget disaggregation as a precondition for better health financing decisions; this is an achievable, low-cost near-term reform (see Implementation Roadmap: Immediate/90 Days).
- The Universal Healthcare Access Coalition's existing 34-member public-private reform proposal is a ready-made vehicle NEXEC and government could engage directly, rather than commissioning a parallel process.

Thematic Analysis

Organised by theme rather than by speaker, this chapter synthesises discussion that recurred across the government keynotes, the private-sector keynote, both panels, the research presentation and the open floor.

The single most repeated claim across the entire Summit, made independently by the Deputy Minister, both panels, the private-sector keynote and multiple audience members, is that South Africa's health workforce problem is a pipeline-coordination failure rather than a talent-supply failure. Graduates exist in nursing, medicine, dentistry, pharmacy, rehabilitation and podiatry; posts, accreditation pathways and workplace-readiness support do not reliably connect to them. The Deputy Minister's seven-stage formulation — education, qualification, accreditation, workplace exposure, placement, employment, and advancement, leadership and ownership — is adopted in this report as the reference model against which institutional accountability should be assessed at each stage

The Youth Integration Pathway

A pipeline is judged not by entries at the start, but by who completes, transitions, is absorbed, and ultimately owns productive assets.

Two structural findings recur within this theme. First, no single institution owns accountability for a graduate's progress across the full pathway — universities, professional councils, SETAs, provincial departments, hospitals and Treasury each control one stage and can each demonstrate compliance with their own mandate while a graduate falls into the space between mandates. Second, workforce “readiness” was reframed by multiple speakers as a shared institutional obligation: it is unjust, in the Deputy Minister's formulation, to describe a graduate as insufficiently work-ready when the actual barrier is an unfunded post, an accreditation delay or an inaccessible recruitment process.

Financing discussion ran across the two government keynotes, the Treasury contribution to Panel Two, and repeated audience interventions. The consistent through-line was that South Africa's NHI debate is more constrained by implementation capability — facility functionality, medicine supply reliability, referral pathways, workforce distribution and public trust — than by an absolute shortage of money in the system. Multiple speakers separately noted that health expenditure is already substantially subsidised through a combination of tax-funded public financing and employer/individual contributions to medical schemes, and that the more productive financing question is how existing resources are pooled and redistributed rather than whether new resources can be found. Treasury's own contribution added a specific, actionable point: health spending is not currently analysed as a disaggregated function within the budget in a way that would allow targeted instruments — such as risk-adjusted social insurance contributions or outcomes-linked social financing instruments — to be properly designed and costed.

The decline in South Africa's local pharmaceutical manufacturing capacity — from a local antiretroviral production share cited at approximately 92% in 2008 to approximately 22% today — was treated by the private-sector keynote as a health-security issue as much as an industrial one, reinforced by COVID-era supply-chain disruption evidence. The four-point policy response proposed (regulatory harmonisation, value-for-money procurement scoring, export incentives, and donor procurement reform) is carried forward into this report's Recommendations chapter as a distinct, government-and-industry-facing agenda, separate from the youth-workforce agenda, though the two intersect directly in medical-device and health-technology enterprise procurement.

Thematic Analysis cont.

Across Panel One, the Business, Transformation & Inclusion address and the private-sector keynote, procurement access — not funding availability, not entrepreneurial capability — was named repeatedly as the binding constraint on youth health enterprise growth. The Progressive Business Forum's contribution added a specific institutional finding: development finance capital is, on its own account, abundant and available across South African and multilateral development finance institutions, yet does not reach health-sector youth innovators, and no dedicated health-sector vertical could be readily identified within national employment or enterprise-development funds. Public procurement's legislated targets for allocation to previously disadvantaged groups, including women, youth and persons with disabilities, exist on paper; this Summit's evidence suggests they are not being tracked or enforced at the level of individual health-sector tenders.

Digital health was addressed from two distinct angles that this report treats as complementary rather than competing. Government's Acting Director-General and the private-sector keynote both argued for a shared, verified national digital patient record system, tied to professional council registration, as an efficiency and safety intervention — reducing clinical administrative time and diagnostic error, at a connectivity investment cost acknowledged to be substantial against current infrastructure budgets. Separately, a medical-student panellist demonstrated digital platforms as a direct-to-public health education channel, reaching audiences at a scale — over 100,000 followers, individual videos exceeding a million views — that conventional public health communication rarely achieves. Both are digital health investments; neither currently receives institutional support proportional to demonstrated impact.

The SAMRC's research capacity presentation described a five-pillar model spanning funding stewardship, knowledge generation, innovation translation, next-generation research capacity development, and policy translation — while candidly acknowledging that the last of these, translating research evidence into implemented policy, remains the weakest link, hampered by a disconnect between researchers, policymakers and implementers who are frequently not speaking to one another in practice. The presentation also flagged a specific funding risk: reduced international research collaboration funding from a major bilateral partner, with direct implications for ongoing genomic surveillance and vaccine-development capacity.

Oral health and podiatry, historically peripheral to national health workforce planning, were each argued from the floor to carry a strong prevention-economics case: a podiatry consultation costing a small fraction of a diabetic amputation; an oral health workforce of approximately 8,500 professionals, four-fifths of them in private practice, serving a population exceeding 60 million, against a backdrop of high childhood dental caries prevalence and late-stage oral cancer detection. This report treats both as evidence that workforce planning organised solely around medicine and nursing understates the economic return available from investing in allied and oral health professions.

The private-sector keynote's “one health” framing — treating zoonotic disease, climate-linked epidemiological change and antimicrobial resistance as cross-departmental rather than health-department-only problems — was echoed by the Ministerial Advisor's emphasis on prevention and health promotion, and by the rising cardio-metabolic-renal non-communicable disease burden described across multiple sessions. The consistent implication is that the Department of Health cannot resolve the country's emerging disease burden alone; trade and industry (food and tobacco regulation), transport (active mobility infrastructure), and education portfolios were all named as necessary co-owners of prevention outcomes.

The Teddy Bear Foundation's contribution to Panel Two, reinforced by a child-rights advocate from the floor, made a distinct and specific case: healthcare training produces technically competent, single-discipline graduates poorly equipped for the trauma, poverty and family dysfunction that shape the presentations they will actually see, particularly in child health. The case examples offered — injuries mistaken for accidents in the absence of social-work follow-up — describe a training and referral-system gap with direct child-safety consequences, not only a workforce-development one.

Ten Strategic National Findings

Finding 1: South Africa does not primarily face a shortage of healthcare talent. It faces a shortage of institutional coordination.
Graduates in medicine, nursing, dentistry, pharmacy, rehabilitation and podiatry exist in numbers the system is not currently absorbing, while facilities report severe staffing pressure. The binding constraint is the handoff between training, accreditation, funding and placement institutions, none of which is accountable for the graduate's full journey.

Finding 2: Procurement, not funding availability, is the primary barrier to youth health enterprise growth.
Development finance capital was described from the floor as abundant but inaccessible to health-sector youth innovators; every youth entrepreneur on the programme identified procurement access, not capital or capability, as their binding constraint.

Finding 3: An allocation is not an outcome.
The 2026 Budget's R21.3 billion medium-term provincial allocation for doctor employment and R5.9 billion Human Resources and Training Grant are necessary but not sufficient; their value depends on transparent, timely, equitably distributed appointments

Finding 4: NHI's central constraint is delivery capability, not the availability of money.
Multiple speakers, across government and the private sector, independently concluded that facility functionality, medicine supply, referral pathways, workforce distribution and public trust — not financing architecture alone — will determine whether National Health Insurance succeeds.

Finding 5: Local pharmaceutical and medical-device manufacturing capacity has eroded to a level that constitutes a health-security risk.
A decline in local antiretroviral production share from approximately 92% to approximately 22% over roughly a decade and a half was cited as evidence, reinforced by COVID-era supply-chain disruption.

Finding 6: Primary healthcare under-investment is a false economy.
Tertiary-level speakers described late-stage, high-cost complications — including preventable amputation and late-detected cancer — as the direct, avoidable consequence of under-resourced prevention and primary care.

Finding 7: Health workforce training does not adequately prepare graduates for the social context of their patients.
Child-protection and multidisciplinary-care evidence described technically competent graduates unable to recognise or respond appropriately to trauma, poverty, gender-based violence and family dysfunction shaping the presentations they see.

Finding 8: Digital platforms built by young practitioners already outperform conventional public health communication at scale.
Individually-run health-education platforms reaching over 100,000 followers and single videos exceeding a million views were cited as under-recognised public health assets.

Finding 9: Research evidence is not the constraint on better health policy; translation into implementation is.
The national research council's account identified a persistent, acknowledged disconnect between researchers, policymakers and implementers as the weakest link in its own five-pillar model.

Finding 10: The single largest statutory youth-development funder was functionally absent from its own sector's national convening.
The National Youth Development Agency was represented only by a delegate acting on behalf of its Deputy Chairperson, a gap NEXEC's own leadership named directly and critically as a governance and coordination risk.

Recommendations

Recommendations are organised by stakeholder group, reflecting the Summit's own design principle that implementation responsibility is distributed rather than singular.

Government (National and Provincial)

- Disaggregate the national health budget by function, to enable design of targeted financing instruments beyond conventional tax-based allocation.
- Publish a standing quarterly account, against the Deputy Minister's 90-day marker, of placement numbers, funded posts filled, procurement access granted to youth enterprises, and outstanding commitments from this Summit.
- Direct the National Youth Development Agency to formalise structured engagement with NEXEC's proposed Cross-Sector Working Circle, with senior leadership representation at future convenings.
- Advance the four-point local-manufacturing policy agenda raised in the Private Sector Keynote, particularly public procurement scoring reform and activation of the General Export Incentive Scheme for pharmaceutical exports.

Private Sector

- Extend partnership beyond sponsorship and corporate social investment into paid workplace experience, procurement commitments and patient capital for youth- and women-owned health enterprises, as urged directly in the Government Keynote Address.
- Engage the Universal Healthcare Access Coalition's existing 34-member reform proposal as a vehicle for structured public-private collaboration, rather than initiating parallel processes.
- Support mobile clinic and screening infrastructure through corporate social-investment channels, targeted at early detection of the non-communicable disease burden identified in this report.

Hospital Groups

- Formalise and expand postgraduate specialist training partnerships between public registrars and private academic hospitals, building on existing models cited during Panel Two.
- Review compensation-of-employees budget structures against service delivery outcomes to identify where funded-but-unfilled posts persist.

Professional Councils

- Accelerate accreditation pathway reform for allied and oral health professions identified in this report as economically significant but historically under-prioritised in workforce planning.
- Continue and expand ethical-rules reform enabling group and multidisciplinary practice models, reducing the solo fee-for-service practice model described as increasingly unsustainable and inequitable.

Universities and Training Institutions

- Introduce compulsory business, procurement and entrepreneurship literacy modules across health training curricula, addressing the readiness gap raised repeatedly from the floor.
- Develop intersectoral, multidisciplinary training components — bringing social work, child protection and trauma-informed practice into clinical curricula — in direct response to the Teddy Bear Foundation's evidence.
- Expand distance and blended learning models to increase training-place capacity without proportional increases in physical infrastructure cost.

Recommendations

Development Agencies and Funders

- Establish or designate a dedicated health-sector vertical within existing development finance and enterprise-support funds, addressing the funding-access gap identified by the Progressive Business Forum.
- Support NEXEC's proposed Health Economy Observatory and Cross-Sector Working Circle as recipients of coordination and monitoring funding, rather than funding parallel, duplicative platforms.

NEXEC

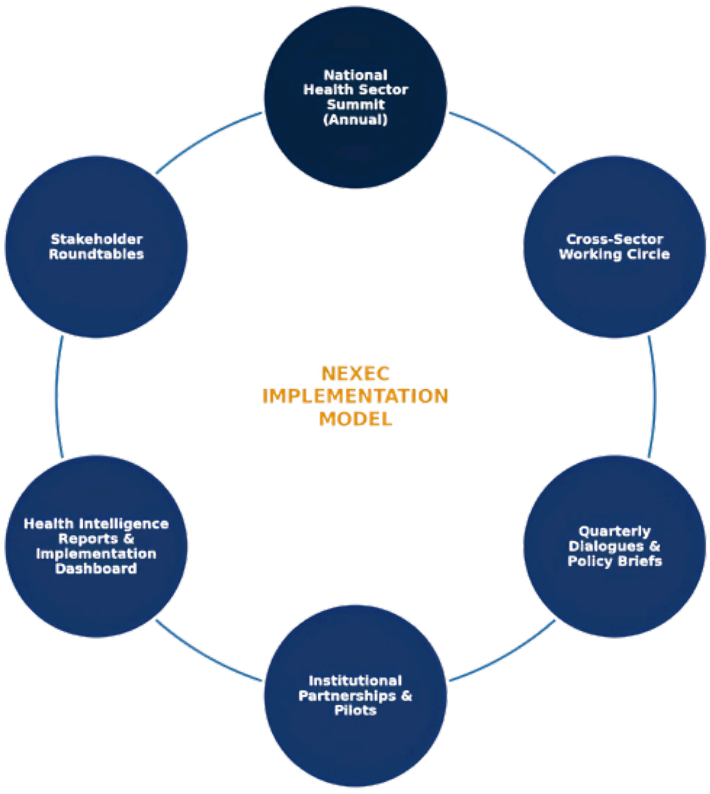
- Enforce strict time governance in future Summit editions so that youth-leadership sessions are never the first casualty of over-running discussion, directly addressing the loss of Panel Three.
- Publish the Health Sector Summary Report, Mapped Delivery Opportunities and Participant Directory committed to in the Summit's concept note, and report against them at the next convening.
- Escalate the National Youth Development Agency's absence through direct engagement with its accounting authority, rather than allowing it to recur unaddressed.

Young Professionals and Youth-Led Enterprises

- Use existing professional and business forums (SAPPF, POHF, PBF, BMF and equivalents) as entry points for mentorship and market access, as explicitly urged by multiple panellists with lived experience of building without institutional support.
- Engage the Cross-Sector Working Circle and NEXEC's Health Subcouncil directly to ensure procurement-readiness and accreditation barriers are logged and tracked against the 90-day accountability marker.

NEXEC Implementation Programme

NEXEC's Health Subcouncil commits to the following recurring institutional mechanisms, intended to convert this Summit from a single event into a standing national platform.



NEXEC Implementation Programme

Quarterly Dialogues — smaller, focused follow-up convenings tracking specific commitments made at the annual Summit.

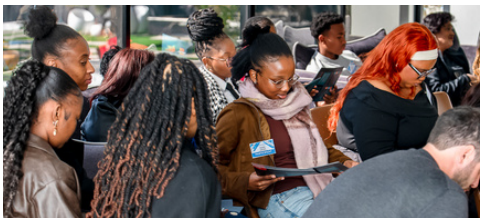
Health Intelligence Reports and a Policy Brief Series — shorter, more frequent publications between annual Summits, keeping the evidence base current.

Cross-Sector Working Circles — standing working groups on the specific delivery opportunities identified in this report (procurement accelerator, community health worker formalisation, digital health record system).

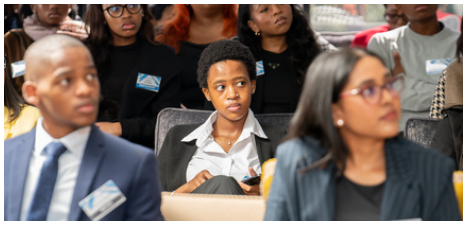
A Young Healthcare Professionals Network — connecting delegates such as this Summit's panellists to one another and to institutional partners between convenings

A Research Programme and Health Economy Observatory — building the SAMRC's stated capacity-development ambitions into an ongoing NEXEC-supported monitoring function

Stakeholder Roundtables and an Implementation Dashboard — providing the transparent, trackable reporting this report's Implementation Roadmap requires.



An Annual Summit — with this report itself serving as the baseline against which the next edition's progress is measured



Risks To Implementation

The Summit's proceedings point to five interlocking categories of risk that could stall this agenda if left unaddressed. Institutionally, the most immediate concern is the National Youth Development Agency's absence at senior leadership level despite being the largest statutory youth-development funder in the room's own stated remit — an absence NEXEC's leadership named directly rather than let pass quietly.

On funding, SAMRC's own account flagged shrinking international research collaboration support from a major bilateral partner, with direct consequences for genomic surveillance and vaccine-development capacity going forward. Alongside this sits a structural gap rather than a shortage: development finance capital was repeatedly described as abundant across the country's DFIs, yet no dedicated vertical currently exists to channel it toward youth-led health enterprises specifically.

Policy risk is concentrated in delivery capability rather than financing architecture. Multiple government and private-sector speakers converged on the same point: NHI's success will be determined by facility functionality, medicine supply reliability and workforce distribution, none of which improve automatically with budget allocation alone. The local-manufacturing agenda carries a parallel risk, since its four proposed levers — regulatory harmonisation, procurement scoring reform, export incentives and donor procurement reform — require coordination across Health, Trade and Industry, Treasury and Science and Innovation that sits outside any single speaker's mandate.

Capacity constraints compound both of these. Provincial-level execution was named, by government's own speakers, as the weakest point in the chain between national resourcing and actual service delivery, and the connectivity investment required for a national digital health record system was acknowledged by the Acting Director-General himself to be substantial relative to current infrastructure budgets. Underlying all of this is a political risk this report treats as the most consequential: public trust in NHI and broader reform depends on visible, near-term delivery, and a further cycle of well-attended dialogue without measurable follow-through — the exact pattern NEXEC's own leadership warned against in its closing remarks — risks deepening the scepticism this Summit was convened to counter.

Government Closing: Prof. Nicholas Crisp
Acting Director-General
National Department of Health

Prof. Crisp opened not with data but with a personal organising principle — justice — and used it to reject any comfortable reading of the day's proceedings: by his own account, South Africa's health system does not currently deliver it. He grounded this in a simple resource-concentration critique: the country spends the bulk of its health resources on a comparatively small share of the population, while the majority are left, in his words, without a functioning route into care. He illustrated this with his own history as the sole doctor at a rural district hospital for more than a year, where patients arrived by wheelbarrow because they had delayed seeking care out of fear of what it would cost them — a story he used to argue that fragmented, fee-dependent access is a structural failure, not an individual one.

He extended the critique to the workforce itself: South Africa has more than 160 distinct categories of registered health professional, each trained, regulated and often paid in isolation from the others, while the patient in front of them experiences a single, undivided set of needs. Treating HIV, diabetes and pregnancy as three separate systems requiring three separate visits, he argued, reflects institutional convenience rather than patient reality.

A Vision for Reform

Crisp defined universal health coverage deliberately broadly — every person receiving the care they need, when and where they need it, at adequate quality, regardless of income or geography — and used that definition to criticise narrower readings of the concept that quietly exclude the poorest or most marginalised. His account of National Health Insurance's operating logic was the most technically detailed of the day: a single fund purchasing care from accredited providers — public, private or NGO, ownership immaterial — with providers paid on a capitation basis for a defined population rather than fee-for-service, and hospitals funded according to the community they serve rather than a patient's ability to pay. He was candid that this model remains contested and only partially detailed in implementing regulation.
Two supporting priorities featured prominently:

- A single, interoperable digital patient record, portable across providers and authenticated against professional council registration, which he argued would save clinicians significant administrative time per consultation — though he was equally candid that connecting several thousand public facilities on a current budget in the order of R100 million a year makes national rollout a multi-year undertaking, not a near-term fix.
- Rescuing domestic vaccine and pharmaceutical manufacturing capacity built during the COVID period, which he said requires closer coordination between Health, Treasury and the science and innovation portfolio than currently exists.

Crisp's contribution reinforces, from inside government, the same conclusion this report reaches from industry, academic and youth-practitioner evidence elsewhere: NHI's success depends less on the financing model on paper than on whether fragmented professional, provincial and departmental mandates can be made to serve one patient pathway. His closing message to the room's younger delegates was an explicit offer of continued mentorship and collaboration — a direct, personal echo of the Summit's own "Missing Link" framing.

Strategic Partner Spotlight

Advancing Prevention, Oral Health and Community Wellbeing

Oral health is a fundamental pillar of overall health, influencing nutrition, chronic disease management, educational outcomes and quality of life. Yet it remains one of the most under-recognised components of South Africa's broader health agenda. As a global leader in consumer health, Haleon South Africa continues to strengthen oral healthcare through scientific innovation, trusted consumer brands, public education and partnerships that promote prevention as the first line of healthcare.

Haleon's contribution to the NEXEC National Health Sector Summit 2026 extended beyond attendance. The company supplied oral healthcare products for all delegates, with Sensodyne and Parodontax included in every delegate welcome package. Haleon also donated premium branded gift sets presented to competition winners ahead of the Government Closing Address. Representing the organisation was Ms Kwara Kekana, Corporate Affairs Manager, whose participation reflected Haleon's commitment to engaging directly with national conversations on healthcare transformation. This contribution exemplified the kind of private-sector partnership championed throughout the Summit—not sponsorship from a distance, but meaningful participation through both people and products.

Beyond the Summit, Haleon has established itself as a significant contributor to oral health promotion in South Africa. Its portfolio—including Sensodyne, Parodontax, Sensodyne Pronamel, Aquafresh and Corsodyl—is supported by investments in public education, professional engagement and preventative healthcare. As a global partner of the FDI World Dental Federation's World Oral Health Day, Haleon continues to advance awareness of oral health as an essential component of overall wellbeing.

Among its most significant local initiatives is the Aquafresh Oral Health Education Programme, which has reached more than 240,000 learners across over 1,000 South African schools since its launch in 2020. Complementing this is the Confidence Libraries Initiative, which combines literacy development with oral health education by delivering fully equipped mobile libraries to under-resourced schools. These programmes recognise that children's health, confidence and educational attainment are closely interconnected, demonstrating how preventative healthcare can extend beyond clinical settings into communities and classrooms.

The need for such interventions remains significant. South Africa continues to experience a high burden of preventable oral disease among children, reinforcing the importance of early intervention, public education and improved access to preventative care. The Summit echoed these priorities through discussions on oral health, prevention and community-based healthcare, recognising that investment in prevention delivers substantial long-term health, social and economic returns.

Haleon's participation in the Summit, combined with its established national prevention programmes, demonstrates the valuable role that the private sector can play in strengthening South Africa's healthcare ecosystem. It also presents opportunities for future collaboration with youth-led healthcare enterprises, oral health practitioners and community-based initiatives as envisaged through the Summit's recommendations on prevention, workforce development and public-private partnership.

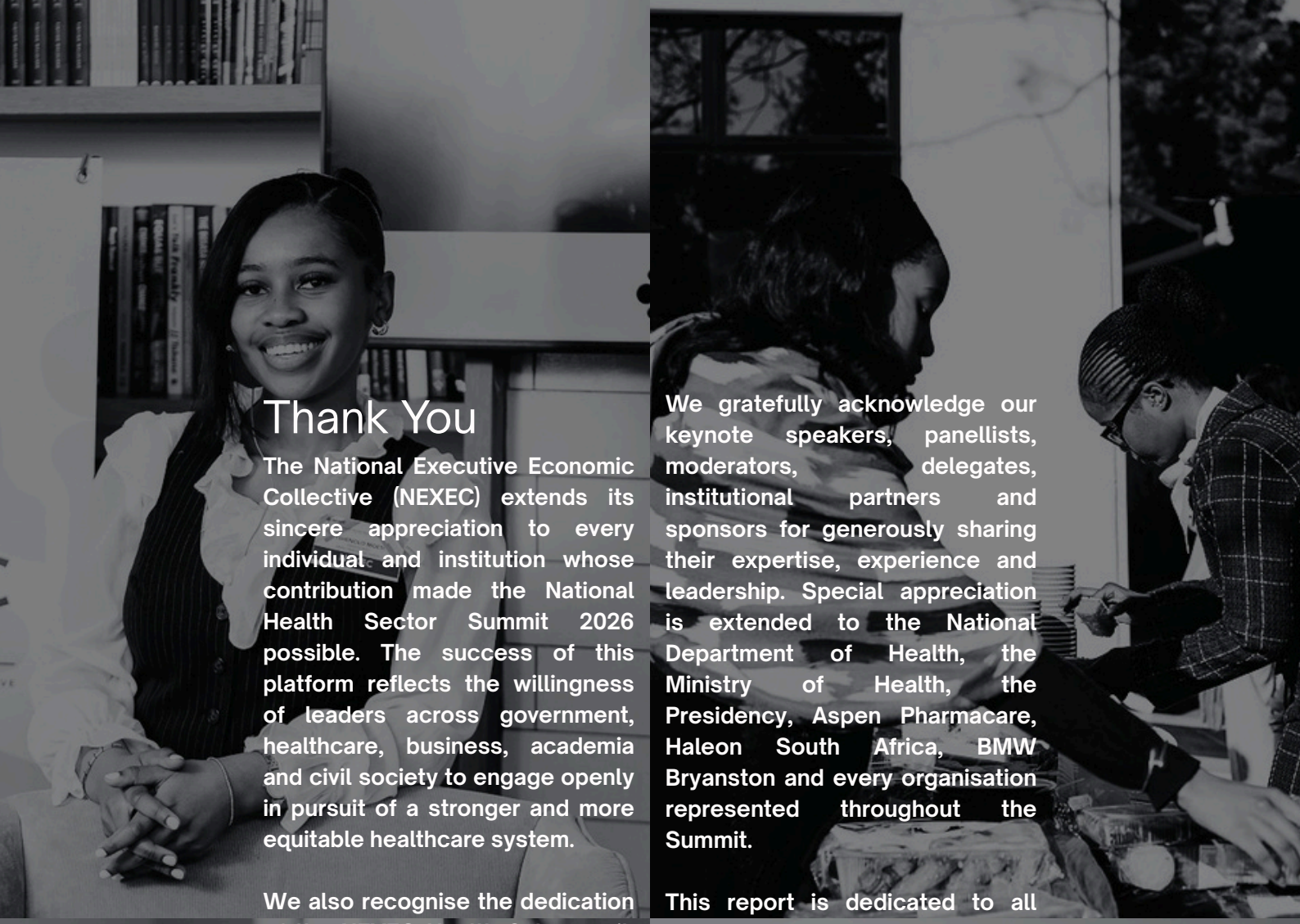
NEXEC gratefully acknowledges Haleon South Africa for its valued partnership and contribution to the National Health Sector Summit 2026. Their support reflects a shared commitment to prevention, health education and collaborative action in building a healthier and more resilient South Africa.

CONCLUSION

This Summit should be read not as an event, but as the first edition of a platform NEXEC intends to sustain annually. Its proceedings converge on a single strategic conclusion, stated at the outset of this report and restated here: the distance between South Africa's unemployed health graduates and its underserved communities is not two problems requiring two policy responses, but one problem of institutional coordination requiring a single, accountable pathway.

The measure of this Summit's success will not be whether its analysis was persuasive or its speeches well received. It will be whether, when this platform convenes again, a young professional has found a place to serve, a community has gained access to better care, an enterprise has entered a value chain it was previously shut out of, and institutions that once worked alongside one another have begun, at last, to work as one system.

"The Summit is not here to produce another set of good intentions. It is here to produce a record: evidence of barriers named specifically, and of commitments made concretely."



Thank You

The National Executive Economic Collective (NEXEC) extends its sincere appreciation to every individual and institution whose contribution made the National Health Sector Summit 2026 possible. The success of this platform reflects the willingness of leaders across government, healthcare, business, academia and civil society to engage openly in pursuit of a stronger and more equitable healthcare system.

We also recognise the dedication of the NEXEC Health Subcouncil, the organising committee, volunteers and support teams whose professionalism ensured the successful delivery of the Summit. Finally, we thank every young healthcare professional, student, entrepreneur and practitioner who participated with the conviction that healthcare transformation is achieved not through dialogue alone, but through sustained collaboration and implementation.

We gratefully acknowledge our keynote speakers, panellists, moderators, delegates, institutional partners and sponsors for generously sharing their expertise, experience and leadership. Special appreciation is extended to the National Department of Health, the Ministry of Health, the Presidency, Aspen Pharmacare, Haleon South Africa, BMW Bryanston and every organisation represented throughout the Summit.

This report is dedicated to all those working every day to strengthen South Africa's healthcare system. May the partnerships formed, ideas shared and commitments made continue to shape meaningful action long after the Summit concluded.

www.nexec.co.za

@nexecsouthafrica

health@nexec.co.za

Design Quarter

Photos Here