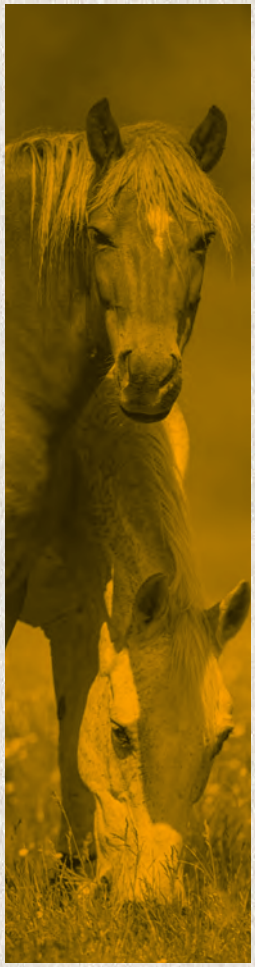
Health and Welfare Sector
Education and Training Authority
HWSETA



SECTOR SKILLS PLAN

2022 2023

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FOREWORD

The Health and Welfare Sector Education and Training Authority (HWSETA) is pleased to present its 2022-2023 Sector Skills Plan (SSP) accompanied by the updated Continuous Improvement Plan (CIP), updated Research Agenda and Top 10 OFO based Sector Priority Occupations List (Pivotal). The development of this SSP has been done in adherence to the provisions and in alignment with the New Department of Higher Education and Training (DHET) 2020 SSP Framework. This SSP has responded positively to the Continuous Improvement Plan post the one-on-one session held between the HWSETA and the DHET 2021 as indicated below.

This SSP is a roadmap that details the path chosen by the HWSETA towards achieving the goals set by the Executive Authority, and the Honourable Minister of Higher Education, Science and Technology. It is a plan that is approved by the Board of the HWSETA, which comprises of representatives of government, labour, and employers. Government departments that are key and have representatives on the Board are the Department of Social Development (DSD) and the Department of Health (DOH).

This plan seeks to provide current sector skills development needs initially set out in the HWSETA Five Year Sector Skills Plan. Its purpose is also to align sector-based skills needs and programs with socio-economic development priorities of government and the country as stated in the New Growth Path (NGP), the National Development Plan (NDP) 2030, the Medium Term Strategic Framework (MTSF) and the Economic Reconstruction and Recovery Plan (ERRP) and the Economic Reconstruction and Recovery Skills Strategy. The SSP also endeavours to showcase the effects of COVID-19 in the sector as the health and social development sector is in the frontline of fighting the pandemic. The PIVOTAL list for this year's update will therefore aim to support the sector to fight against the spread of this pandemic and effects.

The SSP meets the requirements set out by the DHET in the National Skills Development Plan (NSDP). This SSP is a valuable tool for HWSETA stakeholders and a useful source of information for service providers and the community.

The HWSETA hopes that this comprehensive SSP will contribute to the enhancement of the goals of a developmental state and the democratisation of education and training in the SETA sector and the country at large. It will surely move the country closer to a stage where South Africans will be confident that they have made "Every working place, a training space!"

The HWSETA is committed to working with workers, employers, government departments and communities to move South Africa closer to the goal of the adequate and skilled workforce. It is committed to contributing to the achievement of positive economic growth, job creation and the empowerment of workers, especially women, youth and people living with disabilities.

The Board and staff are confident that the achievement of goals and targets set out in this SSP will be a positive contribution that will result from working together with HWSETA stakeholders and communities to move South Africa forward.

Dr Nomsa Veronica Mnisi
Chairperson: HWSETA Board

Ms Elaine Brass, CA (SA)
Chief Executive Officer: HWSETA

LIST OF ABBREVIATIONS/ACRONYMS

AHPCSA	Allied Health Professions Council of South Africa
AIDS	Acquired Immune Deficiency Syndrome
APP	Annual Performance Plan
AQP	Assessment Quality Partner
ATR	Annual Training Reports
CBO	Community-Based Organisation
CDP	Community Development Practitioner
CDW	Community Development Worker
CESM	Classification of Education Study Material
CHE	Council on Higher Education
CHW	Community Health Worker
CPD	Continuous Professional Development
CYCW	Child and Youth Care Worker
DBE	Department of Basic Education
DHET	Department of Higher Education and Training
DoH	Department of Health
DSD	Department of Social Development
ECD	Early Childhood Development
EISA	External Integrated Summative Assessment
ERRP	Economic Reconstruction Recovery Plan
FET	Further Education and Training
FETC	Further Education and Training Certificate
GDP	Gross Domestic Product
GET	General Education and Training
GETC	General Education and Training Certificate
GP	General Medical Practitioner
GWM&ES	Government-wide Monitoring and Evaluation System
HASA	Hospital Association of South Africa
HEI	Higher Education Institution
HEMIS	Higher Education Management Information System
HET	Higher Education and Training
HIV	Human Immunodeficiency Virus
HPCSA	Health Professions Council of South Africa
HWSETA	Health and Welfare Sector Education and Training Authority
ILO	International Labour Organisation
MRC	South African Medical Research Council
MTEF	Medium Term Expenditure Framework
NC	National Certificate
NCV	National Certificate (Vocational)
NDP	National Development Plan
NEI	Nursing Education Institution
NGO	Non-Governmental Organisation
NGP	New Growth Path
NHA	National Health Act, 61 of 2003
NHI	National Health Insurance
NPC	National Planning Commission
NPO	Non-Profit Organisation
NQF	National Qualifications Framework
NSCA	National Senior Certificate for Adults
NSDS	National Skills Development Strategy
NSF	National Skills Fund
MDR-TB	Multidrug-resistant TB
OBP	Onderstepoort Biological Products
OHSC	Office of Health Standards Compliance
PBSW	Professional Board for Social Work
PBCYC	Professional Board Child and Youth Care
PFMA	Public Finance Management Act
PHC	Primary Healthcare
PIVOTAL	Professional, Vocational, Technical And Academic Learning
PSETA	Public Service Sector Education Training Authority
QCTO	Quality Council for Trades and Occupations
QDP	Quality Development Partner
RIME	Research, Information, Monitoring, and Evaluation
RPL	Recognition of Prior Learning
SACSSP	South African Council for Social Service Professions
SANC	South African Nursing Council
SANDF	South African National Defence Force
SAPC	South African Pharmacy Council
SASSA	South African Social Security Agency
SAVC	South African Veterinary Council
SAW	Social Auxiliary Worker
SDA	Skills Development Act
SDF	Skills Development Facilitator
SDL	Skills Development Levy
SIC	Standard Industrial Classification
SSP	Sector Skills Plan
UMALUSI	Council for Quality Assurance in General and Further Education and Training
WBL	Work-based learning
WHO	World Health Organisation
WIL	Work Integrated Learning
WSP	Workplace Skills Plan
UNDP	United Nations Development Programme

EXECUTIVE SUMMARY

The sector served by HWSETA is extensive and spans portions of the human and animal health systems in South Africa, as well as portions of the social development and social services systems. The economic activities that fall within the scope of the health component of the HWSETA range from all healthcare facilities and services, pharmaceutical services and the distribution of medicine, medical research, Non-Governmental Organisations (NGOs), to veterinary services. The social development component of the sector consists of the government, NGOs, and private social work practices. The health and social development sector is a heterogeneous sector, falling mainly under the Standard Industrial Classification of all Economic Activities (SIC) divisions 86 to 88. The HWSETA exercises jurisdiction over 66 SIC codes as per new SETA landscape gazetted on 22 July 2019.

There are 357 988 filled positions in the Public Service health and social development departments and 431 834 in the private sector bringing total employment in the sector to 789 822. Professionals and technicians and associate professionals respectively form 36% and 23% of the total workforce. The majority of people working in the sector are female and the vast majority are black. Only a small percentage of workers in the sector are living with disabilities. Labour and trade unions are well organised and mobilised within the formal health and social development sector.

A unique feature of the sector is that a majority of the healthcare practitioners, social services professionals and para-professionals are regulated by professional councils. Statutory professional bodies play a formative role in determining the scope of practice for professionals and specialist occupations and also regulate the education and training standards required to work as healthcare or social services practitioners. By controlling and enforcing standards of quality, ethical conduct, and Continuous Professional Development (CPD), these councils promote the rendering of quality health and social services to the broader public.

The NGOs play a very important role in the sector. The government relies on these organisations to offer social services on its behalf. However, these organisations struggle to attract and retain social services professionals. Many NGOs are exempt from paying skills development levies, and so their workers fall outside the SETA levy-grant system for skills development.

Changes in the sector are driven by challenging socio-economic realities, the high burden of disease experienced in the country, high levels of gender-based violence and other social crimes that increase the demand for public health and social welfare services. At the same time, constitutional imperatives compel the state to be development orientated and to take progressive measures to grant everyone access to health care services, sufficient food and water, and social security. This year the COVID-19 pandemic is flagged again as a critical change driver adding to the stress factors already mentioned.

A multitude of national and provincial policies and socio-economic development plans impact the way services are delivered and how work is organised in the health and social development sector. Examples are the introduction of a national health insurance system and the re-engineering and expansion of primary health care.

Some of the statutory professional councils have introduced changes to the scopes of practice, qualifications, and training requirements for health and social services professionals, and in turn, these changes have specific implications for training platforms, training providers and the supply of skills. A case in point is the transformation of the nursing

qualifications framework. This has a significant impact on the supply of nurses.

Interventions are needed to address the considerable gaps in the management of public health operations, its employees, and technology, as well as its capital and financial resources. In the social development sector managers and supervisors require training in leadership and management, governance and service delivery. Apart from the need to train more social workers, the current skills base needs strengthening through occupational-specific and technical training, and work-readiness training. There is a pressing need for supervision training of social workers and improved monitoring of practical workplace training of undergraduates. NGOs require skills to improve governance and organisational management.

The key skills issues that fall within the HWSETA ambit are: skills interventions needed to build the developmental state; the development and sustainment of a skills pipeline into the sector that provides for entry-level as well as higher-level professional skills; the development and sustainment of opportunities for work-integrated learning, an important priority in line with the Economic Reconstruction and Recovery Plan (ERRP); and the development of mid-level skills needed to strengthen health and social development service provision and addressing the skills gaps in the current workforce brought about by changes in policy and service delivery.

Market forces, working conditions, remuneration, and career advancement opportunities are all factors that determine where and for how long people work in a particular workplace. The health and social development sector is grappling with serious human resources- and labour market challenges. These are reflected in high vacancy rates for especially health and social service professionals. The high vacancy rates are caused by, among others, inadequate occupational wages and wage differentials between different components of the sector, poor working conditions and the migration of professionals and other workers to countries with better health systems and from rural to urban areas. The COVID-19 pandemic has increased the demand for certain workers in the sector such as community health workers, nurses, lab technicians and social workers considerably.

Other factors impacting skills supply in the sector include long lead times required to train health professionals; constrained academic and clinical training capacity; a slow graduate output for the health-related occupations; changes in the qualification frameworks of some occupations such as nurses; and the low retention rate of health and social service professionals in the public sector.

Poor management of the health workforce and deficient leadership contribute to a high attrition rate from the health professions. Another labour market challenge relates to skills provision and skills absorption, e.g. social worker scholarships boosted graduate output in the last few years, but budget constraints in the public and private sector hamper employment of many of the newly qualified professionals. However, government made more funds available during the COVID-19 pandemic to employ additional social workers and community health workers. Hopefully these human resources will be retained after the COVID-19 pandemic has ended.

The institutional capacity for education and training of health and social service professionals has been boosted in the past few years. A new medical school was opened at the University of Limpopo in 2016; large numbers of medical students have been sent for training to Cuba; the training of nurses has been moved to a higher education platform, and; new qualifications for mid-level workers have been developed under the QCTO. Although these new developments are not without challenges and are, in some instances disruptions, but is expected to help alleviate the skills shortages experienced in the sector.

The establishment of partnerships with training institutions, employers and statutory bodies lies at the heart of HWSETA skills development operations. The partnerships are structured to provide multiple entry points into work in the health and social development sector and focus on increasing work-based learning (WBL) opportunities. Although some partnerships produced mixed results in the past, valuable lessons were learned, and HWSETA has adopted corrective measures to advance skills production. The current circumstances in the COVID-19 pandemic have asked for extraordinary strategies and partnerships. The HWSETA's pro-active reaction on the pandemic has resulted in a couple of life-saving partnerships and job creation initiatives. HWSETA sees their mandate reaching beyond a skills development responsibility during the COVID-19 pandemic.

HWSETA is only one of a number of institutions tasked with the funding and provision of skills development for the sector and has set skills development priorities to guide it with skills planning and skills provision. This process is first of all rooted in the understanding that the health and social development sector exists to provide decidedly personal services in the private spheres of people's lives and that the recipients of the services are usually ill, at-risk, vulnerable, frail or disabled. Secondly, the locality of skills formation during the working life of the workforce is considered.

Identification of the skills priorities also takes place in the context of informed research. National strategies give prominence to skills development at all qualification levels to advance health, social development, employment, and economic growth. Against these considerations, HWSETA identified the following overarching skills development priority areas:

a) Sustainable skills pipeline into the health and social development sector;
b) The professionalisation of the current workforce and new entrants to the sector;
c) Vital skills and skills set required enabling the state to meet its service delivery obligations as a developmental state; and
d) Skills needs and gaps in the time of the COVID-19 pandemic.

These skills development priorities are also viewed from a strategic perspective. First, a sustainable skills pipeline enables entry into employment in the health and social development sector at different entry points. Second, by prioritising the professionalisation of the workforce, HWSETA can contribute to skills interventions required to improve service quality and efficiency, and also address changes to service provision. Third, HWSETA can support the large-scale skills development interventions needed for the state to enhance the lives, health, well-being, and livelihoods of its citizens. Fourth, extra attention is paid to address skills needs and gaps due to the COVID-19 pandemic.

In giving effect to these skills priorities, the HWSETA will not simply equip learners with the appropriate knowledge, but also with the practical skills, competencies, attitudes, and behaviours to provide efficient and effective services. On a practical level, priority will be given to interventions that specifically address the scarce and critical skills as well as the particular skills sets required in the workplace. A key focus is the escalation of WBL opportunities for learners. For the HWSETA and its stakeholders, it is vital to nurture persons who are employable, competent, and work-ready and equipped with "Day One" skills when they enter employment in the sector. This year the focus is also on the Economic Reconstruction and Recovery Plan (ERRP) and the Economic Reconstruction and Recovery Skills Strategy, which identifies the skills implications of the ERRP and specifically outlines how the post-school education and training (PSET) system has to respond to this demand.

The HWSETA's skills development programmes and projects will be implemented across its operational sub-programmes and within the limitation of financial resources generated through the skills development levy. In addition the consequences of the COVID-19 pandemic may reverberate for years to come; apart from the direct effect, the pandemic has aggravated mental illness, domestic violence, addiction and childhood trauma which all fall into the framework of the work done in the health and welfare sector.

Ms Elaine Brass, CA (SA)
Chief Executive Officer: HWSETA

RESEARCH PROCESS AND METHODS

The research unit of the HWSETA conducts several research projects every year in order to inform the skills planning process. The studies that were conducted in the year preceding this SSP are listed in the table at the end of this section.

The research that informs this year's SSP update consists of three projects, each designed to provide the information needed to fulfil the requirements of the six chapters of the SSP. These projects are conducted (more or less) simultaneously and culminate in the chapters of the SSP. The projects commence in May each year and continue until the end of July. In addition the HWSETA also conducted a desktop study on the COVID-19 pandemic in 2020.

1) Policy Analysis Project

This year's policy analysis project focuses on specific critical areas in the health and social development sectors that are in the process of being addressed by the Government. The study aims to ascertain the progress made so far and the obstacles encountered in the implementation of policies and strategies. The areas included are:

- The implementation of the National Health Insurance (NHI)
- The development of the primary health care system
- The supply of medical doctors in South Africa
- The supply of nurses in South Africa
- The execution of the Skills Strategy of the Economic Reconstruction and Recovery Plan.

This study uses existing data sources such as annual and progress reports and official publications of the entities responsible for the implementation of the respective policies and strategies as well as personal interviews with a selected number of key individuals who have direct knowledge and insight into the respective issues.

2) Demand Side Analysis Project

The annual demand-side project is a quantitative study that is aimed at tracking trends in employment in the Health and Social Development Sector. The study looks at:

- Estimates of total employment;
- The profile of the workforce;
- Employment in specific occupations;
- Vacancies and vacancy rates; and
- Other indications of skills shortages.

This study is mainly based on existing data sources. However, the DHET requires SETAs to do personal interviews with a selected number of employers according to an interview schedule developed by the Department. The findings of these interviews are incorporated into the SSP update where appropriate. The demand-side study covers the private and public health and social development sectors as well as a portion of animal health.

The following datasets and data sources are analysed in the demand-side analysis project:

- The WSP submissions to the HWSETA (2021)
- The WSP submissions to the PSETA (health and social development departments) (2021)
- The Medpages database (2021)
- Discretionary Grant applications submitted to the HWSETA (2021)
- DHET employer interviews (2021)
- HWSETA interviews with specific stakeholders (2018-2021)

This study is conducted every year from May to July and the results are usually incorporated in the second submission of the SSP. A significant number of large public and private organisations requested an extension for the submission of WSPs which means

that the demand data was only available in June and updated in the second submission end of July 2021.

Although NGOs and NPOs, which are exempted from levy payments and who had not submitted WSPs are excluded from this year's analysis, the HWSETA is in the process of assisting these Organisations to submit WSPs. Their submission will be a shortened and simplified version of the WSP in order to bring them into the skills development arena. The information from this special initiative will hopefully be available from next year onwards.

3) Supply Side Analysis Project

This study looks at the supply of skills to the Health and Social Development Sector. It tracks changes in the supply of skills over time and it investigates supply-side blockages. The study is quantitative and qualitative in nature. Existing data sources are analysed. Professional councils that do not publish their registration figures are contacted by email or telephonically to request registration figures.

The study covers education and training from the school level to professional registration. It includes higher education and professional qualifications as well as occupational qualifications. The following data sources and datasets are analysed:

- Department of Higher Education and Training HEMIS database - Higher Education Management Information System for annual qualification output (2019)[1]
- HWSETA's information on occupational qualifications (2021)

This study culminates in the consolidation and completion of analysis between May to July.

4) COVID-19 Pandemic Research

In addition this year the HWSETA also conducted a desktop study on: Sector kills planning during the COVID-19 pandemic: A case of the health and welfare sector. The aim of this study is to provide background to the COVID-19 pandemic in the sector. It addresses the following: likely effects of the pandemic on the health and social development sector; the effect on the sector skills planning process; skills development interventions in the sector to be effected by the pandemic; partnerships to mitigate the effects of COVID-19 in addressing skills priorities; and adding COVID-19 research projects to the research agenda.

After the first submission of the SSP to the DHET on 15 June each year, the HWSETA engages in consultative workshops with stakeholders who are then given the opportunity to make inputs concerning the skills needs of the different components of the sector. The SSP is also presented to the HWSETA Board at their strategic planning session. Comments from these consultative processes are included in the SSP where appropriate.

Table 1-0: Summary of Research Process and Methods: Data Sources

Topic	Nature (Design) of the Study	Objectives of the Study	Data Source	Sample Size and Scope	Timeframe
Secondary Data Analysis					
SSP Demand Analysis Project	Quantitative	To track trends in employment in the Health and Social Development Sector	HWSETA Levy Payers HWSETA WSPs Submissions 2021 PSETA WSP Submissions 2021 Medpages Database	Levy-paying Organisations in HWSETA – 10 743, WSP Submissions – 1 307, Individual employee records – 181 863, PSETA WSP Submissions – 20 Departments Medpages database – 75 054 records	Current SSP submission reflects data as in May 2021

[1] *This is the most recent data available from DHET*

Table 1-0: Summary of Research Process and Methods: Data Sources *contd.*

Topic	Nature (Design) of the Study	Objectives of the Study	Data Source	Sample Size and Scope	Timeframe
Secondary Data Analysis					
SSP Supply Analysis Project	Quantitative and qualitative	To track trends in the supply of qualifications relevant to the Health and Social Development Sectors and to track trends in professional registrations	HEMIS Data (DHET) Professional council registers	20 Professional councils	May – July 2021
Desktop study on Sector kills planning during the COVID-19 pandemic: A case of the health and welfare sector	Desktop	The aim of this study is to provide background to the COVID-19 pandemic in the sector and to look at: 1) likely effects of the pandemic on the health and social development sector the effect on the sector skills planning process 2) skills development interventions in the sector to be effected by the pandemic 3) partnerships to mitigate the effects of COVID-19 in addressing skills priorities adding COVID-19 research projects to the research agenda	Desktop review		May 2021
Primary Research					
Survey of non-funded Skills Development Providers readiness to resume training during COVID-19 level 3- lockdown	Quantitative and qualitative	1) Establishing how many skills development providers were ready to resume with training during level 3 COVID-19 Lockdown 2) Establishing measures put in place by non-funded Skills Development Providers to curb the spread of the COVID-19 in their training places	Semi-structured interviews (Sample framework: HWSETA stakeholder database)	1 006 HWSETA's none-funded skills development providers	May-December 2020
Secondary Data Analysis					
Effects of COVID-19 on the implementation of the Work-based Learning Programmes	Quantitative	1) Assessing employer's achievement levels against set targets on the WBL programmes over 2018/19-2019/20 prior COVID-19 pandemic	Semi-structured Interview (Sample framework: HWSETA stakeholder database)	131 employer organisations that participated in HWSETA's Work Based Learning Programme between 2018/19	May-December 2020

Table 1-0: Summary of Research Process and Methods: Data Sources *contd.*

Topic	Nature (Design) of the Study	Objectives of the Study	Data Source	Sample Size and Scope	Timeframe
Secondary Data Analysis *contd.*					
		2) Assessing employer's efficiency levels against set targets on the WBL programmes over 2018/19 – 2019/20 prior COVID-19 pandemic 3) Exploring the effects of 2018/19 – 2019/20 performance or non-performance on the current implementation of HWSETA Word-Based Learning programmes for 2020/21 4) Evaluating the effects of COVID-19 on the current implementation of HWSETA Work-Based Learning programmes for 2020/21		and 2019/20 financial years	
A baseline study of the FDP training on COVID-19 in the workplace	M&E	1) To identify, analyse, and document the problem that is being addressed by the programme 2) To explore how the programme has been designed to meet its goals and objectives 4) To identify successes gained thus far and challenges experienced 5) To explore the possibility of sustainability of the programme	Interviews (Sample framework: Programme coordinators and secondary data from the M&E report submitted to HWSETA)	1 304 learners who participated in the FDP programme in the workplace	March 2021
COVID -19 relief projects – Baseline evaluation of project "Community Chest COVID-19 Relief Fund".	Quantitative	1) Identifying, analysing and documenting the problem addressed by the programme. 2) Exploring how the programme was designed to meet its goals and objectives. 3) Identifying the stage of implementation of the programme 4) Identifying successes gained thus far and challenges experienced. 5) Exploring the possibility of the sustainability of the programme	In-depth interviews (Sample framework: Project's MOA and proposal)	6 programme directors and affiliated coordinators from provincial NGOs	April 2020–March 2021

Table 1-0: Summary of Research Process and Methods: Data Sources *contd.*

Topic	Nature (Design) of the Study	Objectives of the Study	Data Source	Sample Size and Scope	Timeframe
Secondary Data Analysis*contd.*					
KZNPPHC Health promotion Project	Explanatory mixed methods strategy: Quantitative and Qualitative	1) Identifying, analysing, and documenting the problem that is being addressed by the programme. 2) To explore how the programme has been designed to meet its goals and objectives. 3) To identify the stage of implementation of the programme. 4) To identify successes gained thus far and challenges experienced. 5) To explore the possibility of sustainability of the programme	In-depth interview s	5 interviews	April 2020
Track and Tracer Study Technical Report – Follow-Up Learners 2020/21	Quantitative	1) Follow-up on previously track and traced learners who indicated that they were unemployed to find out if their employment status has not changed. 2) To determine the learners career pathways ever since completing the HWSETA program 3) To determine whether the learners are discouraged or still actively seeking employment	Computer Assisted Telephonnic Interviews (CATI) (Sample framework: Previous HWSETA Track and Tracer study Information)	1 876 beneficiaries	April 2020–March 2021
Track and Tracer Study Technical Report – New Learners 2020/21	Quantitative	1) Determining the rate of employment rate learners that completed HWSETA funded learnerships, artisan, bursary, and internship programme, 2) Determining whether these learners found jobs within six months upon successful completion of the programmes. 3) Evaluating the nature of the employment provided to the learners that participated on the programmes	Computer Assisted Telephonnic Interviews (CATI) (Sample framework: HWSETA Performance Information and SETMIS)	906 beneficiaries	April 2020–March 2021

Table 1-0: Summary of Research Process and Methods: Data Sources *contd.*

Topic	Nature (Design) of the Study	Objectives of the Study	Data Source	Sample Size and Scope	Timeframe
Secondary Data Analysis *contd.*					
Outcomes evaluation of the HWSETA Track and Tracer Study 2019/20	Quantitative	1) Determining the rate of employment rate learners that completed HWSETA funded learnerships, artisan, bursary, and internship programme 2) Determining whether these learners found jobs within six months upon successful completion of the programmes 3) Evaluating the nature of the employment provided to the learners that participated on the programmes	Computer Assisted Telephonnic Interviews (CATI) (Sample framework: Seta Quarterly Management Reporting database (SQMR) and SETMIS)	2 250 learners who entered and completed HWSETA learnership, artisan, bursary, and internship Programmes	June 2020-May 2021

1. SECTOR PROFILE

1.1 Introduction

This chapter provides an overview of the scope of coverage of the health and social development sector, the key role players in the sector and the economic performance of the sector. The chapter also includes an employer and labour market profile of the sector. The data sources that were used are the Budget Reviews and Estimates of National Expenditure of National Treasury, the Emergency Budget published on 24 June 2020 to address COVID-19 needs, the PSETA and HWSETA WSP data and data from Medpages.

1.2 Scope of Coverage

The HWSETA's sector comprises economic activities from five sections of the Standard Industrial Classification of all Economic Activities (SIC) i.e. Manufacturing (C), Wholesale and retail trade (G); Professional, scientific and technical activities (M), Public administration and defence and compulsory social security (O) and Human health and social work activities (Q). The table below shows the applicable SIC Codes and their descriptions.

Table 1-1: SIC Codes and Descriptions

Section	SIC Code	SIC Description
C	21000	Manufacture of pharmaceuticals, medicinal chemical & botanical products
	32500	Manufacture of medical & dental instruments & supplies
G	47620	Retail sale of pharmaceutical & medical goods, cosmetic & toilet articles in specialised stores
M	75000	Veterinary activities
O	84121	Regulation of the activities of providing health care, education, cultural services & other social services at National Government level
	84122	Regulation of the activities of providing health care, education, cultural services & other social services, at the Provincial Government level
	84123	Regulation of the activities of providing health care, education, cultural services & other social services, at the Local Government level

Table 1-1: SIC Codes and Descriptions *contd.*

Section	SIC Code	SIC Description
	84220	Administration, supervision & operation of health activities for military personnel in the field
Q	86100	Hospital activities
	86201	Medical practitioner & specialist activities
	86202	Dentist & specialist dentist activities
	86209	Other medical & dental practice activities
	86900	Other human health activities e.g. nurses, paramedical practitioners, medical laboratories, blood banks, ambulances
	87100	Residential nursing care facilities
	87200	Residential care activities for mental retardation, mental health & substance abuse
	87300	Residential care activities for the elderly & disabled
	87900	Other residential care activities e.g. orphanages, temporary homeless shelters
	88100	Social work activities without accommodation for the elderly & disabled
	88900	Other social work activities without accommodation e.g. welfare, guidance, adoption

Source: Standard Industrial Classification of all Economic Activities (SIC), 7th edition Statistics South Africa, 2012

Figure 1 provides a graphical representation of the South African health and social development system. The sector served by the HWSETA is extensive and spans the human- and animal health systems as well as the social development and social services systems. However, not all the entities in the South African health and social development system form part of the HWSETA sector and there is considerable overlap with several other SETAs e.g. the national and provincial departments of health and social development submit WSPs to the PSETA. The medical personnel employed in the South African National Defence Force (SANDF) and in other state departments such as the Department of Corrections fall within the ambit of the SASSETA.

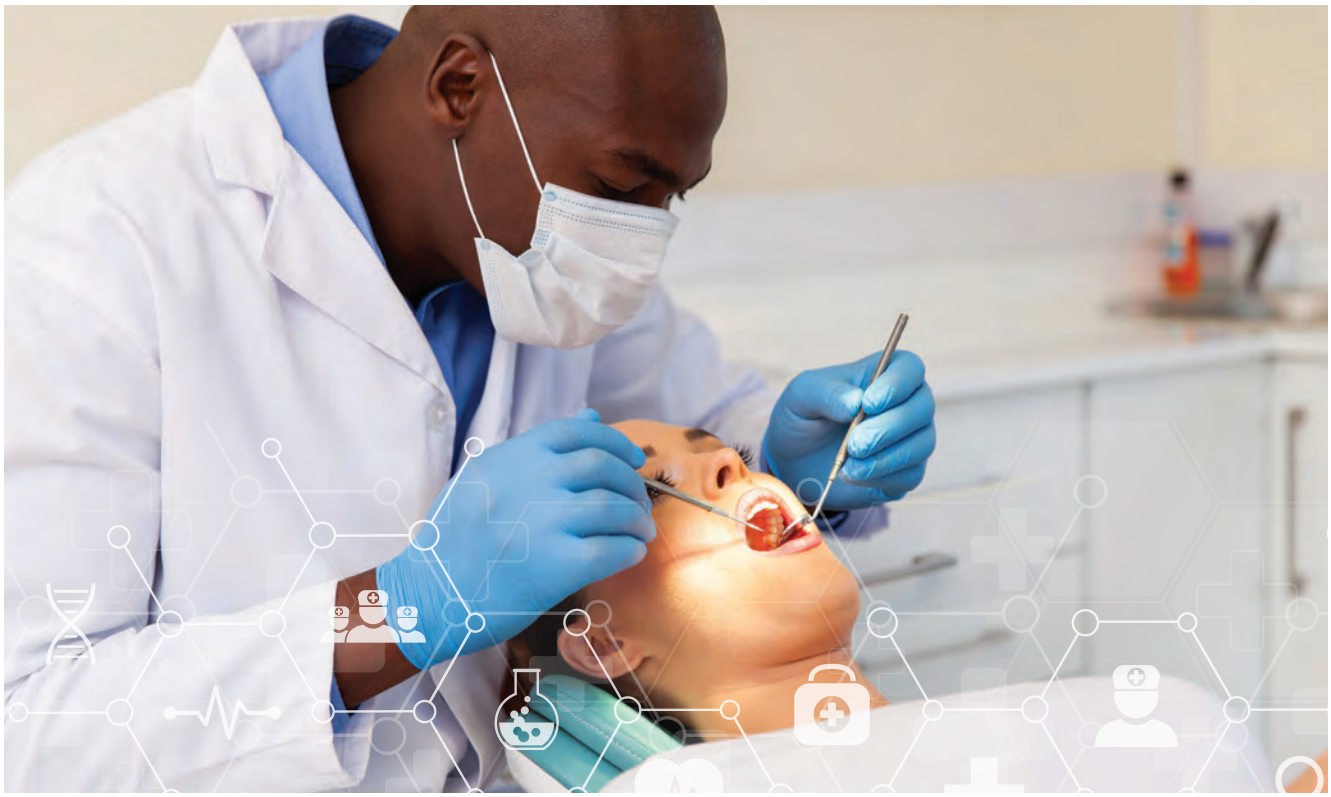
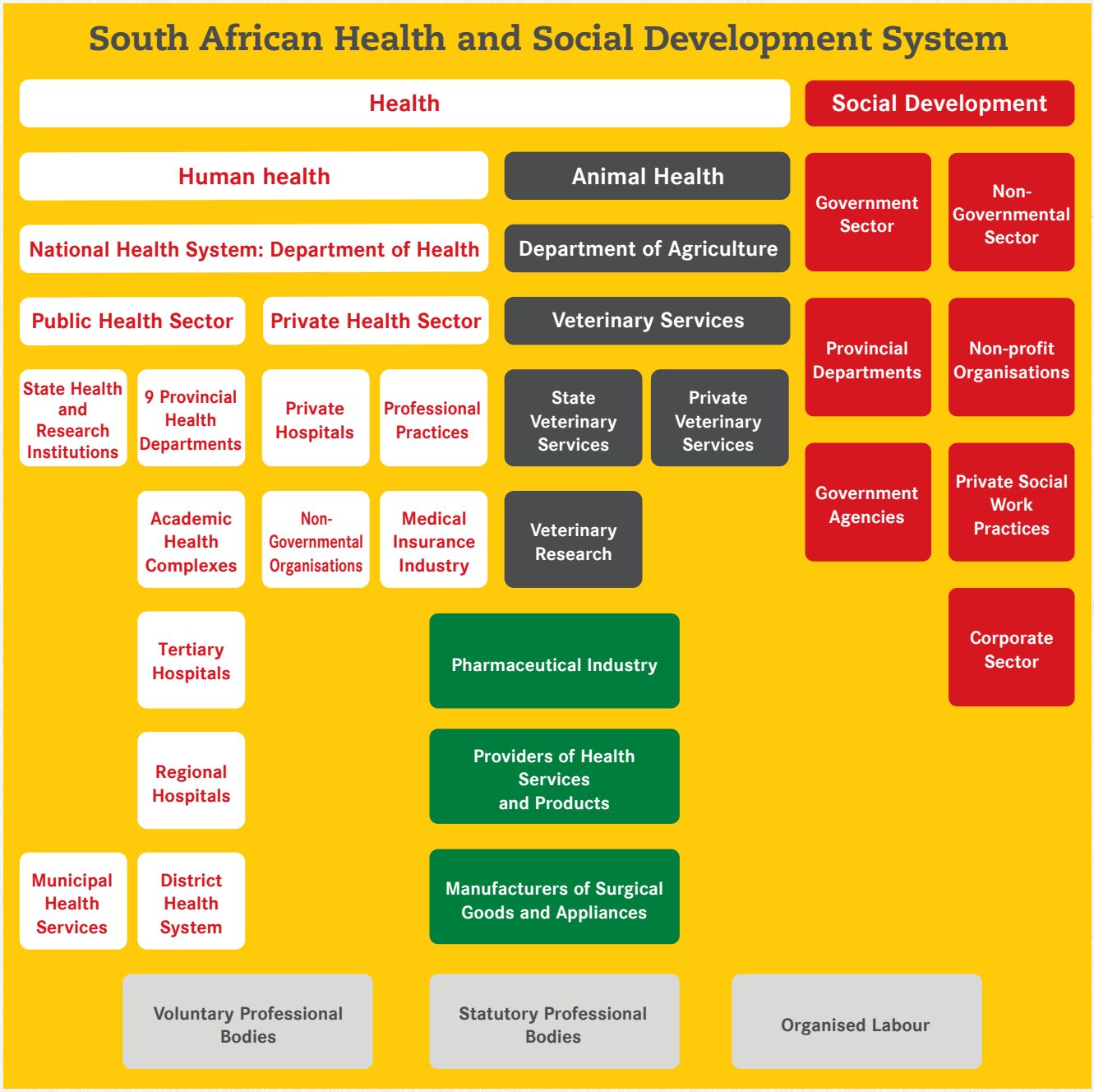


Figure 1: The South African Health and Social Development System



1.3 Key Role-Players

The sector is driven and regulated by a host of role players from both the public and private sectors. They include government departments and agencies, statutory and voluntary professional bodies, NGO's, CBO's and NPO's, labour and trade unions, and research- and training institutions. The role players and their primary roles and responsibilities in relation to the NSDP outcomes are summarised below:

Table 1-2: Key Rold-Players in the Sector

Role Player	Key Roles in Relation to the NSDP Outcomes
National Departments of Health and Social Development	Review and develop policies, legislation, standard-setting and oversight coordination of services rendered by provinces including skills development and capacity building
Provincial Departments of Health and Social Development	Implement policies and regulations at different levels. Another key role is to facilitate and support training and capacity development aligned with outcome 3 of the NSDP: Improving the level of skills development. This is also attained through linking education and workplace (Outcome 2 of the NSDP)
Municipal Health Services	
Government Agencies	
NGOs, CBOs, and NPOs	Serves as agents of advocacy for delivering the health and social services as well as provision for skills development in the sector. This is aligned with outcome 4 of the NSDP: Skills development support for entrepreneurship and cooperative development
The Hospital Association of South Africa (HASA)	Represents the interests of members, provision of the registered practitioner's database, ensuring adherence to professional conduct and continued professional development through NSDP outcome 7: encourage and support worker-initiated training
Statutory professional bodies	
Voluntary professional bodies	
Labour and trade unions	The shaping of labour market policies, labour relations practices, and human resources management in the sector. This includes ensuring that employers invest in skills development which is linked to the SDP outcome 7: encourage and support worker-initiated training
Research institutions; Medical Research Council; Human Sciences Research Council; National Health Laboratory Service; & Onderstepoort Veterinary Institute	Conducting sector-relevant, related research which results in high levels of skills development -aligned with outcome 3 of the NSDP

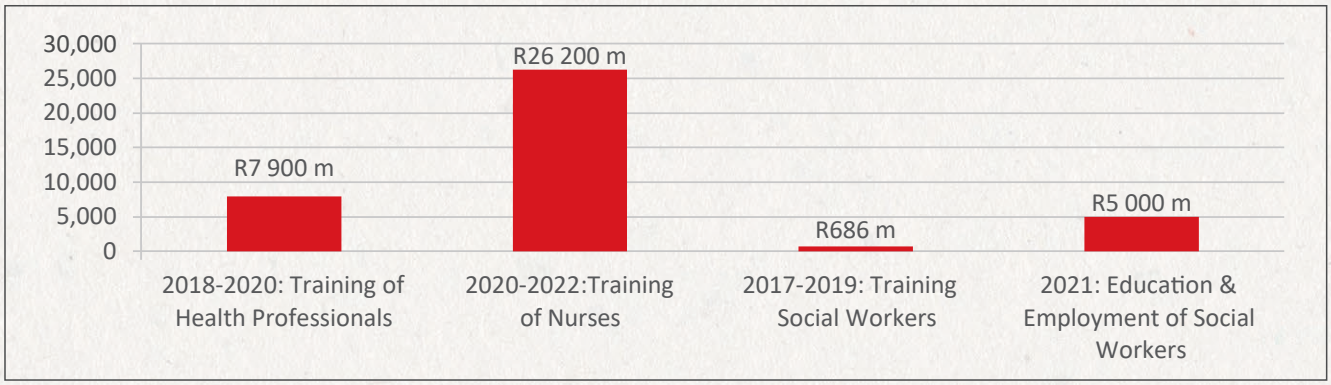
1.4 Economic Performance

1.4.1 Sector's Contribution to the Economy

The health and social development sector contributes to growth in the South African economy by creating employment, income, and economic value through the provision of infrastructure for service delivery. Both the public and private health sectors contribute health services infrastructures such as hospitals, out-patient clinics, and pharmacies, and exist to serve the health needs of South Africans (National Treasury 2021b). The animal health sector contributes to animal health infrastructure (e.g. mobile clinics), it promotes livestock production, game farming and animal health and it contributes to the skills needed to prevent and treat diseases that pose a risk to animal and human health (National Treasury 2021b). Veterinary and para-veterinary services support improved livestock production (including health and safety of animal products and quality animal products for international markets) as well as food security required for economic growth (National Treasury 2021b).

The sector makes a significant contribution to train health professionals, nurses, and social workers; of the R39.6 billion that have been invested in the training of health professionals and social workers since 2018, two thirds (66%) were allocated for the training of nurses specifically (see figure 2). This investment is even more crucial during the COVID-19 pandemic as the demand for professional nurses remains high.

Figure 2: Contribution to the Training of Health Professionals and Social Workers



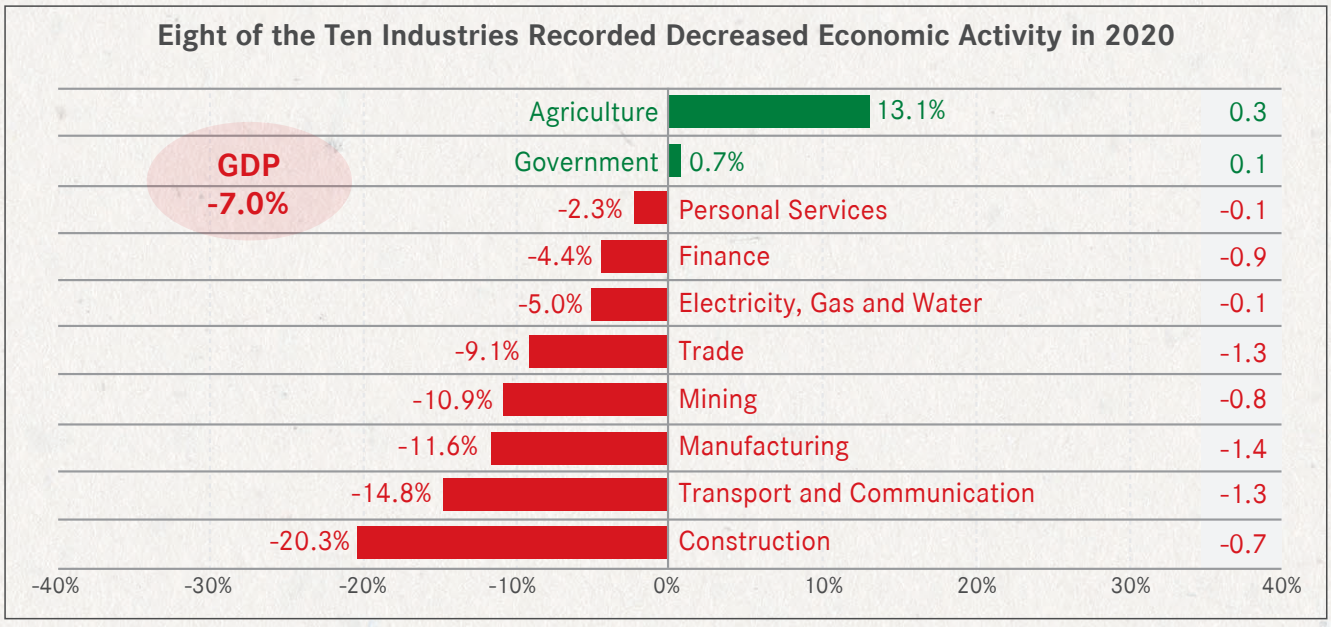
Source: National Treasury 2019, 2021b

The global economic effects of the COVID-19 pandemic are far-reaching and will likely be long-lasting. In South Africa, the large increase in unemployment and income losses has entrenched existing inequalities. Government is rolling out a mass COVID-19 vaccination campaign for which R9 billion has been allocated over the next three years. Of this amount, the DoH allocated R6.5 billion to procure and distribute vaccines which will stimulate logistics and transport industries. The vaccination rollout will not only provide immediate health benefits for millions of South Africans, but will contribute to economic recovery and global trade (National Treasury 2021a).

Since the COVID-19 pandemic the demand for personal protective equipment (PPE) such as face masks and hand sanitisers contributed to the growth in the production of these items in other sectors of the economy. In addition the demand for vaccines has provided international manufacturers such as Aspen with the opportunity for fill and finish of vaccines at their facilities in South Africa, contributing to building the vaccine manufacturing capacity of South Africa in order to improve access to vaccines in Africa (The Conversation 2021; fin24 2021).

Figure 3 below shows industry growth in South Africa for the first quarter of 2021 in comparison to the fourth quarter in 2020. The public health and social development services form part of the Government sector, private health and social development services are part of the sector called personal services, retail pharmacies fall under trade while manufacturing of pharmaceuticals, medicinal chemical and botanical products forms part of the manufacturing sector. In terms of health and social development activity only the Government sector had a marginal growth of 0.7%.

Figure 3: Industry Growth in the 1st Quarter of 2021 in Comparison with the 4th Quarter in 2020

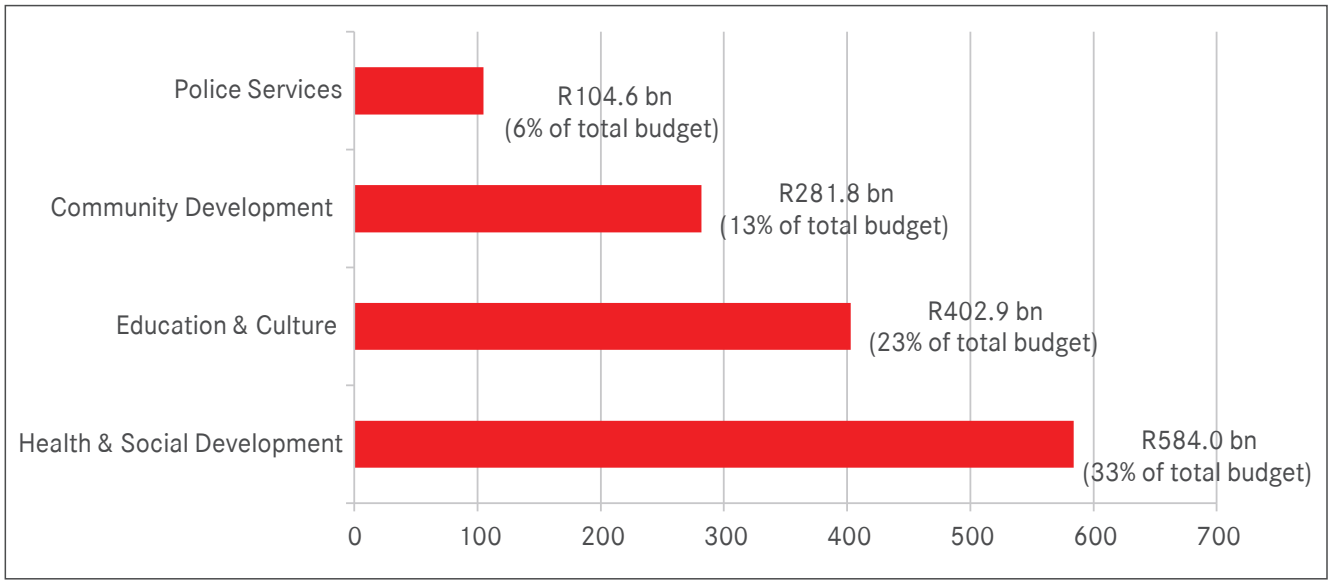


Source: Stats SA 2020

1.4.2 Current Economic Performance

Healthcare expenditure comes from three sources. General tax revenues finance the public sector, while medical schemes and out-of-pocket payments finance private care. Public sector health and social development budgets respectively account for 14.2% (R248.8 billion) and 18.9% (R335.2 billion); in total 33.1% (R584.0 billion) of government expenditure (see figure 4 for comparison with other key sectors in the public domain) (National Treasury 2021a).

Figure 4: Health and Social Development Proportion of the Budget (Public Sector), 2021



Source: National Treasury 2021a, 2021b

The 2021 Budget meets urgent pandemic-related spending pressures, such as procuring COVID-19 vaccines, expanding the public employment initiative, and continuing social and economic relief measures. A further R8 billion is allocated to the provincial equitable share through National Treasury in 2021/22 to enable provincial health departments to continue their prevention, testing and treatment interventions, including managing hospitalisations resulting from a possible third wave of COVID-19 infections (National Treasury 2021a).

In terms of social development provinces received R3.5 billion from the Department of Social Development through the early childhood development grant to improve access to quality early childhood development services (National Treasury 2021b). In this regard the HWSETA has a significant role to play in terms of building ECD capacity; it is the lead SETA to the upskilling of ECD Practitioners, fulfilling the request of the ERRP Skills Strategy (HWSETA 2021). DSD has allocated R195.5 billion to the monthly payment of grants for the 2021/2022 financial year, paying over 18 million social grants to beneficiaries. This is the largest anti-poverty programme in South Africa (DSD 2021).

Approximately 15% of South Africans access private healthcare as members of medical schemes (Council of Medical Schemes 2019). This means that the remaining 85% mostly use public health services. The demand for private health care continues to grow as is seen in the growth of medical scheme membership from 6.7 million in 2000 to 8.9 million by December 2019, which accounts for an annual growth of 1.5% over the period. Principal members covered an average of 1.20 dependents, decreasing from 1.32 in 2018 (Council for Medical Schemes 2020). This may all change once the NHI is active and possibly funded through taxes paid by all employed South Africans; medical schemes may then be funded separately over and above tax paid for the NHI as proposed by the HPCSA (Businesstech 2021). A total of R186.66 billion was collected in risk contributions from members in 2019 and expenditure on relevant healthcare services was reported at R169.07 billion (Council for Medical Schemes 2020). Medical scheme reserves in South Africa are currently estimated to be more than R90 billion (Businesstech 2021).

According to the National Institute for Communicable Diseases (NICD 2021), of those who had conducted COVID-19 test in South Africa, there were 4570 and 16142 admissions to hospitals (both public and private) on 28 June 2020 and 30 July 2021 respectively. This illustrates a percentage increase of 253% (3.5 times more) in COVID-19 hospital admissions in South Africa within a duration of thirteen months. This change is consistent with an increasing number of COVID-19 test being conducted between 28 June 2020 (156 7084) and 30 July 2021 (14 806 616). Importantly, more than halve

(53%) of 16142 COVID-19 hospital admissions on 31 July 2021 were taking place in the private sector.

1.4.3 Future Outlook

The global and local economic contraction has impacted the health and social development sector directly. The focus is now responding to the COVID-19 pandemic, including rolling out government's vaccination strategy. However, there will also be an ongoing focus on implementing the NHI, preventing and treating communicable and non-communicable diseases, investing in health infrastructure, supporting tertiary health care services and providing social assistance to eligible beneficiaries (National Treasury 2021b).

The government estimates that health expenditure will grow by only 0.8% per year, from R58.1 billion in 2020/21 to R59.4 billion in 2023/24. An estimated 85.9% (R157.7 billion) of the department's budget over the MTEF period will be transferred to provinces through conditional grants, increasing by 0.3%, from R52.1 billion in 2020/21 to R52.6 billion in 2023/24 (National Treasury 2021b).

Social development expenditure is expected to grow by 2.2% per year, from R230.8 billion in 2020/21 to R216.1 billion in 2023/24. This is mainly due to a decrease in the social grant budget following the termination of social assistance for the COVID-19 pandemic in 2020/21 wherein an additional R32.8 billion was allocated (National Treasury 2021b).

With the emphasis on universal access to quality ECD services, R3.5 billion is allocated as a conditional grant to provincial departments of social development over the MTEF period. This will allow provincial departments to increase the subsidy rate as well as the number of children subsidised from 668 518 in 2020/21 to 717 767 in 2023/24 (National Treasury 2021b). This includes allocations of R380 million through the early childhood development grant to provide support to 83 333 ECD-related workers, and R76 million to extend the contracts of 1 809 social workers employed to provide psychosocial support to individuals and families affected by COVID-19.

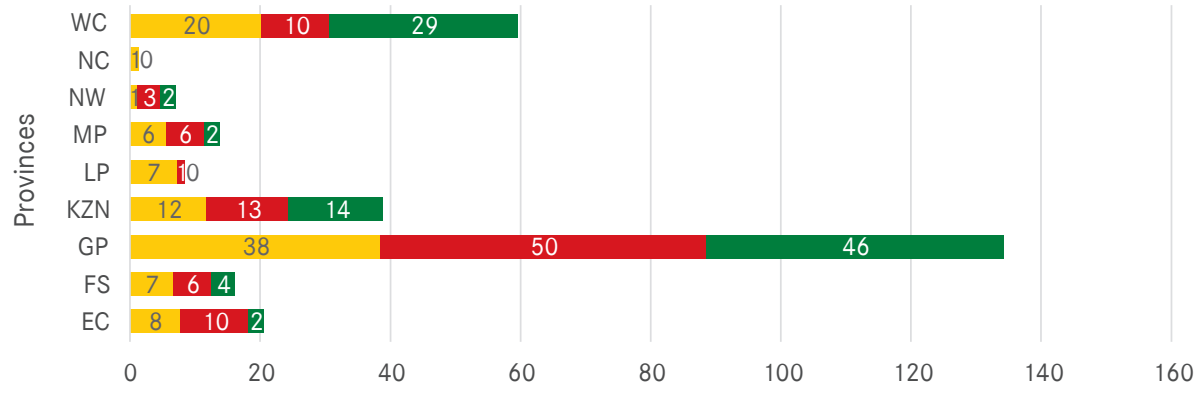
Overall, public sector budgets for 2021/22 to 2023/24 reflect that health and social spending programmes are given priority, despite pressure on resources (National Treasury 2021a). There is a direct relationship between spending (in the public and private sectors) and the demand for workers. Public sector budgets are major determinants of both the number of positions created and salary levels and, consequently, of the ability of institutions to attract and retain staff. In the private sector, the linkages are somewhat more complex but equally significant. Although there is an increase on the public sector health and social development budgets, it is not clear what future funding will look like given the current poor economic circumstances in South Africa.

1.5 Employer Profile

1.5.1 Overview

The health and social development sector is a heterogeneous sector in many ways. The size and type of organisations in the sector differ: Public health comprises large (150 or more employees) national and provincial departments of health and social development. In contrast, most of the organisations in private health are small: 82% of the organisations in private health fall within the category that is generally known as "small organisations". Medium size organisations with 50 to 149 employees make up 10% of the organisations in the private sector and the large Organisations constitute 8%. However, large organisations such as hospital and pharmacy groups employ more than half of the workers in private health. Employers can be broadly grouped into community services; complementary health services; doctors and specialists; hospitals and clinics; and research and development institutions. In the 2020/2021 financial year, a total of 11 103 organisations paid skills development levies to the HWSETA. These are organisations with payrolls in excess of R500 000 per year. Small practices may be excluded from this number. Figure 5 shows the provincial distribution of organisations in the private sector according to size. Gauteng province dominates according to spread for all employer sizes while the Northern Cape has the smallest spread of employers for all different sizes.

Figure 5: Provincial Distribution of Employers in the Private Sector by Size



	EC	FS	GP	KZN	LP	MP	NW	NC	WC
Small	8	7	38	12	7	6	1	1	20
Medium	10	6	50	13	1	6	3	0	10
Large	2	4	46	14	0	2	2	0	29

Source: HWSETA WSP submissions 2021

1.5.2 Non-Profit Organisations

Much of the health-related community-based care in South Africa is provided by non-profit organisations (NPOs), and a HWSETA study (2015a) shows that these organisations provide paid and unpaid employment to many workers in the sector. As of September 2020, 233 180 NPOs were registered with the Department (DSD 2020), up from 49 827 in 2007/08. The vast majority of registered NPOs (95%) are voluntary associations, while 3% are not-for-profit companies and 2% are non-profit trusts. Few of the NPOs are registered as employers with the HWSETA and they are therefore not included in the labour market profile. The HWSETA indicated that NPOs work with relatively small numbers of full-time staff and to a large extent rely on volunteers and part-time staff. Africans and women dominate the NPO workforce (HWSETA 2015a).

Social services rendered by NPOs include services such as homes and specialised services for handicapped persons; geriatric care, in-home services, and specialised youth services. In the health sector, NPOs contribute to research, education, policy advocacy, and development and care in areas such as HIV/AIDS, emergency care, mental health, public health, cancer, orphans and vulnerable children and palliative care. NPOs in the animal health sector provide veterinary-, animal protection, and animal welfare services.

1.6 Labour Market Profile

1.6.1 An Estimate of Total Employment

Three data sources were used to construct a profile of the labour force: Data from the workplace skills plans (WSPs) submitted by private sector employers to the HWSETA, data from such plans submitted by public sector employers to the Public Service SETA (PSETA) as well as data furnished to the HWSETA from the private Medpages database. The data analysis provided information on 789 822 people who are formally employed in the health and social development sector. Of these, approximately 431 834 (55%) are employed in private sector organisations (referred to later as the “private sector”) and levy-paying public sector organisations, while 357 988 (45%) work in the public service departments.

Estimates of total employment in the health and social development sector can be seen in Table 1-3. Employment in the public service component of the sector increased from 325 763 in 2013 to 357 760 in 2021. The average annual growth of employment in the public sector was only 1.2% over the 2013 to 2021 period. The private sector component of the sector, on the other hand, showed an average annual growth of 6.4% over the 2013 to 2021 period from 262 503 to 431 834 respectively. The average annual growth for the total sector was 3.8% over the same period. The positive growth in employment in the sector is expected due to the COVID-19 demands. However, the 2021/2022 aftermath COVID-19 employment figures may show a different trend.

Table 1-3: Health and Social Development Sector: Total Employment 2013-2021

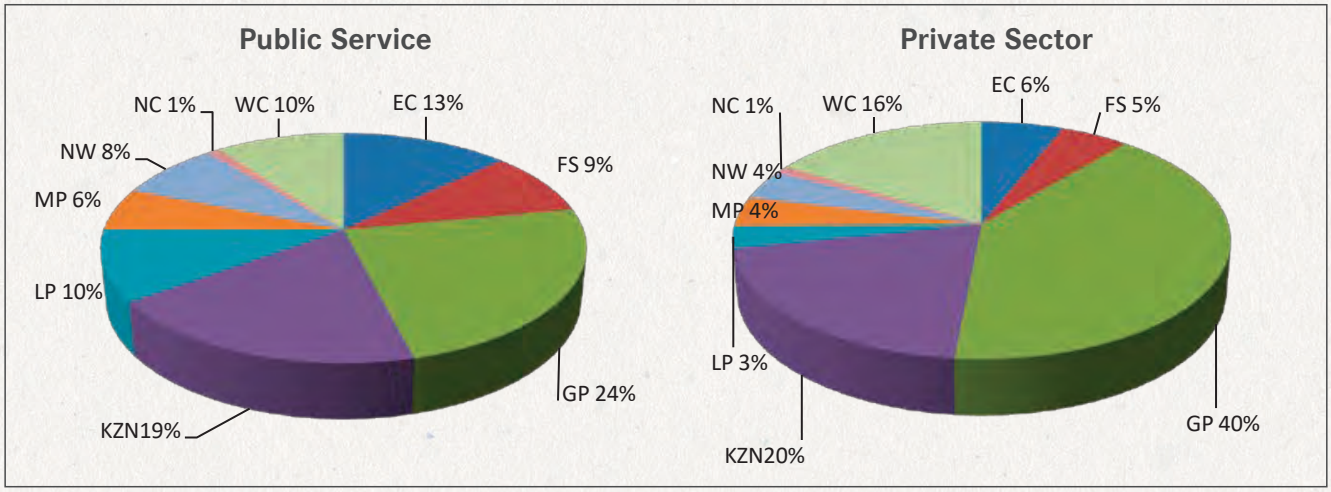
	2013	2014	2015	2016	2017	2018	2019	2020	2021	AAG %
Public	325 763	310 256	312 884	330 015	332 654	333 060	334 762	352 760	357 988	1.2
Private	262 503	276 513	319 002	274 140	266 466	343 246	368 527	374 069	431 834	6.4
Total	**588 266**	**586 769**	**631 886**	**604 155**	**599 120**	**676 306**	**703 289**	**726 829**	**789 822**	**3.8**

Sources: Calculated from HWSETA and PSETA WSP submissions 2013 to 2021, Medpages database 2013 -2021

1.6.2 Provincial Distribution of Employment

The figure below shows the provincial distribution of employees in the Public Service and the private sector. Compared to private health, the Public service has higher percentages of health workers in provinces with large rural, poor populations depending on public health services e.g. Eastern Cape, North West and Limpopo.

Figure 6: Provincial Distribution of Employment in the Public Service and Private Health Sector: 2021



Sources: Calculated from HWSETA and PSETA WSP submissions 2021

1.6.3 Occupational Distribution of Employment

Currently, professionals and technicians and associate professionals comprise 59% of total employment in both the public service and in the private sector (Table 1-4). In the health and social development sector, a large portion of managerial positions is filled by professionals. Professionals include medical and dental specialists and practitioners, registered nurses, pharmacists, veterinarians and other health-related occupations such as homoeopaths. Professionals in support functions such as human resource professionals, financial professionals and scientists also form part of this group. Technicians and associate professionals include occupations such as technicians, enrolled and veterinary nurses, ancillary healthcare workers, ambulance officers, and pharmacy sales assistants as well as allied health workers such as chiropractors and administrative support workers such as office administrators.

It is important to note that nurses represent the majority of workers in the sector and that the demand for nurses remains high. The changes in the nursing qualification framework had a huge impact on the output of nurses which means that the demand will increase even more over the next couple of years. The increased demand for nurses during the COVID-19 pandemic made this problem worse. The recruitment of retired nurses to meet the demand also causes a dilemma; because of their age they form part of the vulnerable group and therefore cannot offer their services. The demand for medical or laboratory technicians, community health workers and social workers has also increased since the start of the pandemic. However, a major risk for workers in the sector is contracting the virus, which can have a significant effect on employment.

Table 1-4: Public Service and Private Sector Employment per Occupational Group: 2021

Occupational Group	Public Service		Private Sector		Total Sector	
	Number of employees	%	Number of employees	%	Number of employees	%
Managers	10 202	3	32 312	7	42 514	5
Professionals	145 659	41	139 064	32	284 723	36
Technicians and Associate Prof	78 619	22	105 859	25	184 478	23
Clerical Support Workers	44 970	13	62 611	14	107 581	14
Service and Sales Workers	47 431	13	53 707	12	101 138	13
Skilled Agricultural, Forestry, Fishery, Craft and Related Trades Workers	1 427	0	3 531	1	4 958	1
Plant and Machine Operators and Assemblers	3 053	1	7 867	2	10 920	1
Elementary Occupations	26 627	7	26 883	6	53 510	7
Total	**357 988**	**100**	**431 834**	**100**	**789 822**	**100**

Sources: Calculated from HWSETA and PSETA WSP submissions 2021, Medpages database July 2021

1.6.4 Population Group

More than two-thirds (70%) of the health and social development sector employees are African (Table 1-5). In the Public Service 80% of the workforce is African compared to 62% in the private sector. Whites form around 6% of the Public Service workforce compared to 19% in the private sector.

Table 1-6 shows the population group distribution in the different occupational groups in 2020. In the Public Service, 80% and more of clerical support workers, service and sales workers and elementary occupations were African respectively, 76% professionals, 79% technicians and associate professionals and 62% managers. In private health, 54% of professionals and 61% technicians and associate professionals were African, while 75% of service and sales and 86% of elementary occupations were filled by Africans. In the total sector, 70% of all managers were black[2], while more than 80% filled the positions across all the other occupational groups respectively.

[2] *African, Coloured and Indian*

Table 1-5: Health and Social Development Sector: Total Employment by Population Group 2014-2021

	2014		2015		2016		2017		2018		2019		2020		2021	
Public Service	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
African	251 905	81	256 564	82	269 571	82	271 926	82	274 685	82	281 646	84	279 945	79	286 150	80
Coloured	31 464	10	30 124	10	31 784	10	36 644	11	32 017	10	27 454	8	43 878	12	42 853	12
Indian	8 781	3	8 891	3	10 325	3	5 884	2	8 874	3	8 730	3	9 058	3	9 145	3
White	18 106	6	17 305	6	17 721	5	17 860	5	17 484	5	16 932	5	19 879	6	19 840	6
Non-South African					614		340									
Total	**310 256**	**100**	**312 884**	**100**	**330 015**	**100**	**332 654**	**100**	**333 060**	**100**	**334 762**	**100**	**352 760**	**100**	**357 988**	**100**
Private Sector	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
African	135 491	49	143 339	53	136 254	50	138 563	52	181 413	53	210 247	57	214 272	58	266 087	62
Coloured	44 242	16	37 651	14	44 378	16	37 605	14	48 462	14	52 376	14	54 685	15	51 646	12
Indian	16 591	6	16 146	6	17 253	6	16 188	6	23 577	7	19 869	5	20 208	5	30 826	7
White	80 189	29	71 402	27	76 255	28	74 110	28	89 794	26	86 034	23	84 904	23	83 276	19
Non-South African			706	0												
Total	**276 513**	**100**	**269 244**	**100**	**274 140**	**100**	**266 466**	**100**	**343 246**	**100**	**368 527**	**100**	**374 069**	**102**	**431 834**	**100**
Total Sector	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
African	393 135	67	399 903	69	405 825	67	410 489	69	456 098	67	491 893	70	494 217	70	552 237	70
Coloured	76 280	13	67 775	12	76 162	13	74 249	12	80 479	12	79 830	11	98 563	14	94 499	12
Indian	23 471	4	25 037	4	27 578	5	22 072	4	32 451	5	28 599	4	29 266	4	39 971	5
White	93 883	16	88 707	15	93 976	16	91 970	15	107 278	16	102 966	15	104 783	15	103 116	13
Non-South African			706		614		340									
Total	**586 769**	**100**	**582 128**	**100**	**604 155**	**100**	**599 120**	**100**	**676 306**	**100**	**703 289**	**100**	**726 829**	**103**	**789 822**	**100**

Sources: Calculated from HWSETA and PSETA WSP submissions 2014 to 2021, Medpages database 2014 to July 2021

Table 1-6: Population Group Distribution according to Occupational-Group: 2021

Occupational Group	African		Coloured		Indian		White		Total	
Public Service	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Managers	6 296	62	1 540	15	823	8	1 543	15	10 202	100
Professionals	111 387	76	15 429	11	5 612	4	13 231	9	145 659	100
Technicians and Associate Professions	61 775	79	12 674	16	1 483	2	2 687	3	78 619	100
Clerical Support	36 149	80	6 640	15	645	1	1 536	3	44 970	100
Service and Sales	43 523	92	3 075	6	368	1	465	1	47 431	100
Skilled Agricultural, Forestry, Fishery, Craft and Related Trades	1 173	82	173	12	38	3	43	3	1 427	100
Plant and Machine Operators and Assemblers	2 586	85	344	11	92	3	31	1	3 053	100
Elementary Occupations	23 261	87	2 978	11	84	0	304	1	26 627	100
Private Sector	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Managers	15 817	49	2 508	8	2 673	8	11 315	35	32 312	100
Professionals	75 005	54	13 715	10	12 118	9	38 226	27	139 064	100
Technicians and Associate Professions	64 765	61	12 261	12	9 271	9	19 561	18	105 859	100
Clerical Support	35 376	57	9 194	15	5 782	9	12 259	20	62 611	100
Service and Sales	40 250	75	8 580	16	1 011	2	3 866	7	53 707	100
Skilled Agricultural, Forestry, Fishery, Craft and Related Trades	2 442	69	438	12	145	4	507	14	3 531	100
Plant and Machine Operators and Assemblers	5 737	73	1 246	16	431	5	454	6	7 867	100
Elementary Occupations	23 113	86	2 817	10	353	1	601	2	26 884	100
Total Sector	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Managers	22 113	52	4 048	10	3 496	8	12 858	30	42 514	100
Professionals	186 392	65	29 144	10	17 730	6	51 457	18	284 723	100
Technicians and Associate Prof	126 540	69	24 935	14	10 754	6	22 248	12	184 478	100
Clerical Support	71 525	66	15 834	15	6 427	6	13 795	13	107 581	100
Service and Sales	83 773	83	11 655	12	1 379	1	4 331	4	101 138	100
Skilled Agricultural, Forestry, Fishery, Craft and Related Trades	3 615	73	611	12	183	4	550	11	4 958	100
Plant and Machine Operators and Assemblers	8 323	76	1 590	15	523	5	485	4	10 920	100
Elementary Occupations	46 374	87	5 795	11	437	1	905	2	53 511	100

Sources: Calculated from HWSETA and PSETA WSP submissions 2021

1.6.5 Gender

Table 1-7 shows the gender distribution in the sector from 2014 to 2021. Male's share in employment in the sector varied between 26% and 30% while females formed between 70% and 74% of the workforce.

Table 1-7: Health and Social Development Sector: Gender Distribution 2014-2021

	2014	2015	2016	2017	2018	2019	2020	2021
Public Service	%	%	%	%	%	%	%	%
Male	27	27	28	32	28	27	27	26
Female	73	73	72	68	72	73	73	74
Total	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**
Private Sector	%	%	%	%	%	%	%	%
Male	30	25	25	28	25	27	28	29
Female	70	75	75	72	75	73	72	71
Total	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**
Total Sector	%	%	%	%	%	%	%	%
Male	28	26	27	30	27	27	28	28
Female	72	74	73	70	73	73	72	72
Total	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**

Sources: Calculated from HWSETA and PSETA WSP submissions 2014 to 2021, Medpages database, 2014 - July 2021

Females are in the majority in all occupation groups, except for the groups: Plant and Machine Operators and Assemblers and Skilled Agricultural, Forestry, Fishery, Craft and Related Trades, which includes occupations such as delivery drivers and artisans which are mostly filled by males (Table 1-8).

Table 1-8: Gender Distribution according to Occupational-group: 2021

Occupational Group	Male		Female		Total	
Public Service	**N**	**%**	**N**	**%**	**N**	**%**
Managers	4 372	43	5 830	57	10 202	100
Professionals	29 709	20	115 950	80	145 659	100
Technicians and Associate Prof	20 704	26	57 915	74	78 619	100
Clerical Support	14 313	32	30 657	68	44 970	100
Service and Sales	13 172	28	34 259	72	47 431	100
Skilled Agricultural, Forestry, Fishery, Craft and Related Trades	1 193	84	234	16	1 427	100
Plant and Machine Operators and Assemblers	2 351	77	702	23	3 053	100
Elementary Occupations	8 713	33	17 914	67	26 627	100
Private Sector	**N**	**%**	**N**	**%**	**N**	**%**
Managers	12 243	38	20 069	62	32 312	100
Professionals	40 179	29	98 885	71	139 064	100
Technicians and Associate Prof	23 000	22	82 859	78	105 859	100
Clerical Support	20 136	32	42 475	68	62 611	100
Service and Sales	13 330	25	40 377	75	53 707	100
Skilled Agricultural, Forestry, Fishery, Craft and Related Trades	2 625	74	906	26	3 531	100
Plant and Machine Operators and Assemblers	6 204	79	1 663	21	7 867	100
Elementary Occupations	8 289	31	18 595	69	26 884	100
Total Sector	**N**	**%**	**N**	**%**	**N**	**%**
Managers	16 615	39	25 899	61	42 514	100
Professionals	69 888	25	214 835	75	284 723	100
Technicians and Associate Prof	43 704	24	140 774	76	184 478	100
Clerical Support	34 449	32	73 132	68	107 581	100
Service and Sales	26 502	26	74 636	74	101 138	100
Skilled Agricultural, Forestry, Fishery, Craft and Related Trades	3 818	77	1 140	23	4 958	100
Plant and Machine Operators and Assemblers	8 555	78	2 365	22	10 920	100
Elementary Occupations	17 002	32	36 509	68	53 511	100

Sources: Calculated from HWSETA and PSETA WSP submissions 2021, Medpages database, July 2021

1.6.6 Age Distribution

Table 1-9 shows the total age distribution in the Public Service, private health and the total sector from 2014 to 2021. The overall age profile remained relatively stable in the Public service over the period with people under 35 forming between 25-32% of the workforce and people older than 55 constituting 10-14% of the workers over the period. The percentage of employees younger than 35 years in the private sector is markedly higher – around 37-41% of the total workforce.

Table 1-9: Health and Social Development Sector: Age Distribution 2014-2021

	2014	2015	2016	2017	2018	2019	2020	2021
Public Service	%	%	%	%	%	%	%	%
Younger than 35	30	31	32	29	27	25	26	26
35 to 55	59	57	58	61	63	62	63	63
Older than 55	11	12	10	10	10	14	11	11
Total	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**
Private Sector	%	%	%	%	%	%	%	%
Younger than 35	37	41	40	37	39	38	38	35
35 to 55	54	50	49	49	51	51	50	50
Older than 55	9	9	11	14	11	12	12	15
Total	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**
Total Sector	%	%	%	%	%	%	%	%
Younger than 35	33	36	35	32	34	31	32	31
35 to 55	57	54	54	57	56	56	56	56
Older than 55	10	10	11	11	11	13	12	13
Total	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**

Sources: Calculated from HWSETA and PSETA WSP submissions 2014 to 2021, Medpages database 2014 - July 2021

The 2021 age distribution of employees in the health and social development sector by occupational group is given in Table 1-10. In the public sector, 9% of the professionals are over the age of 55 compared to 21% in the private sector. The larger numbers of people under the age of 35 in the private sector are concentrated in the occupational group's Technicians and Associate Professionals (41%) and Clerical Support Workers (42%).

Table 1-10: Age Distribution of Employees in the Public Service and Private Health according to the Occupational Group: 2021

Occupational Group	Under 35		35 to 55		Older than 55		Total	
Public Service	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Managers	1 819	18	6 614	65	1 772	17	10 205	100
Professionals	41 528	29	90 898	62	13 248	9	145 674	100
Technicians and Associate Prof	19 764	25	48 712	62	10 043	13	78 519	100
Clerical Support	14 055	31	26 558	59	4 359	10	44 972	100
Service and Sales	8 485	18	33 599	71	5 349	11	47 433	100
Skilled Agricultural, Forestry, Fishery, Craft and Related Trades	133	9	972	68	322	23	1 427	100
Plant and Machine Operators and Assemblers	877	29	1 618	53	558	18	3 053	100
Elementary Occupations	5 795	22	17 497	66	3 335	13	26 627	100
Private Sector	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Managers	8 446	26	17 533	55	5 903	19	31 881	100
Professionals	36 118	27	71 176	52	28 285	21	135 579	100
Technicians and Associate Prof	42 742	41	49 512	48	11 556	11	103 810	100
Clerical Support	26 187	42	29 512	47	6 448	10	62 148	100
Service and Sales	22 834	43	25 657	48	5 004	9	53 495	100
Skilled Agricultural, Forestry, Fishery, Craft and Related Trades	994	28	1 756	50	741	21	3 491	100
Plant and Machine Operators and Assemblers	2 429	31	3 775	48	1 591	20	7 795	100
Elementary Occupations	8 012	30	14 598	55	4 159	16	26 769	100
Total Sector	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Managers	10 265	24	24 147	57	7 675	18	42 086	100
Professionals	77 646	28	162 074	58	41 533	15	281 253	100
Technicians and Associate Prof	62 506	34	98 224	54	21 599	12	182 329	100
Clerical Support	40 242	38	56 070	52	10 807	10	107 120	100
Service and Sales	31 319	31	59 256	59	10 353	10	100 928	100
Skilled Agricultural, Forestry, Fishery, Craft and Related Trades	1 127	23	2 728	55	1 063	22	4 918	100
Plant and Machine Operators and Assemblers	3 306	30	5 393	50	2 149	20	10 848	100
Elementary Occupations	13 807	26	32 095	60	7 494	14	53 396	100

Sources: Calculated from HWSETA and PSETA WSP submissions and Medpages database July 2021

1.6.7 Disability

In 2021, 0.6% of the workers in the sector were people with disabilities. Of the 1 415 workers with disabilities in the Public Service, 85 (6%) were employed as managers, 280 (20%) as professionals, 216 (15%) as technicians and associate professionals and 542 (38%) as clerical support workers. Of the 3 294 workers with disabilities in the private sector 366 (8%) were employed as managers, 971 (21%) as professionals, 835 (18%) as technicians and associate professionals, 1 626 (35%) as clerical support workers and 501 (11%) as service and sales workers.

1.7 Conclusion

The profile presented in this chapter has various implications for skills planning in the sector. The health and social development sector served by the HWSETA is extensive and spans the human- and animal health systems in South Africa, as well as the social development- and social services systems. Given the size and complexity of this sector, skills needs have to be considered holistically with due consideration of the specific needs of each of the components of the sector. The fact that the sector consists of a public and a private component and that these two components differ vastly in terms of resources, functioning and skills situations will be further illustrated in the chapters to come. Suffice to say at this stage that the skills situation in the public sector is intertwined with the availability, allocation, and administration of public funds while the private sector is to a larger extent subject to market forces. The labour market situation of the total sector is therefore quite complex and quantitative expressions of current and future skills needs have to be interpreted with great care.

Healthcare and social service practitioners are regulated by a number of statutory professional councils. These bodies play a formative role in determining the scope of practice for professionals and specialist occupations and also regulate the education and training standards required to work as healthcare or social service practitioners. For this reason, they form an integral part of the skills system and the HWSETA has to work in close co-operation with them. At the occupational level the demand for nurses stays a critical issue as they form the majority of the sector's workforce and form the backbone of most services offered. The increased demand for nurses during the COVID-19 pandemic exacerbated this problem. A major risk for workers in the sector is contracting the virus, which can have a significant effect on employment.

NPOs play an essential role in service delivery for the health and social development sector as they are major providers of community development and care services for vulnerable target groups in South Africa but few NPOs are registered as employers with the HWSETA. Engaging with them and providing in their skills needs remains a major challenge for the SETA. They face significant economic hardship due to financial challenges which has now worsen due to the COVID-19 pandemic; less funding opportunities are now available and they have to compete for scarce skills.

A large proportion of the organisations in private health are small (employ fewer than 50 people), while large organisations (150 and more employees) employ the majority of the workforce. Formal employment in the health and social development sector is estimated just over 780 000, with 55% employed in private sector organisations and 45% working in public service departments. For the HWSETA it is important to balance the needs of the small and the large organisations and those of the public and private sector components of its sector. The average annual growth for the total sector was 3.8% over the 2013-20201 period. The positive growth in employment in the sector from 2020 to 2021 was expected in the light of the immediate COVID-19 demands. However, the 2022/2023 employment figures may show a different trend due to reasons such as constraint budgets and the loss of frontline workers due to COVID-19.

2. KEY SKILLS CHANGE DRIVERS

2.1 Introduction

This chapter starts with a discussion of various change drivers that influence the demand for skills in the sector and the supply of skills to the sector. Some of the change drivers are generic to the health and the social development parts of the sector while others are specific to either one of them. However, the COVID-19 pandemic needs again special reference as it continues to pose major challenges to the sector. The second part of the chapter deals with the implications of national strategies and plans for skills planning in the sector. Because of the COVID-19 pandemic the focus this year is on the Economic Reconstruction and Recovery Plan (EERP), the Economic Reconstruction and Recovery Skills Strategy, and the revised Medium Term Strategic Framework (MTSF). The data sources that were used in this chapter included a desktop review and interviews with key stakeholders in the sector.

2.2 Change Drivers

2.2.1 COVID-19 Pandemic

"The COVID-19 pandemic is the defining global health crisis of our time and the greatest challenge we have faced since World War Two" (UNDP 2020). It has shown to be much more than a health crisis; it created devastating economic, social and political crises across the world. The International Labour Organisation (ILO) estimated that nearly half of the global workforce is at risk of losing livelihoods (ILO 2020). The expanded unemployment rate of South Africa in the 4th quarter of 2020 confirms this; 42.6% (Stats SA 2020).

While the workforce of many sectors in the economy was hit hard by the lockdown, the demand for workers in the health and welfare sector immediately increased. A total of about 50 000 CHWs were deployed nationally to screen and trace people. They were drawn from the existing cohort of CHWs who form part of the Ward Based Primary Healthcare Outreach Teams (WBPHCOT) as well as newly recruited. It highlighted again the important role that CHWs can play in universal health care.

DSD boosted its capacity to assist families and communities affected by COVID-19 with the recruitment of 1 809 unemployed social workers. In addition another 1 210 social work graduates were provided with a one-year internship opportunity in a joint venture between the State Information Technology Agency (SITA), the South Africa Council for Social Service Practitioners SACSSP), DSD and Wits Consortium.

The HWSETA immediately reacted on the pandemic by forming crucial partnerships and funding stakeholders. COVID-19 is a change driver as it affects the HWSETAs budget allocation in reprioritising COVID-19 relates skills development partnerships. These partnerships range from skills development initiatives to funding the deployment of unemployed social workers and protective gear of health workers and contributing to economic development that leads to employment (see chapter 4). The challenge in 2021 for the HWSETA is to implement the applicable elements of the ERRP and specifically the linked skills strategy in order to address skills shortages and gaps and to contribute to the national drive of economic recovery (HWSETA 2021).

The COVID-19 pandemic will remain one of the major change drivers in the health and welfare sector for years to come. The implication is a further increase in the demand for certain skills in the sector such as nurses and social workers. The sector will need to have strategies in place in order to ensure that the supply of skills is sufficient and sustainable. This will all need to happen with less funding due to the economic consequences of COVID-19.

2.2.2 Overall change Drivers for Health and Social Services

a) Challenging Socio-economic Realities

Challenging socio-economic realities drive the need for public health services and social development interventions in South Africa. Poverty affects the majority of South Africans and vast social inequalities continue to persist (National Treasury 2021a). Despite a general decline in poverty between 2006 and 2011, poverty levels rose again in 2015. More than half of South Africans were poor in 2015, with the poverty headcount increasing to 55.5%. This means that over 30.4 million South Africans were living in poverty in 2015 (StatsSA 2017). For the fourth quarter in 2020, the unemployment rate (strict definition) was recorded at 32.5%, the highest since the start of the Labour Force Surveys in 2008 (StatsSA 2020a), showing the effect of the COVID-19 pandemic. DSD are going to pay over 18 million social grants to beneficiaries in 2021/2022, and it is expected that this number will reach 19 million in 2022/2023. These realities increase the demand for public health and social welfare services and contribute to the already excessive workloads of public health and social welfare workers.

b) High Burden of Disease

Good health reduces poverty, improves educational performance, increases productivity, and as a result, stimulates economic growth. The high burden of disease in South Africa hampers economic growth and development. In 2020 an estimated 7.8 million people in South Africa were living with HIV/AIDS (DoH 2020).

South Africa has one of the highest tuberculosis (TB) incidences in the world, with more than 360 000 new cases diagnosed in 2019 (WHO 2020). Maternal- and infant mortality rates remain high (StatsSA 2020b) while the burden of disease is exacerbated by factors such as an aging population and the rising incidence of chronic diseases and obesity (CMS 2019). In addition persons with existing diseases are very susceptible to COVID-19. These factors increase the demand for health services and the need for more healthcare workers at all levels. The strategies implemented by the government to counter the burden of disease are some of the major change drivers in the health and social development sector.

c) High Levels of Interpersonal Violence and other Social Crimes

High levels of interpersonal violence have thrust the injury death rate of 1 393.2 per 100 000 populations to more than double the global average, and necessitate the provision of wide-ranging and integrated preventative and remedial social services (IHME 2019). Excessive substance abuse adds to the social burden. The COVID-19 pandemic made the situation worse for women, especially during the lockdown period. Organisations such as Rise Up Against Gender Based Violence reported that they could not cope with the number of calls from women who needed assistance (Mail & Guardian 2020). Skilled professionals are needed to provide these specialised services.

d) Changes to the scopes of practice of professions in health and social services

Shifting service demands and technological progress necessitate changes to the scopes of practice of some professions and occupations in the sector. As a result, existing practitioners require new skills sets to close current skills gaps. New occupations have emerged due to changing goals in health and social services. For example, qualifications in community health, community development and child and youth care have been registered the last couple of years. The need is growing for work-ready and well-trained mid-level workers to share tasks and extend service capacity in the resource-constrained environments of healthcare and social development; a case in point is the high demand for community health workers to assist with tracking and tracing of potential COVID-19 cases. Fortunately a cohort of about 50 000 community health workers was ready to be deployed nationally to assist with the COVID-19 pandemic. More health professionals require training in rural and community settings to meet local needs, while academics involved in health professional education need further training to teach on expanded training platforms (Stakeholder Interviews 2020, 2021).

e) Advanced Professionalism and Practice Standards

The statutory councils controlling the health and social services professions are driving measures to advance professionalism and practice standards across the professions. Healthcare and social services practitioners (HPCSA 2017; SACSSP 2019) are required to engage in mandatory accredited continuing professional development (CPD) in order to retain their registration status (i.e. the statutory authority to practice in a particular field). The DSD and DoH set national norms and service standards to advance the quality of social welfare services, and to improve both the safety in and quality of health care services (DoH 2015; DSD 2015b; DSD 2013). In the health sector, the Office of Health Standards Compliance (OHSC) was created in 2013 through the National Health Amendment Act of 2013 and, in terms of section 78 of the Act. All private and public health facilities are subjected to inspection, quality assurance and accreditation processes controlled by the OHSC (National Treasury 2015a; OHSC 2015).

2.2.3 Specific change Drivers in Social Development

a) The State's Constitutional Obligations (Sec 27&28)

Constitutional (Sec 27&28) imperatives compel the state to be development orientated and to take progressive measures to grant everyone access to health care services, sufficient food and water, and social security. It is recognised that to achieve economic growth and a decent living standard, the country requires a high quality, accessible health system, and comprehensive and sustainable social development services to protect vulnerable persons (NPC 2012a; National Treasury 2015b). However, policymakers acknowledge that South Africa's health and social welfare issues cannot be tackled in isolation, because socio-economic factors influence people's health status. By recognising the relationship between poverty, malnutrition and the lack of access to services, and diseases such as HIV/AIDS and TB, Government policies aim to also address the social determinants of health. As a result, these considerations necessitate that changes be made to the skills base and skills content of available human resources in the health and social development sector.

b) Social welfare policies and services becoming more development orientated

Service agendas aim to promote social inclusion and strengthen social cohesion; enable families and individuals to access services and economic and social opportunities; reach out to vulnerable people and care for persons living with disabilities (DSD 2015b).

Legislation and social development programmes aim to progressively expand the reach of social security provision and to care for children in particular. These measures have a major impact on the obligations, duties and skills mix of the social development workforce.

c) Review of the White Paper for Social Welfare

While the White Paper for Social Welfare originally served as a guideline document for the social development sector, a review of the White Paper was initiated by the Minister of Social Development and the review report was published on October 2016. The Review found that there were huge gaps in social welfare service provision in critical areas affecting the well-being of children, youth in trouble with the law, the elderly, people with disabilities and those who are experiencing substance addictions and violence. These gaps in services leave the poorest individuals and households in extreme distress and undermine the transformation and change agenda identified in the NDP Vision 2030. Social workers interviewed in the review reported high levels of stress, overwhelming workloads, and burnout, as well as too few supervisors who are able to focus on the training and development of their teams. The COVID-19 pandemic has exacerbated this problem tremendously; although more social workers were recruited and deployed, the high levels of stress and heavy workloads continue.

2.2.4 Specific change Drivers in Health

a) National Health Insurance

The first phase in implementing the NHI, which will provide citizens with universal access to a defined package of health care services, was pilot programmes running in key districts around the country since 2012. The White Paper was published in 2017, and the National Health Insurance Bill was approved by Cabinet in July 2019 and sent to Parliament to be tabled. It has since been subjected to an extensive public consultation process and is scheduled for further parliamentary debates before it is presented to the president for promulgation. Progress has also been made in terms of the Health Patient Registration System (HPRS) with 57 million individuals registered in 3 111 public health facilities. The NHI fund will be set up as soon as the NHI Bill is passed (Minister Mkhize IOL 2021).

A very important driver of change will be the provision and maintenance of sufficient skills to implement the NHI. The success of the NHI will depend on the skills of health workers in general, who are trained to offer all levels of care, from primary health care to specialised secondary care and highly specialised tertiary levels of care. Moreover, it will also depend on the skills of the workers who are going to be responsible for the operational functioning of the NHI (Stakeholder Interview 2019). The role of the HWSETA is crucial in this regard. Partnerships have already been established with all provincial governments to train their staff on governance of the NHI. The COVID-19 pandemic has also shown that the public and private health sector can cooperate, which is an important factor to ensure the success of the NHI.

b) Re-engineering and Expansion of Access to Primary Health Care

Primary healthcare (PHC) was re-engineered through four streams to improve timely access and to promote health and prevent disease. These streams are municipal ward-based primary health care outreach teams (WBPHCOTs), integrated school health programme (ISHP), district clinical specialist teams (DCSTs), and contracting of non-specialist health professionals. Each WBPHCOT team is led by a nurse, and the process of strengthening the nursing colleges as the primary training platform is underway. The need was identified for a large cohort of community health workers that can be part of the WBPHCOTs in municipal wards where at least 60% of the households are poor (EE Research Focus 2017). This plan has now been escalated by the COVID-19 pandemic; in 2020 a cohort of about 50 000 community health workers was deployed to assist with testing and tracking, flagging again the importance of these workers in a primary health care setup.

c) Human Resources Planning for the Future

Since the Human Resources for Health (HRH) Strategy - South Africa 2030 (DoH 2011) was published several new government plans were put into action which required a revision of the HRDSA (HRDC 2017). The review focused on specific issues to address blockages within the education and training and skills development pipeline. Over the years several different HRH interventions were implemented addressing issues such as: staffing norms and skills mix; recruitment and retention of staff; training and educational reforms; information for workforce planning; and leadership and organisational culture (van Ryneveld 2020). However, the HRH crisis remains and are characterised by staff shortages, inequities and mal-distribution between urban and rural areas and between the public and private health sectors (SA Lancet National Commission 2019). The COVID-19 pandemic highlighted again the important role that nurses play in the health sector and social workers in the social development sector; human resources planning in this regard remains therefore critical in order to meet current and future demand.

d) Technological Change

New technologies have a profound effect on the sector. In some instances, it allows for the automation of processes, which leads to a reduction in employment. Simultaneously, technological developments also have a constant effect on treatment methodologies and interventions. Studies have shown that the 4IR requires changes in the skills requirements for certain occupations in the health sector. This creates opportunities for inclusion of technology modules in certain undergraduate curricula and the up-skilling of the current workforce through tailored skills development training courses (HWSETA 2020b). This inclusion, according to the ERRP Skills strategy, will be a way of addressing the 'curriculum shortcomings' by the SETAs such as targeting digital literacy. The COVID-19 pandemic has specifically drawn the attention to technological advancement in the laboratory services industry relating to big data and telepathology (NHLS 2020).

2.3 Policy Frameworks Affecting Skills Demand and Supply

2.3.1 The Economic Reconstruction and Recovery Plan and the linked Skills Strategy

The Economic Reconstruction and Recovery Skills Strategy is linked to the Economic Reconstruction and Recovery Plan (ERRP) and was put into place to support both the management of the COVID-19 pandemic and the economic and social recovery in relation to skills development. It is a short-term plan designed to create a balance between the short- and long-term skills needs of the country and ensure that the skills system is strengthened. The focus is the immediate rollout of skills development interventions to make sure that the ERRP is supported in all regards. The HWSETA will focus on the implementation of the strategy as well as the revised MSTF. In response to the immediate requirements the HWSETA will: revise the Annual Performance Plan (APP) for 2021-2022; prioritise funding for skills development interventions required for the ERRP; and align the strategic and sector skills planning to the strategy and revised MSTF. Interventions two, three, five and seven are applicable to the sector: Updating or amending technical and vocational education programmes; increased access to programmes resulting in qualifications in priority sectors; access to workplace experience; and retraining/up-skilling of employees to preserve jobs (HWSETA 2021).

2.3.2 The National Development Plan

The overall aim of the National Development Plan (NDP) in relation to health and social development is to enable all South Africans to maintain a decent living standard, have universal access to healthcare and enjoy adequate social protection (2012b). Table 2-1 summarises the strategic actions needed to achieve these aims and the resulting implications for skills planning in the health and social development sector.

Table 2-1: Implications of NDP for Skills Planning in the Health and Social Development Sector

Strategic Actions	Implications for Skills Planning
Health: Access to quality health care for all, reduce disease burden and raise life expectancy	
Strengthen the health system: Build service capacity & expertise Set norms & standards for care	Supply adequate skills mix across the entire health system to provide effective, efficient, affordable & quality care; Train more professional & specialist nurses & strengthen nurse training platforms; and Improve health system management, safety in healthcare & clinical governance
Re-engineer primary healthcare	Deploy ward-based outreach teams & expand school health services; Contract in-sessional doctors & deploy clinical specialist teams trained in family health; and train nurses in primary health care
Expand community-based care & environmental health	Train community health workers to focus on maternal, child & women's health & basic household & community hygiene & expand environmental health services
Increase access to antiretroviral treatment & reduce TB infection rates	Train more health professionals & health workers to monitor treatment, & employ more pharmacists & pharmacy technicians to distribute & administer medication
Provide National Health Insurance to give universal healthcare coverage	Improve financial management & procurement of health services, medicine & goods; Improve health facilities & expand training of health professionals; and set staffing norms & improve human resources capacity, training & HR management

Table 2-1: Implications of NDP for Skills Planning in the Health and Social Development Sector *contd.*

Strategic Actions	Implications for Skills Planning
Social Development: Provide integrated social protection & enable citizens to live with dignity	
Expand basic social welfare services for vulnerable groups	Provide protection & care services for children, families, the elderly & disabled; train more social service workers on all occupational levels, and build management & governance capacity of NGOs to sustain service provision
Enable children to access social care, education safety & nutrition	Expand provision of early childhood development programmes & train ECD practitioners; address the social impact of HIV/AIDS & other challenges on children; strengthen child protection services, supervision & mentorship for youth & orphans; and train caregivers & social work specialists (e.g. probation officers & registered counsellors)
Support communities with sustainable livelihoods & household food security	Train community development practitioners & enhance skills set of the current workforce; and build the capacity of community-based Organisations to provide effective community development
Reduce social crime & support victims	Increase social care & support to families & victims, and train social workers to manage substance abuse & crime prevention programmes

Source: National Planning Commission 2012d; DoH 2015, DSD 2015a & 2015b

2.3.3 Provincial Plans and Programmes

While the national departments of health and social development develop the policies and drive the priorities to achieve the NDP's goals, implementation is carried out in the provinces. A study conducted in May 2017 on the Strategic Plans and Annual Reports of all provincial departments of health and social development showed that there is a need for provincial and national departments to ensure alignment of programmes aimed at improving human resource development and skills planning outcomes (EE Research Focus 2017). The human resources function in provincial government department continues to be perceived as a transactional unit, rather than a strategic unit within departments, which has an implication for human resources and skills development planning (PSETA 2019). The COVID-19 pandemic has made this more crucial than ever. The high prevalence of COVID-19 in some provinces demonstrated the importance of sufficient human resources planning and the importance of human resources- and skills development in order to provide a competent workforce that is able to react on a pandemic of this nature.

2.3.4 White Paper for Post-School Education and Training

The HWSETA implemented strategies outlined in the White Paper for Post-School Education and Training (DHET 2013). The White Paper aims to create an integrated post-school education and training system that meets the country's developmental needs. Increasing student access to higher education and improving their success rate are vital strategies to develop the high-level skills needed in the sector. The Open Learning Policy Framework for Post-School Education and Training is also applicable in this regard (DHET 2017). Cooperation between education and training institutions and the workplace is an important strength and the promotion of work-integrated learning to better prepare learners for the labour market is crucial. The Skills Strategy linked to the ERRP aligns with the White Paper by emphasising the importance of workplace experience (DHET 2021).

2.3.5 National Skills Development Plan 2030

The National Skills Development Plan (NSDP) 2030 derives from both the NDP and NGP with the mission "to ensure that South Africa has adequate, appropriate and high-quality skills that contribute towards economic growth, employment creation, and social development" (DHET 2019). The role of SETAs regarding the demand and supply of skills is again emphasised in the plan. The NSDP focuses on the following outcomes through the activities of the SETAs: (i) identifying and increasing production of occupations in high demand; (ii) linking education and the workplace; (iii) improving the level of skills; (iv) increase access to occupationally directed programmes; (v) supporting the growth of public colleges as key providers of skills required for socio-economic development; (vi) supporting skills development for entrepreneurship and cooperative development; (vii) encouraging and supporting worker initiated training; and (viii) supporting career development services.

2.4 Implications for Skills Planning

In a resource-constrained environment with enormous demands for health care and social services, South Africa needs to develop skills to deliver cost-effective health care and social development interventions. The HWSETA cannot meet the vast spectrum of skills and has to prioritise skills development interventions. The key skills issues that fall within the HWSETA ambit are the following: First, the HWSETA has to support skills interventions needed to build the developmental state. In this regard, the HWSETA will assist national efforts to expand the numbers of health professionals needed to provide all levels of care under the NHI and facilitate skills development. Second, the HWSETA will focus this year and onwards on skills development interventions required for the ERRP skills strategy such as: updating technical and vocational education programmes; increase access to programmes resulting in qualifications in priority sectors; providing access to workplace experience opportunities; and retraining/up-skilling of employees to preserve jobs. Third, the HWSETA's skills planning should continue contributing to a sustainable skills pipeline into the sector and address entry-level as well as higher-level professional skills. Fourth, in order to support cost-effective skills interventions while also expanding service capacity, the HWSETA has to contribute to the development of mid-level skills needed to strengthen health and social development service providers. Fifth, the HWSETA also has a responsibility to respond to skills gaps in the current workforce brought about by: changes in policy and service delivery; technological developments; skills shortages driven by legislative changes, the human rights-based development agenda and health pandemics like COVID-19.

2.5 Conclusion

National and provincial policies and strategic development agendas are aligned to the NDP and in changing the way social services and human- and animal health care are accessed and delivered. The needs and service expectations of the primary health care and social development systems are expanding and have necessitated changes to the skills base of the workforce. Pandemics like COVID-19 emphasise the importance for government to include such occurrences in their strategic development planning. The Economic Reconstruction and Recovery Skills Strategy will be a primary driver in the sector the next couple of years.

3. OCCUPATIONAL SHORTAGES AND SKILLS GAPS

3.1 Introduction

This chapter starts in the first section with the identification and discussion of occupations in which skills shortages are experienced and a discussion of skills gaps that persist in the workforce. The second section describes the extent and nature of the skills supply to the sector. This is followed by an explanation of the HWSETA's Sector Priority Occupations list (PIVOTAL list). The data sources that were used are the PSETA and HWSETA WSP data, HEMIS data from DHET, and the data of the various professional bodies in the sector.

3.2 Hard-to-Fill Vacancies

One of the clearest indicators of skills shortages is vacancies that remain unfilled for long periods of time despite employers' active recruitment efforts. The employers that submitted WSPs to the HWSETA and the PSETA in 2021 reported a total of 7 470 hard-to-fill vacancies. These vacancies were distributed over 220 occupations. Just over half (51.5%) of these vacancies were for professionals and just over a third (37.1%) for technicians and associate professionals (Table 3-1).

Table 3-1: Hard-to-Fill Vacancies according to Occupational Group

Occupational Group	Private	Public	Total	%
Managers	282	46	328	4.4
Professionals	2 419	1 427	3 846	51.5
Technicians and Associate Professionals	2 566	209	2 775	37.1
Clerical Support Workers	58	2	60	0.8
Service and Sales Workers	278	143	421	5.6
Skilled Agricultural, Forestry, Fishery, Craft and Related Trades Workers	9	25	34	0.5
Plant and Machine Operators and Assemblers		3	3	0.0
Elementary Occupations	3		3	0.0
Total	**5 615**	**1 855**	**7 470**	**100.0**

Sources: Calculated from HWSETA and PSETA WSP submissions 2021

The occupations, in which more than 20 vacancies were reported (as presented in Table 3-2), account for 16% (35/220) of all hard-to-fill vacancies reported by employers from HWSETA and PSETA WSP submissions. From the figures presented in the table, it is clear that both the public and private health sectors suffer from a severe shortage of registered nurses, medical doctors, specialists and pharmacists. The reason for the huge shortage of nurses is due to the change of the nursing qualifications; the nursing training institutions only started training on the new qualifications in 2020. Employers also reported that the reason for the scarcity of registered nurses (medical) and nursing support workers is resignation of staff due to the COVID-19 pandemic; nurses in South Africa are battling under the strain of the pandemic. Other occupations where severe shortages are experienced are for example ambulance officers in the public sector, hospital and retail pharmacists, physiotherapists, radiographers, occupational therapists, clinical psychologists, and social counselling workers. Reasons for shortages relate to general scarcity of people with the required qualifications, unsafe working conditions, lack of experience, high turnover rate scarcity in a specific geographic location, and funds for training not sufficient. Since the WSP datasets used for HTFV analysis does not account for emerging occupations, survey research studies will explore more on emerging occupations and emigration as a factor explaining supply challenges. This will confirm and quantify the relevance and level of need or demand of occupations such as those associated with maintenance of ventilators.

It should be noted that not all occupations listed in Table 3-2 will have a SETA intervention aligned to them as the budget is limited to programmes where there are occupations with the highest vacancies and high demand occupations are prioritised. Although, employers are encouraged to submit separate applications for training programmes they wish to implement within their organisations.

Table 3-2: Hard-to-Fill Vacancies according to the Occupation (OFO 2019 Version)

OFO Occupation		Private	Public	Total	Qualification was Terminated, Pool became Smaller	Limited Numbers Trained	Resign due to COVID-19	Scarcity of People with Required Qualifications	Unsafe Working Conditions	Lack of Experience	High Turnover Rate	Scarcity in Area/Geographic Location	Funds for Training not Available
2019-322101	Enrolled Nurse	2 364		2 364	X								
2019-222108	Registered Nurse (Medical)	1 779	78	1 857			X	X					
2019-532903	Nursing Support Worker	213	139	352		X	X						
2019-221101	General Medical Practitioner	9	268	277				X					
2019-222101	Clinical Nurse Practitioner	9	230	239				X					
2019-222104	Registered Nurse (Community Health)	102	98	200			X	X					
2019-325802	Intensive Care Ambulance Paramedic / Ambulance Paramedic	4	108	112				X	X	X			
2019-222103	Registered Nurse (Child and Family Health)	12	74	86				X					
2019-226203	Retail Pharmacist	83		83				X		X	X		
2019-134201	Medical Superintendent	39	38	77				X					
2019-221210	General Medicine Specialist Physician	3	74	77				X					
2019-222105	Registered Nurse (Critical Care and Emergency)	52	25	77				X					
2019-321101	Medical Diagnostic Radiographer	17	53	70				X		X		X	
2019-222112	Registered Nurse (Surgical)		69	69				X					

Table 3-2: Hard-to-Fill Vacancies according to the Occupation (OFO 2019 Version) *contd.*

OFO Occupation		Private	Public	Total	Qualification was Terminated, Pool became Smaller	Limited Numbers Trained	Resign due to COVID-19	Scarcity of People with Required Qualifications	Unsafe Working Conditions	Lack of Experience	High Turnover Rate	Scarcity in Area/Geographic Location	Funds for Training not Available
2019-226201	Hospital Pharmacist	15	50	65						X			
2019-222109	Registered Nurse (Medical Practice)	4	59	63				X					
2019-222111	Registered Nurse (Operating theatre)	24	18	42				X					
2019-222117	Midwife	8	34	42				X					
2019-222113	Paediatrics Nurse	1	36	37				X					
2019-226902	Occupational Therapist	8	29	37								X	
2019-263401	Clinical Psychologist	6	31	37				X					
2019-263501	Social Counselling Worker	35		35				X					
2019-222116	Nurse Manager	20	13	33				X				X	
2019-532901	First Aid Attendant	30		30									X
2019-321104	Sonographer	26	3	29				X					X
2019-134402	Community Development Manager	28		28						X			
2019-242401	Training and Development Professional	28		28				X					
2019-121101	Finance Manager	27		27						X			

Table 3-2: Hard-to-Fill Vacancies according to the Occupation (OFO 2019 Version) *contd.*

OFO Occupation		Private	Public	Total	Qualification was Terminated, Pool became Smaller	Limited Numbers Trained	Resign due to COVID-19	Scarcity of People with Required Qualifications	Unsafe Working Conditions	Lack of Experience	High Turnover Rate	Scarcity in Area/Geographic Location	Funds for Training not Available
2019-226401	Physiotherapist	3	24	27								X	
2019-222110	Registered Nurse (Mental Health)		26	26				X					
2019-142103	Retail General Manager	23		23								X	
2019-441301	Coding Clerk	23		23				X					
2019-221203	Emergency Medicine Specialist	19	2	21				X					
2019-332208	Pharmacy Sales Assistant	13	8	21								X	
2019-221212	Forensic Pathologist		20	20				X					
Total		**5 027**	**1 607**	**6 634**									

Sources: Calculated from HWSETA and PSETA WSP submissions 2021

3.3 Skills Gaps

The difference in the skills required for the job and the actual skills possessed by the employees is called a skill-gap. In the research for the SSP and during engagements with stakeholders in the sector over the last few years specific skills gaps were identified.

3.3.1 Skills Gaps in the Social Sector

Employers in the sector identified the following skills gaps at the high level (managers and professionals), mid-level (technicians, associate professionals, and service workers), and the lower level (elementary occupations) (Stakeholder interviews 2020, 2021). The gaps in terms of work-from-home skills, especially the use of technology is applicable at all levels. However, it is important to note that most of the workers in the sector are working on site (hospitals, clinics, practices, etc.) and it is only the support staff which has the option to work-from home; most organisations use a rotation model in this regard (Stakeholder interviews 2021).

3.3.2 Skills Gaps in the Social Development Sector

a) High level (managers and professionals)

- Leadership, team management and conflict management skills.
- Industrial relations skills.
- Monitoring, evaluation and impact assessment skills.
- Project management skills tailored to the social services sector.
- Virtual counselling.

b) Mid-level (technicians, associate professionals, and service workers)

- Communication and business report writing skills.
- Technical monitoring and evaluation skills.
- Time management skills.
- Computer skills in order to utilise and maintain computerised information systems.

c) Lower level (elementary occupations)

- Literacy and computer skills.
- Communication skills.
- Understanding of and compliance to policies.
- Occupational health and safety.

3.3.3 Skills Gaps in the Health Sector

a) High level (managers and professionals)

- Leadership and strategic planning skills.
- Business acumen.
- Change and crisis management skills.
- Managing diversity and managing millenniums.
- Emotional Intelligence (EQ) and self-management skills.

b) Mid-level (technicians, associate professionals, and service workers)

- Interpretation of and compliance to policies skills.
- Computer skills in order to utilise and maintain computerised information systems.
- Customer (client) skills.
- Basic nursing skills i.e., focus on the patient, empathy; this is found to be even more important now during the pandemic.

c) Lower level (elementary occupations)

- Literacy and computer skills.
- Communication skills.
- Understanding of and compliances to policies skills.

3.4 Extent and Nature of Supply

This section outlines some of the identified critical elements of supply to the sector. These include education and training provision, training capacity, training output, and a summary of the supply-side constraints. Along with the identified constraints, there is also a brief indication of how the HWSETA seeks to respond to these constraints. The training of healthcare professionals is a topic that impacts on us all. The goal of health professional education is to deliver a cadre of well-trained and appropriately skilled health workers who are responsive to the needs of the communities in which they work. This can be done through an appropriate health science education model that includes education from further education and training, undergraduate and postgraduate education through to the maintenance of professional competence.

The HWSETA conducted a study to determine if employers and skills development providers had resumed training during the COVID-19 level 3 lockdown period. Three quarters (75%) (290/388) of all the employers and 82% (84/103) of the skills development providers who participated in the survey indicated that they had resumed training during this period. This is very positive in terms of skills development and the supply of skills (HWSETA 2020c).

3.4.1 Entry in the Health and Welfare Development Sector

Prospective workers enter the sector at different levels, either directly from secondary school, or following post-school training, or with little or no formal school training. The positive or negative output from the secondary school system underlies the greater part of skills supply to the sector. For example, a good Grade 12 pass, with mathematics, physical and life sciences is

a basic entry requirement into most of the tertiary-level study programmes which enable access to the health sector. Such programmes include health sciences, nursing sciences, pharmacy, optometry, radiography, veterinary sciences, and the other allied health sciences. Although Grade 12 mathematics and science are not barriers to entry into the social development sector, however, a well-developed level of non-cognitive skills is essential. Much attention is currently paid to increase the quality of basic education (NPC 2020). A strategy to get more entrants into education in the health professions is to encourage individuals to obtain qualifications in fields in which there are more opportunities for employment (DHET 2020). However, the effect of the disruption of contact education due to the COVID-19 pandemic must not be underestimated. One implication may be that there will be fewer learners with a NSC with mathematics and science. This will have an impact on the intake of students in the health sciences field.

3.4.2 Post-school Training

a) Scope of Institutional Training Capacity

Post-school training for over a 100 registered health professions take place at public and private HEIs and training colleges. Training health and veterinary professionals take longer and it requires a clinical health service-teaching platform to ensure the quality development of the essential clinical skills and patient care services. Most prospective health professionals are trained in academic health complexes established under the National Health Act (Sec 51) that aim to provide comprehensive academics, clinical and in-service training at all levels of care, from primary- to tertiary level, and specialised care.

Based on regulatory requirements, the private higher education sector has been restricted from producing certain health professionals. However, various learning centers in the larger hospital groups are registered as private higher education institutions and TVET colleges. These institutions train nursing staff as well as professionals in emergency and critical care ranging from basic to undergraduate and postgraduate levels. Ancillary healthcare professionals are trained in infection control and as surgical technologists. Several hospital groups support technical training programmes to address shortages in technical skills, such as artisans.

The Training of Doctors

Historically the training of doctors was undertaken by eight South African medical schools which produced approximately 1 300 doctors per annum. In January 2016, a new medical school was opened at the University of Limpopo with 60 students as its first intake. This medical school is over the longer-term linked to the presidential project of building an academic hospital in Limpopo, namely the Limpopo Central Hospital (DoH 2019). Another government intervention aimed at the training of doctors is known as the Nelson Mandela/Fidel Castro Medical Collaboration. This collaboration stems from the shortage of medical doctors in South Africa, in particular in the rural areas. The programme recruits students from rural areas that have a shortage of doctors and sends them to Cuba for medical training. There are currently about 1 200 students in Cuba.

The Training of Nurses

The institutional arrangements for the training of nurses underwent fundamental changes. The qualification requirements for entry into the nursing and midwifery professions have been increased to higher NQF levels. The implication of these changes is that the nursing colleges have now become higher education institutions (HEIs). The first group of nursing students on the new qualifications started in 2020. However, nursing colleges reported that the disruption of contact education also forced them to apply digital nursing education methods and with regard to the clinical components (practicals) they have to work around the COVID-19 pandemic surges.

Occupational Qualifications

The educational landscape has changed dramatically with the introduction of the Occupational Qualifications Sub-framework of the NQF and the Quality Council for Trades and Occupations (QCTO). Training institutions that are accredited by the QCTO offer the qualifications and upon completion of the knowledge, practical skills and workplace components of the qualifications candidates write the EISA.

Training Offered by NGOs

NGOs also contribute to skills provision for the sector. Generally, NGOs offer non-accredited training to volunteers, CHWs and community caregivers. Most of these organisations lack the capacity to seek accreditation to offer the formal qualifications registered on the NQF.

Workplace Training

Most of the occupations that are found in the health and social development sector require workplace training. In some instances, they require work-integrated learning (WIL) where the workplace components form part of the qualifications and in many instances, health professionals have to complete an internship before they qualify for professional registration. This means that employers in the sector form a critical component of the institutional

arrangements for education and training in the sector. As per regulations, workplace training is also subjected to norms and standards that are imposed by the professional councils. In line with the skills strategy linked to the ERRP the focus this year is on providing sufficient WIL or WBE opportunities to learners in the sector.

3.4.3 Student Output from the Public Higher Education Training Sector Institutions

The analysis of the supply of skills at HET level is based on information obtained from the DHET's Higher Education Management Information System (HEMIS). Student output in the fields of study relevant to the health and social development sector over the period 2010 to 2019 is shown in Table 3-3.

If all the health-related and social welfare fields of study are considered, the total output from the Public HET sector grew on average by 2.1% from 2010 to 2019 at first three-year B Degree level and 5.4% at first four-year B Degree level. Over the nine-year period, most of the professional (four-year) degrees showed a positive average annual growth except for dentistry and oral sciences, alternative and complementary medicine and medical systems, and somatic bodywork and related therapeutic services. The output of first four-year degrees in medicine increased on average with 5.2% per annum over the nine-year period. The output of the four-year nursing degree has grown on average by 6.1% per annum over the same period. Output in social work has grown on average by 6.4% per year.

Interruption of contact education and training due to the COVID-19 pandemic in 2020 will only be seen in the 2020 HEMIS data. Many students may not be able to meet the clinical/practical requirements of the respective programmes, depending on the duration of the academic interruption. It is expected that the pandemic will have an effect on the enrolment of students in future as fewer learners have passed mathematics and science at Grade 12 level at the end of 2020 due to the disruption in contact education.

Table 3-3: Number of Health-related and Social Work Qualifications awarded by Public HEIs: 2010 to 2019

HEMIS Study Fields	Qualifications	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	AAG (%)
Chiropractic	First BDegree (4 years)	48	44	52	53	40	45	60	24	44	56	1.7
Communications Disorders Sciences and Services	First BDegree (4 years)	114	153	141	134	169	199	202	232	243	256	9.4
Dentistry, Advanced Dentistry and Oral Sciences	First BDegree (3 years)	50	38	52	68	84	82	55	33	36	46	-0.9
	First BDegree (4 years)	212	157	201	177	212	166	205	199	207	210	-0.1
Health and Medical Administrative Services	First BDegree (3 years)	200	179	230	271	235	235	220	212	253	265	3.2
	First BDegree (4 years)	258	290	270	253	91	213	158	358	364	377	4.3
Medicine	First BDegree (3 years)	1	25	40	59	60	39	81	58	51	51	54.9
	First BDegree (4 years)	637	704	660	542	557	847	996	843	1 039	1 002	5.2
Medical Clinical Sciences	First BDegree (3 years)	55	65	102	141	93	74	72	122	85	57	0.4
	First BDegree (4 years)	1 015	936	999	973	1 024	1 125	941	1162	1 103	1 185	1.7
Nursing	First BDegree (3 years)	302	271	278	395	364	415	454	316	323	260	-1.6
	First BDegree (4 years)	891	958	927	943	1 171	1 159	1 200	1379	1 354	1 517	6.1
Optometry	First BDegree (4 years)	127	115	90	81	81	120	127	116	94	160	2.6
Pharmacy, Pharmaceutical Sciences and Administration	First BDegree (3 years)	1			1	0	0	11	11	5	2	4.6
	First BDegree (4 years)	466	509	561	687	723	950	834	878	972	955	8.3
Podiatric Medicine/Podiatry	First BDegree (4 years)	6	16	3	13	15	3	31	29	23	37	22.4
Public Health	First BDegree (3 years)	20	23	63	66	63	246	256	316	97	89	18.0
	First BDegree (4 years)	172	201	210	231	236	246	256	316	254	293	6.1
Rehabilitation and Therapeutic Professions	First BDegree (3 years)	57	52	41	83	90	123	147	124	149	123	8.9
	First BDegree (4 years)	526	555	578	598	633	712	742	728	769	693	3.1
Veterinary Medicine	First BDegree (3 years)	25	25									
	First BDegree (4 years)	32	29	32	34	33	33					
Veterinary Biomedical and Clinical Sciences	First BDegree (3 years)	25	25									

Table 3-3: Number of Health-related and Social Work Qualifications awarded by Public HEIs: 2010 to 2019 *contd.*

HEMIS Study Fields	Qualifications	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	AAG (%)
	First BDegree (4 years)	97	86	95	103	98	99	131	136	183	212	9.1
Dietetics and Clinical Nutrition Services	First BDegree (3 years)	16	24	20	7	7	7	4	6			
	First BDegree (4 years)	110	127	118	124	127	117	166	184	184	160	4.2
Alternative and Complementary Medicine and Medical Systems	First BDegree (3 years)	10	6	7	16	19	10	23	11	26	32	13.6
	First BDegree (4 years)	24	26	28	9	26	18	16	16	31	21	-1.5
Somatic Bodywork and Related Therapeutic Services	First BDegree (3 years)	10	5	8								
	First BDegree (4 years)	47	42	40	39	28	38	41	46	48	45	-0.4
Movement and Mind-Body Therapies and Education	First BDegree (3 years)	0	14	20								
	First BDegree (4 years)	7	6	6	11	4	15					
Medical Radiologic Technology/Science (Radiography)	First BDegree (3 years)	29	41	33	43	39	52	44	48	49	84	12.5
	First BDegree (4 years)	77	106	98	125	130	152	192	231	252	378	19.4
Clinical Technology	First BDegree (4 years)										10	
Health Professions and Related Clinical Sciences, Other	First BDegree (3 years)	7	0	0	27	80	0	0	62			
	First BDegree (4 years)	11	45	47	161	132	86	80	22	114	126	31.2
Social Work	First BDegree (3 years)	65	85	48	107	126	96	123	125	64	49	-3.1
	First BDegree (4 years)	1 169	1 297	1 671	1 881	2 121	2 362	2 618	2815	2 518	2 049	6.4
Total	**First BDegree (3 years)**	**874**	**878**	**942**	**1 282**	**1 261**	**1 379**	**1 490**	**1 444**	**1 138**	**1 057**	**2.1**
	First BDegree (4 years)	**6 046**	**6 402**	**6 827**	**7 172**	**7 649**	**8 705**	**8 996**	**9 714**	**9 796**	**9 741**	**5.4**

Source: HEMIS 2019

a) Skills Supply through Nursing Colleges

From 2020 all new nursing qualifications are offered by public and private Nursing Education Institutions (NEIs) in the higher education setting. The qualifications are: (i) one-year Higher Certificate in Nursing (NQF Level 5) leading to registration as a Nursing Auxiliary; (ii) three-year Diploma in Nursing (NQF Level 6) leading to registration as a General Nurse; and (iii) four-year Bachelor Degree of Nursing (NQF Level 8) leading to registration as a Professional Nurse and Midwife. There are currently 11 private Nursing Education Institutions (NSIs) that are accredited to offer the new nursing qualifications, 45 public NEIs, and 19 universities and universities of technology (SANC 2021). There are still a number of institutions that are accredited to deliver the legacy qualifications during the phasing out period.

The number of nurses who qualified at various levels between 2010 and 2020 can be seen in Table 3-4. A total of 36 688 Nurses qualified with a four-year qualification over the ten-year period, showing an average annual growth of 2.0%, while another 37 624 Nurses completed the Bridging Programme between 2010 and 2020, showing a negative average annual growth of -1.4%. This decrease as well as the decrease in pupil Nurses and pupil Auxiliaries is due to the phasing out of the legacy qualifications. The Hospital Association of South Africa (HASA) emphasises that the output of nurses can increase significantly if the SANC allows private hospitals to train more nurses (HASA 2019). This was confirmed by interviews with big private hospitals in the sector (Interview 2021).

Table 3-4: Number of Graduates at NEIs: 2010 to 2020

Program	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	AAG %
Four-year Program	2 966	2 966	3 225	3 261	3 221	3 291	3 528	3 322	3 564	3 736	3 608	2.0
Bridging Course*	2 655	2 964	3 929	3 291	2 889	4 136	3 326	3 014	3 953	5 169	2 298	-1.4
Pupil Nurses	7 511	7 391	7 732	8 954	6 949	8 756	7 879	6 001	825	95	8	-49.6
Pupil Auxiliaries	5 125	5 232	5 009	5 909	6 141	5 795	6 726	587	39	29	32	-39.8
Total	**18 257**	**18 553**	**19 895**	**21 415**	**19 200**	**21 978**	**21 459**	**12924**	**8 381**	**9 029**	**5 946**	**-10.6**

**Bridging into professional nurse category*
Source: SANC 2021

b) Skills Supply through Occupational Qualifications

As indicated earlier, the HWSETA plays an important role in terms of the quality assurance of a range of qualifications. These qualifications play a key role in the supply of important skills to the sector and in the period 2013 to 2020 over 26 500 candidates qualified in Child and Youth Care Work, Social Auxiliary Work and Community Health Work (Table 3-5).

Table 3-5: Student Output in Qualifications Overseen by HWSETA: 2013 – 2020

Qualification	2013	2014	2015	2016	2017	2018	2019	2020	Total
FET Certificate NQF L4: Child and Youth Care Work	521	344	1 113	1 405	376	480	866	899	6 004
FET Certificate NQF L4: Social Auxiliary Work	2 476	1 209	844	713	471	279	979	454	7 425
FETC NQF L4: Community Health Work	352	463	644	361	280	191	1279	274	3 844
NC NQF Level 2: Community Health Work	629	2 418	2 786	1 744	230	584	872	61	9 324
Total	**3 978**	**4 434**	**5 387**	**4 223**	**1 357**	**1 534**	**3 966**	**1 688**	**26 567**

Source: HWSETA MIS May 2012

In 2016 a total of 558 students graduated with the new Occupational Certificate: Health Promotion Officer (NQF Level 3) and in 2017 this figure declined slightly to 477.

3.4.4 Professional Registration of Health Professionals

Healthcare and social services professionals are required to register with their respective professional councils in order to practice or work legally. Although the registers include those working abroad and in other sectors, as well as retirees and economically inactive persons they provide an indication of growth in the number of professionals available.

a) Registrations with the Health Professions Council of South Africa (HPCSA)

The HPCSA controls 136 registration categories through twelve professional boards. Table 3-6 shows the registration figures for a number of key professions over the period 2010 to 2020. Since 2010, the number of registered dentists grew on average by 2.0% per year, medical interns (i.e. medical graduates in training) by 4.0%, and medical practitioners by 2.4%. The ranks of physiotherapists (3.6%), occupational therapists (5.1%), radiographers (2.7%), and psychologists (2.6%) also increased over the period. The number of registered medical technologists increased only slightly (by 1.2% per year) over the total period. The same counts for speech therapist and audiologist; the number only increased by 1.3%.

Table 3-6: Number of selected Professionals Registered with the HPCSA as at 31 December of 2010 to 2020

Registration Category	Number of Persons Registered											
	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	AAG %
Dentist	5 296	5 423	5 652	5 787	6 062	6 126	6 331	6 409	6 430	6 530	6 472	2.0
Medical Intern	3 619	3 862	3 338	3 396	3 279	3 215	3 653	3 780	3 745	4 430	5 370	4.0
Medical Practitioner	36 633	37 289	38 652	40 258	42 146	42 550	44 145	44 858	46 014	46 839	46 516	2.4
Medical Technologist	5 383	5 552	4 948	5 045	5 350	5 331	5 576	5 616	5 793	5 975	6 088	1.2
Occupational Therapist	3 490	3 668	3 945	4 238	4 569	4 765	4 980	5 174	5 410	5 682	5 718	5.1
Optometrist	3 083	3 168	3 342	3 458	3 628	3 645	3 751	3 773	3 812	3 837	3 899	2.4
Physiotherapist	5 773	5 954	6 328	6 585	7 001	7 122	7 370	7 665	7 856	8 153	8 185	3.6
Psychologist	6 914	7 073	7 245	7 433	7 895	8 047	8 409	8 449	8 770	8 881	8 978	2.6
Radiographer	6 208	6 500	6 225	6 645	7 088	7 239	7 378	7 729	7 794	8 168	8 121	2.7
Speech Therapist & Audiologist	1 388	1 426	1 448	1 448	1 501	1 573	1 519	1 547	1 594	1 612	1 582	1.3

Source: HPCSA 2021

b) Registrations with the South African Nursing Council (SANC)

The number of registered, enrolled and auxiliary nurses registered with the SANC reached 287 456 in 2016, but decreased to 280 231 in 2020 (Table 3-7). In the period from 2010 to 2020, the average annual growth in registration for all these categories was only 1.9%. Enrolled nurses increased on average by 1.5% per year. The decrease in registrations for auxiliaries from 2016 to 2020 (over 8 000) and for enrolled nurses from 2017 to 2020 (over 13 500) can be expected due to the change in the qualification framework and teach out period of the legacy qualifications.

The situation with regard to the nurses in training is reflected in the bottom part of Table 3-7. The total number of registered nurses in training had dropped from about 43 300 in 2010 to just more than 23 000 in 2020 (an average annual negative growth of -6.0%). The number of student nurses i.e. those enrolled in the four-year programme also shows a decline with a growth of -0.4 % over the same period. The number of pupil nurses and pupil nursing auxiliaries dropped substantially from 2016 to 2020. This is the result of the changes in the nursing qualifications that are currently being implemented. All the old programmes are in their training out periods while the nursing colleges only started to deliver the new qualifications in 2020. The delay in the accreditation process of nursing colleges as HEIs effected the new enrolments considerably (Interview 2021).

Table 3-7: Number of Nurses Registered with the SANC: 2010 to 2020

Registration Category	Number of Persons Registered											
	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	AAG %
Registered	115 244	118 262	124 045	129 015	133 127	136 854	140 597	142 092	146 791	153 095	154 024	2.9
Enrolled	52 370	55 408	58 722	63 788	66 891	70 300	73 558	74 556	70 552	64 638	61 028	1.5
Auxiliaries	63 472	64 526	65 969	67 895	70 419	71 463	73 301	70 431	68 361	67 104	65 179	0.3
Total	**231 086**	**238 196**	**248 736**	**260 698**	**270 437**	**278 617**	**287 456**	**287 079**	**285 704**	**284 837**	**280 231**	**1.9**
Student	19 778	20 581	20 920	20 956	21 303	20 549	21 339	21 286	21 280	20 822	19 084	-0.4
Pupil	16 836	16 428	16 424	15 337	18 767	18 846	10 773	4 442	3 502	2 917	2 579	-17.1
Pupil Nursing Auxiliaries	6 711	5 744	5 910	6 747	8 549	9 312	2 990	2 364	2 310	1 874	1 666	-13.0
Total	**43 325**	**42 753**	**43 254**	**43 040**	**48 619**	**48 707**	**35 102**	**28 092**	**27 092**	**25 613**	**23 329**	**-6.0**

Source: HPCSA 2021

c) Registrations with the South African Pharmacy Council (SAPC)

From 2012 to 2021, the average annual growth for registered pharmacists and pharmacist interns was 2.8% and 8.3% respectively (Table 3-8). The registration figures in the support staff categories showed higher growth over this period. Basic Pharmacist Assistants grew by 20.6% annually over the period. The number of people registered in this category grew steadily from 2012 to 2015, more than doubled between 2015 and 2016, and slightly decreased again between 2019 and 2020. Post-basic pharmacist assistants grew at an annual average of 14.6% per year.

Table 3-8: Number of Registrations with the SAPC: 2012 to 2020

Registration Category	Number of Persons Registered									
	2012	2013	2014	2015	2016	2017	2018	2019	2020	AAG (%)
Basic Pharmacist Assistant	867	1 184	1 774	1 937	4 898	3 965	4 367	4 293	3 877	20.6
Learner Basic Pharmacist Assistant	3 807	4 372	3 500	3 510	3 166	3 080	3 326	3 208	3 110	-2.5
Post-basic Pharmacist Assistant	4 533	5 371	6 086	6 713	7 973	10 191	11 681	13 103	13 481	14.6

Table 3-8: Number of Registrations with the SAPC: 2012 to 2020 *contd.*

Registration Category	Number of Persons Registered									
	2012	2013	2014	2015	2016	2017	2018	2019	2020	AAG (%)
Learner Post-basic Pharmacist Assistant	1 693	1 956	1 849	2 098	2 642	2 084	2 431	2 173	2 170	3.2
Pharmacist	12 805	13 119	13 589	13 658	14 053	14 552	15 231	15 722	16 020	2.8
Pharmacist Intern	619	732	808	857	1 045	1 036	1 086	1 082	1 171	8.3
Specialist Pharmacist	13	13	13	13	13	13	13	11	10	-3.2
Community Service Pharmacist*					642	806	758	807	813	6.1
B Pharm Student*					3 708	4 183	4 287	4 520	4 013	2.0

*Source: SAPC 2021. *From 2016*

d) Registrations with the Allied Health Professions Council of South Africa (AHPCA)

In 2021 a total of 2 573 people were registered with the AHPCSA (Table 3-9). Since 2011, the total number of registrations dropped on average by 1.5% per year. Generally, allied health professionals and complementary practitioners work in the private sector.

Table 3-9: Total Registrations with the AHPCSA: 2011 to 2021

Registration Category	Number of Persons Registered											
	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	AAG %
Acupuncture	118	113	99	66	64	61	57	54	53	52	50	-8.2
Ayurveda Doctor	12	14	15	15	17	17	13	13	12	12	12	0.0
Chinese Medicine	153	156	152	155	156	160	157	153	157	159	156	0.2
Chiropractic	603	628	647	667	731	773	808	835	877	886	910	4.2
Homoeopathy	546	565	559	557	569	572	581	584	580	585	592	0.8
Naturopathy	91	95	89	91	92	88	86	80	80	78	76	-1.8
Osteopathy	48	49	47	46	40	40	36	37	38	37	36	-2.8
Phytotherapy	39	40	38	40	43	49	51	48	48	48	50	2.5
Therapeutic Aromatherapy	342	306	242	222	179	157	131	121	105	100	94	-12.1
Therapeutic Massage Therapy	174	163	146	138	125	111	103	102	95	92	92	-6.2
Therapeutic Reflexology	783	735	662	635	584	535	501	491	446	444	439	-5.6
Unani-Tibb	81	79	70	71	73	74	67	66	69	69	66	-2.0
Total	**2 990**	**2 943**	**2 766**	**2 703**	**273**	**2 637**	**291**	**284**	**2 560**	**2 562**	**2 573**	**-1.5**

Source: AHPCS 2021

e) Registrations with the South African Veterinary Council (SAVC)

The number of veterinarians registered with the SAVC grew on average 3.5% from 2 842 in 2011 to 3 720 in 2021 (Table 3-10). The average annual growth for animal health technicians was 3.2% over this period, veterinary nurses 2.9%, and veterinary technologists 5.5%.

Table 3-10: Number of Registrations with the SAVC: 2011 to 2021

Registration Category	Number of Persons Registered											
	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	AAG %
Veterinarians	2 842	2 902	3 006	3 102	3 174	3 222	3 340	3 548	3 658	3 718	3 720	2.7
Veterinary Specialists	139	147	157	164	167	163	184	207	206	205	212	4.3
Animal Health Technicians	1 008	1 043	1 039	1 034	1 004	1 013	1 041	1 205	1 281	1 283	1 376	3.2
Laboratory Animal Technologists	21	21	21	20	17	19	17	16	15	19	15	-3.3
Veterinary Nurses	542	573	589	602	611	606	640	709	732	769	719	2.9
Veterinary Technologists	210	246	260	287	280	279	311	334	354	349	358	5.5
Veterinary Physiotherapists*											60	
Professionals in Training	1 693	1 926	2 077	2 221	1 635	1 411	1 411	1 655	1 415	1 415	1 252	-3.0
Total	**4 762**	**6 858**	**7 149**	**7 430**	**6 888**	**6 713**	**6 944**	**7 674**	**7 661**	**7 758**	**6 712**	**3.5**

**New para-veterinary profession*
Source: SAVC 2021

f) Registration with the South African Council for Social Service Professions (SACSSP)

From 2016 to 2021, (Table 3-11), the average annual growth for registered social workers, and social auxiliary workers were 5.4% and 5.3% respectively, compared to 7.9% for child, and youth care workers.

Table 3-11: Social Workers, Social Auxiliary Workers, Child and Youth Care Registered with the SACSSP: 2016 to 2021

Registration Category	Number of Persons Registered						
	2016	2017	2018	2019	2020	2021	AAG %
Social Workers	27 130	20 017	32 657	33 404	34 569	35 328	5.4
Social Auxiliary Workers	9 235	10 142	11 182	11 589	11 824	11 954	5.3
Child & Youth Care Workers	5 113	6 303	7 503	8 122	9 071	7 467	7.9
Total	**41 478**	**36 462**	**51 342**	**53 115**	**55 464**	**54 749**	**5.7**

Source: SACSSP 2021

3.4.5 Summary of the Supply-side Constraints and HWSETA Interventions

The readiness of candidates for education and training required to work in the sector is a major constraint identified in the sector. Stakeholders are concerned about the high drop-out rate of undergraduates and the number of learners who seem under-prepared for tertiary level studies and grapple with language- and cultural barriers.

- *Through the careers awareness and guidance programmes, the HWSETA is ensuring that relevant information reach potential sector candidates. This access to information about prerequisites of the sector will enhance the level of preparedness for learners.*

Academic criteria for admission to social work programmes are generally in the lower ranges, and students tend to under-estimate the training demands.

- *In addition to the university support that is offered to students, at the sector entry point, the HWSETA is funding the Social Work Internships and also the implementation of the induction programme to ensure that relevant competencies and cognitive traits are refined for effective service delivery.*

High drop-out rates at nursing colleges are a further indication that prospective learners are not prepared for training at post-school level (Stakeholder interviews 2019, 2020).

- *The HWSETA is working closely with the training institutions to extend a wide range of support programmes which are aimed at giving an additional chance for students to succeed. In addition, the HWSETA also provides funding for the modernisation of teaching aids, upgrading the qualifications of nurse educators and equipping skills laboratories. All the endeavours are aimed to sustain the supply of nurses to the health sector.*

NGOs offer non-accredited training to volunteers, CHWs and community caregivers. Most of these organisations lack the capacity to seek accreditation to offer the formal qualifications registered on the NQF.

- *The HWSETA is working closely with NGO's to ensure that relevant capacity building programmes are designed, accredited and presented to benefiting relevant personnel to improve NGOs performance.*

Training capacity for health professionals remains limited due to infrastructure constraints and restrictions on academic clinician posts, bed count, laboratories and other clinical teaching resources (Stakeholder interviews 2019, 2020).

- *In addition to the existing Cuba Doctors Training programme, the HWSETA offers bursaries to students in medical schools across the country. Post-graduates research bursaries are also offered to ensure that young researchers and academics are prepared well to train the next generation of health professionals.*

The increased enrolment of social work students has put pressure on student-lecturer ratios at public HEIs. Academic departments struggle to cope with training demands and the growing student numbers against the present subsidy formulae. The DSD and academics have raised concerns about the quality of formal education and practical training of undergraduates in social work (Stakeholder Interviews 2019).

- *Social Work training capacity is amongst the key priority areas which are benefiting from the direct HWSETA interventions. Partnerships with previously disadvantaged Universities such as Walters Sisulu, Zululand, Venda, and Limpopo have benefited funding which enhanced the delivery of quality training programmes, postgraduate supervision, and mentoring capacity.*

There are limited training capacity at TVET colleges, accredited private providers and NGOs in certain areas that are important to the health sector.

- *Besides funding programmes which are directed at students, the HWSETA's further support a number of TVET colleges lecturer capacity-building programmes, which benefits a wide range of programme delivery and ultimately workplace practice and supervision.*

As part of the transition to new qualifications in nursing, from 2020 onwards nursing education has been placed in higher education. Auxiliary nurses and staff nurses require NQF level 5 and NQF level 6 qualifications respectively, general nurses need advanced diplomas (NQF level 7), and professional nurses must attain professional degrees (NQF level 8). Nursing colleges struggle to comply with all the requirements to offer training at this level.

- *The HWSETA is funding a wide range of programmes which are aimed at benefiting students and also build lecturing capacity at both public and private nursing colleges. This approach is targeting the offering of quality clinical education and also the production of qualified clinical preceptors and clinical supervisors. For example, the HWSETA has partnered with the Nursing Education Association (NEA), to extend the reach of capacity building for Nursing Educators, which will benefit the delivery of accredited training at nursing colleges. This will enhance the confidence, credibility and increase student enrolments in the Colleges and that, in turn, will have a positive effect on the skills development.*

The interruption of contact education and training due to the COVID-19 pandemic in 2020 had an effect on the clinical/practical requirements of the respective programmes, depending on the duration of the academic interruption. Enrolment figures have dropped as expected in 2021.

- *The HWSETA continues funding potential students in different disciplines in order to ensure the supply of skills to the sector.*

3.5 The HWSETA Sector Priority Occupations List (PIVOTAL List)

3.5.1 Overview

PIVOTAL is an acronym, which means professional, vocational, technical and academic learning programmes that result in qualifications or part qualifications that are registered on the NQF. These programmes often combine theoretical, practical and workplace training. PIVOTAL programmes, therefore, include internships, work-integrated learning, apprenticeships, work experience placements that lead to a trade test or professional designation (candidacy), bridging course/ examinations of qualifications that lead to a designation.

SETAs are obliged to develop PIVOTAL list as part of their sector skills planning processes. These lists are meant to align training programmes offered in and

for the sector to the scarce skills or skills shortages experienced in the sector. The PIVOTAL list is then used to guide funding decisions in the SETA.

In the preparation of a PIVOTAL list, the HWSETA has to take a holistic view of its sector as per SIC code distribution assigned, the skills composition and skills needs of the sector and the education and training pipelines that supply skills into the sector. It has to be borne in mind that the Health and Social Development Sector is a large and complex sector and that it does not only depend on core health and social service professions and occupations. There are support occupations that are relatively small in number, but that is critically important for the functioning of hospitals and other facilities, for example, financial occupations and some of the trades. Another factor that has to be borne in mind in the development of the list is the SETA's obligations in terms of national strategies. All SETAs have an obligation to assist with the alleviation of unemployment and poverty.

3.5.2 Methodology

The development of the PIVOTAL list starts with an analysis of the occupations in the sector and employment in those occupations. This is followed by an analysis of the vacancies in the Hard-To-Fill (HTFV) occupations and (in the case of the public sector Organisations) the number of people that employers say they need to augment their current workforce. This analysis, which is based on the WSPs submitted to the HWSETA and the PSETA provides a basic list of occupations in which scarcity is experienced, with employment and vacancy information on each occupation.

A second step in the process is a systematic analysis of the discretionary funding applications received from employers and training institutions. The list is augmented with information from this analysis. In the funding applications, stakeholders motivate their applications with information on the labour market. The quantities of each identified occupation are based on people required to fill vacancies or as defined by public sector employers. This informs the ranking of occupations in terms of priority. Stakeholder engagements around the PIVOTAL list take the form of interviews conducted with key respondents in the sector. Clarification is sometimes needed regarding the figures presented by employers in their WSP submissions.

The PIVOTAL list is ranked according to the number of people needed. However, this ranking does not necessarily signify preferential funding. The type and nature of the learning programmes that lead to each identified occupation are identified in a further step. The finalisation of the list from the financial year concerned updates the 3-year trends of HTFV to account for variations that arise from changing number of the employer organisations submitting their WSPs. This, in turn, leads to the interventions indicated in the SETA PIVOTAL list. The number of interventions that the SETA can support depends on various considerations:

- SETA funding available in a particular year. It must be kept in mind that most of the learning programmes required for professional occupations in the sector stretch over a period of four years or longer. The SETA cannot fund learners on an ad hoc basis and change the funding mechanisms from year to year. The learners who are supported cannot afford their studies and if the SETA funding were to be withdrawn they may fall out of the system. This would constitute wasteful expenditure on the SETA's side. For this reason, the SETA must set targets keeping its long-term commitments in mind.
- Other funding available in the sector. The government departments in the sector also provide financial support in the form of bursaries.
- Demand and uptake from employers and training institutions.

Finally, an increased percentage of learners trained and finding employment in the sector is the envisaged outcome of the identified interventions.

3.5.3 Approval of the PIVOTAL List

The process of organising the PIVOTAL List culminates in the submission of the PIVOTAL List for consideration and approval by the Board. Upon the completion of this consideration, the PIVOTAL List is then signed Board's Chairperson.

3.6 Conclusion

The demand for new and different skills mixes in the health and social development sector continues to outstrip supply. This is largely due to the state's expanding agenda to improve access to adequate health care and social development services, changes in the way these services are delivered to the public and the COVID-19 pandemic. Evidently, high vacancy rates are reported for health and social service professionals.

It is evident from the foregoing analysis that the health and social development sector is challenged by significant occupational mismatches, especially in respect of the professional workforce. These mismatches are seen at a number of levels. First, there are imbalances between skills output versus the occupational demand in the workplace e.g. vacancies. Second, there are mismatches between skills provision (output) and actual skills absorption in the labour

market. Skills absorption is determined by a variety of factors including workforce budgets, human resources practices, management of health and social welfare systems and working conditions. Third, mismatches exist when the education system fails to produce the package of skills required in the workplace, i.e. the combination of knowledge, clinical skill, capability, professional ethos and work-readiness needed when entering the profession on day one. In line with the EERP Skills Strategy the focus will be on the provision of WBL opportunities to ensure the work-readiness of entrants to the sector. Fourth, mismatches exist due to changes in the work environment, service delivery models and the scopes of professional responsibility, e.g. the re-engineering of primary health care, and the new nurse practitioner categories and new qualifications.

Other factors impacting skills supply include long lead times required to train health professionals; constrained academic and clinical training capacity; slow graduate output; and the low retention rate of health- and social service professionals in the public sector. The strengthening of clinical and practical training platforms for pre-service skills provision to the sector is a key strategic area.

The state's expanding development agenda referred to in Chapter 2 that is aimed at improving access to health care and social services may not be affordable. Therefore, it could be argued that occupational demand in the sector should also be measured in terms of what the state can afford, and not only in terms of service demands. Many of the government's positive strategies to improve the supply and retention of skills in the sector may be compromised by budget constraints and institutional problems such as weak management systems, sub-functional working environments, and poor human resources practices. Unless major improvements in leadership and management of the health and social development systems at all levels are made, migration of professionals out of the public sector and emigration to other countries are likely to continue. The regulatory bodies in the sector need to speed up processes to recognise emerging occupational categories and professions and institute the required regulatory frameworks for such professions and occupations. For as long as those arrangements are not in place, efforts to supply some of the critical skills for healthcare and social development will be hamstrung.

In addition the COVID-19 pandemic will continue to have a considerably effect on the supply of skills to the sector for several reasons: The further increase in demand for certain workers in the sector such as general medical practitioners (specifically in the public sector) and nurses; the decrease in output at HEIs because of the disruption of contact education; the delay in the commencement of the new nursing qualifications; and the decrease in enrolments due to fewer learners obtaining a NSC with mathematics and science. However, the fact that a large proportion of employers and skills development providers resumed training during the COVID-19 level 3 lockdown period shows that they are committed to sustaining skills development in the sector (HWSETA 2020c).

4. SETA PARTNERSHIPS

4.1 Introduction

Among the keystones in advancing the developmental state are the improvement of citizens' lives with accessible healthcare, adequate social protection, and opportunities for socio-economic participation. On its own, the HWSETA cannot meet these demands and therefore the SETA depends on the collaboration of many different entities. Last year the HWSETA established extraordinary new partnerships because of the COVID-19 pandemic. The SETA's pro-active reaction on the pandemic has resulted in a couple of life-saving partnerships and job creation initiatives. As mentioned earlier the HWSETA sees their mandate reaching beyond a skills development responsibility during the pandemic. This chapter reports on existing and planned partnerships.

4.2 Existing Partnerships

The table below provides information on the following: the partners; the objectives and duration of partnerships; the impact (value-add); and challenges and success factors. The priorities of the partnerships relate to the following: Unemployed Youth; supporting post-school institutions to be able to supply skills to the sector; providing work-based experience opportunities such as WIL or internships to new entrants to the sector; building NHI capacity; stimulate economic activity and cooperative development; training learners on ECD learnerships; developing artisans and technicians; and providing opportunities for pharmacist and assistants to work optimally especially in the time of the COVID-19 pandemics. Most of these partnerships are linked to the priorities of the NSDP and the ERRP Skills Strategy.

Table 4-1: Current Partnerships

Priority	Partners	Objectives	Duration	Impact (Value-Add)	Challenges	Success Factors
Unemployed Youth	750AMPED (Amplified) Youth Campaign	Recruiting, training and strategically deployment of unemployed youth	Signed 31 March 2020. Implementation period: 1 April 2020 to 31 March 2022	Job creation	Project management difficulties emanating from unpredictable changes of COVID-19 Lockdown levels	Working together focusing on awareness campaigns
	Netcare Youth Employment Services (YES)	Upgrade skills of porters Train TVET college learners in advanced stock management Prepare learners for trade tests or final assessments to become technicians	Signed 25 February 2021 Implementation period: 01 January 2021 to 31 December 2021	Unemployed youth training and employment	No challenges	Netcare employed all Youth that completed the programmes
Post-school institutions (colleges and universities)	Higher Health	Capacity building for HEIs and TVET colleges' academic and support staff and students in health and hygiene matters	31 March 2020 to 31 March 2023	Advancing health of HE students	No challenges	Development of tools, frameworks and guidelines to use

Table 4-1: Current Partnerships *contd.*

Priority	Partners	Objectives	Duration	Impact (Value-Add)	Challenges	Success Factors
Post-school institutions (colleges and universities)	Student support services	Advance the wellness of students Assist clinics with their staff needs	31 March 2020 to 31 March 2023	Ensure that potential workers are physically and mentally well in order to make a productive contribution to the economy of South Africa	No challenges	Support services of post-school institutions identify needs well in order for HWSETA to provide necessary support
	15 public TVET colleges	Establish schools of health and social development Support artisan training programs Support work-readiness programs Train animal health technicians	Signed 23 February 2021 Implementation: Valid from the signature date for a period of 36 Months	Delivering of HWSETA qualifications Contribute to maintenance of hospital equipment Improve employability of graduates Ensure animal health (food production)	Colleges not meeting the accreditation requirements of quality assurance bodies	Relationship with and support of Centres of Specialisation
	Faculty of Veterinary Science at the University of Pretoria	Equip the skills laboratory Funding work-integrated learning Research bursaries	Signed 31 March 2020 Implementation 01 July 2021 -to 31 December 2020	Improve employability of graduates Strengthening veterinary lecturing capacity – ensure sustainable supply	No challenges	Long established partnership driven by the need for transformation
Work experience / WIL / internship opportunities	DSD DHET	Provision of workplace experience opportunities for unemployed social workers	Implementation: February 2021 till January 2022	Improve employability of graduates	Identifying (finding) workplaces and mentors	Sustaining employment of 1 800 social workers
	Provincial DSDs Provincial DoHs Wits Health Consortium District municipalities	Provision of internships for students in the core fields of the sector	Signed: 04 August 2020 Implementation: valid from signature date and shall endure for the period of 12 months and will continue to be valid for a further 12 months after	Improve employability of graduates	Budgetary constraints and availability of workplaces	In-roads into rural communities because of the scope of the partnerships

Table 4-1: Current Partnerships *contd.*

Priority	Partners	Objectives	Duration	Impact (Value-Add)	Challenges	Success Factors
Work experience / WIL / internship opportunities			the beneficiaries have completed training			
NHI capacity	All provincial Departments of Health	Train staff on the governance of the NHI	DOH & MP- Signed in March 2019 Implementation: The agreement is valid from the signature date and shall endure for the period that the programme is intended (within 2 years) and will continue to be valid for further 12 months after beneficiaries have completed	Build capacity for the NHI	Budgetary constraints	Success of partnership limited by pandemic
Stimulate economic activity Cooperative development	Dunacor Skills Hub	Train millwrights and diesel mechanics	Signed: 16 February 2021 Implementation: Valid from the signature date for a period of 36 Months	Employed at public hospitals (maintenance)	Meeting entry requirements (maths & science)	Rural development, only recruiting from rural areas First cohort completed trade test
	Afribiz Foundation and Ruo & Rui Medicals	Train 13 co-operatives in producing COVID-19 needed equipment Clothing manufacturing	Signed 19 February 2021 Implementation: 1 March 2021 till February 2022	Employment opportunities created for 780 women	Lack of skills in rural communities to manage their own projects	Working closely with rural communities
Pharmacists and assistants demand (in the time of (COVID-19)	SAPC	Train pharmacist on vaccination	Signed 31 March 2021 Implementation: 1 April 2021 till March 2022	Up-skilling of pharmacists	Budgetary constraints	Partnership creates high interest in the sector (incentive for pharmacist training)
	NC DoH NW DoH	Train basic- and post-basic pharmacist assistants	Implementation: 01 June 2021 till 32 December 2022	Establish a registration framework and process for Departments	Departments not keeping record of the registration certificates	The departments can now deliver on their mandates

Table 4-1: Current Partnerships *contd.*

Priority	Partners	Objectives	Duration	Impact (Value-Add)	Challenges	Success Factors
ECD	DSD Various community organisations	Train high numbers on ECD learnerships	Signed 24 March 2020 Implementation: April 2020 till March 2021	Meeting ECD targets	Budgetary constraints	Foster good relationships with DSD and community organisations
Artisan and technician development	Small business MP DoH	Recruitment and placement of unemployed artisans Maintenance of hospital equipment	Signed: 04 December 2019 Implementation: 07 January 2020 till 07 December 2021	Employment for artisans Development of small business Meeting artisan targets	Supply can't meet the demand Budgetary constraints	Growing small business and linking them to government
Union capacity building	Workers College	Build the capacity of unions in labour market policy development and labour market analysis	Signed 8 November 2018 Implementation: Valid form the signature date and shall endure for the period of 18 months and will continue to be valid for a further 12 months after the beneficiaries have completed training	Improve union capacity	Availability of union representatives due to COVID-19 conditions	Providing articulation from FET band into HET band
Traditional healers capacity building	Association of Traditional Healers Nelson R Mandela School of Medicine	Train traditional healers in patient safety	Signed 30 March 2020 Implementation: 24 months from the time of signing the MOA	Patient safety	COVID-19, placed on hold in 2020	

4.3 Planned Partnerships

The HWSETA has decided to take the partnerships that they have already developed and established to a next level within the constraints of their budget due to the COVID-19 pandemic and the skills development levy holiday for employers. The SETA is already engaging various stakeholders in pursuit of research partnerships as it relates to public universities through the Postgraduate research bursary programme. Further, research partnerships are sought to increase the organisation's understanding of the sectoral changes such as with Workers College of SA on workforce changes amongst the shop stewards. As per the ERRP strategy, the organisation is also targeting partnerships around medical equipment maintenance to build capacity for the NHI through the government departments.

4.4 Conclusion

The establishment of partnerships with entities such as education and training institutions, employers, statutory bodies, community organisations, and trade unions has been at the heart of HWSETA skills development operations. The partnerships are structured to provide multiple entry points into work in the health and social development sector. Multi-partner cooperation enables the development of industry-relevant knowledge, skills, capabilities, and attitudes required to perform in accordance with the norms, standards and ethical framework for each occupation.

All new partnerships will be aligned to the NSDP 2030, the ERRP Skills Strategy and priorities of all other government strategies. HWSETA will continue to work with its current partners and will engage in new

partnerships and projects to strengthen mechanisms for skills provision to the health and social welfare sector. HWSETA partnerships produced mixed results in the past: while well-planned partnership structures, supportive networks and the involvement of all beneficiaries contributed to the success, progress was hampered by a lack of finance, poor stakeholder responses in some instances, labour market constraints that prevented learners from entering gainful employment, and most recently COVID-19 conditions. Moving forward, the HWSETA will continue to adopt corrective measures and different strategies to advance the successful production of skills. By increasing its capacity to track the progress of partners, providers, and learners through research, the HWSETA will be able to respond to challenges sooner, in order to improve the outcomes of skills development partnerships. The HWSETA will continue to engage with its stakeholders and conduct research to keep abreast of changing skills needs in the sector.

5. SETA MONITORING AND EVALUATION

5.1 Introduction

In terms of the NSDP 2030 SETAs are required to monitor and report on their performance on a regular basis. This means that the HWSETA must report on the value that they add and the contribution that they make to the improvement of the skills situation in the country. This chapter outlines the monitoring and evaluation framework and approach of the HWSETA.

5.2 Monitoring and Evaluation Policy Framework

The HWSETA has a Monitoring and Evaluation Policy (M&EP) which is aligned with the Government-wide Monitoring and Evaluation System (GWM&ES) as well as the National Treasury Framework for Managing Programme Performance Information. The GWM&ES is essentially aimed at contributing to 'improved governance, promote learning and enhance the effectiveness of public sector Organisations and institutions and accountability reporting'. The GWM&ES objectives also include the collection, collation, analysis, and dissemination of information on the progress and impact of programmes. The M&E policy is essential and key in strengthening the HWSETA's strategic planning, performance monitoring, evaluation, and reporting system. The monitoring and evaluation policy aspires to strengthen governance within the sector by improving transparency, strengthening accountability relationships, and by building a performance culture that will foster better achievement of strategic objectives through good-practice approaches to project management. To ensure that the HWSETA achieves its objectives, regular (quarterly and annually) monitoring and evaluation of projects and programmes are necessary. This enables management to assess the effectiveness of its decisions and actions. It also provides management with information on which they can base future decisions.

The M&E approach adopted by HWSETA defines the SETA as a learning organisation[3], where accurate, quality data and precise analysis inform strategic planning, decision-making, and prioritisation of interventions. This enhances strategic corporate learning and empowers the accounting authority with credible data to critically reflect, respond quicker, justify their actions and account for expenditure. The Performance Monitoring Plan as defined in the M&EP for HWSETA has been designed with several objectives in mind. It provides a tool to:

- Monitor and evaluate the effectiveness and efficiency of projects;
- Measure project progress and project risk management;
- Report accurate reliable information to its governance structures and stakeholders;
- Generate appropriate information to enable the organisation to grow, learn lessons, and share best practices; and
- Use for accountability, planning and implementing of HWSETA sector skills needs interventions.

5.3 Approach and Institutionalisation of Monitoring and Evaluation

HWSETA has established the Research, Information, Monitoring, and Evaluation (RIME) unit to accommodate the inter-relatedness of the different functions or processes regarding M&E. The main focus of RIME is therefore to strengthen the planning, monitoring, implementation and reporting framework activities. The tool for the execution of M&E is the Monitoring and Evaluation Reporting Plan (MERP), which is designed to evaluate and monitor how effectively and efficiently each programme or project and its management has contributed to the desired change. The overall goal of the MERP is to provide critical information not only to HWSETA and DHET to guide implementation in order to achieve programme

[3] *A learning organisation is an organisation skilled at creating, acquiring and transferring knowledge, and at modifying its behaviour to reflect new knowledge and insights. It is an organisation that insists on accuracy and precision of data (evidence), rather than using assumptions as background for decision-making (fact-based management).*

objectives, but also to employers and other interested stakeholders. The approach of the HWSETA to monitoring[4] is the following:

- Articulating programme or project objectives;
- Linking activities and resources to programme or project objectives;
- Converting the programme or project objectives into performance indicators and setting targets;
- Regularly (continuously) collecting data on these programme or project indicators and comparing actual results with targets (reporting Quarterly and annually); and
- Reporting progress on a programme or project to managers (process owners responsible for the performance indicator targets as per Technical Indicator Protocol [TID]) and alerting them to complications. For optimal performance, the HWSETA is structured into four programmes with their relevant leaders owning the process and target responsibility. These four programmes are; programme 1: Administration, programme 2: Skill planning and impact assessment, programme 3: Skill Development programmes and projects, and programme 4: Quality assurance and qualification development.

The approach of the HWSETA in terms of evaluation[5] is the following:

- Analysing why intended outcomes were or were not achieved;
- Assessing specific causal contributions of activities to outcomes;
- Examining successful and unsuccessful outcomes;
- Providing insights into outcomes, underlining significant programme or project achievements and recommending improvements where necessary; and
- Recommending research projects to further enhance the evaluation of certain programmes or projects.

The approach of the HWSETA in terms of impact assessment[6] is the following:

- Reviewing all monitoring and evaluation activities, processes, reports, and analysis;
- Providing an in-depth understanding of various causal relationships and the mechanisms through which they operate; and
- Synthesising a range of programmes and projects and using a tracer study methodology to identify the outcomes that are directly caused by the programme or project.

5.4 Monitoring And Evaluation Of Strategic Priorities

Achieving strategic priorities remains the focus of the HWSETA. Experience has shown that it is critical for the RIME to be involved in the planning phase of projects to ensure continuous tracking of progress and sustainability of programmes. The monitoring of projects enables the effective management of risk. Learning from past experience the following mechanisms are now in place to ensure achievement of strategic priorities:

- Involving the RIME unit in the planning phase of programmes and projects;
- Providing insights to improve planning - training and making managers aware of linking strategic objectives to outcomes in such a way that it will ensure impact;
- Decentralising monitoring and evaluation to regional offices - the regional offices are firstly closer to the programmes or projects and secondly they have more capacity because they have fewer programmes and projects to monitor and evaluate;
- Forming partnerships with stakeholders such as employers who are determined to be successful in achieving strategic objectives and ensuring the impact of outcomes; and
- Not focusing only on avoiding risk, but focusing on achieving an end result that will have an impact on the lives of each unemployed and employed learner who are beneficiaries of HWSETA programmes and projects.

The previous SSP update of the HWSETA listed three skills development priorities, and all priorities were included in the strategic plan update of 2021/2022 and linked to performance indicators for implementation through the annual performance plan.

a) The Skills Pipeline into the Health and Social Development Sector

The sustainable skills pipeline enables entry into employment in the health and social development sector at different entry points across PSET sub-systems. The White paper for Post-School Education and Training (2013, p.viii) proposes that "*employers must be drawn closer to the education and training*

[4] Monitoring refers to the regular systematic collection and analysis of information to track the progress of programme or project implementation against pre-set targets and objectives - did we deliver?

[5] Evaluation refers to the objective, formal, periodic, structured and systematic analysis of programme or project performance - what has happened as a result of the programme or project?

[6] Assessment of the impact of a programme or project refers to the value or contribution the outcomes have caused - have we made a difference? Impact assessment is a comparative exercise conducted to assess the degree to which the intended net effects of social programs (interventions) have been achieved.

process". As an implementation strategy, the National Skills Development Plan (NSDP 2019, p.16) conceives "*the role of SETAs as intermediary bodies [which] is posited as key factor in linking the world of work and education*". More recently the Skills Strategy that supports the ERRP states under intervention five the importance of "*Access to workplace experience*". This intervention focuses on ensuring that the strategy considers those individuals who have completed learning but cannot access the workplace in the absence of experience.

In this respect, the sustainable skills pipeline of the HWSETA is primarily implemented through work-based training as a way of managing the linkages between institutional and workplace learning. To this end the HWSETA establishes partnerships with employers to increase the number of work-based experience opportunities. In terms of M&E Table 5-1 illustrates the extent to which HWSETA allocated its resources and achieved against set targets of the two key indicators of the skills pipeline to enable employment. The third indicator gives an indication of the extent to which the WBL, as the model of implementation, is effective in realising intended outcome.

HWSETA increased its budget allocation by 8% in 2020/21 from 2019/20 towards the WBL programmes to support workplace capacity both at partnerships and student levels (Table 5-1); it serves as confirmation of the commitment to this priority. The performance of the set target of WBL student placement, though, was decreased by 0.2% in 2020/21 from the 2019/20 baseline. However, the change is insignificant; the organisation maintained its performance expectations on the WBL programme. In terms of increasing the workplace capacity through partnerships with employers the performance showed substantial progress (88%). These partnerships also yielded substantial progress (63%) in the actual number of unemployed learners entered into WBL programme even though COVID-19 had a negative effect on recruitment activity (late matric results by DBE). The latter led to the suspension or partial implementation of WBL programmes by employers due to the lockdown.

In terms of assessing the outcomes (what is evaluated) from performance outputs (what is monitored) of the WBL programme, the employment rate in 2020/21 from the tracer study was 62% compared to 60% of the 2019/20 baseline. This confirms the effectiveness of the WBL as a delivery model to enable employment as an outcome through the skills pipeline. It thus can be deduced that HWSETA's skills pipeline priority is being implemented appropriately with effective outcomes but requires more operational adjustments going forward in the context of COVID-19 pandemic to efficiently produce desired outputs within set targets instead of the current 26% achievement of outputs. With sustained or improved implementation performance of WBL programmes in this trajectory, the skills pipeline would ultimately contribute to the realisation of HWSETA impact statement 2 "*The HWSETA contributes to the development of the post-school system that produces increasing productive workers and work-ready graduates for the health and welfare sector by 2030.*" The plan of action is to continue with Tracer studies to monitor outputs, outcomes and impacts.

Table 5-1: M&E of Skills Priority 1: The Skills Pipeline

Result Chain Level	Indicator	Target	Realised	%	Rating of Performance
Impact "*The HWSETA contributes to the development of the post-school system that produces increasing productive workers and work-ready graduates for the health and welfare sector by 2030*					
Outcome *80% of qualified technicians, artisans and unemployed learners previously funded by the HWSETA for learnership, bursaries and internships finding employment per year*	Percentage of qualified WBL unemployed learners finding employment within 6 months of completing the learning programme (tracer study)	Indicator was changed in 2020/21 thus no targets	84% employed within 6 months 79% permanently employed 78% employed in the health sector 65% Youth 68% females	62% employment rate (2% increase from the 2019/20 employment rate)	[51% to 99%] Substantial progress
Output *Number of unemployed students who complete the artisan, Learnership, Bursary and Internship programme funded by the HWSETA*	Number of unemployed students who complete the artisan, Learnership, Bursary and Internship programme funded by the HWSETA	4 194	1 074	26%	[26% to 50%] Moderate success
Activity *Number of unemployed students who enrolled to the artisan, Learnership, Bursary and Internship programme funded by the HWSETA*	Number of unemployed students entered into Work-Based Learning (WBL) programmes (TVET, & university WIL, internships, learnerships, and apprenticeships)	6 980 (0.2% decrease from the 2019/20 baseline)	4 385	63%	[51% to 99%] Substantial progress
Number of employers in the sector who open-up their workplaces for learning through partnerships with HWSETA in the reporting period	Number of employers in the sector who open-up their workplaces for learning through partnerships with HWSETA in the reporting period	271 (75% increase from 2019/20 baseline of 155)	238	88%	[51% to 99%] Substantial progress
Input	*Discretionary Grand Budget for artisanship, learnership, bursary, and internship*				

b) Professionalisation of the Workforce

The NSDP posit that South Africa has low productivity, transformation, and mobility in the workplace "*largely as a result of inadequate, quality assured training for those already in the labour market*" (2019, p.17). It is in this context that the professionalisation of the workforce, as a skills development priority identified by previous SSPs, seeks to contribute to skills interventions targeting the employed workers to improve service quality, efficiency, and change service provision with the view of improving "the overall productivity of the economy" (NSDP 2019, p.18). In essence, the primary focus of professionalisation of the workforce is upskilling to improve quality and productivity. At an implementation level, HWSETA prioritises the PIVOTAL programmes for those in the labour market to acquire qualifications or part qualification on the NQF. These include learnerships, internships, apprenticeships and skills programmes (including the NGO/NPO and trade union officials), adult education training, lecturer development, and recognition of prior learning for the employed labour force (see Table 5-2).

In 2020/21 HWSETA decreased its budget allocation to PIVOTAL programmes for upskilling workers by 9% from that of 2019/20 while increasing its set target on number of workers by 61% to 20260. In terms of implementation performance, Table 5-2 shows that HWSETA overachieved (123%) against the set targets of the number of workers in PIVOTAL programmes for upskilling. This level of performance, exceeding set targets, is attributed to the use of e-learning platforms for delivery of skills programmes by HWSETA when there were many limitations in the sector as a result of COVID-19 pandemic. As such, the use of e-learning mitigated against negative effects of COVID-19 pandemic which resulted in some employers revising their implementation strategies more towards vaccination programmes.

While the implementation performance of the PIVOTAL programmes for upskilling the workers in the sector exceeded the set target, achievement of set output targets (completions) were exceeded at 271%. At outcome level, lack of evaluation of outcomes in 2020/21 financial year such as tracer study means that HWSETA cannot account for results at this level. The plan of action going forward for the HWSETA is to improve mechanisms of assessing outcomes (evaluation) relating to career progression of the workers either through promotion within the same organisation or appointment in a higher position by another organisation. This will be a proxy for improved productivity of employers confirming the contribution of professionalisation of the workforce towards impact statement 3 stating 'HWSETA contributes to the improved level of skills for 80% of the workforce within the health and welfare sector by 2030, which is evidenced by higher productivity of employers, and/or career progression either through promotion within the same organisation or appointment in a higher position or appointment in a higher position by another organisation'. The mechanism will the use of Tracer Study for the employed as an evaluation tool for assessing outcomes using the online-based survey platforms.

Table 5-2: M&E of Skills Priority 2: Professionalisation of the Workforce

	Indicator	Target	Realised	%	Rating of Performance
Impact *Reduction of Hard to fill Vacancies in the health and welfare sector by 2026*					
Outcome *80% of qualified technicians, artisans and unemployed learners previously funded by the HWSETA for learnership, bursaries and internships finding employment per year*	No tracer study has been conducted				

Table 5-2: M&E of Skills Priority 2: Professionalisation of the Workforce *contd.*

	Indicator	Target	Realised	%	Rating of Performance
Output *Number of employed students who complete the artisan, Learnership, Bursary and Internship programme funded by the HWSETA*	Number of workers who completed the PIVOTAL	7 613	20 634	271%	[100% and above] achieved or exceeded
Activity *Number of employed students who enrolled to the artisan, Learnership, Bursary, Internship, skills, AET, lecturer development, and RPL programmes funded by the HWSETA*	Number of workers in the PIVOTAL	20 260 (61% increase from 2019/20 baseline of 12923)	24 984	123%	[51% to 99%] Substantial progress
Input	*Discretionary Grand Budget for the professionalisation of the workforce*				

c) Vital Skills required for the Developmental State

Vital skills required for the developmental state refers to supporting large-scale skills development interventions needed for the state to enhance the lives, health, well-being and livelihoods of its citizens. By definition, "*a discussion about a developmental state is about state capacity…able to construct and deploy institutional architecture within the state and mobilise society towards the realisation of its developmental project*" (Public Service Commission 2013 p.2).Thus, this skills priority focuses on supporting the capacity of the public sector and NPO/NGO sector. By design, the nature of support is more institutional to effect change systematically at a large-scale rather than at an individual level.

In pursuit of the formation of skills required for state capacity, the NSDP advances the White paper on PSET position which "*proposes an expansion of this institutional type [TVET] to absorb the largest enrolments growth in the post-school system… [with the view that] the growth of stronger TVET colleges will expand the provision of mid-level technical and occupational qualifications*" (2019 p.19). The NSDP further acknowledges the need to accommodate or extend access to those that do not qualify to transit to PSET-sub systems such as TVET colleges and universities due to them either not completing their schooling or never attending school. This group has culminated to what is mostly known as the 'Not in Employment Education and Training (NEETs)'. As a solution, the NSDP acknowledges Community Education and Training (CET) institutional type to "*cater for the knowledge and skills needs of the large numbers of adults and youth requiring education and training opportunities, unemployed people, and those employed but in low or semi-skilled occupations*" (NSDP 2019 p.20).

At an implementation level, the vital skills priority is advanced both at institutional and individual level to support the capacity of the public sector, TVETs, and CETs. Table 5-3 illustrates the institutional support intervention for public sector capacity and interventions at individual level for TVETs and CETs. The HWSETA reprioritised appropriately as a response to the COVID-19 pandemic by offering more support for the public sector capacity institutionally than the needs for TVETs and CETs at individual level. As a result, HWSETA increased its budget allocation to support public sector capacity by 165% in 2020/21 from 2019/20 to R15 million while increasing its set target on the number of projects by 163% in 2020/21 from 2019/20. In terms of implementation performance, HWSETA overachieved at 124% against set targets on the number of projects aimed at the public sector (DoH & DSD) education and training in the reporting period.

At learner/student level intervention, HWSETA overachieved at 123% against the set target of the

number of learners supported in TVET colleges, other public colleges, and AET (unemployed). The support speaks to TVETs and CETs capacity through expansion of education and training. This was in spite of an 83% decrease in budget allocation from the 2019/20 budget. The plan of action is to use the Tracer study as an evaluation tool for assessing outcomes of beneficiaries using the online-based survey platforms.

Table 5-3: M&E of Skills Priority 3: Vital Skills required for the Developmental State

Indicator	Target	Realised	%	Rating of Performance
Institutional level: Number of education and training projects aimed at the public sector (DoH & DSD)	21 (163% increase from 2019/20 baseline of 8)	26	124%	[100% & >] Achieved or Exceeded
Learner/student level: Number of unemployed learners in TVET colleges, other public colleges, and CETs - support TVET and CETs capacity through expansion of education and training	1 307 (0.2% decrease from the 2019/20 baseline)	1 604	123%	[100% & >] Achieved or Exceeded

5.5 Conclusion

The HWSETA's Strategic Plan is the main source that provides the framework for monitoring progress and measuring and evaluating the impact of skills development interventions in the sector. HWSETA will continue to use the results of M&E to identify the overall programme focus, streamline the implementation of current programmes and inform the development and implementation of new strategies and programmes. Emphasis would be placed on evaluation by ensuring that track and tracer studies are extended to employed cohorts.

6. STRATEGIC SKILLS PRIORITY ACTIONS

6.1 Introduction

As the HWSETA is only one of a number of institutions tasked with the funding and provision of skills development for the sector, it is important to outline the specific role that the SETA will play. This chapter consolidates findings from the previous chapters and presents the main skills provision priority areas of the HWSETA for 2022/23, although there is a five-year planning period. Skills priority actions are informed by the following: The analysis of the skills situation in the sector; needs identified by stakeholders; the NSDP outcomes; key national policies; and the HWSETA's own goals.

6.2 Findings from Previous Chapters

Key findings from earlier chapters are summarised as follows to guide the HWSETA in setting skills priority actions for the next planning period:

Chapter 1:

- Service provision depends on specialised professionals and skilled paraprofessionals.
- Statutory councils have a core role to regulate almost all aspects of professions and occupations.
- NPOs are vital to state partners in providing community-based healthcare and social services.
- The HWSETA's skills planning and -provision must be aligned to regulatory requirements for the sector's work—force and the unique needs of service providers in the sector.
- Serious budgets constraints due to effect of COVID-19 and poor economic circumstances.
- The demand for certain workers such as nurses is even more critical due to COVID-19 pandemic.

Chapter 2:

- The NDP and change drivers envisage a functional state capable of delivering the full spectrum of human development- and healthcare needs.
- The need for primary care and community-based services, as well as the workforce, is expanding.
- Skills development interventions must link to the NSDP and the ERRP, be targeted, cost-effective and prioritised to:
  - build the developmental state;
  - enable sustainable skills to pipeline into the sector;
  - strengthen work-integrated learning;
  - expand service capacity via the production of mid-level skills; and to
  - professionalise the workforce.
- Human resources planning, specifically in the provinces is critical in order to meet the current and future demand.
- The COVID-19 pandemic has shown that the public and private health sector can cooperate, which is an important factor to ensure the success of the NHI.
- Pandemics like COVID-19 emphasize the importance for government to include such occurrences in their strategic development planning.

Chapter 3:

- Employers face major complex and long-term skills challenges.
- The skills needs of the public service component of the sector are complex and interlinked with the availability of state funding for health and social welfare services.
- Skills demand outstrips supply in certain occupational groups – most of all in the medical and nursing professions.
- Management and supervision skills are needed at all levels.
- A strategic priority is to strengthen education capacity and clinical- and practical training platforms, especially for nurses.
- Effective delivery of national healthcare initiatives and social services programmes depend on a skilled and professionalised workforce.
- The COVID-19 pandemic has had a considerable effect on supply of skills to the sector: It further increased the demand for certain workers in the sector such as nurses; the decrease in output because of the training out phase of the old nursing qualifications and the commencement only in 2020 of training on the new qualification; the disruption of contact education; and the decrease in enrolments due to fewer students obtaining a NSC with mathematics and science.

Chapter 4:

- Partnerships with training institutions, employers and statutory bodies are structured to provide multiple entry points into work.
- Through multi-partner cooperation, it is possible to develop the industry-relevant knowledge, skills, and capabilities needed to meet the norms and standards for each occupation.

Chapter 5:

- An M&E framework adopted by HWSETA is demonstrated as a management tool to assess decisions and actions
- An assessment of M&E approach and the extent to which M&E has been institutionalised both as a technical competency and a system is conducted. Using the HWSETA's three key development priorities, a plan of action is identified as strengthening the evaluation aspect of the M&E framework by extending track and tracer studies (as an evaluation tool) from unemployed to the employed to better account for outcomes and impact constructs.

6.3 Recommended Actions

The HWSETA has identified skills priorities for the sector and determined processes that need to be followed thereafter. Skills implications for the national strategies and plans have been detailed in the previous chapters of this SSP. The HWSETA's actions in addressing skills priorities in the health and social development sector begin with the HWSETA's processes put in place to set skills development priorities. This is followed by outlining strategic goals of the SETA in line with the identified skills development priorities and aligning the HWSETA's strategic plans with national strategies and plans.

6.3.1 Skills Development Priorities

The HWSETA appreciates that the skills challenges faced by its sector are vast and exist at every occupational level. The HWSETA also has a limited budget and shares the responsibility for skills development with many other role players and stakeholders. Against this background the HWSETA identified the following overarching skills development priority areas:

a. Sustainable skills pipeline into the health and social development sector;
b. The professionalisation of the current workforce and new entrants to the sector;
c. Vital skills and skills set required to enable the state to meet its service delivery obligations as a developmental state; and
d. Skills needs and gaps in the time of the COVID-19 pandemic.

These skills development priorities are viewed from a strategic perspective. Firstly, a sustainable skills pipeline enables entry into employment in the health and social development sector at different entry points. Secondly, by prioritising the professionalisation of the workforce, the HWSETA can contribute to skills interventions required to improve service quality and efficiency, and also address changes to service provision. Thirdly, the HWSETA can support the large-scale skills development interventions needed for the state to enhance the lives, health, well-being, and livelihoods of its citizens.

Table 6-1 outlines the key challenges that exist in these three skills development priority areas.

Table 6-1: Key Challenges in the HWSETA Skills Development Priority Areas

	Skills development priority area		Key challenges
Sustainable Skills Pipeline	NQF levels 1-4	Secondary school	Gr 12 maths + Physical science- and/or Life sciences
			Effective career guidance
			Communication skills
			Low literacy levels of HBCs & CHWs
		TVET Colleges	Lecturer & infrastructure capacity to train in vocational occupations
			On-site technical training & links with industry
			Access to accredited workplace training

Table 6-1: Key Challenges in the HWSETA Skills Development Priority Areas *contd.*

	Skills development priority area		Key challenges
Sustainable Skills Pipeline	NQF levels 1-4	Nursing and Ambulance colleges	The high drop-out rate in nursing colleges
			Transform to teach under new qualifications set in higher education
			Set academic & clinical training capacity in higher education
			Nursing training capacity of private hospitals limited by SANC
	NQF levels 5 to 7/8	Post-school to first degree	Financial assistance & bursary funding
			Limited academic & clinical training capacity
			Practical workplacement under required supervision levels
			Slow growth in health sciences & veterinary graduates
	NQF levels 8 to 10	Post-graduate & specialist level	Financial assistance & bursary funding
			Limited academic & clinical training capacity
			Shortage of advanced nurses & nurse educators; medical specialists, social services technical specialists
	Sustained employment: Up-skill in the workplace	New entrants	The gap between graduation, professional registration & entry to work in the sector
			Work-ready with Day One Skills to serve
			Availability of public sector posts
		Employers	Capacity to provide vocational training & work-integrated learning
			Slow absorption of new professional graduates in the public sector
			Leadership, HR & financial management; management of health facilities & social welfare service facilities
			Retention of health & social services professionals
			Capacity to meet new norms & quality standards for services
			Skills development challenges & needs of NGOs
		Current employees	Scarce & critical skills shortages in key professions & occupations
			Up-skill to meet new norms & standards for the practice
			Skills distribution: urban v rural areas
			Health & social development information systems

Table 6-1: Key Challenges in the HWSETA Skills Development Priority Areas *contd.*

	Skills development priority area		Key challenges
The professionalisation of the current workforce	In service and at work	New entrants	Work-ready with Day One Skills to serve
			On-boarding & orientation of social services professionals
			A mix of technical & practical skills with appropriate behaviours
		Employers	Positive & supportive working environments
			Cost & time for CPD training
			Meet diverse CPD training needs to retain registered professionals
		Current employees	Up-skill to meet the changed scope of practice requirements
			Up-skill to attain new & higher level qualifications
			Up-skill to meet new norms & standards for the practice
			Articulation between vocational & other post-school occupational training
Grow a developmental state	Public sector and NPO sector	Learners/ students	Training at lower occupational levels often informal
			Service provision in the rights-based context
			Candidate selection for large-scale scholarship programmes
		New entrants	Service provision in the rights-based context
			Lack of posts to absorb new entrants into public service
		Employers	Weak governance and management systems in the public sector & NGOs
			Sustainability of NPOs providing social services for state
			Scale & diversity of training interventions required
		Current employees	Service provision in the rights-based context
			Large numbers of volunteers & part-time workers with poor/little skills
			Weak accountability

6.3.2 Strategic Goals of the HWSETA

Table 6-2 outlines the HWSETA's outcome orientated strategic outcomes for the period 2021/2022 which are critical for the achievement of the SETA's legislative and policy mandates. These outcomes also provide context for the HWSETA's skills development priorities over the medium to longer term. These HWSETA strategic outcomes are aligned with the NSDP outcomes and the ERRP.

Table 6-2: The HWSETA Strategic Outcomes for the Period 2021/2022

	Strategic Outcome Orientated Goals of the HWSETA
1	Research, monitoring, evaluation, and impact system of the HWSETA provide a credible skills planning and evaluation system that ensures that its funding initiatives yield good impact in the strategic period
2	The HWSETA delivers its mandate efficiently and effectively through its well capacitated organisational structure and business processes that are automated and integrated in the strategic period
3	The HWSETA promotes linkages between education and the workplace to increase work-based learning opportunities in the health and welfare sector in the strategic period
4	The HWSETA provides quality assurance services for the health and welfare sector that ensures quality in occupational education and training in the strategic period
5	The HWSETA supports the growth of the public college system so that public colleges may qualify as a centres of specialisation in the strategic period
6	The HWSETA supports career development services related to the health and welfare sector and makes them accessible to rural and targeted youths in the strategic period
7	The HWSETA supports career development services related to the health and welfare sector and makes them accessible to rural and unemployed youths in the strategic period
8	The HWSETA contributes to the improvement of level of skills for 50% of the South African workforce through various learning programmes that address the critical skills required by the sector in the strategic period.
9	The HWSETA contributes to increased access, by the unemployed, into occupationally directed programmes of the health and welfare sector in the strategic period.
10	The HWSETA supports officials from NGOs, NPOs, and Trade Unions in order to strengthen governance and service delivery, and thus advance social, rural, and community development in the strategic period
11	The HWSETA supports skills development for entrepreneurial and cooperative activities, as well as the establishment of new enterprises and cooperatives in the strategic period

6.3.3 Measures to Support National Priorities and Plans

This section considers the NDP, national strategies and focal areas in the NSDP and ERRP, which shape skills planning by the HWSETA. Through its multi-dimensional agenda, the NDP gives prominence to three vital areas: economic growth and job creation; education and skills; and building a capable and developmental state. The NDP offers a long-term strategy to grow employment and expand opportunities through education, vocational training, and work experience; strengthen health and nutrition services, and increase social security and community development (NPC 2012a). In its skills planning the HWSETA takes direction from the NDP as follows:

- The NDP (2012c:268) requires of SETAs to focus on skills development for existing workplaces, the current workforce and unemployed persons who wish to enter employment in their sector. Training should take place across all the NQF qualification levels required in the sector. The HWSETA's skills programmes interventions already address these requirements and will continue to do so in the future.
- The NDP (NPC 2012c:261) states that work experience improves productivity and enables a virtuous cycle that grows the economy. The NDP (NPC 2012c:287) requires SETAs to increase linkages between post-school education and workplaces, to provide funding for work experience programmes and internships. The HWSETA works actively to provide funding for internships, work-integrated learning and work experience across many occupations.
- The NDP (NPC 2012c:266) calls for an expanded

system of further education and training and skills development opportunities to young people who obtained a low pass in the NSC, as well as older people who wish to improve their skills, as well as people who had no or little access to education. The HWSETA will continue to support skills programmes that further these NDP goals.

- The NDP calls for the production of highly skilled professionals (NPC 2012c:289) to be expanded and for SETAs to provide more financial support to assist students from disadvantaged backgrounds (NPC 2012b:68). The NDP states that more people need to access post-school education and attain qualifications at an intermediate or high level (NPC 2012c:286). The HWSETA funding provisions address these aspects.
- The NDP requires SETAs to build strong relationships between TVET colleges, other training institutions, industry, and employers. The HWSETA works in partnership with such institutions to deliver vocational and occupationally directed training.
- The NDP (NPC 2012c:288) calls for strong quality assurance and qualification system to support public training provision and enable and regulate private training provision. The HWSETA is actively involved in the development of occupation qualifications for the health and social development sector and acts as AQP for some occupational qualifications.
- In line with calls in the NDP for increased access to career guidance (NPC 2012c:287), the HWSETA has a dedicated project in this regard.

In line with NSDP and ERRP priorities, all projects and funding programmes of the HWSETA target the participation of learners who are African, women, disabled, youth and residents of rural areas. Table 6-3 shows the link between the NSDP outcomes, the ERRP and the HWSETA's skills priorities.

Table 6-3: Alignment of NSDP Outcomes, the ERRP and HWSETA Skills Development Priorities

	NSDP Outcomes	HWSETA Skills Development Activities
1	Identifying and increasing the production of occupations in high demand	• Conduct extensive research to understand changing skills needs in general, as well as the effect of the COVID-19 pandemic on skills needs and gaps • Engage with stakeholders, training providers, employers & key role-players • Monitor and track the performance of skills development partners & learners
2	Increase access to occupationally -directed programmes	• Targeted funding to train artisans and learners in vocational occupations • Form partnerships to develop occupational qualifications & fund learning programmes under those qualifications • Support training via learnerships and internships
3	Supporting the growth of public colleges as key providers of skills required for socio-economic development	• Support learners in pre-apprenticeship training • Support vocational training of unemployed learners at TVET colleges
4	Linking education and the workplace	• Provide funding for experiential learning to produce work-ready graduates • Improve workplace productivity by funding relevant skills programmes • Support skills formation via learnerships and compulsory work experience
5	Supporting skills development for entrepreneurship and cooperative development	Provide funding to address skills development needs of NGOs and cooperatives
6	Improving the level of skills	• Support skills programmes to advance skills in sign language in the sector • Support adult education & opportunities to enhance the mobility of disabled persons • Use discretionary grant funding for targeted projects in the public sector • Fund development of critical and scarce skills at high-, medium- and low occupational levels
7	Supporting career development services	Career guidance initiatives market occupations in the health and social development sector
8	Encouraging and supporting worker initiated training	Funding employers to develop the skills of the workforce

In preparing this SSP for the health and social development sector, the HWSETA recognises the contributions of a variety of state organs, national government departments, statutory professional councils and national employer bodies to identify and describe skills requirements for service provision in the sector. The skills issues identified in this SSP link into the Medium-Term Strategic Framework (MTSF); White Paper for Post-School Education and Training; National Health Insurance in South Africa (Green Paper); Human Resources for Health 2030; Pharmacy Human Resources in South Africa 2011; The National Nursing Strategic Plan for Nurse Education, Training and Practice 2012/13 – 2016/17; Draft Early Childhood Development Policy, Draft Policy for Social Service Practitioners; National Environmental Health Policy; Draft Municipal Ward-based Primary Healthcare Outreach Team Policy Framework and Strategy; Industrial Policy Action Plan (IPAP), the New Growth Plan (NGP), the National Skills Accord (NSA) and the Economic Reconstruction and Recovery Skills Strategy.

6.3.4 HWSETA Skills Priority Actions for the Period 2021/2022

a) The skills pipeline into the health and social development sector

The overriding priority for the HWSETA is to strengthen and sustain the inflow of skills to the health and social development sector at all qualification levels on the NQF. This will entail extending access from those transiting from basic education to other Post-school education and training (PSET) sub-system such as TVET and those falling through transitory pathways such as the Not in Employment, Education, or Training (NEETs). As such, the skills pipeline broadens access and sequences its form of support to beneficiaries with the intention of progressing them from entry skills levels to intermediate or high skills levels desirable to health and social development sector labour market. This approach requires continuity on the funding model adopted by HWSETA to prioritise the nature and level of skill formation from beneficiaries. At practical level, this means funding one beneficiary in more than one qualification continuously until skills formation desired by the market is produced. The strategic choice of which qualifications to fund for will be premised on occupations in demand and skills scarcity in the sector. In this way, the HWSETA will contribute effectively towards closing the skills gap in the health and social development sector.

b) Professionalisation

The HWSETA will play a formative role to ensure that the workforce has access to quality education and training to achieve their career development goals. The SETA will support initiatives of statutory bodies, organs of state and employers to address inadequate service quality in the provision of health services as well as the inconsistent delivery of social welfare services. Interventions aiming to advance the awareness of practitioners and workers of their ethical responsibilities towards patients and/or clients and the larger community will be supported. The HWSETA skills priority actions will include:

- Support for programmes to improve service quality and enhance consistency in service provision;
- Enabling the current workforce to up-skill to bridge skills gaps brought on by changes to the scopes of practice or regulatory environment of occupations and professions in the health and social development sector;
- Monitoring and evaluation of training provided by accredited providers;
- Skills formation to improve leadership and management at all levels in the health and social development sector, and in the Public Service in particular;
- Funding for appropriate skills programmes to improve productivity in the workplace and promote economic growth;
- Funding to up-skill the current workforce to meet norms and standards set for service provision in healthcare and social development/welfare services;
- Promoting adult education and training and lifelong learning; and
- Addressing the changes in skills need due to the COVID-19 pandemic.

All of the above priority actions will be premised on the WSP dataset that organisations submit and report on their 'top-up' skills and pivotal programmes necessary for their workforce to be productive and competitive in the market. Thus, the funding model of these interventions will be informed by the WSP analysis of skills needs reported in the sector to ensure relevance and responsiveness.

c) Vital Skills required for the Developmental State

The HWSETA will support the formation of skills that will enable the state to meet its constitutional obligations in its interaction with and service provision to its citizens. The HWSETA skills priority actions will include:

- Support for skills development needed to implement the National Health Insurance system;
- Support for public TVET colleges to improve on-site practical and vocational training capacity;
- Advancing the production of health professionals,

nurses, ECD workers and a spectrum of social services practitioners;

- Building skills to advance social- and community development;
- Funding skills development interventions for persons who serve or provide care to persons with disabilities;
- Targeted funding to enable skills development in NPOs, NGOs and community-based Organisations;
- Funding skills projects aimed at offering youth and older persons a second chance to enter employment in the health and social development sector.
- Addressing the changes in skills need due to the COVID-19 pandemic.

For the HWSETA, the formation of partnerships with quality partners and the strengthening of existing partnerships will be key success factors in accomplishing the strategic goals that underscore these skills priorities. The HWSETA's skills development programmes and projects will be implemented within the ambit of the financial resources available through the skills development levy. The HWSETA will allocate mandatory grants and discretionary grants to finance skills development projects and programmes that are aligned with the Annual Performance Plan. Additional projects will be identified, planned and supported to address the COVID-19 pandemic.

6.4 Conclusion

This Chapter outlined the broad skills development priority areas and actions for the health and social development sector over the period 2021/2022. In designing and implementing skills programmes and skill projects, the HWSETA will be guided by four skills development priority themes:

- Sustainable skills pipeline into the health and social development sector;
- The professionalisation of the current workforce and new entrants to the sector; and
- Vital skills and skills set required enabling the state to meet its service delivery obligations as a developmental state; and
- Skills needs and gaps in the time of the COVID-19 pandemic.

The HWSETA's skills development programmes and projects will be implemented across its operational sub-programs and within the ambit of financial resources generated through the skills development levy.

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ANNEXURE A

Health and Welfare Sector
Education and Training Authority
HWSETA

PIVOTAL SKILLS LIST 2022 2023

SECTORAL PRIORITY OCCUPATIONS AND INTERVENTION LIST

OFFICIAL SIGN OFF

It is hereby, certified that this first draft sectoral priority occupations and intervention list (pivotal skills list) was developed by the management of the Health and Welfare SETA.

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Ms Elaine Brass, CA (SA)

Chairperson: HWSETA Board
Dr Nomsa V. Mnisi


SECTORAL PRIORITY OCCUPATIONS AND INTERVENTION LIST 2022-2023									
SETA Name	**Period**	**Occupation Code**	**Occupation**	**Specialisation/ Alternative Title**	**Intervention Planned by the SETA**	**NQF Level**	**NQF Aligned**	**Quantity Needed**	**Quantity to be Supported by SETA**
HWSETA	2022/23	2019-2221	Nurse Professionals	Registered Nurse (Medical)	Learnership: Advanced Diploma in Medical and Surgical Nursing	6	Y	1 343	443
				Registered Nurse (Critical Care and Emergency)	Learnership: Higher Certificate in Critical Care and Emergency Nurse	5	Y	439	145
				Registered Nurse (Disability and Rehabilitation)	Bursary: Diploma in Nursing (Community, Psychiatry and Midwifery)	7	Y	433	143
				Clinical Nurse Practitioner	Learnership: Higher Certificate in Auxilliary Nurse	5	Y	250	83
				Registered Nurse (Operating Theatre)	Bursary: Bachelor of Nursing Science	7	Y	178	60
				Registered Nurse (Child and Family Health)	Learnership: Higher Certificate in Maternity Nurse	5	Y	141	46
				Registered Nurse (Surgical)	Learnership: Advanced Diploma in Medical and Surgical Nursing	6	Y	76	25
				Registered Nurse (Mental Health)	Learnership: Diploma in Psychiatric Nurse	6	Y	33	11
				Nurse Manager	Bursary: Postgraduate Diploma/Studies in Health Services Management	5		33	11
HWSETA	2022/23	2019-221101	General Medical Practitioner	General Practitioner (GP)	Bursary: Bachelor of Medicine and Bachelor of Surgery	8	Y	737	243
HWSETA	2022/23	2019-532903	Nursing Support Woker	Nursing Assistant	Learnership: Higher Certificate Auxilliary Nurse	5	Y	356	200

SECTORAL PRIORITY OCCUPATIONS AND INTERVENTION LIST 2022-2023 *contd.*									
SETA Name	**Period**	**Occupation Code**	**Occupation**	**Specialisation/ Alternative Title**	**Intervention Planned by the SETA**	**NQF Level**	**NQF Aligned**	**Quantity Needed**	**Quantity to be Supported by SETA**
HWSETA	2022/23	2019-226201	Hospital Pharmacist	Clinical Pharmacist/ Hospital Service Pharmacist/Hospital Pharmacist	Bursary: Bachelor of Pharmacy	8	Y	163	20
					Learnership: FETC & NC Pharmacist Assistance	4	Y		34
HWSETA	2022/23	2019-221210	General Medicine Specialist Physician	General Medicine Specialist Physician	Bursary: Postgraduate Studies	8	Y	112	37
HWSETA	2022/23	2019-321101	Medical Diagnostic Radiographer	Medical Diagnostic Radiation Technologist/ Radiographer	Bursary: Diploma in Diagnostic Radiography	5	Y	97	32
HWSETA	2022/23	2019-226203	Retail Pharmacist	Pharmacist Assistant/ Community Pharmacist/ Dispensing Chemist	Learnership: FETC Pharmacist Assistance	4	Y	87	15
					Learnership: NC Pharmacist Assistance	3	Y		15
HWSETA	2022/23	2019-2635901	Social Counselling Worker	Bereavement Councellor/Genetic Councellor/Women's Welfare Councellor/Wellness Councellor/Trauma Councellor/HIV/AIDS Councellor	Bursary: Bachelor of Social Work	8	Y	49	16
HWSETA	2022/23	2019-2635907	Adoption Social Worker	Health Care Social Worker/ Reintegration Worker/ Clinical Social Worker/ Occupational Social Worker/Forensic Social WorkerAdoptions Worker	Master's Degree in Social Work (Speciality in Adoption Social Work)	9	Y	23	5
					Postgraduate Certificate or Diploma appropriate to a speciality in Adoption Social Work	6	Y		5
HWSETA	2022/23	2019-225101	Veterinarian	Veterinarian	Bursary: Bachelor of Veterinary Sciences	8	Y	36	12

Notes

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& training

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