SECTOR SKILLS PLAN

for the Health & Social Development Sector in South Africa

2024/25

FOREWORD

The Health and Welfare Sector Education and Training Authority (HWSETA) is pleased to present its 2024-2025 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 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 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 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 programmes with the 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), the National Skills Development Plan (NSDP), the National Human Resources Development Strategy South Africa (2010-2030), the Economic Reconstruction and Recovery Plan (ERRP), and the Economic Reconstruction and Recovery Skills Strategy.

The SSP also endeavours to showcase the post-COVID-19 effects in the sector as the health and social development sector was on the frontline of fighting the pandemic. The Sectoral Priority Occupations and Interventions (SPOI) list for this year's update will therefore aim to support the sector in fighting the post-COVID-19 effects in the sector.

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 democratization 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 an 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 Nomfundo V Mnisi
Chairperson: HWSETA Board

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

ABBREVIATIONS & ACRONYMS

AAG	Average Annual Growth	NGO	Non-Governmental Organisation
AHPCSA	Allied Health Professions Council of South Africa	NHA	National Health Act, 61 of 2003
AIDS	Acquired Immune Deficiency Syndrome	NPC	National Planning Commission
APP	Annual Performance Plan	NPO	Non-Profit Organisation
ATR	Annual Training Reports	NQF	National Qualifications Framework
CBO	Community-Based Organisation	NSC	National Senior Certificate
CDW	Community Development Worker	NSDP	National Skills Development Plan
CET	Community Education and Training	OFO	Organizing Framework for Occupations
CHW	Community Health Worker	OHSC	Office of Health Standards Compliance
CMS	Council for Medical Schemes	PHC	Primary Healthcare
CPD	Continuous Professional Development	PIVOTAL	Professional, Vocational, Technical, and Academic Learning
DHET	Department of Higher Education and Training	PSETA	Public Service Sector Education Training Authority
DCST	District Clinical Specialist Teams	PSET	Post-school Education and Training System
DOH	Department of Health	QCTO	Quality Council for Trades and Occupations
DSD	Department of Social Development	RIME	Research, Information, Monitoring, and Evaluation
ECD	Early Childhood Development	RPL	Recognition of Prior Learning
EISA	External Integrated Summative Assessment	SACSSP	South African Council for Social Services Professions
ERRP	Economic Reconstruction & Recovery Plan	SAMA	South African Medical Association
GBV	Gender-Based Violence	SANC	South African Nursing Council
GWM&ES	Government-wide Monitoring and Evaluation System	SANDF	South African National Defence Force
HASA	Hospital Association of South Africa	SAPC	South African Pharmacy Council
HEI	Higher Education Institution	SARS	South Africa Revenue Service
HEMIS	Higher Education Management Information System	SASSA	South African Social Security Agency
HET	Higher Education and Training	SASSETA	Safety and Security Sector Education and Training Authority
HIV	Human Immunodeficiency Virus	SAVC	South African Veterinary Council
HPCSA	Health Professions Council of South Africa	SAW	Social Auxiliary Worker
HRDC	Human Resources Development Council	SDA	Skills Development Act
HRH	Human Resources for Health	SDL	Skills Development Levy
HTFV	Hard-To-Fill-Vacancies	SETA	Sector Education and Training Authority
HWSETA	Health and Welfare Sector Education and Training Authority	SIC	Standard Industrial Classification of all Economic Activities
IHME	Institute for Health Metrics and Evaluation	SPOI	Sectoral Priority Occupations and Interventions
ILO	International Labour Organisation	SSP	Sector Skills Plan
ISHP	Integrated School Health Programme	STATS SA	Statistics South Africa
M&E	Monitoring & Evaluation	TB	Tuberculosis
MERP	Monitoring & Evaluation Reporting Plan	TVET	Technical and Vocational Education and Training
MOA	Memorandum of Agreement	UHC	Universal Health care
MOU	Memorandum of Understanding	UNDP	United Nations Development Programme
MTEF	Medium Term Expenditure Framework	WBL	Work-based learning
NDOH	National Department of Health	WBPHCOT	Ward-Based Primary Health Care Outreach Teams
NDP	National Development Plan	WHO	World Health Organisation
NEA	Nursing Education Association	WIL	Work Integrated Learning
NEI	Nursing Education Institution	WSP	Workplace Skills Plan

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 heterogeneous, 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 the new SETA landscape gazetted on 22 July 2019. There are 351 104 filled positions in the Public Service health and social development departments and 406 923 in the private sector bringing total employment in the sector to approximately 758 027.

Professionals and technicians and associate professionals respectively form 37% and 20% 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 mobilized within the formal health and social development sector.

A unique feature of the sector is that most 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. They 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 developmentally orientated and to take progressive measures to grant everyone access to health care services, sufficient food and water, and social security.

The post-COVID-19 effects are flagged as a critical change driver. 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 This has a significant impact on the supply of nurses as reflected in the supply data.

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 team management, special fund-raising, and project management skills tailored to the social services sector. In the health sector leadership and strategic planning skills are also high on the list for managers. Both sectors experience a lack of data analytical skills at this level.

The key skills issues that fall within the HWSETA ambit are skills interventions needed to build the developmental state; the development and sustainment of 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); 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; and sustained professionalization of the workforce.

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, especially among health 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, inequitable distribution of resources, 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. The government made more funds available during the COVID-19 pandemic to employ additional social workers and community health workers. Unfortunately, these human resources were not retained after the COVID-19 pandemic ended.

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 health-related occupations; changes in the qualification frameworks of some occupations such as nurses; interruption of contact education during the

pandemic impacting on clinical work of students; and the low retention rate of health- and social service professionals in the public sector.

Poor management of and working conditions in the health workforce contribute to a high attrition rate in the health professions, especially in the public sector. Another labour market challenge relates to skills provision and skills absorption, e.g., social worker scholarships boosted graduate output a couple of years ago, but budget constraints in the public and private sectors hamper the employment of many of the newly qualified professionals.

The institutional capacity for the 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, and a tenth one shortly afterwards at the Nelson Mandela University in the Eastern Cape.

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 in some instances disruptions, they are 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 circumstances during the COVID-19 pandemic asked for extraordinary strategies and partnerships. The HWSETA's proactive reaction to the pandemic has resulted in a couple of life-saving partnerships and job creation initiatives. HWSETA saw its mandate reaching beyond a skills development responsibility

during the COVID-19 pandemic. HWSETA is only one of several 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. 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) A sustainable skills pipeline into the health and social development sector enables entry into employment at different entry points;
b) The professionalization of the current workforce and new entrants to the sector to improve service quality and efficiency and address changes in service provision;
c) Vital skills and skills set required to enable the state to meet its service delivery obligations as a developmental state; and
d) Skills development initiatives linked to the ERRP.

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, work-ready, and equipped with "Day One" skills when they enter employment in the sector.

This year the focus is again on the Economic Reconstruction and Recovery Plan (ERRP) and the linked skills strategy. The action plan of the HWSETA for 2023-2024 in terms of the ERRP looks as follows: A total of 2 424 students, 15 skills development providers, and one digital skills programme will be funded to support the ERRP skills strategy. However, implementation of ERRP takes place within the limitation of financial resources generated through the skills development levy.

Yet, the Human Resources for Health Strategy very importantly states that a major mind-shift is needed to appreciate that the health workforce is an investment, rather than an expenditure item. To this end, HWSETA continues to pursue a health and welfare workforce that has an optimum skills mix; equitable distribution of resources; and excellent competencies.

Ms Elaine Brass, CA (SA)

Chief Executive Officer: HWSETA

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RESEARCH PROCESS & METHODS

The research unit of the HWSETA conducts several research projects every year 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 fulfill the requirements of the six chapters of the SSP. These projects are conducted simultaneously and culminate in the chapters of the SSP. The projects commence in May each year and continue until the end of July.

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
- Other indications of skills shortages.

This study is mainly based on existing data sources. The DHET also requires SETAs to do personal interviews with a selected number of employers according to an interview schedule developed by the Department. Occupation-focused studies were also conducted in 2022/23 including medical practitioners, pharmacists, and pharmacist assistants.

The findings of the interviews with medical and pharmacy stakeholders such as the relevant councils, voluntary associations, employers, and medical and pharmacy schools are incorporated in the SSP update where applicable. 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 Workplace Skills Plan (WSP) submissions to the HWSETA (2023)
- The WSP submissions to the PSETA (health and social development departments) (2023)
- The Medpages database (2023)
- Discretionary grant applications submitted to the HWSETA (2022-2023)
- DHET employer interviews (2022 and 2023)
- HWSETA interviews with specific stakeholders (2018-2023)

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 2023.

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 assists these Organisations to submit WSPs. Their submission is shortened and simplified version of the WSP to bring them into the skills development arena. The information from this special initiative improved the submission rate of the NPOs as reported by the HWSETA NPO training needs analysis for skills planning research study.

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 investigates supply-side blockages. The study is quantitative and qualitative in nature. Existing data sources were analysed. Professional councils that do not publish their registration figures are contacted by email or telephonically to request registration figures.

In addition to this data on supply, interviews were also conducted with all the medical and pharmacy schools, councils, voluntary associations, and employers as part of the occupation-focused research (medical practitioners, pharmacists, and pharmacist assistants) in 2022/23. The study covers education and training from the post-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 (2021)
- HWSETA 's information on occupational qualifications (2022)
- Databases of all the relevant Councils (i.e., HPSCA, SANC, SAPC, AHPCSA, SAVC, and SACSSP (2022-2023).
- This study culminates in the consolidation and completion of analysis between May to July.

4) Supplementary research on key issues

[4] In 2022, a study was conducted between March and September on the effect of COVID-19 on shop stewards in the South African health and social development sectors. This study's main findings highlighted the need to use workplaces as training spaces for workers to improve on their capabilities. Other research projects conducted in the 2022-2023 cycle that informed the HWESTA with skills planning, relate to the following topics: determining the level of exposure and adoption of 4IR in the health sector and how

4 This is the most recent data available from DHET.

it created skills gaps; identifying appropriate skills intervention responses to the identified skills gaps emanating from the current and historical trends in the migration of health care professionals in South Africa; and determining (through tracer studies) the employability of students after completion of graduate and post-graduate studies funded by the HWSETA.

These types of studies are ongoing during the year. After the first submission of the SSP to the DHET in mid-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 updates of the SSP where applicable.

Table 1-0 Summary of research process and methods: Data sources

Topic	Nature (design) of the study	Objectives of the study	Data collection methods	Data sources	Sample size and scope	Timeframe
Primary and secondary research						
1. SSP Demand Analysis Project	Quantitative	To track trends in employment in the Health and Social Development Sector.	Secondary Research method	HWSETA Levy Payers HWSETA WSPs Submissions 2023 PSETA WSP Submissions 2023 Medpages Database March 2023	Levy-paying Organisations in HWSETA – 12 107, WSP Submissions – 1944, Individual employee records – 218 299, PSETA WSP Submissions – 20 Departments Medpages database – 95 707 records	March – June 2023
2. SSP Supply Analysis Project	Mixed Method	To track trends in the supply of qualifications relevant to the Health and Social Development Sectors and to track trends in professional registrations. Focused occupational research on medical practitioners, pharmacists and pharmacist assistants	Secondary Research method Primary & Secondary Research method	HEMIS Data (DHET) 2021 (most recent) Professional council registers (May-June 2023) SAPC, HPCSA & Colleges of Medicine data	6 Statutory Professional Councils Voluntary Professional Bodies 49 semi-structured stakeholder interviews HPCSA and SAPC register data (2022-2023) Mid-year population data (2022)	May-June 2023 November 2022-May 2023
3. The migration of healthcare professionals	Mixed Method	1) To establish the current and historical trends in the migration of the health care Professionals in South African 2)To establish the extent to which the current and historical trends in the migration of the health care Professionals in South African health sector created skills gaps as either opportunities or threats 3)To identify appropriate skills intervention responses to the identified skills gaps emanating from the current and historical trends in the migration of the health carer Professionals in the South Africa.	Primary & Secondary Research method	Secondary data sourced from Medpages, OECD and SANC. Primary data was collected thorugh semi-structured interviews and online survey.	46 Private Hospitals (28 Private and 18 private) 5 600 Healthcare Professionals (841 Specialist Medical Practitioners; 710 General Medical Practitioners; 256 Professional Nurses; 105 Pharmaceutical Technicians; 46 Medical Technicians) 5 Industry Associations Key Informants	March-June 2022

Table 1-0 Summary of research process and methods: Data sources						
Topic	**Nature (design) of the study**	**Objectives of the study**	**Data collection methods**	**Data sources**	**Sample size and scope**	**Timeframe**
Primary and secondary research						
4. Alignment of the Occupational Qualifications developed by the HWSETA to sectoral needs and demand	Mixed Method	1) To assess the internal and external factors that inform the HWSETA's process of qualification development 2) To determine the alignment of the qualifications developed by the HWSETA to the sectoral needs 3) To determine the outcomes of these occupational qualifications on employment by measuring and mapping exit pathways after completion of training	Primary & Secondary Research method	Primary data collection through Structured Survey (Web-based) In-depth face to face Interviews and Computer Assisted Telephonic Interviews (CATI) Secondary data collection through document analysis	3 Training providers 7 Key Informants Qualification Development Process 236 Qualification Beneficiaries	July 2022-September 2023
5. Investigating the Effects of Covid-19 on shop stewards in the health and social development sector	Quantitative Method	1)To investigate the resultant effects of COVID-19 on shop stewards from trade unions in the health and social development sector. 2)To obtain the perceptions of shop stewards from the trade unions in the health and social development sector about the skills gaps in trade unions considering the direct and indirect challenges posed by COVID-19. 3)To explore the experiences of shop stewards from trade unions in the health and social development sector regarding the barriers to accessing required skills to respond to COVID-19. 4)To determine the barriers for shop stewards to access the skills they require to offer effective responses towards the control of COVID-19	Primary Research method	Primary data collected through Survey monkey.	440 Shop stewards from 5 different unions	March 2022-September 2022
6. The Level of Exposure and adoption of 4IR in the Health Sector	Mixed Method	1)To determine the level of exposure and adoption of 4IR among four occupation groups within the health sector. 2) To what extent has the exposure and adoption of 4IR created skills gaps as either opportunities or threats. 3) To determine the extent of exposure and adoption in 4IR changes of the nature of work in terms of tasks and occupations. 4) To determine occupations at risk of being replaced by automation or 4IR technologies from the four occupation groups. 5)To determine the potential impact of 4IR on employment within the four occupation groups.	Primary Research method	Online survey Semi Structured Interviews with key informants Focus groups with key informants	33- Focus groups participants 123 online surveys 6- semi structured interviews with key informants	March 2022-September 2022

Table 1-0 Summary of research process and methods: Data sources						
Topic	**Nature (design) of the study**	**Objectives of the study**	**Data collection methods**	**Data sources**	**Sample size and scope**	**Timeframe**
Primary and secondary research						
7. A 8 Year Review of WSP Submission and actual training needs	Mixed Method	1)To determine how many levy and non-levy paying organizations have submitted their WSPs over the last eight years. 2)To determine the organisation size of the organisations that have submitted the WSP over the last 8 years. 3)To determine if the planned training identified by employers over the eight years were implemented as intended under the actual training. 4)To identify employer organisations who submit WSP/ATR and participate in HWSETA's discretionary grant programmes as expressed through our expression of interest.	Secondary Research method	2016- 2017 to 2022-2023 WSP and ATR Submissions 1 Interview with HWSETA Skills Development Division	1835 Organisations	October 2022-February 2023
8. Employment trends and the determining factors within the health and social sector	Mixed Method	1)To establish if there were any job losses/gains within the health and social as of 2022 2)To establish which occupations contributed mostly towards the job losses/gains within the health and social sector as of 2022 3)To explore the primary reasons for job losses/gains as of 2022 4)To establish the common skills gaps in 2022 5) To establish the emerging occupations and skills gaps in 2022	Primary & Secondary Research method	Primary data collection through survey monkey and analysis of the 2016- 2022 WSP/ATR Submissions	36 824 Registered Organizations on the WSP 462 organizations that participated on Survey Monkey	October 2022-February 2023
9. HWSETA Track and Tracer Study: Employed (Artisans, Learnership, Under-graduate, and Post-graduate Bursary) 2022/23	Quantitative	1) To determine whether the qualification has provided a career progression 2) To determine the change in salary/wage after obtaining the qualification 3) To determine the utilization of skills after completion 4) To determine learner perceptions towards the programme	Primary Research method	Computer Assisted Telephonic Interviews (CATI) (Sample framework: SETA Quarterly Management Reporting database (SQMR) and SETMIS	188 learners who completed HWSETA learning or work experience in bursaries and learnerships	April -June 2023
10. HWSETA Track and Tracer Study: TVET WIL and University WIL 2022/23	Quantitative	1) To determine the attainment of full qualification after completion of the WIL programme 2) To determine learners' experiences towards the WIL Programme 3) To determine learner employability after completion of the WIL programme	Primary Research method	Computer Assisted Telephonic Interviews (CATI) Sample framework: SETA Quarterly Management Reporting database (SQMR) and SETMIS)	429 learners who completed HWSETA TVET and University WIL Programmes	April-May 2023

Table 1-0 Summary of research process and methods: Data sources						
Topic	**Nature (design) of the study**	**Objectives of the study**	**Data collection methods**	**Data sources**	**Sample size and scope**	**Timeframe**
Primary and secondary research						
14. Levy-Exempt Organisations and Small and Emerging Businesses 2022/23	Quantitative	1) Have the levy-exempt organisation and SMEs received training that was prescribed in their plans? 2) How many training needs have the levy- exempt organisations and SMEs received from what they have planned in the past two years? 3) To what extend has the HWSETA- funding interventions improved the governance of levy exempt organisations? 4) Is there a continuation of benefits since the receipt of HWSETA SME support initiatives? 5) Which types of support led to the sustainability (continuation of benefits) of SMEs and addressed the constraints to sustainability?	Primary Research method	Telephonic interviews	220 Beneficiaries	April-June 2023
15. Employment trends and the determining factors within the health and social sector	Quantitative	1) To establish if there were any job losses/gains within the health and social as of 2022 2) To establish which occupations contributed mostly towards the job losses/gains within the health and social sector as of 2022 3) To explore the primary reasons for job losses/gains as of 2022 4) To establish the common skills gaps in 2022 5) To establish the emerging occupations and skills gaps in 2022	Primary & Secondary Research method	Primary data collection through survey monkey 2016-2017 to 2022-2023 WSP and ATR Submissions	2993 Organizations that reported on total employment profile from WSP. 462 Organizations that participated on the survey	October 2022-February 2023

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 (2023) and Estimates of National Expenditure of National Treasury (2023), the PSETA and HWSETA WSP data (May 2023 submissions), and data from Medpages (May 2023).

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 the 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
	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 1-1 below 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 other state departments such as the Department of Corrections fall within the ambit of the SASSETA.

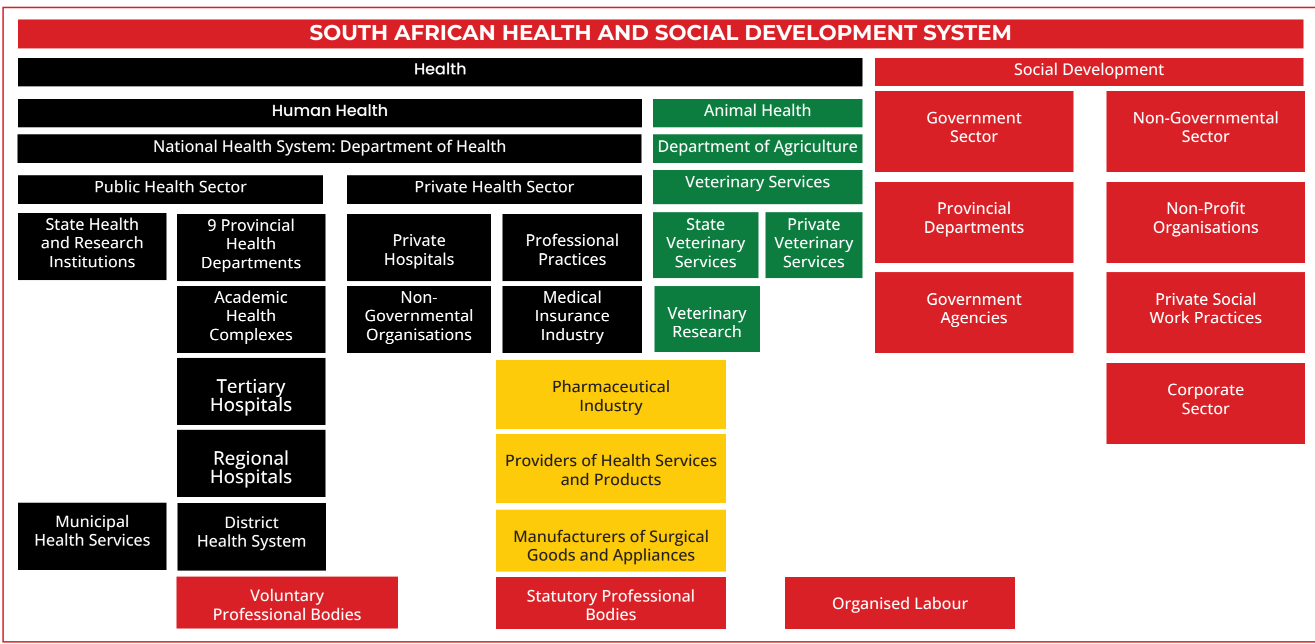


Figure 1-1 The South African health and social development system

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, NGOs, CBO's and NPO's, labour and trade unions, and research- and training institutions. The role players and their primary roles and responsibilities concerning the National Skills Development Plan (NSDP) outcomes are summarised below:

Table 1-2 Key role-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. These departments play a critical role in NSDP outcome 2 and 4 which is "linking education and the workplace and increase access to occupationally directed programmes"
Accounting Authority	The HWSETA Accounting Authority is responsible for governing and managing the SETA in accordance with the PFMA and other legislations. The Accounting Authority delegated some of its responsibilities and functions to one or more committees for practical purposes. These committees are mechanisms to help the Accounting Authority in fulfilling its duties and responsibilities, in accordance with the implementation of the NSDP 2030.
TVET Colleges, Nursing Colleges, Community Colleges and Public Universities	TVET Colleges, Nursing Colleges, Community Colleges and Universities are an important part of the PSET system's skills development ecosystem. They serve as a vital link between the HWSETA and the industry. In developing their capacity, the HWSETA collaborates closely with the TVET Colleges, Nursing Colleges, Community Colleges and DHET. Public Universities provide the HWSETA with critical research capacity.
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 the workplace (Outcome 2 of the NSDP).
Municipal Health Services	
Government Agencies	
NGOs, CBOs, and NPOs	Serves as agents of advocacy for delivering 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 the registered practitioner's database, ensures adherence to professional conduct and continued professional development through NSDP outcome 7: encourage and support worker-initiated training.
Statutory professional bodies	
Voluntary professional bodies	

Role Player	Key roles in relation to the NSDP outcomes
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 NSDP 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. Sector's contribution to the economy

The health and social development sector contribute 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 to 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), promotes livestock production, game farming, and animal health and 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 training health professionals and social workers. As there is a shortage of medical practitioners, the government increased the number of medical student intakes at South African medical schools through a combination of bursary schemes that specifically target students from underprivileged areas. In addition, training of South African doctors in other countries such as Cuba is also funded. In line with the increased training, the number of interns who need to be accommodated by the different provinces also increased, which was funded in the 2022 budget; R2.1 billion over two financial years for medical interns, and R5.4 billion in 2022 to support various aspects of the training of health professionals in the different provinces (National Treasury 2022b). For this same purpose, the 2023 budget allocated R7.8 billion over the medium term through the human resources and training grant. In addition, a further R8.7 billion is allocated for the training of medical specialists specifically, as there are dire shortages of medical specialists in South Africa (National Treasury 2023b).

The global economic effects of the COVID-19 pandemic were far-reaching. In South Africa, the large increase in unemployment and income losses have entrenched existing inequalities; in the fourth quarter of 2022, the unemployment rate was 32.7%, equating to 7.8 million people (Stats SA 2023a). Post-COVID-19 recovery strategies such as the Economic Reconstruction and Recovery Plan (ERRP) therefore focus on job creation and skills innovation, while the COVID-19 social relief of distress grant focuses on income support. The latter, which were initiated to provide short-term support for low-income households in 2020, has now been extended to the end of March 2024 and R35.7 billion has been allocated in 2023/24 to this end (National Treasury 2023a).

The figure below shows industry growth in South Africa for the fourth quarter of 2022 in comparison to the third quarter of 2022 (Stats SA 2023a). 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 chemicals, and botanical products form part of the manufacturing sector. In terms of public health and social development activity, the Government sector contracted by 0.7%. Personal services, which include private health-related activities, showed low (0.2%) increased activity.

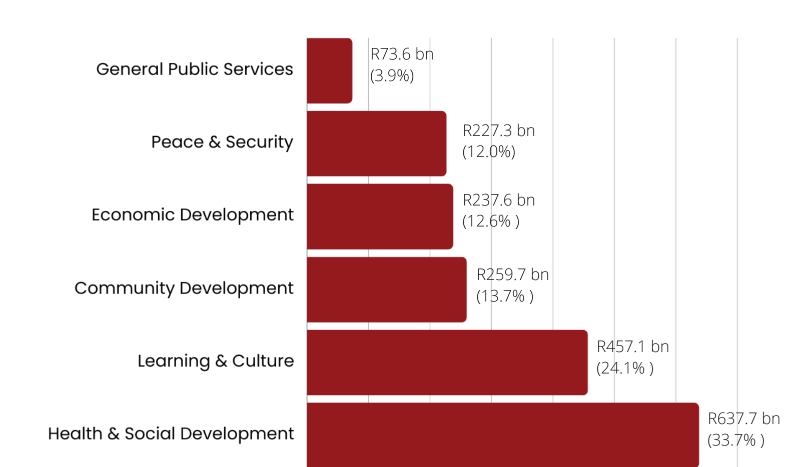
Figure 1-2 Industry growth in the 4th quarter of 2022 in comparison with the 3rd quarter in 2022

Source: Stats SA 2023a.

1.4.2. Sector's contribution to the economy

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 13.7% (R259.2 billion) and 20.0% (R378.5 billion); in total 33.7% (R637.7 billion) of government expenditure (see figure below for comparison with other key sectors in the public domain) (National Treasury 2023a).

Figure 1-3 Health and Social Development proportion of the budget (public sector), 2023



Source: National Treasury 2023a, 2023b.

The South African Social Security Agency (SASSA) is going to pay social grants to the amount of R253.8 billion in 2023/24 (National Treasury 2023a). The total number of grant beneficiaries is expected to increase to approximately 19.2 million in 2024/25.

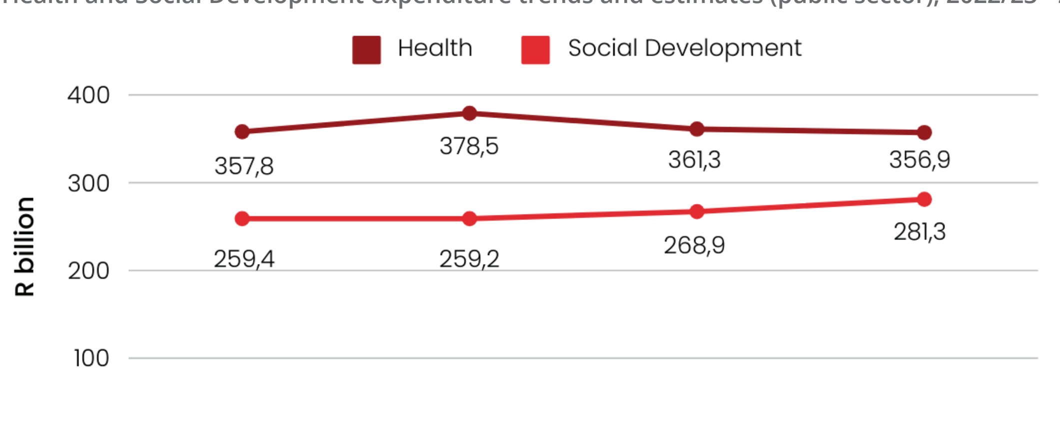
According to the Council for Medical Schemes (CMS), approximately 15% of South Africans access private healthcare as members of medical schemes (CMS 2021). This means that the remaining 85% mostly use public health services. The demand for private health care continues to grow as is seen in the growth of medical scheme membership from 6.7 million in 2000 to 8.9 million in 2021, although there was a slight decrease of 56 910 during 2020 (CMS 2021). 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 Health Professions Council of South Africa (HPCSA) (Businesstech 2021).

In 2021 the total gross relevant healthcare expenditure incurred by medical schemes increased by 14.5% to R205.80 billion from R179.70 billion in 2020. Risk claims increased by 14.9% to R186.15 billion from R162.00 billion in 2020. In 2021, medical schemes incurred a surplus of R12.18 billion compared with R24.84 billion in 2020, representing a decrease of 50.9% (CMS 2021). South Africa's private hospital groups reported increased activity again after the pandemic, including expansion initiatives (Moneyweb 2022, Daily Maverick 2022). Although the industry saw a significant decline in net healthcare results in 2021, from R19.93 billion in 2020 to R820.52 million in 2021, overall solvency levels increased due to significant increases in investment income; the investment income showed a net surplus of R12.18 billion in 2021 (CMS 2021).

1.4.3. Future outlook

The government estimates that health expenditure will increase at an average annual rate of 2.7%, from R259.2 billion in 2023/24 to R281.3 billion in 2025/26. Social development expenditure is expected to decrease by an average of 0.1% over the period, from R378.5 billion in 2023/24 to R356.9 billion in 2025/26 (National Treasury 2023b). Almost a third (32.4%) of the total MTEF allocation will go to Health and Social Development.

Figure 1-4 Health and Social Development expenditure trends and estimates (public sector), 2022/23 - 2025/26



Source: National Treasury 2023b.

In total an amount of R1.10 trillion is allocated over the MTEF period for social grants and welfare services, including initiatives to strengthen advocacy for the empowerment of women, youth, and people living with disabilities. Social grants remain the largest spending area, constituting 88% of Social Development spending over the period. Expenditure on social grants will increase from R233 billion in 2022/23 to R248.4 billion in 2025/26. Social grant coverage is expected to increase from about 18.6 million beneficiaries in March 2023 to 19.6 million beneficiaries by March 2026; this excludes the COVID-19 social relief of distress grant. About 70% of total grant expenditure over the MTEF period is allocated to the child support grant and old age grant; these two grants will be provided to a total of 17.5 million beneficiaries in 2023/24 (National Treasury 2023b).

There will 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 developing the health workforce. In terms of the NHI, an amount of R2.2 billion is allocated to the direct national health insurance grant for provincial health departments; the budgets are earmarked to contract health professionals and health services. In addition, the national health insurance indirect grant is allocated R6. 9 billion over the MTEF.

Sufficient health infrastructure remains a challenge as confirmed by key stakeholders during interviews (2023). In reaction to this are projected investments of R26.9 billion in the Hospital Systems programme over the medium term; R22.2 billion of this amount is planned to be transferred to provinces through the health facility revitalisation grant, and the remainder through the health facility revitalisation component of the national health insurance indirect grant.

Overall, public sector budgets reflect that health and social spending programmes are given priority, despite pressure on resources (National Treasury 2023a). 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, the ability of institutions to attract and retain staff. In the private sector, the linkages are somewhat more complex but equally significant.

1.5. EMPLOYER PROFILE

1.5.1. Overview

The health and social development sector is heterogeneous 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. Each province has a department of Social Development and a department of Health. The National Department of Social Development and the National Department of Health are in Gauteng. The distribution of employment in the sector across provinces is reported in Figure 1-6.

In contrast, most of the organisations in private health are small: 86% 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 7% of the organisations in the private sector and large organisations constitute 6%. However, large organisations such as hospitals and pharmacy groups employ more than half of the workers

in private health. Private employers can be broadly grouped into hospitals and clinics; doctors and specialists; dentistry services; other health related services; laboratory services; medical aid schemes; complementary health services; veterinary services; community services; and research and development institutions.

In the 2022/2023 financial year, 12 107 of 40 549 organisations registered under the HWSETA domain by the South African Revenue Service (SARS) database paid skills development levies to the HWSETA. These are organisations with payrolls over R500 000 per year.

Of the 12 107 organisations submitting paying their skills development levies, only 1 944 submitted WSPs. Recognizing this low WSP/ATR submission rates, HWSETA has commissioned a study on non-submissions in 2023/24 research agenda to gain insight for strategies that should be adopted to improve submission rates. The figure below 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 1-5 Provincial distribution of employers in the private sector by size, 2023

	GP	KZN	WC	LP	EC	NW	MP	FS	NC
Small	28%	14%	2%	10%	7%	7%	4%	4%	3%
Medium	3%	1%	1%	0%	1%	0%	0%	0%	0%
Large	3%	1%	9%	0%	0%	0%	0%	0%	0%

Percentage distribution of employers across province by size

Source: HWSETA WSP submissions 2023.

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 an HWSETA study (2015) shows that these organisations provide paid and unpaid employment to many workers in the sector. As of May 2022, 258 796 NPOs were registered with the Department (DSD

2022), 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; the NPO workforce remains predominantly female, African, and at educational levels equivalent to intermediate levels (HWSETA 2015).

This is confirmed by the recent study conducted by HWSETA in 2022 on NPO training needs analysis for skills planning showing a pattern of an increasing share of the micro (1 – 10 employees) NPOs between 2018 and 2020.

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 WSPs submitted by private sector employers to the HWSETA and by public sector employers to the PSETA in May 2023 as well as data furnished to the HWSETA from the private Medpages database of March 2023.

The data analysis provided information on 758 027 people who are formally employed in the health and social development sector, ranging from managers, professionals, technicians and associate professionals, clerical support workers, service and sales workers, craft and trades workers, plant and machine operators, and elementary workers. Of these, approximately 406 923 (54%) are employed in private sector organisations (referred to later as the "private sector"), while 351 104 (46%) work in the public service departments.

Estimates of total employment in the health and social development sector can be seen in the figure below. Employment in the public service component of the sector increased from 325 763 in 2013 to 351 104 in 2023. The average annual growth of employment in the public sector was 0,8% over the 2013 to 2023 period.

The private sector component of the sector, on the other hand, showed an average annual growth of 4.5% over the 2013 to 2023 period. The total sector (public and private) showed an average annual growth of 2.6%. On average, over the 2013 to 2023 period, there were approximately 335 000 employees working in the public service and 341 000 in the private health and welfare sector per year.

Figure 1-6 Total employment in the health and social development sector, 2013-2023

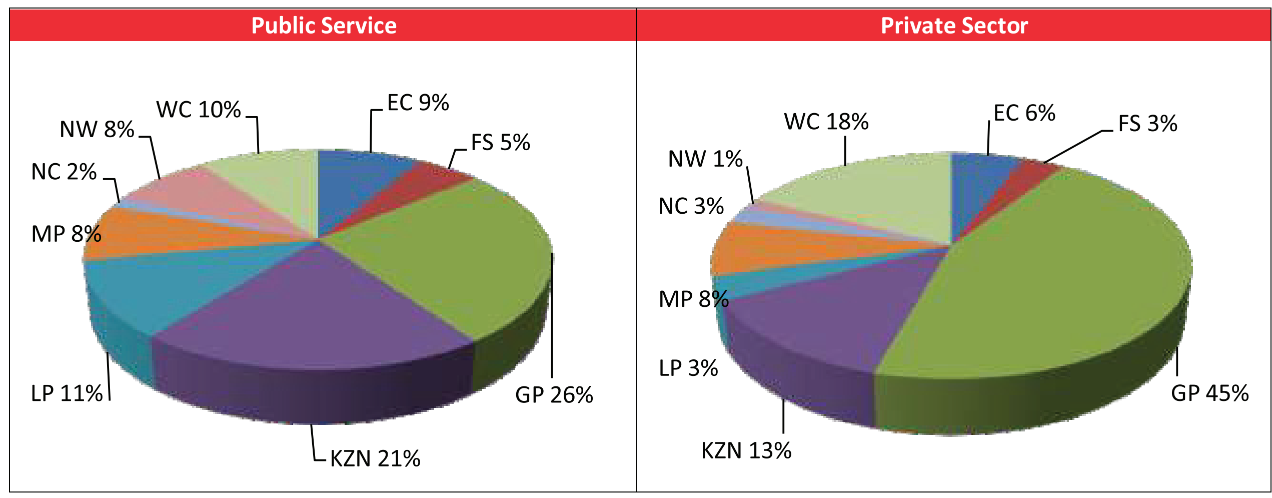
	2013	2014	2015	2016	2017	2,018	2019	2020	2021	2022	2023
Public	325,763	310,256	312,884	330,015	332,654	333,060	334,762	352,760	357,988	345,825	351,104
Private	262,503	276,513	319,002	274,140	266,466	343,246	368,527	374,069	431,834	432,880	406,923

Source: Calculated from HWSETA and PSETA WSPs 2013 -2023, Medpages data 2013 -2023.

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.

Figure 1-7 Provincial distribution of employment in the public service and private health sector, 2023



Sources: Calculated from HWSETA and PSETA WSPs 2023, Medpages data 2023.

1.6.3. Occupational distribution of employment

Currently, professionals and technicians, and associate professionals comprise 61% of total employment in the public service and 53% in the private sector (Table 1-3). In the health and social development sector, a large portion of managerial positions is filled by professionals. In the health sector, professionals include medical and dental specialists and practitioners, registered nurses, pharmacists, veterinarians, and other health-related occupations such as homeopaths. 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.

Table 1-3 Public Service and private sector employment per occupational group, 2023

Occupational Group	Public Service		Private Sector		Total Sector	
	Number of employees	%	Number of employees	%	Number of employees	%
Managers	10 966	3	41 741	10	52 707	7
Professionals	145 596	41	135 350	33	280 946	37
Technicians and Associate Prof	71 378	20	81 445	20	152 823	20
Clerical Support Workers	35 363	10	53 520	13	88 883	12
Service and Sales Workers	53 064	15	46 893	12	99 957	13
Skilled Agricultural, Trades Workers	1 374	0,4	12 432	3	13 806	2
Plant and Machine Operators	3 120	1	7 388	2	10 508	1
Elementary Occupations	30 243	9	28 155	7	58 398	8
Total	351 104	100	406 923	100	758 027	100

Sources: Calculated from HWSETA and PSETA WSPs 2023, Medpages data 2023.

The HWSETA conducted two occupation focused studies recently: one on pharmacists and pharmacist assistants and one on medical practitioners. The data showed that the national density of pharmacists per 100 000 population in South Africa was only 23 in 2022, compared to 47 per 100 000 globally; to reach 80 out of 100 on the SDG universal health care effective coverage index, 94 pharmacists are needed per 100 000 population (HWSETA 2023a). The same count for medical practitioners; the densities per 100 000 population are far below the international requirements. In 2019 the density for general practitioners per 100 000 of the public sector population was 33.1, and for medical specialists 0.9 (NDoH 2020b), and for medical specialists in the private sector 68.8 per 100 000 private population (Percept 2019). These figures again highlight the skew distribution between public and private human resources for health in South Africa (see discussion in chapter two).

1.6.4. Population group

More than three quarters (77%) of the health and social development sector employees are African (Table 1-4). In the Public Service, 85% of the workforce is African compared to 70% in the private sector in 2023. This represents an increase of 5% in the Public Service from 2022, and an increase of 9% in the private sector. Whites form around 5% of the Public Service workforce compared to 14% in the private sector.

Table 1-5 shows the population group distribution in the different occupational groups in 2023. In the Public Service, 82% and more of professionals, technicians and associate professionals, clerical support workers, service and sales workers, craft and related trades, plant and machine operators and assemblers, and elementary occupations were African respectively, and 74% managers. In private health, 61% of professionals and 72% of technicians and associate professionals were African, while 78% of service and sales, 61% of clerical workers, and 88% of elementary occupations were filled by Africans. In the total sector, 78% of all managers were black[4], while 85% and more filled the positions across all the other occupational groups respectively.

4 African, Coloured and Indian.

Table 1-4 Health and social development sector: Total employment by population group, 2016-2023

	2016		2017		2018		2019		2020		2021		2022		2023	
Public Service	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
African	269 571	82	271 926	82	274 685	82	281 646	84	279 945	79	286 150	80	276 011	80	299 039	85
Coloured	31 784	10	36 644	11	32 017	10	27 454	8	43 878	12	42 853	12	43 655	13	26 564	8
Indian	10 325	3	5 884	2	8 874	3	8 730	3	9 058	3	9 145	3	7 411	2	8 457	2
White	17 721	5	17 860	5	17 484	5	16 932	5	19 879	6	19 840	6	18 748	5	17 044	5
Non-South African	614		340													
Total	**330 015**	**100**	**332 654**	**100**	**333 060**	**100**	**334 762**	**100**	**352 760**	**100**	**357 988**	**100**	**345 825**	**100**	351 104	100
Private sector	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
African	136 254	50	138 563	52	181 413	53	210 247	57	214 272	58	266 087	62	265 325	61	285 727	70
Coloured	44 378	16	37 605	14	48 462	14	52 376	14	54 685	15	51 646	12	56 443	13	43 293	11
Indian	17 253	6	16 188	6	23 577	7	19 869	5	20 208	5	30 826	7	24 765	6	19 768	5
White	76 255	28	74 110	28	89 794	26	86 034	23	84 904	23	83 276	19	86 347	20	58 135	14
Non-South African																
Total	**274 140**	**100**	**266 466**	**100**	**343 246**	**100**	**368 527**	**100**	**374 069**	**102**	**431 834**	**100**	**432 880**	**100**	406 923	100
Total sector	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
African	405 825	67	410 489	69	456 098	67	491 893	70	494 217	70	552 237	70	541 336	70	584 766	77
Coloured	76 162	13	74 249	12	80 479	12	79 830	11	98 563	14	94 499	12	100 098	13	69 857	9
Indian	27 578	5	22 072	4	32 451	5	28 599	4	29 266	4	39 971	5	32 176	4	28 225	4
White	93 976	16	91 970	15	107 278	16	102 966	15	104 783	15	103 116	13	105 095	13	75 179	10
Non-South African	614		340													
Total	**604 155**	**100**	**599 120**	**100**	**676 306**	**100**	**703 289**	**100**	**726 829**	**103**	**789 822**	**100**	**778 705**	**100**	758 027	100

Table 1-5 Population group distribution according to the occupational group, 2023

Occupational Group	**African**		**Coloured**		**Indian**		**White**		**Total**	
Public Service	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Managers	8 107	74	1 030	9	668	6	1 161	11	10 966	100
Professionals	119 803	82	9 689	7	5 475	4	10 629	7	145 596	100
Technicians and Associate Professions	59 263	83	7 636	11	1 154	2	3 325	5	71 378	100
Clerical Support	29 631	84	3 986	11	658	2	1 088	3	35 363	100
Service and Sales	50 156	95	2 108	4	314	1	486	1	53 064	100
Skilled Agricultural, Forestry, Fishery, Craft, & Related Trades	1 229	89	90	7	30	2	25	2	1 374	100
Plant and Machine Operators and Assemblers	2 772	89	227	7	85	3	36	1	3 120	100
Elementary Occupations	28 078	93	1 798	6	73	0	294	1	30 243	100
Private sector	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Managers	26 296	63	2 493	6	2 404	6	10 547	25	41 741	100
Professionals	83 226	61	11 101	8	9 948	7	31 075	23	135 350	100
Technicians and Associate Professions	58 608	72	8 404	10	3 642	4	10 791	13	81 445	100
Clerical Support	32 551	61	7 970	15	3 999	7	9 000	17	53 520	100
Service and Sales	36 675	78	7 648	16	800	2	1 770	4	46 893	100
Skilled Agricultural, Forestry, Fishery, Craft, & Related Trades	11 745	94	252	2	120	1	316	3	12 432	100
Plant and Machine Operators and Assemblers	6 147	83	932	13	92	1	217	3	7 388	100
Elementary Occupations	24 706	88	2 466	9	359	1	624	2	28 155	100

Occupational Group	African		Coloured		Indian		White		Total	
Total Sector	N	%	N	%	N	%	N	%	N	%
Managers	34 403	65	3 523	7	3 072	6	11 708	22	52 707	100
Professionals	203 029	72	20 790	7	15 423	5	41 704	15	280 946	100
Technicians and Associate Prof	117 871	77	16 040	10	4 796	3	14 116	9	152 823	100
Clerical Support	62 182	70	11 956	13	4 657	5	10 088	11	88 883	100
Service and Sales	86 831	87	9 756	10	1 114	1	2 256	2	99 957	100
Skilled Agricultural, Forestry, Fishery, Craft, & Related Trades	12 974	94	342	2	150	1	341	2	13 806	100
Plant and Machine Operators and Assemblers	8 919	85	1 159	11	177	2	253	2	10 508	100
Elementary Occupations	52 784	90	4 264	7	432	1	918	2	58 398	100

1.6.5. Gender

Table 1-6 shows the gender distribution in the sector from 2014 to 2023. Male's share in employment in the sector varied between 26% and 30% while females formed between 70% and 74% of the workforce over the years.

Table 1-6 Gender distribution in the health and social development sector, 2014-2023

	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
Public Service	%	%	%	%	%	%	%	%	%	%
Male	27	27	28	32	28	27	27	26	28	27
Female	73	73	72	68	72	73	73	74	72	73
Total	100	100	100	100	100	100	100	100	100	100
Private sector	%	%	%	%	%	%	%	%	%	%
Male	30	25	25	28	25	27	28	29	29	33
Female	70	75	75	72	75	73	72	71	71	67
Total	100	100	100	100	100	100	100	100	100	100
Total sector	%	%	%	%	%	%	%	%	%	%
Male	28	26	27	30	27	27	28	28	29	30
Female	72	74	73	70	73	73	72	72	71	70
Total	100	100	100	100	100	100	100	100	100	100

Sources: Calculated from HWSETA and PSETA WSPs 2014-2023, MedPages data 2014-2023.

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 include occupations such as delivery drivers and artisans which are mostly filled by males.

Table 1-7 Gender distribution according to the occupational group, 2023

Occupational Group	Male		Female		Total	
Public Service	**N**	**%**	**N**	**%**	**N**	**%**
Managers	4 289	39	6 677	61	10 966	100
Professionals	34 856	24	110 740	76	145 596	100
Technicians and Associate Prof	19 123	27	52 255	73	71 378	100
Clerical Support	11 437	32	23 926	68	35 363	100
Service and Sales	13 901	26	39 163	74	53 064	100
Skilled Agricultural, Forestry, Related Trades	1 122	82	252	18	1 374	100
Plant and Machine Operators and Assemblers	2 373	76	747	24	3 120	100
Elementary Occupations	9 248	31	20 995	69	30 243	100
Private sector	**N**	**%**	**N**	**%**	**N**	**%**
Managers	15 963	38	25 778	62	41 741	100
Professionals	39 468	29	95 882	71	135 350	100
Technicians and Associate Prof	19 646	24	61 799	76	81 445	100
Clerical Support	17 560	33	35 959	67	53 520	100
Service and Sales	11 863	25	35 031	75	46 893	100
Skilled Agricultural, Forestry, Fishery, Craft, and Related Trades	11 217	90	1 215	10	12 432	100
Plant and Machine Operators and Assemblers	6 508	88	879	12	7 388	100
Elementary Occupations	11 502	41	16 653	59	28 155	100
Total Sector	**N**	**%**	**N**	**%**	**N**	**%**
Managers	20 252	38	32 455	62	52 707	100
Professionals	74 324	26	206 622	74	280 946	100
Technicians and Associate Prof	38 769	25	114 054	75	152 823	100
Clerical Support	28 997	33	59 885	67	88 883	100
Service and Sales	25 764	26	74 194	74	99 957	100
Skilled Agricultural, Forestry, Related Trades	12 339	89	1 467	11	13 806	100
Plant and Machine Operators and Assemblers	8 881	85	1 626	15	10 508	100
Elementary Occupations	20 750	36	37 648	64	58 398	100

Sources: Calculated from HWSETA and PSETA WSPs 2023, MedPages data 2023.

1.6.6. Age distribution

Table 1-8 shows the total age distribution in the Public Service, private health, and the total sector from 2014 to 2023. 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 33-41% over the period. In the private sector people older than 55 constituted 9-15% of the workers over the period.

Table 1-8 Age distribution in the health and social development sector, 2014-2023

	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
Public Service	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**
Younger than 35	30	31	32	29	27	25	26	26	26	24
35 to 55	59	57	58	61	63	62	63	63	63	65
Older than 55	11	12	10	10	10	14	11	11	11	10
Total	100	100	100	100	100	100	100	100	100	100
Private sector	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**
Younger than 35	37	41	40	37	39	38	38	35	40	33
35 to 55	54	50	49	49	51	51	50	50	49	54
Older than 55	9	9	11	14	11	12	12	15	11	13
Total	100	100	100	100	100	100	100	100	100	100
Total sector	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**
Younger than 35	33	36	35	32	34	31	32	31	30	29
35 to 55	57	54	54	57	56	56	56	56	57	59
Older than 55	10	10	11	11	11	13	12	13	13	12
Total	100	100	100	100	100	100	100	100	100	100

Sources: Calculated from HWSETA and PSETA WSPs 2023, MedPages data 2023.

The 2023 age distribution of employees in the health and social development sector by the occupational group is shown in Table 1-9. In the public sector, 10% of the professionals are over the age of 55 compared to 22% in the private sector. In total, 15% of professionals are over the age of 55 in the health and welfare sector. The larger numbers of people under the age of 35 in the private sector compared to the public sector are concentrated in the following occupational groups: Managers (35%), Services and Sales (45%), Clerical Support (42%), Technicians and Associate Professionals (33%), Trades (42%), and elementary workers (34%).

Table 1-9 Age distribution of employees in the Public Service and private health according to the occupational group, 2023

Occupational Group	Under 35		35 to 55		Older than 55		Total*	
Public Service	N	%	N	%	N	%	N	%
Managers	1 646	16	6 551	64	1 965	19	10 162	100
Professionals	38 923	27	88 939	63	13 758	10	141 620	100
Technicians and Associate Prof	16 154	24	44 822	66	6 640	10	67 616	100
Clerical Support	9 108	27	21 321	64	2 712	8	33 141	100
Service and Sales	8 943	18	36 668	72	5 182	10	50 793	100
Skilled Agricultural, etc	179	14	823	64	290	22	1 292	100
Plant and Machine Operators	644	23	1 544	56	572	21	2 760	100
Elementary Occupations	5 438	20	18 168	67	3 586	13	27 192	100

Occupational Group	Under 35		35 to 55		Older than 55		Total*	
Private sector	N	%	N	%	N	%	N	%
Managers	14 587	35	22 421	54	4 734	11	41 743	100
Professionals	27 383	23	65 982	55	26 092	22	119 458	100
Technicians and Associate Prof	24 948	33	43 350	58	6 679	9	74 923	100
Clerical Support	22 249	42	26 930	50	4 266	8	53 445	100
Service and Sales	20 963	45	22 544	48	3 298	7	46 804	100
Skilled Agricultural, etc	5 185	42	6 436	52	658	5	12 278	100
Plant and Machine Operators	1 588	22	4 724	64	1 072	15	7 384	100
Elementary Occupations	9 553	34	15 713	56	2 635	9	27 901	100
Total sector	N	%	N	%	N	%	N	%
Managers	16 233	31	28 972	56	6 699	13	51 905	100
Professionals	66 306	25	154 921	59	39 850	15	261 078	100
Technicians and Associate Prof	41 048	29	88 172	62	13 319	9	142 539	100
Clerical Support	31 357	36	48 251	56	6 978	8	86 586	100
Service and Sales	29 906	31	59 212	61	8 480	9	97 597	100
Skilled Agricultural, etc	5 364	40	7 259	53	948	7	13 570	100
Plant and Machine Operators	2 232	22	6 268	62	1 644	16	10 144	100
Elementary Occupations	14 991	27	33 881	61	6 221	11	55 093	100

Sources: Calculated from HWSETA and PSETA WSPs 2023, MedPages data 2023.

** Age totals are not the same as race and gender because of missing data in records.*

1.6.7. Disability

In 2023, 4% of the workers in the sector were people with disabilities. Of the 30 792 workers with disabilities, 1 633 (5%) were employed as managers, 8 800 (29%) as professionals, 6 020 (20%) as technicians and associate professionals, 4 658 (15%) as clerical support workers, 4 260 (14%) as service and sales workers, 196 (1%) as skilled agricultural, craft and related trades workers, 568 (2%) as plant and machine operators and assemblers, and 4 657 (15%) as elementary 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. It is sufficient 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 must be interpreted with great care.

Healthcare and social service practitioners are regulated by several statutory professional councils. These bodies play a formative role in determining the scope of practice for professionals and specialist occupations and 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 must work in close cooperation 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.

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 for their skills needs remains a major challenge for the SETA. They face significant economic hardship due to financial challenges which had worsened even more during the COVID-19 pandemic; few funding opportunities are now available, and they have to compete for scarce skills.

Formal employment in the health and social development sector is estimated at about 758 000, with 54% employed in private sector organisations and 46% 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 2.6% over the 2013-2023 period. The growth in employment in the sector from 2020 to 2022 was expected in light of the immediate COVID-19 demand for extra workers to assist the population with health and social development services.

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 segments of the sector while others are specific to either one of them. Although COVID-19 is now classified as endemic, it still needs reference as the consequences of the pandemic continues to pose 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 has been on the EERP (the Economic Reconstruction and Recovery Skills Strategy) the last two years. 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 coronavirus 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 was at risk of losing livelihoods (ILO 2020). The expanded unemployment rate of South Africa in the 4th quarter of 2022 confirmed this (42.6%). This equates to approximately 11.8 million people (Stats SA 2023b).

The HWSETA continues to monitor the effects of covid-19 in the health and social sectors. As such, the HWSETA conducted a study in 2022 that made it possible to continue tracking jobs lost or gained within the health and social sector as well as linking the determining factors towards the job losses or gains.

While the study does not identify Covid-19 as a major determinant of either jobs lost or gained, the findings show that the economic crises which may be a direct consequence of Covid-19 is the main determining factor towards jobs lost in 2022.

Over the next few years, the COVID-19 pandemic will continue to be a major change driver in the health and welfare sector. Since the government's efforts toward a national drive of economic recovery, such as the ERRP, skills development has been at the forefront of such economic reconstruction efforts.

For example, the COVID-19 social relief of distress grant will be extended for another year until 31 March 2024 to mitigate the impact of the slow economic recovery and increased poverty due to the pandemic (National Treasury 2023a).

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. The challenge of poverty and unemployment are significant factors that shape the health and social development sector in South Africa. Poverty affects the majority of South Africans and vast social inequalities

continue to persist (National Treasury 2023a). The latest Household Affordability Index by the Pietermaritzburg Economic Justice & Dignity group (PMBEJD) showed that an estimated 30.4 million people are currently living below the upper-bound poverty line of R1 417 a month; this is about half of the population. In terms of the food poverty line of R663 a month, the estimation is some 13.8 million people (PMBEJD January 2023).

For the fourth quarter of 2020, the unemployment rate (strict definition) was recorded at 35.3%, the highest since the start of the Labour Force Surveys in 2008 (Stats SA 2022b), showing the effect of the COVID-19 pandemic at the time. Although the unemployment rate has dropped a bit, it still stands at a high 32.7% for the fourth quarter of 2022 (Stats SA 2023b).

These high levels of unemployment explain the expected increase in the number of social grants beneficiaries to 19.6 million by March 2026 (National Treasury 2023a).

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 2022 an estimated 8.5 million people in South Africa were living with HIV/AIDS (Stats SA 2022a). 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).

In 2021 the national TB incidence rate per 100 000 population was 513 (WHO 2022). Maternal- and infant mortality rates remain high in South Africa (Stats SA 2022a), while the burden of disease is exacerbated by factors such as an aging population and the rising incidence of chronic diseases and obesity.

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 (GBV) reported that they could not cope with the number of calls from women who needed assistance.

The Foundation for Human Rights reported a 54% increase in GBV cases during lockdown across all provinces in South Africa (Mail&Guardian 2020).

The National Strategic Plan on Gender-Based Violence and Femicide speaks to the requirements for additional skills to address the surge of gender-based violence in the country (DWYDP 2020). The HWSETA reacted by providing support for special skills development programmes on gender-based violence (HWSETA 2023).

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 skill 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 in 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 was the high demand for community health workers in 2020 and 2021 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. The HWSETA qualifications in the community health, health promotion and youth care fields confirm the focus on mid-level skills training in the sector.

Also, 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; 2023).

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 are required to engage in mandatory accredited continuing professional development (CPD) to retain their registration status, i.e., the statutory authority to practice in a particular field (HPCSA 2017; SACSSP 2019; SAPC 2016; SAVC 2017; SAPC 2016).

The DoH and DSD set national norms and service standards to advance the quality of health and social welfare services and to improve both the safety 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, 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 recognized 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 changes in terms of 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 developmental 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).

These services are delivered in an environment marked by high levels of poverty, unemployment, and inequality (DSD 2022). To respond adequately to these challenges, the DSD committed itself through its plans that relate to social assistance, social welfare and community development services. Legislation and programmes, therefore, aim to progressively expand the reach of social security provision.

The care for children is particularly eminent in this regard as stipulated in the National Plan of Action for Children (DSD 2019); the child grant and the new extended child support grant for orphans are evidence of that (National Treasury 2022a).

These measures have a major impact on the obligations, duties, and skills mix of the social development workforce. However, the responsibility for ECD programmes and centres migrated from the DSD to the Department of Basic Education in April 2022 (DSD 2022).

c) White Paper for Social Development

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 in 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 can focus on the training and development of their teams.

The COVID-19 pandemic exacerbated this problem tremendously during 2020 and 2021. Currently high levels of stress and heavy workloads continue amongst this group of professionals due to difficult socio-economic conditions in South Africa.

2.2.4. Specific change drivers in health

a) National Health Insurance

South Africa has committed to attaining universal health care (UHC) by 2030 as part of the United Nation's Sustainable Development Goals. The main strategy to attain UHC is to implement it through a National Health Insurance system which will provide citizens with universal access to a defined package

of health care services. The first phase of NHI was piloted with its 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 was further deliberated; the parliamentary Portfolio Committee on Health considered and adopted the NHI Bill on Friday 27 May 2023.

Round two of the Presidential Health Summit that took place in May 2023 centred on getting closer to realising the NHI. Ten key areas for intervention to advance the introduction of the NHI were identified: human resources; access to medicines, vaccines, and health products; infrastructure planning; private sector engagement; quality, safety, and primary healthcare; public sector financial management; leadership and governance; community engagement; health information systems; and pandemic preparedness.

A very important driver of change will therefore 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 specialized secondary care and highly specialized 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.

b) Human Resources for Health

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 strategy (HRDC 2017; DoH 2020b). The review considered that HRH is one of the nine pillars of the 2019 Presidential Health Compact, and it 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 is characterised by staff shortages and inequity in the distribution of skilled health professionals between the public and private sectors as well as between urban and rural areas. This inequity exacerbates shortages in the public health sector that takes care of most of the South African population, with an extraordinarily complex disease burden (DoH 2020; SA Lancet National Commission 2019; Stakeholder Interviews 2023).

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 to meet current and future demands. Very importantly, the revised HRH strategy states that a major mind shift is needed to appreciate that the health workforce is an investment, rather than an expenditure item (DoH 2020). The health and welfare workforce is at the heart of an efficient and well-functioning system when the following are in place: an optimum skills mix; equitable distribution of resources; excellent competencies; high standards; and support and motivation to deliver essential services (DoH 2020).

c) Lack of a national integrative HRH data system

South Africa lacks an integrative data to use in the event of HRH planning. Different data sources are available, but the data limitations are often illustrated by the variation in the numbers and taxonomy/nomenclature of the data sets.

The DoH pledged Under Goal 2: Institutionalise data-driven and research informed health workforce policy, planning, management, and investment of the 2020 HRH review, to develop a Data Warehouse that stores and analyses HRH data, and under Goal 3: Produce a competent and caring multi-disciplinary health workforce through an equity-oriented, socially accountable education and training system, to develop a publicly available minimum national dataset of HRH education information.

The DoH indicated that this HRH Registry is in the process of being developed by using existing data sources. The first two modules are called Active Health Workforce Stock and Health Workforce. They also mentioned that South Africa has adopted the WHO National Health Workforce Accounts (NHWA), which is based on a comprehensive health labour market framework for UHC (DoH 2020).

d) Shortage of Nurses

The shortages of nurses were flagged as one of the crucial drivers of change in the sector by key stakeholders (Stakeholder Interviews 2022; 2023). Disruption of training was mentioned as the major reason, and stakeholders are highly concerned about the impact over the longer-term. Changes in the qualification framework and delay in training commencement on the new curriculum caused a shortage of enrolled nurses, as well as specialist nurses. In addition, private institutions indicated that they feel constrained in terms of the number of nurses that they are allowed to train; they can train more nurses and contribute more to the supply of nurses as prescribed by the SANC; "Unless more nurses are trained to address South Africa's critical nursing shortage, the country is headed for a health catastrophe" (businesstech 2023).

Estimations of shortages are in the range of 26 000 to 62 000 professional nurses, and it is expected to reach 100 000 by 2030 (businesstech 2023). Nurses are now listed on the revised critical skills list of the Department of Home Affairs, meaning that foreign nationals are eligible for the corresponding work visas and permanent residency to work as nurses in South Africa.

However, stakeholders feel that despite this measure shortages continue to exist; they indicated that, "nurse shortages require government intervention for new education requirements and processes that would allow the private sector to meaningfully contribute to the training of nurses" (businesstech 2023). It is noteworthy that one of the recommendations of the Presidential Health Summit in May 2023 was to address the critical problems of nursing training through greater collaboration between the private and public sectors (Daily Maverick 8 May 2023). For more detailed and updated research on nurses, the National DoH and Public-Private Growth Initiative have commissioned a study to Percept.

c) Inequity in public-private and urban-rural distributions

Only about 15% of the population is covered by a medical aid therefore the public sector health facilities are stretched to attend to about 85% of the population's healthcare needs, with insufficient numbers of health professionals, especially medical practitioners and nurses working in the public sector. Interviews with stakeholders (2023) conveyed that medical practitioners who are working in the public

sector for example, are very disillusioned because of the huge disparity in working conditions and facilities compared to the private sector. Improving these areas could make a positive difference in addressing the shortage, especially since many of them are vocationally driven and do want to work in the public sector. In addition, shortages in rural areas remain an ongoing challenge; posts in rural areas can be vacant for years. Stakeholders expressed hope in the NHI to resolve these challenges (Stakeholder Interviews 2023). In terms of the availability of HRH in the rural areas, and in line with the rural district development model, the HWSETA reacted and prioritised 18 of the 44 rural districts as zones of targeted skills development initiatives (HWSETA 2023).

f) Re-engineering and expansion of access to primary health care

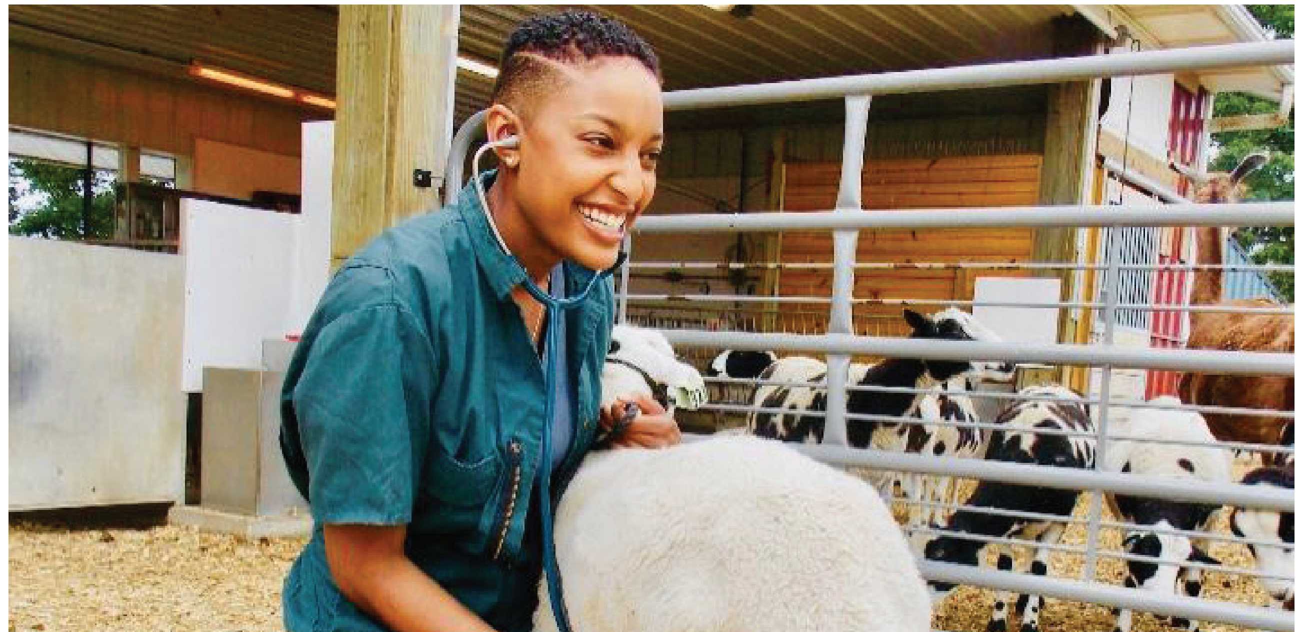
Primary healthcare (PHC) was re-engineered through four streams to improve timely access and promote health and prevent disease. These streams are municipal ward-based primary health care outreach teams (WBPHCOTs), integrated school health programme (ISHP), district clinical specialist teams (DCSTs), and contracting of non-specialist health professionals. Each WBPHCOT team is led by a nurse. In 2017 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. This plan was 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 workers with mid-level skills in a primary health care setup.

g) Technological change

New technologies have a profound effect on the sector. The COVID-19 pandemic has focused attention on technological advancements in the laboratory services industry, particularly big data, and telepathology (NHLS 2020). A study conducted by HWSETA (2022) on exploring the level of exposure and adoption of Fourth Industrial Revolution (4IR) in the health sectors (2022) confirms that there was an elevated level of awareness and willingness to adopt new technologies in different workplaces. The study also revealed that various organisations have made significant capital investments in 4IR. However, the study revealed that job losses in the health sector are unlikely to occur as a direct result of 4IR technology advancement. Further, the institutional reaction time of HE and PSET institutions in incorporating technologies into the curriculum has seen more non-accredited programmes and short courses to up-skill or provide top-up skills to staff. The implication of these findings is that the HWSETA qualification development process needs to be responsive and adaptable to the new changes taking place in the sector as a result of 4IR technologies.

h) Migration

The HWSETA study conducted in 2022 assessing the current and historical trends of the internal and external migration of healthcare professionals shows increasing levels of emigration from 2016 to 2019 before declining in 2020 and increasing again in 2021 and 2022. The decrease in 2020 is explained by the COVID-19 lockdown regulations. The biggest proportion of those emigrating, according to the study survey sample, is specialist medical practitioners, general medical practitioners, nurses, dentists, and psychologists. These healthcare professionals, in the main, emigrate to UK, Australia, and New Zealand. Importantly, the occupational categories such as medical practitioners and nurses form part of the HTFV as published by HWSETA over the years.



This confirms emigration as one explanatory factor of occupational shortages in the health sector. Reasons for emigration are predominantly push factors which relate to the following: economic instability; safety and security concerns; heavy workload in the sector; and the introduction of the NHI. SAMA conducted a survey in 2021, showing that more than a third (38%) of its members are considering emigrating from South Africa, due to the introduction of the NHI (Businesstech 2023).

2.3. POLICY FRAMEWORKS AFFECTING SKILLS DEMAND AND SUPPLY

2.3.1. The Economic Reconstruction and Recovery Plan and the Linked Skills Strategy

The ERRP and a linked strategy were 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 was the immediate rollout of skills development interventions to make sure that the ERRP is supported in all regards. The focus of the HWSETA is on the implementation of the strategy as well as the revised MSTF.

In response to the immediate requirements the HWSETA: revised the Annual Performance Plans (APPs) for 2021-2022 and thereafter; prioritised funding for skills development interventions required for the ERRP; and aligned the strategic and sector skills planning to the strategy and revised MSTF. Interventions two, three, five, and seven of the ERRP 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). The action plan of the HWSETA for 2023-2024 in terms of the ERRP looks as follows: A total of 2 424 students, 15 skills development providers, and one digital skills programme will be funded to support the ERRP skills strategy (HWSETA 2023).

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 (NPC 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 and expertise Set norms and standards for care	Supply adequate skills mix across the entire health system to provide effective, efficient, affordable, and quality care; train more professional and specialist nurses and strengthen nurse training platforms; and improve health system management, safety in healthcare and clinical governance
Re-engineer primary healthcare	Deploy ward-based outreach teams and expand school health services; contract in-sessional doctors and deploy clinical specialist teams trained in family health; and train nurses in primary health care
Expand community-based care and environmental health	Train community health workers to focus on maternal, child, and women's health & basic household and community hygiene and expand environmental health services
Increase access to antiretroviral treatment and reduce TB infection rates	Train more health professionals and health workers to monitor treatment, and employ more pharmacists and pharmacy technicians to distribute and administer medication
Provide National Health Insurance to give universal healthcare coverage	Improve financial management and procurement of health services, medicine & goods; improve health facilities and expand training of health professionals; and set staffing norms and improve human resources capacity, training and HR management
Social Development: Provide integrated social protection and enable citizens to live with dignity	
Expand basic social welfare services for vulnerable groups	Provide protection and care services for children, families, the elderly and disabled; train more social service workers on all occupational levels, and build the management and governance capacity of NGOs to sustain service provision
Enable children to access social care, education safety and nutrition	Expand provision of early childhood development programmes and train ECD practitioners; address the social impact of HIV/AIDS and other challenges on children; strengthen child protection services, supervision and mentorship for youth and orphans; and train caregivers and social work specialists (e.g., probation officers and registered counsellors)
Support communities with sustainable livelihoods and household food security	Train community development practitioners and enhance the skills set of the current workforce; and build the capacity of community-based organisations to provide effective community development
Reduce social crime and support victims	Increase social care and support to families and victims, and train social workers to manage substance abuse and crime prevention programmes

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

2.3.3. The National Skills Development Plan

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 the 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 must 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 continue to focus on skills development interventions required for the Presidential Youth Employment Initiative and the ERRP skills strategy such as: updating technical and vocational education programmes; increasing 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, 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 the 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 and other factors, the human rights-based development agenda, and health pandemics like COVID-19.

2.5. CONCLUSION

An array of change drivers including challenging socio-economic realities resulting in high levels of poverty, high burden of disease, the recent pandemic, planned implementation of the NHI, and critical shortages of nurses and medical practitioners, to mention a few, will have a definite influence on the demand for skills in the health and social development sector in the years to come.

National and provincial policies and strategic development agendas are therefore aligned with the NDP 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 further expanding and have necessitated changes to the skills base of the workforce.

Pandemics like COVID-19 emphasised the importance for government to include such occurrences in their strategic development planning. The ERRP will remain a primary driver in the sector for the next couple of years and the HWSETA has proof its continued commitment to the implementation of the strategy through its action plan for 2023-2023. HRH is crucial and solutions to address skills shortages and inequity in terms of distribution of human resources remain a major concern in the sector.

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. 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 despite employers' active recruitment efforts. The employers that submitted WSPs to the HWSETA and the PSETA in 2023 reported a total of 1 786 hard-to-fill vacancies (unable to fill within 12 months). These vacancies were distributed over 67 occupations. Most hard-to-fill vacancies are at the professional (59%), and service and sales workers (35%) (Table 3-1) which imply high and intermediate skills levels respectively.

Table 3-1 Implications of NDP for skills planning in the health and social development sector

Occupational Group	Private	Public	Total	%
Managers	77	4	81	5%
Professionals	818	231	1049	59%
Technicians and Associate Professionals	13	9	22	1%
Clerical Support Workers	0	0	0	0%
Service and Sales Workers	626	1	627	35%
Skilled Agricultural, Forestry, Fishery, Craft, and Related Trades Workers	1	6	7	0%
Plant and Machine Operators and Assemblers	0	0	0	0%
Elementary Occupations	0	0	0	0%
Total	**1535 (86%)**	**251 (14%)**	**1786**	**100%**

Sources: Calculated from HWSETA and PSETA WSP submissions 2023.

The occupations, in which vacancies were reported vacant for an average of 12-months and longer are presented in Table 3-2. From the figures presented in the table, the public service has a severe shortage of specialists while the private health sectors suffer from a severe shortage of registered nurses. The latter confirms that the national shortage of nurses remains a critical risk. The HWSETA study conducted in 2022 on the trend analysis of hard-to-fill vacancies between 2018 and 2020 indicates that required work experience and qualifications were two major reasons explaining occupational shortages. This study concluded that occupational shortages stem from supply-side inadequacies which can be characterized as a 'policy problem' independent of demand-side factors. The main reason that employers mention in 2023 for struggling to fill nursing positions, is the limited numbers trained over the last couple of years; the pool to source from became smaller (see table 3.4 for decrease in number of nursing graduates). Table 3.2 indicates, in the order of their importance, three key reasons explaining hard-to-fill vacancies phenomenon as scarcity of people with required qualifications, lack of funding, and scarcity in area/geography.

Table 3-2 Hard-to-fill vacancies according to occupation, private and public sector (2023)

Occupation		Private (2023)	Public (2023)	Total	Change in nursing qualifications/ Pool became smaller	Limited numbers trained	Scarcity of interns	Scarcity of people with required qualifications	Unsafe working conditions	Lack of experience	High turnover rate	Scarcity in area/ geographic location	Lack of funding	No appetite or interest to the post advertised/ preference
2021-222109	REGISTERED NURSE (MEDICAL PRACTICE)	690	0	690								X		
2021-532903	NURSING SUPPORT WORKER	624	0	624	X	X								
2021-221210	GENERAL MEDICINE SPECIALIST PHYSICIAN	5	81	86				X				X		
2021-222103	REGISTERED NURSE (CHILD AND FAMILY HEALTH)	0	35	35				X				X		
2021-221203	EMERGENCY MEDICINE SPECIALIST	38	9	47				X						
2021-122101	SALES AND MARKETING MANAGER	34	0	34							x			
2021-221204	OBSTETRICIAN AND GYNAECOLOGIST	0	21	21				X				X		
2021-134101	CHILD CARE CENTRE MANAGER	14	0	14		x		x					x	x
2021-111202	GENERAL MANAGER PUBLIC SERVICE	9	4	13						x				
2021-111202	GENERAL MANAGER PUBLIC SERVICE	9	4	13						x				
2021-226501	DIETITIAN	2	0	2										
2021-222114	NURSE EDUCATOR	12	0	12				x						
2021-221205	OPHTHALMOLOGIST	0	10	10				x						
2021-321403	DENTAL THERAPIST	9	0	9										
2021-225101	VETERINARIAN	8	0	8										x
2021-263501	SOCIAL COUNSELLING WORKER	8	0	8									x	
2021-221208	PSYCHIATRIST	0	8	8										
2021-222102	AGED CARE REGISTERED NURSE	7	0	7										x
2021-263507	ADOPTION SOCIAL WORKER	5	2	7									x	

Sources: Calculated from HWSETA and PSETA (2023) WSP submissions.

Table 3-2 Hard-to-fill vacancies according to occupation, private and public sector (2023)

Occupation		Private (2023)	Public (2023)	Total	Change in nursing qualifications/ Pool became smaller	Limited numbers trained	Scarcity of interns	Scarcity of people with required qualifications	Unsafe working conditions	Lack of experience	High turnover rate	Scarcity in area/ geographic location	Lack of funding	No appetite or interest to the post advertised/ preference
2021-341204	AUXILIARY CHILD AND YOUTH CARE WORKER	7	0	7										
2021-121205	EMPLOYEE WELLNESS MANAGER	6	0	6									x	
2021-263601	MINISTER OF RELIGION	5	0	5										
2021-263407	COUNSELLING PSYCHOLOGIST	4	1	5						x			x	
2021-221227	DERMATOLOGIST	0	5	5										
2021-643101	PAINTER	0	5	5										
2021-314102	ENVIRONMENTAL SCIENCE TECHNICIAN	4	4	8						x				
2021-263502	ADDICTIONS COUNSELLOR	4	0	4										
2021-221212	FORENSIC PATHOLOGIST	0	4	4				x						
2021-221215	FAMILY PHYSICIAN	0	4	4										
2021-263403	ORGANISATIONAL PSYCHOLOGIST	0	4	4										
2021-222110	REGISTERED NURSE (MENTAL HEALTH)	0	4	4										
2021-134403	CHILD AND YOUTH CARE MANAGER	4	0	4										
2021-222112	REGISTERED NURSE (SURGICAL)	0	4	4										
Other 35 occupations with HTFV less than 4		36	46	82										
Total		**1535**	**251**	**1786**										

Sources: Calculated from HWSETA and PSETA (2023) WSP submissions.

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 skills gaps at different levels were identified.

3.3.1. Skills gaps in the health and 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) (DHET employer interviews 2021, 2022). A gap that has been noticed recently is data analytical skills for professionals in the sector. Many employers indicated that the roles that professionals fulfil these days require data analytical skills. (DHET employer interviews 2021, 2022). Predominant skills gap by level of occupations were identified as follows:

A) High-level (managers and professionals)

- Leadership, team management, and conflict management skills.
- People Management and Industrial relations skills.

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

- Computer skills to utilise and maintain computerised information systems.

C) Lower level (elementary occupations)

- Customer/Client Service skills.

Additionally, the skills gaps that have been reported by the HWSETA employers at a major occupation level are reported in Table 33 on the following page. The Table 34 refers to top nine skills gaps that have been reported by employers at an occupational. These top up skills shows the need for continuing to use the workplaces as learning places for the employed people.

Table 3-3 Skill gaps at major group 2023

OFO CODE	OFO Major Group	Skills Gaps
2021-1	Managers	Emotional Intellegence Skills
		Customer Service Skills
		Leadership and strategic planning skills
2021-2	Professionals	Computer Skills
		Advanced Cardio Life Support
		Data analytical skills
2021-3	TECHNICIANS AND ASSOCIATE PROFESSIONALS	Computer skills
		Time Management
		Occupational health and safety skills
2021-4	CLERICAL SUPPORT WORKERS	Basic Life Support (BLS)
		First Aid skills
		Customer service skills
2021-5	SERVICE AND SALES WORKERS	Basic Life support Skills
		Stress Management
		First Aid Skills
2021-6	SKILLED AGRICULTURAL, FORESTRY, FISHERY, CRAFT AND RELATED TRADES WORKERS	Computer skills
		First Aid Skills
		Advance Driving Skills
2021-7	PLANT AND MACHINE OPERATORS AND ASSEMBLERS	Computer skills
		First Aid Skills
		Conflict Management Skills
2021-8	ELEMENTARY OCCUPATIONS	Communication Skills
		Occupational health and safety skills
		Fire Fighting skills

Source: HWSETA WSP AND HWSETA INTERVIEWS

Table 3-4 Skill gaps at major group 2023

OFO Code	Occupation	Skills Gap
2021-322101	Enrolled nurse	Occupational health and safety skills
		Advanced Cardiac Life Support (ACLS)
		Customer Service Skills
2021-222104	Registered Nurse (Community Health)	Occupational health and safety skills
		Conflict Management skills
		Communication Skills
2021-226203	Retail Pharmacist	Advanced Computer literacy Skills
		Basic Fire Fighting
		Conflict Management skills
2021-321201	Medical Technician	Computer Literacy
		Communication skills
		Customer Service Skills
2021-213110	Medical Scientist	Communication skills
		Time management
		Occupational health and safety skills
2021-432101	Stock Clerk/Officer	Computer Literacy
		Basics of Stores & Stock Control - SAPICS
		Occupational health and safety skills
2021-532203	Community Health Worker	Computer Literacy
		Emotional Intelligence (EQ) skills
		Occupational health and safety skills
2021-532903	Nursing Support Worker	Communication skills
		Basic Life Support (BLS)
		Conflict Management skills
2021-222111	Registered Nurse (Operating Theatre	Communication skills
		Advanced Cardiac Life Support (ACLS)
		Nursing CPD Module 1 to 3

Source: HWSETA planned training data, 2023.

3.4. EXTENT AND NATURE OF SUPPLY

Supply can be influenced by a range of factors such as the number and geographic distribution of healthcare providers, the production, recruitment, retention, and throughput of students, availability, and quality of healthcare educators, as well as the licensing, regulation, scope of practice, migration, and employment status of health care workers. 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 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 in 2020 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 was very positive in terms of skills development and the supply of skills at the time (HWSETA 2020b); it shows that the health sector may not have been affected as much as the other sectors by the pause in contact education. In 2022/23 the HWSETA conducted in-depth studies on medical practitioners and pharmacists, looking at the challenges that medical and pharmacy schools experience in the education and training of these professionals and in providing the output needed to meet the health care needs of the population. Challenges that relate to shortages of academic and clinical staff and insufficient infrastructure seemed to be the main themes (see section 3.4.2).

3.4.1. Entry into the health and welfare development sector

Prospective workers enter the sector at different levels, either directly from secondary school or following post-school training. The positive or negative output from the secondary school system underlies the greater part of the skills supply to the sector. For example, a good Grade 12 pass, in 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 other allied health sciences to mention a few.

Between 2017 to 2021 the participation has increased by an annual average growth rate of 3.5% and 4.6% for those writing mathematics and physical sciences (NSC level) respectively. However, the share of distribution has been on the decline by 7% (from 46% to 37%) and 6% (34% to 28%) for those writing mathematics and physical sciences (NSC) respectively. This indicates that more and more students are not choosing the STEM fields within the basic education sub-system.

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 increasing 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 at secondary school level due to the COVID-19 pandemic must still not be underestimated; the implication is that there will be fewer learners with an NSC in mathematics and science. This will have an impact on the intake of students in the health sciences field.

3.4.2. Post-school Training: Scope of instituional training capacity

Post-school training for over 100 registered health professionals 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 such as medical practitioners. 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 medical practitioners

Historically the training of medical practitioners was undertaken by eight South African medical schools which supply just over 1 400 doctors per annum. In January 2016, the ninth medical school was opened at the University of Limpopo and the first group of students started with their internships recently. This medical school is in the longer term linked to the presidential project of building an academic hospital in Limpopo, namely the Limpopo Central Hospital (DoH 2019).

A tenth medical school was opened in 2021 at the Nelson Mandela University in the Eastern Cape; their first output will only be seen closer to 2030. 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 practitioners 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; just over 5 000 have trained in Cuba since the inception of the programme.

However, during interviews with key stakeholders it was mentioned that government should investigate the option of rather opening another medical school in South Africa to address the shortage of supply rather than extending the Cuba programme. The need for the involvement of the private sector in the training of medical practitioners was also highlighted. Even so, medical schools indicated that they can't increase the intake of medical students because there is currently a lack of internship and community service posts; this should first be resolved before they can increase intake (Stakeholder Interviews 2023).

All medical schools indicated that they struggle with staff issues and infrastructure. Most of the medical schools' teaching staff are joint staff who are practising clinicians; they are over-loaded by having to do their normal hospital work and then teach and conduct research. The schools ideally need more permanent staff to carry some of the load and to assist with administration (Stakeholder Interviews 2023).

The training of pharmacists

There are currently nine pharmacy schools offering training for pharmacists. The same challenges mentioned by medical schools were also highlighted by the pharmacy schools. There is a growing shortage of academic pharmacists, as most pharmacists want to end up in industry where they earn significantly

higher salaries than what government can pay them as lecturers at universities. All the pharmacy schools expressed challenges with staff shortages and infrastructure. Some mentioned they are always propping up with either contract or temporary staff such as post-graduate students to meet the lecturing needs. However, these positions should be permanent as the need is constant. Some institutions need to find money from their other budgets for these contract and staff members, which then constrains capacity and resources elsewhere (Stakeholder Interviews 2023).

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. These changes imply that nursing colleges have now become HEIs. Many of the colleges experienced challenges in this regard, which further impacted on the output of nurses. The first group of nursing students on the new qualifications started in 2020. In addition, nursing colleges reported that during the COVID-19 pandemic, the disruption of contact education also forced them to apply digital nursing education methods regarding the clinical components (practical), which slowed down training. They also had to work around the pandemic surges which had a further impact on the completion time of training.

The HWSETA has shown a strong investment in supporting the training of nurses over the years; this relates to the development of lecturing staff and training infrastructure.

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, community health workers (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 must 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 since 2021 is on providing sufficient WIL opportunities to learners in the sector.

However, the effect of the interruption of contact education and training due to the COVID-19 pandemic can be seen in some of the supply data; many students were not able to meet the clinical/practical requirements of their training. In addition, the lack of internship positions for medical and pharmacy students remains a concern regarding the supply of these professionals; training hospitals mentioned the lack of funding as the major issue (Stakeholder Interviews 2023).

There is also evidence that employers find it currently difficult to release employees for longer-term training such as learnership programmes. The HWSETA has therefore initiated an alternative model that involves the learnership programmes being offered in parts over a longer period than usual (HWSETA 2023).

3.4.3. Student output from the public higher education training sector institutions

The analysis of the supply of skills at the 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 2021 is shown in Table 33.

If the selected health-related and social welfare fields of study are considered, the total output from the Public HET sector grew on average by 2.4% per annum from 2010 to 2021 at the first three-year B Degree level and 4.1% at the first four-year B Degree level. Over the 11 years, most of the professional (four-year) degrees showed a positive average annual growth except for chiropractic, medical clinical science, and somatic bodywork, and related therapeutic services. The dentistry, advanced dentistry and oral sciences field showed no growth (0.0%) over the period.

The output of the first four-year degrees in medicine increased on average by 5.5% per annum over the 11 years. For pharmacy, pharmaceutical sciences, and administration it was 7.2% and for veterinary sciences 6.7%. The output of the four-year nursing degree has grown on average only by 1.5% per annum over the same period, with a decrease of 33.2% in graduate numbers from 1 517 in 2019 to 1 013 in 2021.

This is a good example of the interruption of contact education and training due to the COVID-19 pandemic, as well as the current challenges regarding the new qualification framework and institutional arrangements for nursing.

Many students were not able to meet the clinical/practical requirements of the respective programmes, depending on the duration of the academic interruption. Output in social work (4-year degree) has grown on average only by 1.3% per year, with a decrease of 34.2% in graduate numbers from 2 049 in 2019 to 1 349 in 2021.

Table 3-5 Number of health-related & social work qualifications awarded by public HEIs, 2010-2021

HEMIS Study Fields	Qualifications	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	AAG (%)
Chiropractic	First BDegree (4 years)	48	44	52	53	40	45	60	24	44	56	18	41	-1.4
Communications Disorders Sciences and Services	First BDegree(3 years)											31	31	
	First BDegree (4 years)	114	153	141	134	169	199	202	232	243	256	243	246	7.2
Dentistry, Advanced Dentistry and Oral Sciences	First BDegree(3 years)	50	38	52	68	84	82	55	33	36	46	32	30	-4.5
	First BDegree (4 years)	212	157	201	177	212	166	205	199	207	210	189	211	0
Health and Medical Administrative Services	First BDegree (3 years)	200	179	230	271	235	235	220	212	253	265	334	282	3.2
	First BDegree (4 years)	258	290	270	253	91	213	158	358	364	377	257	281	0.8
Medicine	First BDegree (3 years)	1	25	40	59	60	39	81	58	51	51	113	96	51.4
	First BDegree (4 years)	637	704	660	542	557	847	996	843	1 039	1002	1 097	1 144	5.5
Medical Clinical Sciences	First BDegree (3 years)	55	65	102	141	93	74	72	122	85	57	158	159	10.1
	First BDegree (4 years)	1 015	936	999	973	1 024	1 125	941	1162	1 103	1185	1 090	966	-0.4
Nursing	First BDegree (3 years)	302	271	278	395	364	415	454	316	323	260	320	251	-1.7
	First BDegree (4 years)	891	958	927	943	1 171	1 159	1 200	1379	1 354	1517	1 34	1 053	1.5
Optometry	First BDegree (4 years)	127	115	90	81	81	120	127	116	94	160	136	134	23.9
Pharmacy, Pharmaceutical Sciences and Administration	First BDegree(4 years)	466	509	561	687	723	950	834	878	972	955	961	1006	7.2
Podiatric Medicine/Podiatry	First BDegree (4 years)	6	16	3	13	15	3	31	29	23	37		37	18
Public Health	First BDegree (3 years)	20	23	63	66	63	246	256	316	97	89	118	89	14.5
	First BDegree (4 years)	172	201	210	231	236	246	256	316	254	293	208	236	2.9

Source: HEMIS 2021..

**Veterinarian output*

HWSETA

Table 3-5 Number of health-related & social work qualifications awarded by public HEIs, 2010-2021

HEMIS Study Fields	Qualifications	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	AAG (%)
Rehabilitation and Therapeutic Professions	First BDegree (3 years)	57	52	41	83	90	123	147	124	149	123	122	76	2.6
	First BDegree (4 years)	526	555	578	598	633	712	742	728	769	693	758	714	2.8
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										27	
	First BDegree (4 years)	97	86	95	103	98	99	125	125	165	169	145	158	6.5
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	198	190	5.1
Alternative and Complementary Medicine and Medical Systems	First BDegree (3 years)	10	6	7	16	19	10	23	11	26	32	34	23	7.9
	First BDegree (4 years)	24	26	28	9	26	18	16	16	31	21	39	29	1.7
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	21	10	-13.1
Medical Radiologic Technology/Science (Radiography)	First BDegree (3 years)	29	41	33	43	39	52	44	48	49	84	30	39	2.7
	First BDegree (4 years)	77	106	98	125	130	152	192	231	252	378	411	238	10.8
Clinical Technology	First BDegree (4 years)										10		25	
Health Professions and Related Clinical Sciences, Other	First BDegree (3 years)	7			27	80			62				1	
	First BDegree (4 years)	11	45	47	161	132	86	80	22	114	126	102	110	23.3
Social Work	First BDegree (3 years)	65	85	48	107	126	96	123	125	64	49	30	34	-5.7
	First BDegree (4 years)	1 169	1 297	1 671	1 881	2 121	2 362	2 618	2815	2 518	2049	1 596	1 349	1.3
Total	**First BDegree (3 years)**	**874**	**878**	**942**	**1 282**	**1 261**	**1 379**	**1 490**	**1 444**	**1 138**	**1 057**	**1 322**	**1 138**	2.4
	First BDegree (4 years)	**6 046**	**6 402**	**6 827**	**7 172**	**7 649**	**8 705**	**8 990**	**9 703**	**9 778**	**9 698**	**8 810**	**8 178**	4.1

Source: HEMIS 2021..

**Veterinarian output*

a) Skills supply through nursing colleges

From 2020 all undergraduate 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 Auxiliary 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's Degree in Nursing Sciences (NQF Level 8) leading to registration as a Professional Nurse and Midwife. There are currently 22 private NEIs that are accredited to offer the new nursing qualifications, 54 public NEIs, and 19 universities and universities of technology (SANC 2023). There are still a few institutions that are accredited to deliver the legacy qualifications during the phasing-out period.

The number of nurses who qualified at various levels between 2011 and 2022 can be seen in Table 3-4. A total of 40 577 Professional Nurses qualified with a four-year qualification over the 11-years, showing an average annual growth of 1.0%, while another 38 545 Nurses completed the Bridging Programme between 2011 and 2021, showing an average annual growth of 1.9%. However, the Nursing Education Association (NEA) already warned in 2022 that there is going to be a significant decrease noticeable in output at this level due to the phasing-out of the old qualifications (Interview 2022).

This is highly noticeable in the 2022 output data reflected in the table below; there were no graduates under the bridging course programme. This programme contributed significantly to the supply of nurses until 2021. Another challenge is that for the past two years, no post-basic (specialist) training took place; only a few universities started in 2022 with small numbers of students, which contributes to serious shortages (Interview 2022). This is one of the reasons why the HWSETA has prioritised post-graduate qualifications (specialisations) for nurses as a key action in 2023/24 and onwards (HWSETA 2023c).

The decrease in pupil Nurses and pupil Auxiliaries is due to the phasing out of the legacy qualifications. These courses were terminated in 2015, which means that the numbers below reflect the phasing-out period of the programmes. The first outputs on the new qualifications will only be published by 2023.

The Hospital Association of South Africa (HASA) emphasised 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 hospital groups in the sector (Interviews 2021, 2022 and 2023).

Table 3-6 Number of graduates at NEIs, 2011-2022

Program	Number of graduates												
	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	AAG %
Four-year Program	2 966	3 225	3 261	3 221	3 291	3 528	3 322	3 564	3 736	3 608	3 535	3 320	1
Bridging Course*	2 964	3 929	3 291	2 889	4 136	3 326	3 014	3 953	5 169	2 298	3 576		1.9
Pupil Nurses	7 391	7 732	8 954	6 949	8 756	7 879	6 001	825	95	8	75	85	-33.4
Pupil Auxiliaries	5 232	5 009	5 909	6 141	5 795	6 726	587	39	29	32	34	39	-35.9
Total	**18 553**	**19 895**	**21 415**	**19 200**	**21 978**	**21 459**	**12 924**	**8 381**	**9 029**	**5 946**	**7 220**	**3 444**	**-42.9**

**Bridging into the professional nurse category.*

Source: SANC 2023.

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 2022 over 29 900 candidates qualified in qualifications such as Child and Youth Care Work, Social Auxiliary Work, and Community Health Work (Table 3-5). Community health has become a key area in the domain of primary health care.

Table 3-7 Student output in some qualifications overseen by HWSETA, 2013-2022

	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	Total
L4: Child and Youth Care Work	521	344	1 113	1 405	376	480	866	899	1 119	151	7 123
L4: Social Auxiliary Work	2 476	1 209	844	713	471	279	979	454	353	840	7 778
L4: Community Health Work	352	463	644	361	280	191	1279	274	353	790	4 197
L2: Community Health Work	629	2 418	2 786	1 744	230	584	872	61	111	87	9 324
L4: Health Promotion Officer				744	377	443	714	239	1 369	1 029	1 564
Total	**5 991**	**6 448**	**7 402**	**6 983**	**3 751**	**3 995**	**6 015**	**3 708**	**3 846**	**2 022**	**29 986**

Source: HWSETA MIS May 2023.

3.4.4. Professional registration of health professionals

Healthcare and social services professionals are required to register with their respective professional councils 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 both indicate growth in the number of professionals available and number of student enrolments as a proxy for supply capacity.

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

The HPCSA controls over 130 registration categories through twelve professional boards. Table 3-6 shows the registration figures for several key professions over the period 2012 to 2022. Since 2012, the number of registered dentists grew on average by 1.4% per year, medical interns (i.e., medical graduates in training) by 4.2%, and medical practitioners by 2.4%. The average annual growth for the following health professionals was also positive: occupational therapists (4.0%), radiographers (3.0%), physiotherapists (2.8%), medical technologists (2.4%), psychologists (2.3%), and optometrists (1.9%). The number of registered speech therapists and audiologists increased only slightly (by 0.9% per year) over the period.

Table 3-8 Number of selected professionals registered with the HPCSA as of 31 December, 2012-2022

Registration category	Number of persons registered											
	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	AAG %
Dentist	5 652	5 787	6 062	6 126	6 331	6 409	6 430	6 530	6 472	6 553	6 481	1.4
Medical Intern	3 338	3 396	3 279	3 215	3 653	3 780	3 745	4 430	5 370	4 713	5 016	4.2
Medical Practitioner	38652	40258	42146	42550	44145	44858	46014	46839	46516	49087	49108	2.4
Medical Technologist	4 948	5 045	5 350	5 331	5 576	5 616	5 793	5 975	6 088	6 219	6 269	2.4
Occupational Therapist	3 945	4 238	4 569	4 765	4 980	5 174	5 410	5 682	5 718	6 041	5 825	4
Optometrist	3 342	3 458	3 628	3 645	3 751	3 773	3 812	3 837	3 899	3 990	4 031	1.9
Physiotherapist	6 328	6 585	7 001	7 122	7 370	7 665	7 856	8 153	8 185	8 536	8 309	2.8
Psychologist	7 245	7 433	7 895	8 047	8 409	8 449	8 770	8 881	8 978	9 106	9 112	2.3
Radiographer	6 225	6 645	7 088	7 239	7 378	7 729	7 794	8 168	8 121	8 489	8 387	3
Speech Therapist & Audiologist	1 448	1 448	1 501	1 573	1 519	1 547	1 594	1 612	1 582	1 641	1 586	0.9

Source: HPCSA 2023.

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 gradually to 271 431 in 2022 (Table 3-7). In the period from 2012 to 2022, the average annual growth in registration for all these categories was only 0.9%. Registered nurses increased on average by 2.4%. Registrations for both enrolled and auxiliaries showed a negative growth, -1.1% and -0.7% respectively. The decrease in registrations for auxiliaries from 2016 to 2022 (over 11 700, a drop of about 17%) and enrolled nurses from 2017 to 2021 (over 22 200, a drop of about 30%) can be expected due to the change in the qualification framework and teach out period of the legacy qualifications; this may even be more noticeable in the next few years.

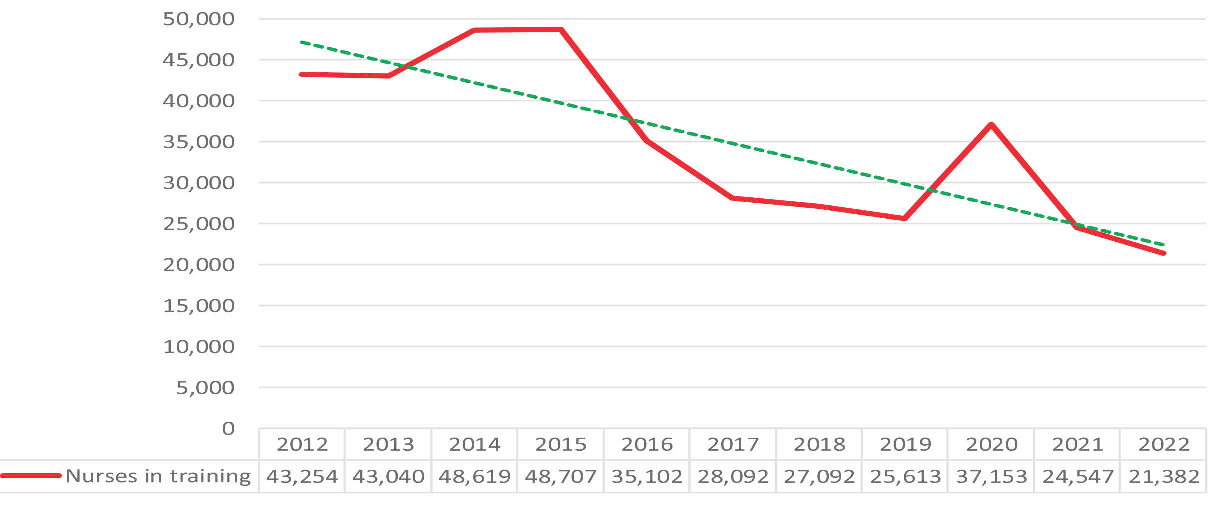
Table 3-9 Number of nurses registered with the SANC, 2012-2022

	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	AAG %
Registered	124 045	129 015	133 127	136 854	140 597	142 092	146 791	153 095	154 024	156 784	157 516	2.4
Enrolled	58 722	63 788	66 891	70 300	73 558	74 556	70 552	64 638	61 033	56 490	52 350	-1.1
Auxiliaries	65 969	67 895	70 419	71 463	73 301	70 431	68 361	67 104	65 187	63 545	61 565	-0.7
Total	**248 736**	**260 698**	**270 437**	**278 617**	**287 456**	**287 079**	**285 704**	**284 837**	**280 244**	**276 819**	**271 431**	**0.9**

Source: SANC 2023.

The NEA warned already in 2022 that there is going to be a significant decrease noticeable in the registration numbers due to the drop in output at NEIs. There are currently only about 21 300 nurses in training at different levels. All the old programmes are in their phasing 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 affected the new enrolments considerably (Interview 2021 2022).

Figure 3-1 Number of nurses in training, 2012-2022



	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022
Nurses in training	43,254	43,040	48,619	48,707	35,102	28,092	27,092	25,613	37,153	24,547	21,382

Source: SANC 2022.

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

From 2013 to 2023, the average annual growth for registered pharmacists and pharmacist interns was 2.9% and 6.8% respectively (Table 3-8). The registration figures in the support staff categories showed higher growth over this period; basic pharmacist assistants grew on average by 11.2% annually over the period. The number of people registered in this category grew steadily from 2013 to 2015, more than doubled between 2015 and 2016, and slightly decreased again between 2019 and 2023. Post-basic pharmacist assistants grew at an annual average of 11.9%.

Table 3-10 Number of registrations with the SAPC, 2013-2023

Registration category	Number of persons registered											
	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	AAG%
Basic Pharmacist Assistant	1 184	1 774	1 937	4 898	3 965	4 367	4 293	3 877	4 111	3 457	3 430	11.2
Learner Basic Pharmacist Assistant	4 372	3 500	3 510	3 166	3 080	3 326	3 208	3 110	3 152	3 603	4 051	-0.8
Post-basic Pharmacist Assistant	5 371	6 086	6 713	7 973	10191	11681	13103	13481	14863	15494	16 528	11.9
Learner Post-basic Pharmacist Assistant	1 956	1 849	2 098	2 642	2 084	2 431	2 173	2 170	2 208	2 184	2 303	1.6
Pharmacist	13119	13589	13658	14053	14552	15231	15722	16020	16541	17113	17 531	2.9
Pharmacist Intern	732	808	857	1 045	1 036	1 086	1 082	1 171	1 260	1 316	1 412	6.8
Specialist pharmacist	13	13	13	13	13	13	11	10	10	10	11	-1.7
Community Service Pharmacist*				642	806	758	807	813	855	871	810	2.4
B Pharm student*				3 708	4 183	4 287	4 520	4 013	3 331	3 727	4 028	0.8

*Source: SAPC 2023. *From 2016*

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

In 2023 a total of 2 591 people were registered with the AHPCSA (Table 3-9). Since 2013, the total number of registrations dropped on average by 0.7% per year. Generally, allied health professionals and complementary practitioners work in the private sector.

Table 3-11 Total registrations with the AHPCSA, 2013-2023

Registration category	Number of persons registered											
	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	AAG %
Acupuncture	99	66	64	61	57	54	53	52	44	44	54	-5.9
Ayurveda doctor	15	15	17	17	13	13	12	12	12	10	10	-4
Chinese medicine	152	155	156	160	157	153	157	158	146	146	145	-0.5
Chiropractic	647	667	731	773	808	835	877	897	917	930	975	4.2
Homoeopathy	559	557	569	572	581	584	580	573	573	572	596	0.6
Naturopathy	89	91	92	88	86	80	80	77	68	68	73	-2
Osteopathy	47	46	40	40	36	37	38	37	33	33	33	-3.5
Phytotherapy	38	40	43	49	51	48	48	49	45	46	49	2.6
Therapeutic aromatherapy	242	222	179	157	131	121	105	98	83	79	75	-11.1
Therapeutic massage therapy	146	138	125	111	103	102	95	94	94	93	91	-4.6
Therapeutic reflexology	662	635	584	535	501	491	446	437	403	427	425	-4.3
Unani-Tibb	70	71	73	74	67	66	69	69	65	63	65	-0.7
Total	**2 766**	**2 703**	**2 673**	**2 637**	**2 591**	**2 584**	**2 560**	**2 553**	**2 483**	**2 511**	**2 591**	**-0.7**

Source: AHPCS 2023.

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

The number of veterinarians registered with the SAVC grew on average by only 1.5% from 3 006 in 2013 to 3 491 in 2023 (Table 3-10). The average annual growth for animal health technicians was 4.4% over this period, veterinary nurses 2.1%, and veterinary technologists 4.2%. Veterinary physiotherapist is a new para-veterinary profession since 2021; 198 have been registered up to date. Since 2022 it is also compulsory for veterinarian graduates to commit themselves to one year of community veterinary service. There are currently 382 vets in community service in the country. A recent survey by the SAVA found that an alarming high number of vets are leaving the country, and that a considerable number are planning to leave. The profession is critical to ensure food safety and security in South Africa and skills shortages in this field needs

to be addressed urgently. The SAVC records show that South Africa are losing up to 150 vets a year to emigration; this figure is based on the number of vets a month requesting letters of good standing from the SAVC to enable them to practise abroad (SAVC 2023).

Table 3-12 Number of registrations with the SAVC, 2013-2023

Registration category	Number of persons registered											
	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	AAG %
Veterinarians	3 006	3 102	3 174	3 222	3 340	3 548	3 658	3 718	3 720	3 500	3 491	1.5
Veterinary specialists	157	164	167	163	184	207	206	205	212	217	216	3.2
Compulsory Community Veterinary Service										323	382	18.6
Animal Health Technicians	1 039	1034	1 004	1 013	1 041	1 205	1 281	1 283	1 372	1 549	1 599	4.4
Laboratory Animal Technologists	21	20	17	19	17	16	15	19	15	14	13	-4.7
Veterinary Nurses	589	602	611	606	640	709	732	769	719	727	723	2.1
Veterinary Technologists	260	287	280	279	311	334	354	349	358	395	394	4.2
Veterinary Physiotherapists*									60	65	73	10.3
Total	**7 149**	**7 430**	**6 888**	**6 713**	**6 944**	**7 674**	**7 661**	**7 758**	**7 708**	**7 997**	**6 891**	**2.4**

**New para-veterinary profession*

Source: SAVC 2023.

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

From 2016 to 2023, (Table 3-11), the average annual growth for registered Social Workers, and Social Auxiliary Workers were 7.2% and 6.9% respectively, compared to 9.2% for Child, and Youth Care Workers. There are just over 31 400 students preparing to become Social Workers, Social Auxiliary Workers, Child and Youth Care Workers, or Auxiliary Child and Youth Care Workers in the next couple of years. These are positive trends in terms of supplying human resources for the delivery of much-needed social services in South Africa, especially with the national focus on children.

Table 3-13 Social Service Professionals and students with the SACSSP, 2016-2023

Registration category	Number of persons registered								
	2016	2017	2018	2019	2020	2021	2022	2023	AAG %
Social Workers	27 130	20 017	32 657	33 404	34 569	35 328	38 443	44 106	7.2
Social Auxiliary Workers	9 235	10 142	11 182	11 589	11 824	11 954	12 716	14 749	6.9
Child & Youth Care Workers	5 113	6 303	7 503	8 122	9 071	7 467	8 358	9 460	9.2
Total	**41 478**	**36 462**	**51 342**	**53 115**	**55 464**	**54 749**	**59 517**	**68 315**	**7.4**
Student Social Workers	10 807	13 36	15 411	16 938	14 582	14 636	14 894		
Student Social Auxiliary Workers	8 528	10 081	11 247	12 276	11 715	15 279	12 540		
Students Child & Youth Care Workers	15	132	0	0	198	263	282		
Student Auxiliary Child and Youth Care Workers	131	214	742	1 245	2 421	3 206	3 773		
Total	**19 481**	**23793**	**27400**	**30 459**	**28 916**	**33 384**	**31 489**		

Source: SACSSP 2023.

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.

Academic criteria for admission to social work programmes are generally in the lower ranges, and students tend to underestimate the training demands. High drop-out rates at nursing colleges are a further indication that prospective learners are not prepared for training at the post-school level (Stakeholder interviews 2019, 2020, 2021, 2022).

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. Training capacity for health professionals remains limited due to infrastructure constraints, shortages of academic clinician posts, bed count, laboratories, and other clinical teaching resources (Stakeholder interviews 2019, 2020, 2023).

The interruption of contact education and training due to the COVID-19 pandemic in 2020 had an impact 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 but increased again in 2022. Similarly, there is limited training capacity at TVET colleges, accredited private providers, and NGOs in certain areas that are important to the health sector.

3.5. THE HWSETA SECTOR PRIORITY OCCUPATIONS AND INTERVENTIONS LIST (SPOIL)

3.5.1. Overview

SETAs are obliged to develop a Sector Priority Occupations 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 SPOI list is then used to guide funding decisions in the SETA.

In the preparation of a SPOI list, the HWSETA takes a holistic view of its sector as per the SIC code distribution assigned, the skills composition and skills need of the sector, and the education and training pipelines that supply skills into the sector. It bears in mind that the Health and Social Development Sector is large and complex 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 are critically important for the functioning of hospitals and other facilities, for example, financial occupations and some trades. Another factor that must be borne in mind in the development of the list is the SETA's obligations in terms of national strategies; a good example is the NHI.

3.5.2. Methodology

The development of the Sectoral Priority Occupations and Interventions (SPOI) List (formerly known as PIVOTAL list) starts with an analysis of the occupations in the sector and employment trends in those occupations. This is followed by an analysis of the Hard-To-Fill-Vacancies (HTFV) reported by organisations in the public and private sector. This analysis, which is based on the WSPs submitted to the HWSETA and the PSETA provides a basic list of occupations in which scarcity (unable to fill vacancies within twelve months) 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, specifically referring to skills needs. 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 SPOI List take the form of interviews conducted with key role players in the sector. Clarification is sometimes needed regarding the figures presented by employers in their WSP submissions.

The occupations on the SPOI List are ranked according to the reasons for HTFV and the number of people needed. Amongst many reasons for the HTFV, scarcity of people with experience, required qualifications, and specialized skills are used to rank priority levels in relation to HWSETA's mandate and control and as per Sector Skills Plan framework and guidelines which emphasizes that SPOIL be based on skills-related reasons. 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 SPOI list is based on the HTFV list but with specific focus occupations that become HTFV due to skills-related reasons. The estimate of the quantity of need in the sector is formulated from the 5-year average of HTFV to account for variations that arise from the changing number of employer organisations submitting their WSPs. This, in turn, leads to the interventions indicated in the SETA SPOI list.

The number of interventions that the SETA can support depends on various considerations:

- SETA funding is 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 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 is 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 Sectoral Priority Occupational and Interventions list

The process of organizing the SPO list culminates in the submission of it for consideration and approval by the Board. Upon approval, the SPOI list is then signed by the 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. 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 several levels. First, there are imbalances between skills output versus the occupational demand in the workplace as indicated by the vacancies data.
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 ERRP 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 and in certain instances decreases in 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 consequences of the COVID-19 pandemic will continue to have a considerable 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 and delayed output at HEIs because of the disruption of contact education during 2020 and 2021; the challenges regarding the new nursing qualifications; and the decrease in enrolments due to low numbers of learners obtaining an NSC with the required mathematics and science achievement.

4. SETA PARTNERSHIPS

4.1. INTRODUCTION

Among the keystones in advancing the developmental state are the improvement of citizens' lives through accessible healthcare, adequate social protection, and opportunities for socio-economic participation. On its own, the HWSETA cannot meet these demands and therefore depends on collaborations with many different entities. Since 2020 the HWSETA established extraordinary new partnerships to address the effects of the COVID-19 pandemic.

Thus, the SETA's proactive reaction to the pandemic has resulted in a couple of life-saving partnerships and job creation initiatives. As mentioned earlier the HWSETA saw its 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 current partnerships and covers the objectives and duration of partnerships; the impact (value-add); and challenges and success factors. The priorities of these partnerships relate to the following: 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 the mid-level skills base in the health sector; providing undergraduate and post-graduate bursary opportunities for unemployed youths and also workers; developing post-school education lecturers; building skills of leaders of trade unions and those of the NGO/NPO sector; stimulating economic activity and cooperative development; and developing artisans and technicians. These partnerships are linked to the priorities of the NSDP and/or the ERRP.

The HWSETA's partnerships are administered through Memorandum of Agreements (MoAs) or Memorandum of Understandings (MoUs) with the objective of establishing and outlining collaborative agreements including service partnerships.

This contract usually follows a certain format that includes, although not limited to the following key sections: definitions of terms; purpose of the agreement; scope of work; obligations of each party; a detailed description of roles and responsibilities; duration; and breach and termination. Whilst getting into this agreement clearly expresses mutual obligations for the HWSETA and the partners, it is often found that most of the partnerships pose some challenges; some are internal and others external to the HWSETA.

Internal challenges such as budget limitations are usually managed through discussions on effective ways of allocating the budget. The external challenges, such as the low completion rates and poor planning and administration, for example, are mitigated by offering partners support during the planning phase; constant communication to ensure that partners understand the requirements and roles that are necessary to have successful outcomes.

Table 4-1 Current partnerships

Priority	Partners	Objectives	Duration	Impact (value-add)	Challenges	Success factors
Post-school education institutions (Colleges)	15 public TVET colleges	Establish schools of health and social development within TVET Colleges Support artisan training programs Support work-readiness programs Support animal health technicians training programmes	February 2021 – February 2024	Facilitates the delivery of HWSETA qualifications within TVET colleges Contributes towards the maintenance of hospital equipment. Improves the employability of graduates Secures animal health for food production	Some colleges not meeting the accreditation requirements of quality assurance bodies. Going forward verification of accreditation requirements will be conducted. Variation in proficiency in administering projects among TVET colleges which affect the duration. Standardization to be effected to ensure uniformity of the intervention.	Build relationship with and support of Centres of Specialisation Provincial officers are now hands on with dealing with the project management due to the decentralization of functions
Work Integrated Learning	TARDI	To enable students who are enrolled with the college to gain workplace experience in line with curriculum for them to graduate	March 2022-March 2025	Linking the world of work and education through training for employment	No challenges	Equity Imperatives: reaches learners in the rural communities 50% of students funded are the youth 60% are women 95% of students will graduate successfully
	Cape Peninsula University of Technology Tshwane University of Technology University of Pretoria Central University of Technology Mangosuthu University of Technology Durban University of Technology Nelson Mandela University Vaal University of Technology	To enable students who are enrolled with universities to gain workplace experience in line with university's curriculum for them to graduate	April 2022-March 2024			

Table 4-1 Current partnerships

Priority	Partners	Objectives	Duration	Impact (value-add)	Challenges	Success factors
Worker Leader Training (Trade Unions)	NPSWU NEHAWU HOSPERSA	To support workers to access credit and non-credit bearing skills programmes To empower capacity building of worker leaders of trade unions in the sector To enable participation of trade unions to meet conditions and requirements for their registration with the Department of Employment and Labour	August 2021 – August 2023	Capacitated leaders of trade Unions with required knowledge on labour issues	Incomplete documentation which resulted in delays in the commencement of the project. Going forward verification of documentation for completeness will be conducted to ensure timely delivery.	The project has started with the exception of one trade union HWSETA strategy where one single project management company coordinates the training for all trade unions Constant communication is maintained to ensure that partners understand the requirements and their respective roles
Undergraduate Bursaries	University of Limpopo Cape Peninsula University of Technology Rhodes University Netcare College University of Johannesburg University of KwaZulu-Natal University of Cape Town Durban University of Technology University of Pretoria Nelson Mandela University University of Free State Heldernburg University North-West University Stellenbosch Walter Sisulu University	To increase the number of workers and unemployed persons that enter, re-enter and complete bursary programmes on qualifications funded by the HWSETA	Ongoing, March 2022 – March 2026	Increase the supply of skilled workforce towards high-end skills by opening doors to further learning from undergraduate to post graduate studies	Financial constraint which restricts funding many students as per demand Going forward, evidence from needs analysis will be analyzed at disaggregated level to better inform planning (budgeting and resourcing) against existing demand in the sector.	Efficient use of available funds to supply pipeline for higher level qualifications Primarily targeting the 'missing middle' students who do not qualify for NSFAs bursary funding

Table 4-1 Current partnerships

Priority	Partners	Objectives	Duration	Impact (value-add)	Challenges	Success factors
Post-Graduate Bursaries	Cape Peninsula University of Technology University of Pretoria Sefako Makgatho University University of Witwatersrand University of KwaZulu-Natal	To increase access into post-graduate higher education programmes To create a pipeline of candidates that qualify to enter into Master's degrees and PhDs	January 2022- January 2028	Increases the number of people with high-level skills in the sector to: • qualify to become lectures at higher education institutions • to fill hard-to fill vacancies that require high-level and/or specialised skills	Financial constraint which restricts funding many students as per demand Going forward, evidence from needs analysis will be analyzed at disaggregated level to better inform planning (budgeting and resourcing) against existing demand in the sector.	Efficient use of available funds to supply pipeline for higher level qualifications Contributes to post-graduate bursary funds available for post-graduate studies, especially for nurses where the shortages are critical
Stimulate economic activity through Cooperative development	Dunacor Skills Hub	Giving cooperatives access to training on millwrights and diesel mechanics	February 2021 – February 2024	Public hospitals will have qualified artisans doing their maintenance	A majority of members of cooperatives do not meet entry requirements (maths & science) into these artisanal programmes. Going forward verification of documentation will be thoroughly assessed to ensure minimum requirements for artisanal programmes are met before intervention commences.	Rural development, only recruiting from rural areas First cohort completed trade test Working closely with rural communities

4.3. PLANNED PARTNERSHIPS

The HWSETA has decided to take the partnerships that they have already established to the next level within the constraints of their budget. In addition, new partnerships are in the planning phase that relates to the following: a partnership with Small and micro enterprises (SMEs) and levy exempt organisations to increase the number of entry-level workplace experience for the youth and to expand production capacity of rural cooperatives. Another planned partnership is with the HWSETA and SACSSP to develop standardised and pilot induction standards for the Social Work Prok Profession for the newly qualified or employed Social Workers.

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 2022; the Gender-Based Violence Policy Framework for Post-school Education and Training System 2020; the Sector Strategy for Employment of Social Service Professionals 2021; 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, most recently consequences of the COVID-19 pandemic, and further budget constraints. 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, 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 regularly. 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) 2007 as well as the DPME Revised Framework for Strategic and Annual Performance Planning 2019.

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 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 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 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, 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.

[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).

5.3. APPROACH AND INSTITUTIONALISATION OF MONITORING AND EVALUATION

HWSETA has established the Research, Information, Monitoring, and Evaluation (RIME) unit which accommodates the inter-relatedness of the different functions or processes regarding M&E. The 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 strategic output and outcome indicators 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 to achieve programme 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 collecting data on these programme or project indicators and comparing actual results with targets; and
- Reporting progress on a programme or project to managers and alerting them to complications.

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 skills development interventions.

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 and measure impact indicators that are a direct result of skills development interventions.

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 and programmes enables the effective management

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 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?

6 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?

of risk. Learning from experience the following mechanisms are now in place to ensure the 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 outputs to outcomes in such a way that it will ensure impact;
- Decentralising monitoring to regional offices - the regional offices are firstly closer to the programmes and projects and secondly, they have more capacity because they have fewer programmes and projects to monitor;
- Forming partnerships with stakeholders such as employers who are determined to be successful in achieving strategic outputs and ensuring value creation by making a meaningful contribution towards the achievement of outcomes; and
- Not focusing only on avoiding risk but focusing on achieving a result that will have an impact on the lives of each unemployed and employed learner who are beneficiaries of HWSETA programmes and projects.

The 2022/2023 SSP update of the HWSETA listed three skills development priorities, and all priorities informed the strategic plan update of 2022/2023 and cascaded to performance indicators for implementation through the annual performance plan. The SSP primarily informs the situational analysis of the strategic document through the synthesis of sectoral needs and priorities identified. The three skills priorities are: skills pipeline into the health and social development sector; professionalisation of the workforce; and vital skills required for the developmental state. The three priorities directly relate and express the ERRP strategic objectives and the obligations of the HWSETA in this regard. For example, the HWSETA increased funding to escalate access to programmes and workplace experiences resulting in qualifications that are in high demand in the health sector, in this way ensuring the skills pipeline (ERRP interventions three and five); and retraining and up-skilling of employees to preserve jobs as well as ensure the continued professionalisation of the workforce (ERRP intervention 7). The priorities are also in line with the Sustainable Development Goals (target 3c) for low- and middle-income countries training and retention of the health workforce.

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 process”. As an implementation strategy, the National Skills Development Plan (DHET: 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. This supports intervention five of the ERRP: access to workplace 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 below 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 indicates the extent to which the WBL, as the model of implementation, is effective in realising intended outcome.

The HWSETA performance on the WBL student placement both at partnership level and student achievement level was at the level classified as good progress [51%-75%]. With respect to completion rates of the WBL programme, moderate success (39%) was achieved. Three factors were highlighted as explaining this level of performance. These were budget constraints, reduced number of leaners recruited, and delayed registrations. At the outcome level, 73% (substantial progress) of qualified WBL unemployed learners findings employment within 6 months in 2022/23 financial year.

These findings illustrate that the employers in the sector may experience the delayed negative economic effect of COVID-19. This confirms that employment is dependent on both supply and demand side factors. It can therefore be deduced that the HWSETA's skills pipeline priority is being implemented appropriately and efficiently with its outcomes strongly influenced by labour market factors. Further, the HWSETA's skills pipeline illustrates that the health and social development sector is also affected by economic factors, visible in the high national unemployment rate.

Table 5-1 M&E of skills priority 1: The skills pipeline, 2022/23

	Indicator	Target	Realised	Rating of Performance
Result Chain Level	**Indicator**	**Target 5yrs**	**Achievement 2022/2023**	**Comments**
Outcome Statement The HWSETA contributes to increased access, by the unemployed, into occupationally directed programmes of the health and welfare sector in the strategic period. 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.	Percentage of qualified WBL unemployed learners finding employment within 6 months of completing the learning programme (tracer study)	60%	44%	2022/23: [51% to 75%] Good Progress
	Percentage of post-school education institutions, professional and employer bodies, and communities of practice who partner with the HWSETA for the education and training of learners funded by the HWSETA in the strategic period	80%	53%	2022/23: [51% to 75%] Good Progress
Result Chain Level	**Indicator**	**Target 2022/2023**	**Achievement 2022/2023**	**Comments**
Output Statement 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	2 096	815	2022/2023: [26% to 50%] Moderate Success
Activity Number of unemployed students who enrolled in the artisan, Learnership, Bursary, and Internship programme funded by the HWSETA. Employers in the sector open up their workplaces for learning through partnerships with the HWSETA in the reporting period.	Number of unemployed students entered into WBL programmes (TVET, & university WIL, internships, learnerships, and apprenticeships)	5 050	3 590	2022-2023: [51%-75%] Good Progress
	Number of employers in the sector who open up their workplaces for learning through partnerships with HWSETA in the reporting period	271	173	2022-2023: [51%-75%] Good Progress

b) Professionalisation of the workforce

The NSDP posits 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" (DHET: NSDP 2019 p.17). It is in this context that the professionalization 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 professionalization 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 qualifications 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 below). It supports intervention seven of the ERRP: retraining/up-skilling of employees to preserve jobs.

The HWSETA performance on the workers in the PIVOTAL programmes both at entry (71%) and completion (70%) levels was at the performance level classified as good progress [51%-75%]. These findings illustrate that HWSETA's implementation is in the right direction of contributing towards productivity for country's competitiveness in the global economy.

It can therefore be deduced that the HWSETA's professionalization of the workforce is being implemented appropriately and efficiently. Outcomes validate the latter claim as it shows that 94% of workers confirmed that their training funded by HWSETA led to productivity after completion. Further assessment should be conducted on the same cohort after a reasonable time to gauge if there is an increase in progress through promotion.

Table 5-2 M&E of skills priority 2: Professionalisation of the workforce, 2022/2023

	Indicator	Target	Realised	Rating of Performance
Result Chain Level	**Indicator**	**Target 5yrs**	**Achievement 2022/2023**	**Comments**
Outcome statement 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 that strategic period	Number of workers who's training directly leads to productivity after completion of learnership, undergraduate, postgraduate bursary programme, RPL, and lecturer development	50%	47%	2022/2023: [76%-99%] Substantial Progress
Result Chain	**Indicator**	**Target 2022/2023**	**Achievement 2022/2023**	**Comments**
Output Statement Number of employed students who complete the artisan, Learnership, bursary, skills, AET, lecturer development, and RPL programmes funded by the HWSETA	Number of workers who completed the PIVOTAL	6 172	4 308	2022/2023: [51%-75%] Good Progress
Activity Number of employed students who enrolled to the artisan, learnership, bursary, skills, AET, lecturer development, and RPL programmes funded by the HWSETA	Number of workers in the PIVOTAL	11 015	7 883	2022/2023: [51%-75%] Good Progress

Source: HWSETA PIR, 2023

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 the 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 in 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" (DHET: NSDP 2019 p.20). This supports interventions two and three of the ERRP: updating or amending technical and vocational education programmes, and increased access to programmes resulting in qualifications in priority sectors.

At an implementation level, the vital skills priority is advanced both at the institutional and individual level to support the capacity of the public sector, TVETs, and CETs. The table below illustrates the institutional support intervention for public sector capacity and interventions at the individual level for TVETs and CETs. In terms of implementation performance, HWSETA overachieved at 250% against set targets for 2022/23 on the number of projects aimed at public sector education and training in the reporting period. At learner/student level intervention, HWSETA achieved substantial progress at 78% against the set target of the number of learners supported in TVET colleges, and other public colleges. The support speaks to TVETs and CETs capacity through expansion of education and training.

Table 5-3 M&E of skills priority 3: Vital skills required for the developmental state, 2022/23

Indicator	Target 2022/2023	Achievement 2022/2023	Comments
Institutional level: Number of education and training projects aimed at the public sector (DoH & DSD).	6	15	[>=100%] Achieved/ 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.	1 760	1381	2022/2023: [76%-99%] Substantial Progress

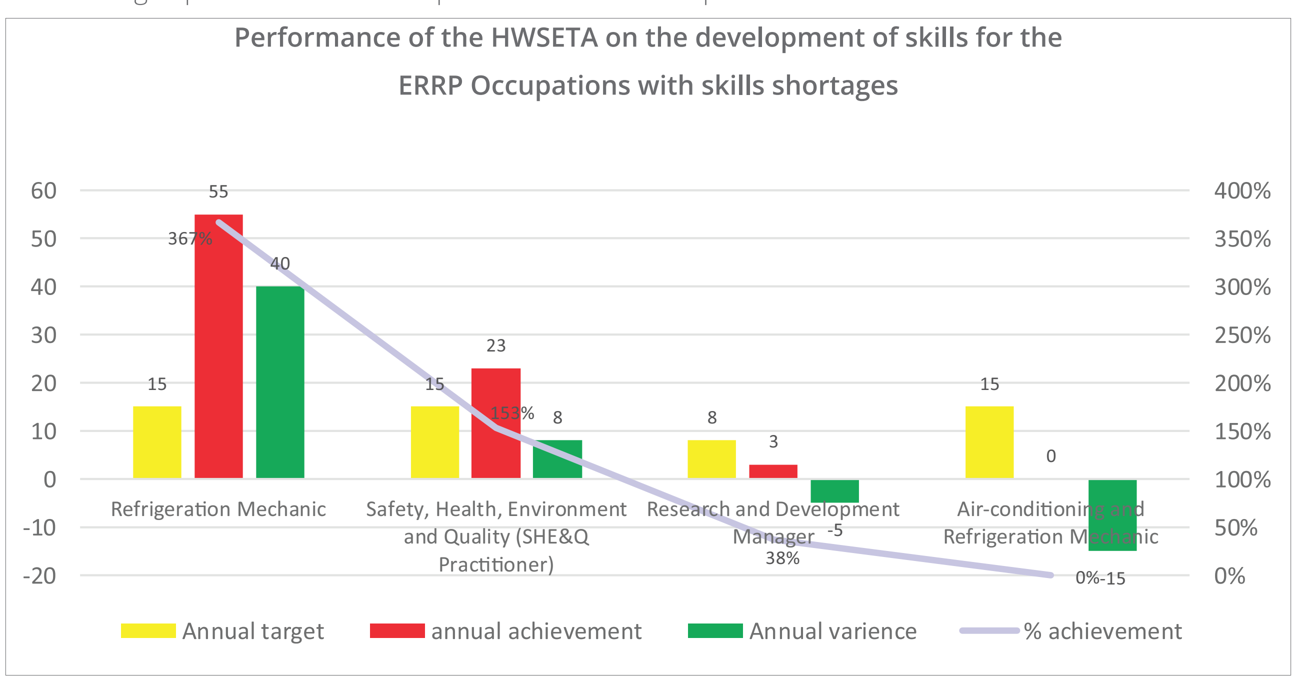
d) Vital skills required for the developmental state Vital skills required for the developmental state

Eight occupations within the ambit of the health and welfare SETA were identified through the ERRP Skills Strategy to have skills shortages, together with a skill that is crosscutting several occupations, that is digital skills. The HWSETA made a commitment to develop these skills in shortage through its funding programmes as follows:

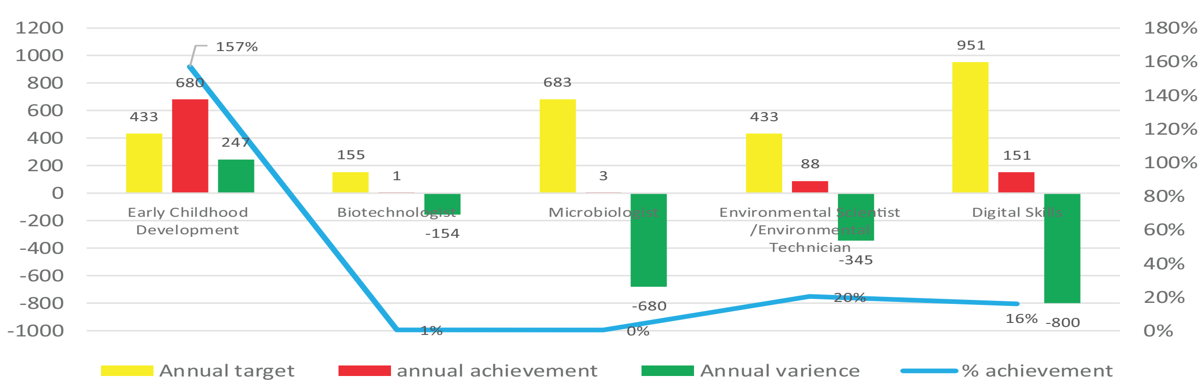
Intervention through which ERRP skills strategy will be supported by the HWSETA.

OCCUPATION	LEARNING PROGRAMME THROUGH WHICH TRAINING WAS IMPLEMENTED	
Research and Development Manager	6.1 6.2	Entries: Post-graduate Bursary Programme for the employed Re-entries: Post-graduate Bursary Programme for the employed
Safety, Health, Environment and Quality (SHE&Q Practitioner)	19.1	Accreditation/re-accreditation of skills development providers
Early Childhood Development Practitioner	29.1 3.1 6.4	Entries: Unemployed learnerships Entries: Employed learnership Entries: Employed undergraduate bursary
Biotechnologist	27.1 27.2 27.4 27.5	Entries: Post-graduate Bursary Programme for the unemployed Re-entries: Post-graduate Bursary Programme for the unemployed Entries: Under-graduate Bursary Programme for the unemployed Re-entries: Under-graduate Bursary Programme for the unemployed
Microbiologist	27.2 7.1	Entries: Unemployed post-graduate Bursary Entries: University Graduate Internships
Environmental Scientist (Environmental Technician)	3.1 29.1	Entries: Learnerships for the employed Entries: Learnerships for the unemployed
Air-conditioning and Refrigeration Mechanic	4.1 26.1	Entries: Apprenticeships for the employed Entries: Apprenticeships for the unemployed
Refrigeration Mechanic	4.1 26.1	Entries: Apprenticeships for the employed Entries: Apprenticeships for the unemployed
CROSS CUTTING SKILL		
Digital Skills	31.1 21.1 8.1 30.1 16.1	Entries: Employed AET Entries: Unemployed AET Entries: Employed Skills Programmes Entries: Unemployed Skills Programmes Lecturer Development

The training implemented for each qualification thus far is presented as follows:



PERFORMANCE OF THE HWSETA ON THE DEVELOPMENT SKILLS FOR THE ERRP OCCUPATIONS WITH SKILLS SHORTAGE



As shown above, The HWSETA offered training to 680 unemployed and employed persons in Early Childhood Development (ECD) and accredited 23 skills development providers for the occupation Safety, Health, Environment and Quality (SHE&Q Practitioner). Three research and development managers and three Microbiologist were provided training through the post-graduate bursary programme. Hundred and fifty-one (151) employed and unemployed persons received training in digital skills through the AET programme. Additionally, access was created for 88 environmental scientists/technicians through undergraduate bursary and work integrated learning programmes.

5.5. PLAN OF ACTION

The strengthening of M&E, which will be accompanied by programme reflection sessions to see what interventions could be implemented to improve our work, will be critical to our mitigation measures. Implementation of planned initiatives should begin earlier in the fiscal year to ensure timely completion. Insights acquired from this document will be discussed during strategy sessions for HWSETA to consider streamlining initiatives and focusing on fewer initiatives that have a greater impact rather than too many that are difficult to implement. The HWSETA conducts frequent programme reflection sessions in which each project is thoroughly examined to determine its strengths and weaknesses. The reflection sessions allow each program to be teased, and this process is aided using project reports. Measurables of the priorities and resolutions taken during strategy sessions will be recorded by the M&E sub-division for tracking of utilization during implementation of the Annual performance plan.

5.6. 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. This chapter has shown the performance levels toward the sector priority areas. HWSETA's performance in 2022/23 is an overachievement for vital skills required for the developmental state, good to substantial progress for professionalisation of the workforce while it is moderate to good achievement for the skills pipeline.

6. STRATEGIC SKILLS PRIORITY ACTIONS

6.1. INTRODUCTION

As the HWSETA is only one of several 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 2024/25, 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 workforce and the unique needs of service providers in the sector.
- The estimated increase in the number of people who are dependent on grants places a constraint on the budget.
- 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.

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 in the public and private sectors, specifically in the provinces and rural areas is critical to meet the current and future demands.
- The lack of a national integrative HR data system for the sector makes HR planning difficult.
- Technology has a profound effect on the sector; the HWSETA reacts with a digital literacy sector that supports the National Digital and Future Skills Strategy for South Africa.

- The ERRP will remain a primary driver in the sector for the next couple of years and the HWSETA has proof its continued commitment to the implementation of the strategy through its action plan.

Chapter 3:

- Employers face major complex and long-term skills challenges.
- The skills need for 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.
- Leadership and management skills are needed at all levels.
- A strategic priority is to strengthen education capacity and clinical- and practical training platforms, especially for nurses, medical practitioners, and pharmacists.
- Effective delivery of national healthcare initiatives and social services programmes depends on a skilled and professionalised workforce.
- The COVID-19 pandemic increased the demand for certain workers in the sector such as nurses, social workers, and community health workers. However, many of the social- and community health workers could not be retained afterwards. The HWSETA reacts with a strategy to support them to develop social entrepreneurial skills.
- The decrease in output of nurses is critical, therefore the support to the education and training of nurses remains a critical priority.

Chapter 4:

- Partnerships with training institutions, employers, and statutory bodies are structured to provide multiple entry points into work.
- The focus on WIL is important in this sector and aligned to the ERRP.
- 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 the M&E approach and the extent to which M&E has been institutionalised both as technical competency and a system is conducted. Using the HWSETA's three key development priorities, a plan of action to strengthen M&E will be accompanied by program reflection sessions to see what interventions could be implemented to improve our work, this critical to our mitigation measures.

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 the 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) Implementation of skills development initiatives linked to the ERRP.

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 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 61 outlines the key challenges that exist in these 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
		Nursing and Ambulance Colleges	The high drop-out rate in nursing colleges
			Transformation of nursing colleges 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 work placement 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

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 2023/2024 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 2023/2024

Strategic outcome-orientated goals of the HWSETA
Research, monitoring, evaluation, and impact system of the HWSETA provide a credible skill planning and evaluation system that ensures that its funding initiatives yield a good impact in the strategic period.
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.
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.
The HWSETA provides quality assurance services for the health and welfare sector that ensures quality in occupational education and training during the strategic period.
The HWSETA supports the growth of the public college system so that public colleges may qualify as a centre of specialisation in the strategic period
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 contributes to the improvement of the 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.
8. The HWSETA contributes to increased access, by the unemployed, into occupationally directed programmes of the health and welfare sector in the strategic period.
9. The HWSETA supports officials from NGOs, NPOs, and Trade Unions to strengthen governance and service delivery, and thus advance social, rural, and community development in the strategic period.
10. 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, NSDP, ERRP, and Presidential Youth Employment Initiative, 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 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. Furthermore, HWSETA's partnerships with employers, public education institutions, and private training providers are being strengthened for the integration of education and training. Priority is given to funding projects that support economic transformation through inclusivity, and supporting skills development initiatives of SMEs, NGOs/NPOs, and cooperatives. Priority is also given to new skills that may be emerging due to the 4IR; as a result, the HWSETA undertook research to understand the current level of exposure and adoption to 4IR. The outcome of the research is applied in planning interventions that relate to 4IR. Table 63 shows the link between the NSDP outcomes, the ERRP, and the HWSETA's skills priorities.

Table 6-3 Alignment of NSDP and ERRP outcomes and HWSETA skills development priorities

NSDP	ERRP	HWSETA skills development priorities
Identifying and increasing the production of occupations in high demand	N/A	Conduct extensive research to understand changing skills needs in general Engage with stakeholders, training providers, employers & key role-players Monitor and track the performance of skills development partners & learners
Increase access to occupationally directed programmes	Updating or amending technical and vocational education programmes (intervention 2)	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 which will also advance the objectives of the Presidential Youth Employment Initiative
Supporting the growth of public colleges as key providers of skills required for socio-economic development	N/A	Support learners in pre-apprenticeship training Support vocational training of unemployed learners at TVET colleges
Linking education and the workplace	Access to workplace experience (Intervention 5)	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 (WIL) which will also advance the objectives of the Presidential Youth Employment Initiative
Supporting skills development for entrepreneurship and cooperative development	N/A	Provide funding to address the skills development needs of NGOs and cooperatives Support unemployed social workers, social auxiliary workers and community development workers to become social entrepreneurs
Improving the level of skills	Increased access to programmes resulting in qualifications in priority sectors (intervention 3)	Support adult education & opportunities to enhance the career 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
Supporting career development services	N/A	Career guidance initiatives market occupations in the health and social development sector
Encouraging and supporting worker-initiated training	Retraining/up-skilling of employees (intervention 7)	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; White Paper for Post-School Education and Training; National Health Insurance in South Africa (Bill); 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; National Integrated Early Childhood Development Policy, Draft Social Service Practitioners Bill; National Environmental Health Policy; Policy Framework and Strategy Municipal Ward-based Primary Healthcare Outreach Team; Industrial Policy Action Plan, the New Growth Plan, the National Skills Accord and the Economic Reconstruction and Recovery Skills Strategy.

6.3.4. HWSETA skills priority actions for the period 2024/2025

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. In addition, the HWSETA will adopt programmes and projects to enable an increased inflow of skills for occupations in demand and skills scarcity in the sector. In

particular, the HWSETA will contribute to the provision of essential and specialised skills for 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.

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:

- Supporting skills development needed to implement the NHI system;
- Supporting public TVET colleges to improve on-site practical and vocational training capacity.
- Advancing the production of health professionals, especially nurses, 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.
- Implementing skills development initiatives linked to the ERRP.

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 are identified, planned, and supported under the ERRP.

The plan of action is premised on HWSETA's strategic stance of monitoring outputs and outcomes towards the pursuit of the desired impact. In this regard, special focus would be on the improvement of the sustainable pipeline from substantial progress towards achievement or overachievement against set targets.

This will entail increasing the number of the reached sample through various efforts through the Tracer study going forward. The Work-based learning (WBL) programmes will enforce strong internal controls in collecting contact details (personal cellular number and personal email addresses) of the beneficiaries to increase reached sample of the Tracer study.

6.4. CONCLUSION

This Chapter outlined the broad skills development priority areas and actions for the health and social development sector over the period 2024/2025. 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.
- Vital skills and skills set required to enable the state to meet its service delivery obligations as a developmental state; and
- Implementation of skills development initiatives linked to the ERRP.

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SECTORAL PRIORITY OCCUPATIONS AND INTERVENTION LIST 2024-2025

SETA NAME	PERIOD	OCCUPATION CODE	OCCUPATION	SPECIALISATION ALTERNATIVE TITLE	INTERVENTION PLANNED BY SETA	NQF LEVEL	NQF ALIGNED	QUANTITY NEEDED	QUANTITY TO BE SUPPORTED BY SETA
HWSETA	2024/2025	2021-532903	Nursing Support Worker	Assistant in Nursing/Hospital Aide/Nurses' Aide/ Paramedical Aide	Learnership Diploma in Nursing	6	Y	847	423
					Higher Certificate in Nursing	5			424
HWSETA	2024/2025	2021-226201	Hospital Pharmacist	Hospital Chemist/ Clinical Pharmacist/Health Service Pharmacist	Masters of Pharmacy	9	Y	277	14
					Post graduate Diploma in Hospital Phramacy Management	8			74
					Bachelor of Pharmacy	8			37
HWSETA	2024/2025	2021-222116	Nursing Manager	Nurse Unit Manager/Charge Nurse/Charge Sister	Master in Nursing Science	9	Y	103	8
					Bursary: Nursing Science	7			24
HWSETA	2024/2025	2021-221204	Obstetrician and Gymaecologist	Child Birth Specialist	Master of Medicine in Obstetrics and Gynaecology	9	Y	58	9
HWSETA	2024/2025	2021-321104	Sonographer	Cardiac Ultrasound Technical/ Ultrasonographer	Post graduate Diploma in General ultrasound	9	Y	57	4
					Master of Diagnostic Ultrasound	8			16
HWSETA	2024/2025	2021-213110	Medical Scientist	Clinical Biochemist/ Microbiologist (Medical Research)/ Clinical Research Associate	Masters Health Science in Biomedical Science	9	Y	54	3
					Bachelor of Health Science Molecular and Medical	8			8
					Bachelor of Science Medical Sciences	7			8
HWSETA	2024/2025	2021-134101	Child Care Centre Manager	Early Childhood Development Centre Manager/ Child Care Centre Director	OC: Child and Youth Care Worker	5	Y	47	23
					OC: Early Childhood Development Pactitioner	4			24
HWSETA	2024/2025	2021-134101	Emergency Medicine Specialist	Emergency Physician	Master of Emergency Care	9	Y	43	3
					Bachelor of Health Science in Emergency Care	8			7
HWSETA	2024/2025	2021-221212	Forensic Pathologist	Forensic Pathologist	Master of medicine in Forensic Pathology	9	Y	35	5
HWSETA	2024/2025	2021-221212	Ophthalmologist	Medical Eye Specialist/ Ophthalmic Optician	Masters in Medicine in Ophthalmology	9	Y	18	3

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