2023 - 2024

SECTOR SKILLS PLAN

Health and Welfare Sector
Education and Training Authority
HWSETA

SECTOR SKILLS PLAN (SSP)

FOR THE HEALTH AND SOCIAL DEVELOPMENT SECTOR IN SOUTH AFRICA

SUBMITTED TO THE DEPARTMENT OF HIGHER EDUCATION AND TRAINING BY
THE HEALTH AND WELFARE SECTOR EDUCATION AND TRAINING AUTHORITY
SUBMISSION SSP 2023-2024

FOREWORD

The Health and Welfare Sector Education and Training Authority (HWSETA) is pleased to present its 2023-2024 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 2022 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 programs with socio-economic development priorities of government and the country as stated in the New Growth Path (NGP), the National Development Plan (NDP) 2030, the Medium-Term Strategic Framework (MTSF), 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 effects of COVID-19 in the sector as the health and social development sector is on the frontline of fighting the pandemic. The Sector Priority Occupations (SPO) List for this year's update will therefore aim to support the sector in fighting against the spread of this pandemic and its effects.

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

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

The HWSETA is committed to working with workers, employers, government departments, and communities to move South Africa closer to the goal of 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 AND ACRONYMS

AAG	Average Annual Growth
AHPCSA	Allied Health Professions Council of South Africa
AIDS	Acquired Immune Deficiency Syndrome
APP	Annual Performance Plan
AQP	Assessment Quality Partner
ATR	Annual Training Reports
CBO	Community-Based Organisation
CDW	Community Development Worker
CET	Community Education and Training
CHE	Council on Higher Education
CHW	Community Health Worker
CIP	Continuous Improvement Plan
CMS	Council for Medical Schemes
CPD	Continuous Professional Development
CYCW	Child and Youth Care Worker
DBE	Department of Basic Education
DHET	Department of Higher Education and Training
DoH	Department of Health
DSD	Department of Social Development
ECD	Early Childhood Development
EISA	External Integrated Summative Assessment
ERRP	Economic Reconstruction & Recovery Plan
FET	Further Education and Training
FETC	Further Education and Training Certificate
GBV	Gender Based Violence
GET	General Education and Training
GWM&ES	Government-wide Monitoring and Evaluation System
HASA	Hospital Association of South Africa
HEI	Higher Education Institution
HEMIS	Higher Education Management Information System
HET	Higher Education and Training
HIV	Human Immunodeficiency Virus
HPCSA	Health Professions Council of South Africa
HPRS	Health Patient Registration System
HRDC	Human Resources Development Council
HRH	Human Resources for Health
HTFV	Hard-To-Fill-Vacancies
HWSETA	Health and Welfare Sector Education and Training Authority
IHME	Institute for Health Metrics and Evaluation
ILO	International Labour Organization
MTEF	Medium Term Expenditure Framework
NEI	Nursing Education Institution
NHA	National Health Act, 61 of 2003
NHI	National Health Insurance
NHLS	National Health Laboratory Services
NPC	National Planning Commission
NPO	Non-Profit Organisation
NQF	National Qualifications Framework
NSDP	National Skills Development Plan
NC	National Certificate
NCV	National Certificate (Vocational)
NDP	National Development Plan
NGO	Non-Governmental Organisation
NGP	New Growth Path
OFO	Organizing Framework for Occupations
OHSC	Office of Health Standards Compliance
PHC	Primary Healthcare
PIVOTAL	Professional, Vocational, Technical and Academic Learning
PPE	Personal Protective Equipment
PSETA	Public Service Sector Education Training Authority
PSET	Post-school Education and Training System
QCTO	Quality Council for Trades and Occupations
RIME	Research, Information, Monitoring, and Evaluation
RPL	Recognition of Prior Learning
SACSSP	South African Council for Social Services Professions
SANC	South African Nursing Council
SANDF	South African National Defence Force
SAPC	South African Pharmacy Council
SASSA	South African Social Security Agency
SASSETA	Safety and Security Sector Education and Training Authority
SAVC	South African Veterinary Council
SAW	Social Auxiliary Worker
SDA	Skills Development Act
SDL	Skills Development Levy
SIC	Standard Industrial Classification of all Economic Activities
SITA	State Information Technology Agency
SSP	Sector Skills Plan
Stats SA	Statistics South Africa
TB	Tuberculosis
TVET	Technical and Vocational Education and Training
UNDP	United Nations Development Programme
WBL	Work-based learning
WHO	World Health Organisation
WIL	Work Integrated Learning
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 345 825 filled positions in the Public Service health and social development departments and 432 880 in the private sector bringing total employment in the sector to approximately 778 705. Professionals and technicians and associate professionals, respectively form 37% and 22% 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 organized and mobilized within the formal health and social development sector.

A unique feature of the sector is that most of the healthcare practitioners, social services professionals, and para-professionals are regulated by professional councils. Statutory professional bodies play a formative role in determining the scope of practice for professionals and specialist occupations. 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 organizations to offer social services on its behalf. However, these organizations 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. This year the COVID-19 pandemic is flagged again as a critical change driver adding to the stress factors already mentioned.

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

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

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

The key skills issues that fall within the HWSETA ambit are: skills interventions needed to build the developmental state; the development and sustainment of 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 health and social service professionals. The high vacancy rates are caused by, among others, inadequate occupational wages and wage differentials between different components

of the sector, poor working conditions, 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.

Other factors impacting skills supply in the sector include long lead times required to train health professionals; constrained academic and clinical training capacity; a slow graduate output for the health-related occupations; changes in the qualification frameworks of some occupations such as nurses; 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 the health workforce and deficient leadership contribute to a high attrition rate in the health professions. Another labour market challenge relates to skills provision and skills absorption, e.g. social worker scholarships boosted graduate output in the last few years, but budget constraints in the public and private sectors hamper employment of many of the newly qualified professionals. However, the government made more funds available during the COVID-19 pandemic to employ additional social workers and community health workers. Hopefully, these human resources will be retained after the COVID-19 pandemic has ended.

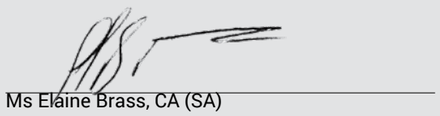
The institutional capacity for education and training of health and social service professionals has been boosted in the past few years. A new medical school was opened at the University of Limpopo in 2016, large numbers of medical students have been sent for training to Cuba, the training of nurses has been moved to a higher education platform and new qualifications for mid-level workers have been developed under the QCTO. Although these new developments are not without challenges and 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 current circumstances in the COVID-19 pandemic have 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 sees 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) 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 needs and gaps in the time of the COVID-19 pandemic with its consequences have influenced the nature of work while aggravating mental illness, domestic violence, addiction, and childhood trauma.

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. However, implementation of ERRP took 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 AND 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. However, the DHET requires SETAs to do personal interviews with a selected number of employers according to an interview schedule developed by the Department. The findings of these interviews are incorporated into the SSP update where appropriate. The demand-side study covers the private and public health and social development sectors as well as a portion of animal health.
The following datasets and data sources are analyzed in the demand-side analysis project:

- The Workplace Skills Plan (WSP) submissions to the HWSETA (2022)
- The WSP submissions to the PSETA (health and social development departments) (2022)
- The Medpages database (2022)
- Discretionary grant applications submitted to the HWSETA (2021-2022)
- DHET employer interviews (2021 and 2022)
- HWSETA interviews with specific stakeholders (2018-2022)

This study is conducted every year from May to July and the results are usually incorporated in the second submission of the SSP. A significant number of large public and private organisations requested an extension for the submission of WSPs which means that the demand data was only available in June and updated in the second submission end of July 2021.

Although NGOs and NPOs, which are exempted from levy payments and who had not submitted WSPs are excluded from this year's analysis, the HWSETA does assist 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.

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 (2020) [1]
- HWSETA 's information on occupational qualifications (2021)

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

4) COVID-19 pandemic research

In addition, the HWSETA in 2021 also conducted two research studies on COVID-19. The first one was on Sector skills planning during the COVID-19 pandemic: A case of the health and welfare sector. This study aimed to provide background to the COVID-19 pandemic in the sector. It addresses the following: likely effects of the pandemic on the health and social development sector; the effect on the sector skills planning process; skills development interventions in the sector to be affected by the pandemic; partnerships to mitigate the effects of COVID-19 in addressing skills priorities. Another study was on the Effects of covid-19 in the Health and Welfare Sector: A Descriptive Analysis on Job Losses and skills dynamics. This study aimed to explore the effects of COVID-19 on job losses and skills dynamics within the Health and Social Sector. In 2022, a study was conducted between April and July on the effect of COVID-19 on shop stewards in the South African health and social development sectors.

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

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

Table 1-0 Summary of research process and methods: Data sources					
Topic	Nature (design) of the study	Objectives of the study	Data collection methods and 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.	HWSETA Levy Payers HWSETA WSPs Submissions 2022 PSETA WSP Submissions 2022 Medpages Database March 2022	Levy-paying Organisations in HWSETA – 12 172, WSP Submissions – 1850, Individual employee records – 206 838, PSETA WSP Submissions – 20 Departments Medpages database – 92 914 records	Current SSP submission reflects data as of May 2022
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.	HEMIS Data (DHET) 2019 (most recent) Professional council registers (May-June 2022)	6 Statutory Professional Councils Voluntary Professional Bodies	May-June 2022
3. Desktop study on Sector kills planning during the COVID-19 pandemic: A case of the health and welfare sector	Desktop	This study aims to provide background to the COVID-19 pandemic in the sector and to look at: 1) likely effects of the pandemic on the health and social development sector and the effect on the sector skills planning process 2) skills development interventions in the sector to be affected by the pandemic 3) partnerships to mitigate the effects of Covid-19 in addressing skills priorities adding Covid-19 research projects to the research agenda	Desktop review	N/A	May 2021
4. Effects of Covid-19 in the Health and Welfare Sector: A Descriptive Analysis on Job Losses and skills dynamics	Mixed Method	1)To establish if there was any workforce change since the beginning of the COVID-19 outbreak within the health and social sector 2)To establish the different change drivers since the beginning of COVID-19 3)To explore implications of the COVID-19 to skill development 4)To explore the effects of COVID-19 on skills needs post-Covid 19 pandemic	Secondary data Structures questionnaires	450 organisations	March 2021-June 2021

Topic	Nature (design) of the study	Objectives of the study	Data collection methods and data sources	Sample size and scope	Timeframe
5. The delivery of Occupational Education and Training through eLearning	Mixed Method	1)To establish the state of preparedness of SDPs to implement the HWSETA eLearning Guidelines 2)To establish progress made by SDPs that had started implementing the HWSETA eLearning guidelines 3)To find out the challenges that caused some SDPs not to be able to implement the HWSETA eLearning guidelines at all	Structured Survey (Web-based) Semi-structured Interview Document Analysis	406 HWSETA Accredited SDPs	July 2021-September 2021
6. A benchmarking exercise on how the Recognition of Prior Learning is implemented in the post-school education sector	Qualitative	1)To establish how other organizations in the PSET are implementing RPL, and the cost (also for the disabled) and hours associated with their RPL process 2)To establish the number of students that have successfully completed their RPL assessments and gained access to the universities 3)To establish how universities respond to the development component of addressing inequalities of the past in South Africa using RPL 4) To provide a comparison between learnerships and RPL in terms of success as well as the dropout rate	Document Analysis Semi-structured Interviews	15 key informants on RPL	October-2021-January 2022
7. Trend analysis of Hard-to-Fill-Vacancies	Quantitative	1)To quantify the distribution of occupational shortages (HTFV) in the health and welfare sector 2)To explore the skills levels associated with occupational shortages (HTFV) in the health and welfare sector 3)To quantify the severity of occupational shortages in the health and welfare sector 4)To ascertain the key reasons explaining the occupational shortages (HTFV) in the health and welfare sector 5)To locate sub-sector, organizational type, and size mostly affected by occupational shortages in the health and welfare sector	WSP & ATR submissions ATR 2019/20, 2020/21, 2021/22	2 485 WSPs & ATRs	March 2021-June 2021

Topic	Nature (design) of the study	Objectives of the study	Data collection methods and data sources	Sample size and scope	Timeframe
8. HWSETA NPO training needs analysis for skills planning	Quantitative	1)To profile the labour market of the NPO workforce between 2018 and 2020 2)To identify the training needs for the NPO sector between 2018 and 2020 3)To assess the association between the training needs and the NPO employment profile (employed and unemployed) between 2018 and 2020 4)To assess the association between the training needs and the area of NPO operation between 2018 and 2020	NPOs that participated in both work skills survey (WSS), work skills plan (WSP) and annul training report (ATR) for 2018, 2019 and 2020	2612 NPOs	July 2021-September 2021
9. Conceptual framework of the AET Programme - Implications for the HWSETA	Mixed Method	1)To assess the conceptualization of the AET Programme in South Africa 2)To assess the conceptualization of the AET Programme within the HWSETA 3)To explore the HWSETA's design of implementation based on the conceptualization of AET	Seta Quarterly Management Reporting database (SQMR); Document Analysis and Focus Group Interview with key informant under CET Colleges	-3779 Leaners who entered the HWSETA-funded AET programme from 2018/19 to 2020/21 financial year -7 participants from the Focus Group Interview	October-2021-January 2022
10. HWSETA Track and Tracer Study: Unemployed (Post-Graduate Bursary, Under-Graduate Bursary, learnerships, and internship Programme) 2021/22	Quantitative	1) To determine the destinations of learners who have completed HWSETA Programmes 2) To determine the nature of employment of learners who received employment 3)To determine the progression of employed learners who participated in the HWSETA Programmes.	Computer Assisted Telephonic Interviews (CATI) (Sample framework: Seta Quarterly Management Reporting database (SQMR) and SETMIS)	1 607 learners who entered and completed HWSETA learning or work experience Programmes	June 2021-May 2022
11. HWSETA Track and Tracer Study: Employed (Learnership, Under-graduate, and Post-graduate Bursary) 2021/22	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	Computer Assisted Telephonic Interviews (CATI) (Sample framework: Seta Quarterly Management Reporting database (SQMR) and SETMIS	120 learners who completed HWSETA learning or work experience in bursaries and learnerships	January 2022

Topic	Nature (design) of the study	Objectives of the study	Data collection methods and data sources	Sample size and scope	Timeframe
12. HWSETA Track and Tracer Study: TVET WIL and University WIL 2021/22	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	Computer Assisted Telephonic Interviews (CATI) (Sample framework: Seta Quarterly Management Reporting database (SQMR) and SETMIS)	308 learners who completed HWSETA TVET and University WIL Programmes	January 2022
13. Outcomes Evaluation measuring improved performance by lecturers due to skills development initiatives funded by the HWSETA	Quantitative	1) To determine the competence or level of performance of lectures after exposure to the skills training programme 2) To determine the degree to which lecturers have acquired the intended knowledge, skills, and abilities after training 3) To determine the degree to which the lecturers' performance has improved (behaviour) following a training intervention 4) To determine lecturers' experiences towards the skills training programme	Telephonic Interviews and Online surveys	36 beneficiaries	April-May 2022
14. Investigating the effects of COVID-19 on shop stewards in the health and social development sector	Quantitative	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 development sector about the skills shortage in trade unions in light of the direct and indirect challenges posed by the effects of COVID-19; and 3) To explore experiences of shop-stewards from trade unions in the health and social development sector regarding the barriers to access required skills to respond to the effects of COVID-19.	Online surveys	441 shop stewards as respondents	April-July 2022

Topic	Nature (design) of the study	Objectives of the study	Data collection methods and data sources	Sample size and scope	Timeframe
15. Assessing the exposure and adoption of the Fourth Industrial Revolution (4IR) in the health sector while highlighting implications for skills development.	Mixed Method	1) To assess the level of exposure of the Fourth Industrial Revolution (4IR) 2) To assess the level of adoption of the Fourth Industrial Revolution (4IR) 3) To assess whether the level of exposure and adoption created skills gaps as either opportunities or threats 4) To assess whether the level of exposure and adoption changed the nature of work in terms of tasks and occupations	Telephonic Interviews, focus groups, and Online surveys	Healthcare professionals survey [82] Employer survey [20] Organization interviews [6] Focus group discussions [33]	April-July 2022
16. Assessing the current and historical trends of the internal and external migration of healthcare professionals in the in the health sector	Mixed Method	1) To assess the current and historical trends in internal migration and external migration in South African health sector created skills gaps as either opportunities or threats 2) To assess whether the current and historical trends in internal migration and external migration in South African health sector 3) To identify appropriate skills intervention responses emanating from the current and historical trends in internal and external migration in South African health sector	Telephonic Interviews, focus groups, and Online surveys	Healthcare professionals survey [5600] Employer HR Managers [3] Organization/associations interviews [4]	April-July 2022

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 (2022) and Estimates of National Expenditure of National Treasury (2022), the PSETA and HWSETA WSP data (May 2022 submissions), and data from Medpages (May 2022).

1.2 SCOPE OF COVERAGE

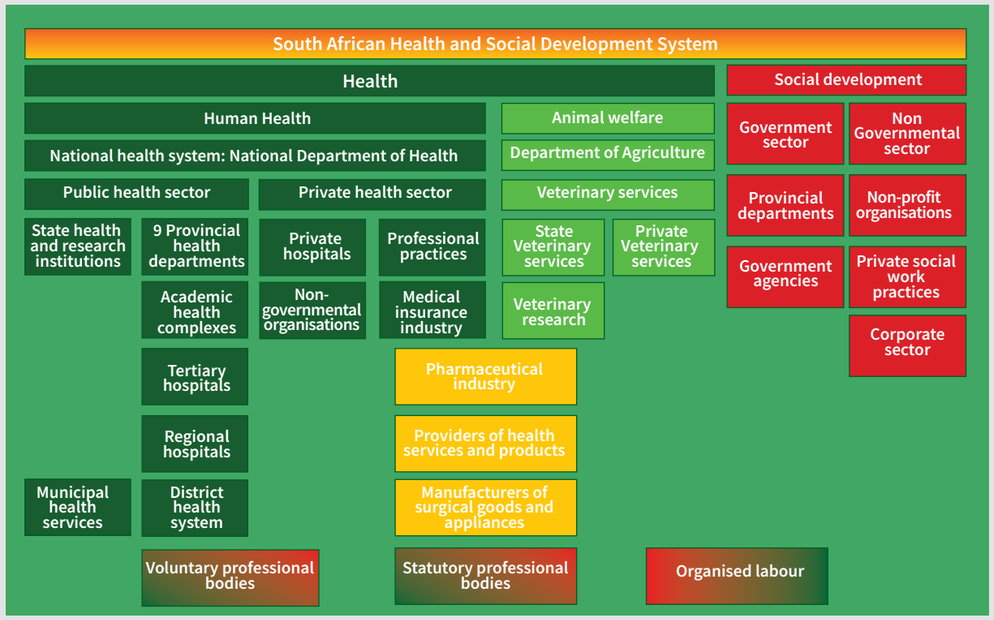
The HWSETA's sector comprises economic activities from five sections of the Standard Industrial Classification of all Economic Activities (SIC) i.e. Manufacturing (C), Wholesale and retail trade (G); Professional, scientific and technical activities (M), Public administration, and defence and compulsory 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 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.



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, research- and training institutions, post-school institutions (CETs, TVETs, nursing colleges, and universities), other government departments (i.e. Department of education and agriculture), and South African Revenue Service (SARS). 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
Provincial Departments of Health and Social Development Municipal Health Services Government Agencies	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)
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) Statutory professional bodies Voluntary professional bodies	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
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 post-school institutions (CETs, TVETs, nursing colleges, and universities)	Conducting sector-relevant, related research which results in high levels of skills development -aligned with outcome 3 of the NSDP Provide the supply training capacity to meet the demands of the health and social development sector labour market.
SARS	Ensures the administration of the revenue generation for the SETA as per Skill Development Levy to encourage learning and development in South Africa.

1.4 ECONOMIC PERFORMANCE

1.4.1 Sector's contribution to the economy

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

The sector makes a significant contribution to train health professionals, nurses, and social workers. To this end, an amount of R2.1 billion has been allocated over the next two financial years for medical interns and R5.4 billion for the current year to support various aspects of the training of health professionals in the different provinces (National Treasury 2022b).

The global economic effects of the COVID-19 pandemic are far-reaching and will likely be long-lasting. In South Africa, the large increase in unemployment and income losses have entrenched existing inequalities; there were 2.1 million fewer jobs in the third quarter of 2021 than in the final quarter of 2019 (National Treasury 2022a). 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 the support. The latter, which were initiated to provide short-term support for low-income households in 2020, was extended to the end of March 2023 and R44 billion has been allocated in 2022/23 in this regard (National Treasury 2022a). Another R15.6 billion is made available to provincial health departments to support their continued response to the COVID-19 pandemic and to bridge shortfalls in essential goods and services. (National Treasury 2022a).

The figure below shows industry growth in South Africa for the fourth quarter of 2021 in comparison to the third quarter of 2021 (Stats SA 2022). The public health and social development services form part of the Government sector, private health and social development services are part of the sector called personal services, retail pharmacies fall under trade while manufacturing of pharmaceuticals, medicinal chemical, and botanical products form part of the manufacturing sector. In terms of public health and social development activity, the Government sector contracted with 0.4%. Personal services, which include private health-related activities, showed increased activity probably from the national vaccination programme. Various hospitals also recorded a rise in non-COVID-19-related patient admissions in the fourth quarter.

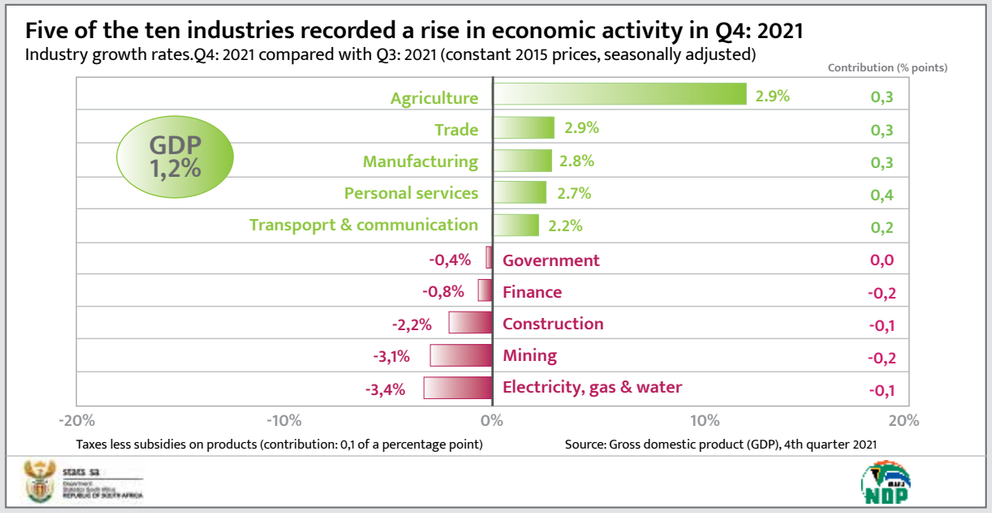


Figure 2 Industry growth in the 4th quarter of 2021 in comparison with the 3rd quarter in 2021
Source: Stats SA 2022

1.4.2 Current economic performance

Healthcare expenditure comes from three sources; general tax revenues finance the public sector, while medical schemes and out-of-pocket payments finance private care. Public sector health and social development budgets respectively account for 12.0% (R259.0 billion) and 16.9% (R364.4 billion); in total 28.9% (R623.4 billion) of government expenditure (see figure below for comparison with other key sectors in the public domain) (National Treasury 2022a).

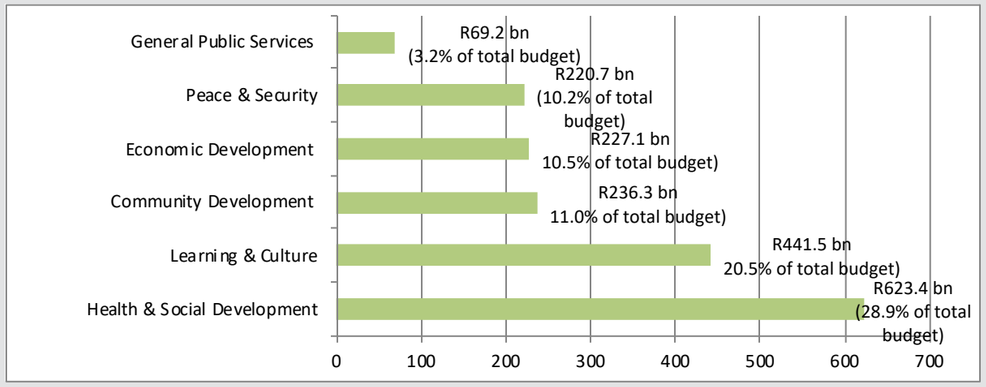


Figure 3 Health and Social Development proportion of the budget (public sector), 2022
Source: National Treasury 2022a, 2022b

The 2022 Budget again meets urgent pandemic-related spending pressures, such as expanding the public employment initiative, continuing social and economic relief measures, and supporting health services. An amount of R44.0 billion is allocated in 2022/23 to extend the special COVID-19 social relief of distress grant for 12 months (until March 2023) and another R21.1 billion is allocated to provincial health departments to support their continued response to the COVID-19 pandemic, the appointment of medical interns and community service doctors, and to bridge any shortfalls in essential goods and services (National Treasury 2022a).

In terms of social development, provinces received R3.5 billion in 2021/2022 from the Department of Social Development through the early childhood development grant to improve access to quality early childhood development services (National Treasury 2021b). In this regard the HWSETA has a significant role to play in terms of building ECD capacity; it is the lead SETA to the upskilling of ECD Practitioners, fulfilling the request of the ERRP Skills Strategy in 2021/22 (HWSETA 2021). However, from 2022/23 the early childhood development function will be shifted from social development to the basic education sector. Over the three-year spending period, an annual average of R1.2 billion will be shifted from the Department of Social Development to the Department of Basic Education as responsibility for early childhood development shifts across these departments (National Treasury 2022a).
The South African Social Security Agency (SASSA) is going to pay social grants to 18.6 million beneficiaries (excluding recipients of the special COVID-19 social relief of distress grant) in 2022/23 (National Treasury 2022a). This is the largest anti-poverty programme in Southern Africa (DSD 2021). The total number of grant beneficiaries will increase by an average annual rate of 1.5%, from 18.4 million in 2021/22 to 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 2020, a total of R199.1 billion was collected in risk contributions from members, compared to R186.7 billion in 2019, and expenditure on relevant healthcare services was reported at R162.0 billion, compared to R169.1 billion in 2019. On average, medical schemes incurred a much lower claims experience compared to 2019. The claims ratio, decreased significantly from 90.6% in 2019 to 81.4% in 2020. This resulted in a net healthcare result of R19.9 billion compared to R1.03 billion in 2019 (CMS 2021). All three of South Africa's hospital groups reported increased activity again, including expansion initiatives (Moneyweb 2022, Daily Maverick 2022).

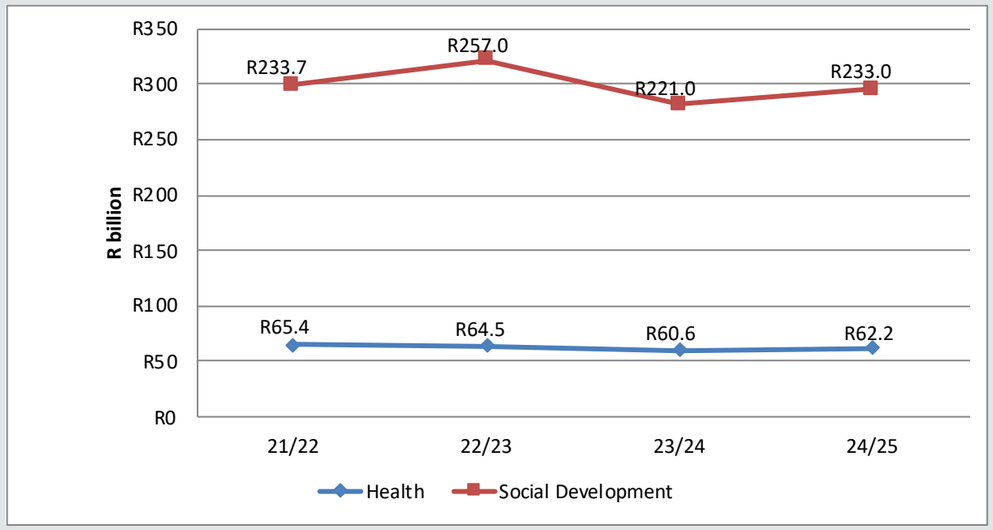
In terms of investment income and net results for medical schemes, it is reported that the investment income positively contributed to a net surplus of R24.9 billion in 2020, compared to a net healthcare result of R19.9 billion. The higher net healthcare results together with the investment yields had a positive effect on the overall reserves of medical schemes during 2020/21, increasing by 33.6%, reaching R97.9 billion (CMS 2021).

1.4.3 Future outlook

The government estimates that health expenditure will decrease at an average annual rate of 1.7%, from R65.4 billion in 2021/22 to R62.2 billion in 2024/25 (see figure below). This is the result of once-off allocations for the COVID-19 response in 2021/22 and baseline reductions effected over the 2021 MTEF period (National Treasury 2022b).

Social development expenditure is expected to decrease by an average of 0.1% over the period, from R233.7 billion in 2021/22 to R233 billion in 2024/25, mainly as a result of the special COVID-19 social relief of distress grant being discontinued in April 2023 (see figure below). New allocations in this budget include R44 billion to extend the special COVID-19 social relief of distress grant until March 2023, R13.1 billion for inflation-related increases in social grants, and R1.6 billion to introduce an extended child support grant for double orphans in the care of relatives.

Figure 4 Health and Social Development expenditure trends and estimates (public sector), 2021/22-2024/25



Source: National Treasury 2022b

South Africa has experienced four waves of COVID-19 infections and is now in the fifth wave, placing significant pressure on the country's health system and its budgets. In responding to the COVID-19 pandemic the immediate focus remains on the pandemic

including further rolling out of the government's vaccination strategy which aims to have vaccinated 70% of the adult population by March 2023. However, there will also be an ongoing focus on implementing the NHI, preventing and treating communicable and non-communicable diseases, investing in health infrastructure, supporting tertiary health care services, and developing the health workforce. In terms of the NHI an amount of R8.8 billion is allocated to related activities over the MTEF period, R6.5 billion of which goes through the NHI indirect grant. Concerning preventing and treating communicable and non-communicable diseases, a total of R84 billion is allocated over the medium term through the district health programmes grant.

Developing the health workforce remains a crucial priority; an additional allocation of just over R3.0 billion is therefore available over the MTEF period through the human resources and training grant, setting its total allocations to R7.8 billion. Important to note that this includes improving the quality of nursing education by supporting all nine provincial health departments to develop training plans for nurses and midwife specialists by March 2023; the sufficient supply of nurses remains a national concern (National Treasury 2022b).

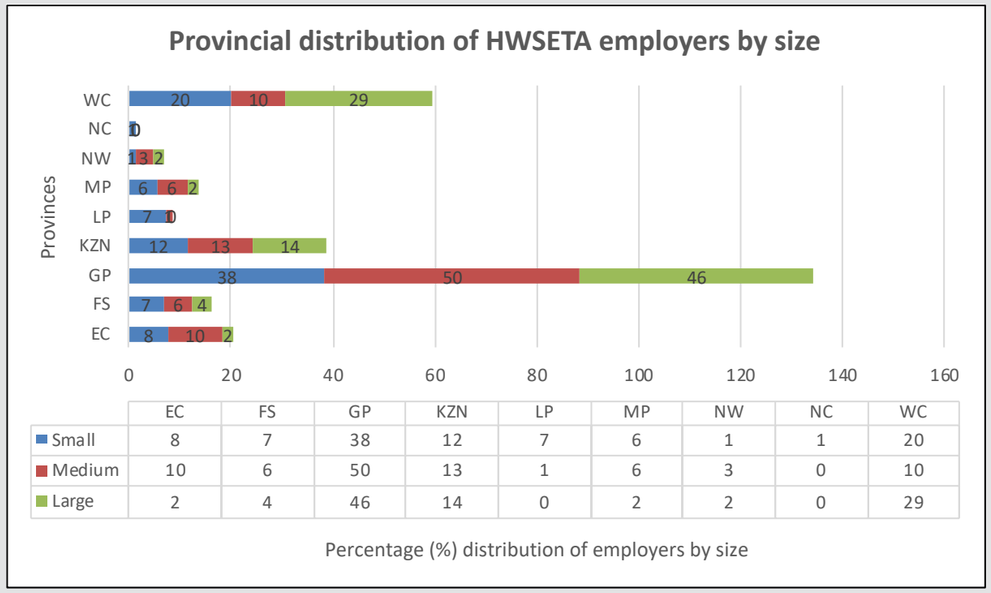
Overall, public sector budgets reflect that health and social spending programmes are given priority, despite pressure on resources (National Treasury 2022a). There is a direct relationship between spending (in the public and private sectors) and the demand for workers. Public sector budgets are major 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. Although public sector health and social development budgets are the second largest of total government expenditure, it is not clear what future funding will look like given the current economic challenges in South Africa.

1.5 EMPLOYER PROFILE

1.5.1 Overview

The health and social development sector is heterogeneous in many ways. The size and type of organizations 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 Figures 1-7.

In contrast, most of the organizations in private health are small: 82% of the organisations in private health fall within the category that is generally known as "small organisations". Medium size organisations with 50 to 149 employees make up 10% of the organisations in the private sector and large organisations constitute 8%. However, large organisations such as hospitals and pharmacy groups employ more than half of the workers in private health. Employers can be broadly grouped into community services; complementary health services; doctors and specialists; hospitals and clinics; and research and development institutions. In the 2021/2022 financial year, 12 172 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 12 172 organisations submitting paying their skills development levies, only 1 850 submitted WSPs. 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.



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

Figure 5 Provincial distribution of employers in the private sector by size
Source: HWSETA WSP submissions 2021.

1.5.2 Non-Profit Organisations

Much of the health-related community-based care in South Africa is provided by non-profit organisations (NPOs), and 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 (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. This indicates a worsening human resource capacity for training and decreasing number of employees in the NPO workforce. As reported in the HWSETA study in 2015, the NPO workforce remains predominantly female, African, and at educational levels equivalent to intermediate levels.

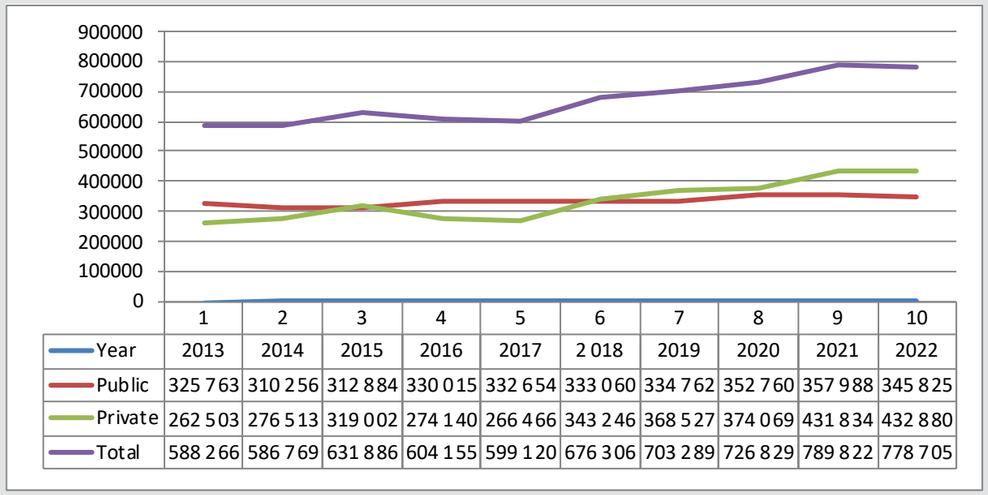
Social services rendered by NPOs include services such as homes and specialised services for handicapped persons; geriatric care, in-home services, and specialised youth services. In the health sector, NPOs contribute to research, education, policy advocacy, and development and care in areas such as 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 2022 as well as data furnished to the HWSETA from the private Medpages database of March 2022. The data analysis provided information on 778 705 people who are formally employed in the health and social development sector. Of these, approximately 432 880 (55%) are employed in private sector organisations (referred to later as the "private sector") and levy-paying public sector organisations, while 345 825 (45%) work in the public service departments.

Estimates of total employment in the health and social development sector can be seen in Figure 6. Employment in the public service component of the sector increased from 325 763 in 2013 to 345 825 in 2022. The average annual growth of employment in the public sector was only 0.6% over the 2013 to 2022 period. There was a slight drop (3%) in employment from 2021 to 2022 in the public sector. The private sector component of the sector, on the other hand, showed an average annual growth of 5.7% over the 2013 to 2021 period from 262 503 to 432 880 respectively. There was a slight increase (0.2%) in employment from 2021 to 2022 in the private sector. The average annual growth for the total sector (public and private) was 3.2% over the same period. The growth in employment in the sector is expected due to the COVID-19 demands for human resources to provide health and social welfare services to the population.



	1	2	3	4	5	6	7	8	9	10
Year	2013	2014	2015	2016	2017	2 018	2019	2020	2021	2022
Public	325 763	310 256	312 884	330 015	332 654	333 060	334 762	352 760	357 988	345 825
Private	262 503	276 513	319 002	274 140	266 466	343 246	368 527	374 069	431 834	432 880
Total	588 266	586 769	631 886	604 155	599 120	676 306	703 289	726 829	789 822	778 705

Figure 6 Health and social development sector: Total employment 2013-2022
Source: Calculated from HWSETA and PSETA WSPs 2013 -2022, Medpages data 2013 -2022.

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.

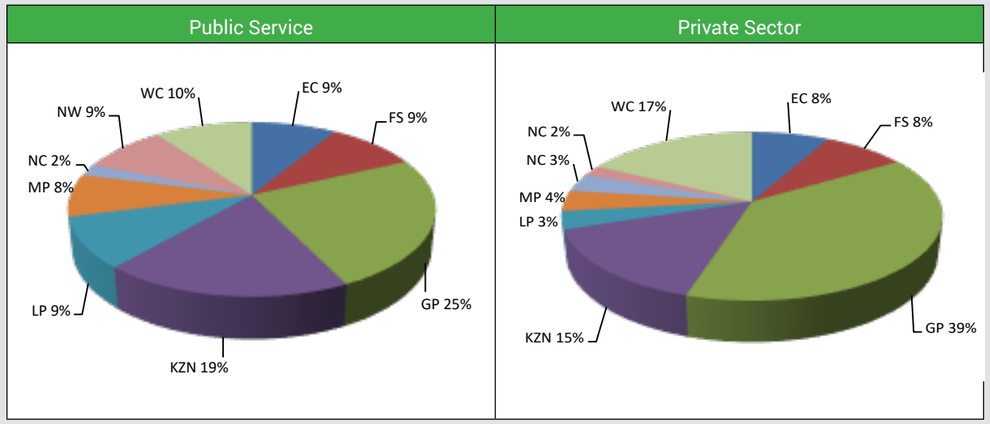


Figure 7 Provincial distribution of employment in the public service and private health sector: 2022
Sources: Calculated from HWSETA and PSETA WSPs 2022

1.6.3 Occupational distribution of employment

Currently, professionals and technicians and associate professionals comprise 60% of total employment in the public service and 58% 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.

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

Table 1-3 Public Service and private sector employment per occupational group: 2022

Occupational Group	Public Service		Private Sector		Total Sector	
	Number of employees	%	Number of employees	%	Number of employees	%
Managers	13 234	4	41 868	10	55 102	7
Professionals	135 633	39	151 788	35	287 421	37
Technicians and Associate Prof	72 226	21	99 494	23	171 720	22
Clerical Support Workers	47 532	14	55 008	13	102 540	13
Service and Sales Workers	52 392	15	47 694	11	100 086	13
Skilled Agricultural, Forestry, Fishery, Craft, and Related Trades Workers	1 222	0.4	4 003	1	5 225	1
Plant and Machine Operators and Assemblers	2 657	1	7 323	2	9 980	1
Elementary Occupations	20 929	6	25 702	6	46 631	6
Total	345 825	100	432 880	100	778 705	100

Sources: Calculated from HWSETA and PSETA WSPs 2022, Medpages data 2022.

1.6.4 Population group

More than two-thirds (70%) of the health and social development sector employees are African (Table 1-4). In the Public Service, 80% of the workforce is African compared to 61% in the private sector. Whites form around 5% of the Public Service workforce compared to 20% in the private sector.

Table 1-5 shows the population group distribution in the different occupational groups in 2022. In the Public Service, 80% and more of clerical support workers, service and sales workers, craft and related trades, plant and machine operators and assemblers, and elementary occupations were African respectively, 77% professionals, and technicians and associate professionals respectively, and 58% managers. In private health, 55% of professionals and 59% of technicians and associate professionals were African, while 74% of service and sales and 87% of elementary occupations were filled by Africans. In the total sector, 76% of all managers were black[2] , while more than 80% filled the positions across all the other occupational groups respectively.

[2]African, Coloured and Indian.

Table 1-4 Health and social development sector: Total employment by population group 2015-2022

	2015		2016		2017		2018		2019		2020		2021		2022	
Public Service	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
African	256 564	82	269 571	82	271 926	82	274 685	82	281 646	84	279 945	79	286 150	80	276 011	80
Coloured	30 124	10	31 784	10	36 644	11	32 017	10	27 454	8	43 878	12	42 853	12	43 655	13
Indian	8 891	3	10 325	3	5 884	2	8 874	3	8 730	3	9 058	3	9 145	3	7 411	2
White	17 305	6	17 721	5	17 860	5	17 484	5	16 932	5	19 879	6	19 840	6	18 748	5
Non-South African			614		340											
Total	**312 884**	**100**	**330 015**	**100**	**332 654**	**100**	**333 060**	**100**	**334 762**	**100**	**352 760**	**100**	**357 988**	**100**	**345 825**	**100**
Private sector	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
African	143 339	53	136 254	50	138 563	52	181 413	53	210 247	57	214 272	58	266 087	62	265 325	61
Coloured	37 651	14	44 378	16	37 605	14	48 462	14	52 376	14	54 685	15	51 646	12	56 443	13
Indian	16 146	6	17 253	6	16 188	6	23 577	7	19 869	5	20 208	5	30 826	7	24 765	6
White	71 402	27	76 255	28	74 110	28	89 794	26	86 034	23	84 904	23	83 276	19	86 347	20
Non-South African	706	0														
Total	**269 244**	**100**	**274 140**	**100**	**266 466**	**100**	**343 246**	**100**	**368 527**	**100**	**374 069**	**102**	**431 834**	**100**	**432 880**	**100**
Total sector	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
African	399 903	69	405 825	67	410 489	69	456 098	67	491 893	70	494 217	70	552 237	70	541 336	70
Coloured	67 775	12	76 162	13	74 249	12	80 479	12	79 830	11	98 563	14	94 499	12	100 098	13
Indian	25 037	4	27 578	5	22 072	4	32 451	5	28 599	4	29 266	4	39 971	5	32 176	4
White	88 707	15	93 976	16	91 970	15	107 278	16	102 966	15	104 783	15	103 116	13	105 095	13
Non-South African	706		614		340											
Total	**582 128**	**100**	**604 155**	**100**	**599 120**	**100**	**676 306**	**100**	**703 289**	**100**	**726 829**	**103**	**789 822**	**100**	**778 705**	**100**

Sources: Calculated from HWSETA and P|SETA WSPs 2015- 2022, MedPages data 2015-2022.

Table 1-5 Population group distribution according to the occupational group: 2022

Occupational Group	African		Coloured		Indian		White		Total	
Public Service	N	%	N	%	N	%	N	%	N	%
Managers	7 673	58	3 257	25	661	5	1 643	12	13 234	100
Professionals	104 222	77	14 831	11	4 475	3	12 105	9	135 633	100
Technicians and Associate Professions	55 383	77	12 991	18	1 145	2	2 707	4	72 226	100
Clerical Support	39 535	83	5 890	12	613	1	1 494	3	47 532	100
Service and Sales	48 322	92	3 307	6	323	1	440	1	52 392	100
Skilled Agricultural, Forestry, Fishery, Craft, & Related Trades	1 004	82	153	13	35	3	30	2	1 222	100
Plant and Machine Operators and Assemblers	2 202	83	344	13	84	3	27	1	2 657	100
Elementary Occupations	17 670	84	2 882	14	75	0	302	1	20 929	100
Private sector	N	%	N	%	N	%	N	%	N	%
Managers	24 610	59	3 063	7	2 736	7	11 460	27	41 868	100
Professionals	83 180	55	15 574	10	11 837	8	41 196	27	151 787	100
Technicians and Associate Professions	58 653	59	14 208	14	6 410	6	20 224	20	99 495	100
Clerical Support	29 931	54	9 506	17	2 960	5	12 611	23	55 008	100
Service and Sales	35 276	74	8 613	18	840	2	2 965	6	47 694	100
Skilled Agricultural, Forestry, Fishery, Craft, & Related Trades	2 875	72	537	13	185	5	406	10	4 003	100
Plant and Machine Operators and Assemblers	5 070	69	1 034	14	599	8	620	8	7 323	100
Elementary Occupations	22 374	87	2 367	9	287	1	674	3	25 702	100
Total Sector	N	%	N	%	N	%	N	%	N	%
Managers	32 283	59	6 320	11	3 397	6	13 103	24	55 102	100
Professionals	187 402	65	30 405	11	16 312	6	53 301	19	287 420	100
Technicians and Associate Prof	114 036	66	27 199	16	7 555	4	22 931	13	171 721	100
Clerical Support	69 466	68	15 396	15	3 573	3	14 105	14	102 540	100
Service and Sales	83 598	84	11 920	12	1 163	1	3 405	3	100 086	100
Skilled Agricultural, Forestry, Fishery, Craft, & Related Trades	3 879	74	690	13	220	4	436	8	5 225	100
Plant and Machine Operators and Assemblers	7 272	73	1 378	14	683	7	647	6	9 980	100
Elementary Occupations	40 044	86	5 249	11	362	1	976	2	46 631	100

Sources: Calculated from HWSETA and PSETA WSPs 2022, MedPages data 2022.

1.6.5 Gender

Table 1-6 shows the gender distribution in the sector from 2014 to 2022. 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 Health and social development sector: gender distribution 2014-2022

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

Sources: Calculated from HWSETA and PSETA WSPs 2014-2022, MedPages data 2014-2022.

Females are in the majority in all occupation groups, except for the groups: Plant and Machine Operators and Assemblers and Skilled Agricultural, Forestry, Fishery, Craft and Related Trades, which includes occupations such as delivery drivers and artisans which are mostly filled by males (Table 1 7).

Table 1-7 Gender distribution according to the occupational group: 2022

Occupational Group	Male		Female		Total	
Public Service	N	%	N	%	N	%
Managers	5 267	40	7 967	60	13 234	100
Professionals	30 345	22	105 288	78	135 633	100
Technicians and Associate Prof	21 012	29	51 214	71	72 226	100
Clerical Support	14 507	31	33 025	69	47 532	100
Service and Sales	14 863	28	37 529	72	52 392	100
Skilled Agricultural, Forestry, Fishery, Craft, and Related Trades	998	82	224	18	1 222	100
Plant and Machine Operators and Assemblers	2 039	77	618	23	2 657	100
Elementary Occupations	7 053	34	13 876	66	20 929	100
Private sector	N	%	N	%	N	%
Managers	16 088	38	25 780	62	41 868	100
Professionals	42 137	28	109 651	72	151 787	100
Technicians and Associate Prof	23 313	23	76 181	77	99 494	100
Clerical Support	15 368	28	39 641	72	55 008	100
Service and Sales	11 530	24	36 164	76	47 694	100
Skilled Agricultural, Forestry, Fishery, Craft, and Related Trades	3 376	84	627	16	4 003	100
Plant and Machine Operators and Assemblers	6 123	84	1 200	16	7 323	100
Elementary Occupations	8 509	33	17 193	67	25 702	100
Total Sector	N	%	N	%	N	%
Managers	21 355	39	33 747	61	55 102	100
Professionals	72 482	25	214 939	75	287 420	100
Technicians and Associate Prof	44 325	26	127 395	74	171 720	100
Clerical Support	29 875	29	72 666	71	102 540	100
Service and Sales	26 393	26	73 693	74	100 086	100
Skilled Agricultural, Forestry, Fishery, Craft, and Related Trades	4 374	84	851	16	5 225	100
Plant and Machine Operators and Assemblers	8 162	82	1 818	18	9 980	100
Elementary Occupations	15 562	33	31 069	67	46 631	100

Sources: Calculated from HWSETA WSPs 2022, PSETA WSPs 2021, MedPages data 2022.

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 2022. The overall age profile remained relatively stable in the Public service over the period with people under 35 forming between 25-32% of the workforce and people older than 55 constituting 10-14% of the workers over the period. The percentage of employees younger than 35 years in the private sector is markedly higher – around 37-41% over the period.

Table 1-8 Health and social development sector: age distribution 2014-2022

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

Sources: Calculated from HWSETA and PSETA WSPs 2014-2022, MedPages data 2014-2022.

The 2022 age distribution of employees in the health and social development sector by the occupational group is given in Table 1-9. In the public sector, 10% of the professionals are over the age of 55 compared to 14% in the private sector. The larger numbers of people under the age of 35 in the private sector are concentrated in the occupational group's Services and Sales (41%), Clerical Support (40%), and Technicians and Associate Professionals (39%).

Table 1-9 Age distribution of employees in the Public Service and private health according to the occupational group: 2022

Occupational Group	Under 35		35 to 55		Older than 55		Total*	
Public Service	N	%	N	%	N	%	N	%
Managers	2 534	19	8 452	64	2 263	17	13 249	100
Professionals	37 194	28	84 324	63	13 002	10	134 520	100
Technicians and Associate Prof	21 288	29	42 430	59	8 522	12	72 240	100
Clerical Support	12 209	28	25 461	59	5 404	13	43 074	100
Service and Sales	10 199	19	36 131	69	6 050	12	52 380	100
Skilled Agricultural, Forestry, Fishery, Craft, and Related Trades	116	9	815	67	291	24	1 222	100
Plant and Machine Operators and Assemblers	649	24	1 426	54	582	22	2 657	100
Elementary Occupations	3 549	17	14 648	70	2 734	13	20 931	100
Private sector	N	%	N	%	N	%	N	%
Managers	11 069	27	24 102	59	5 739	14	40 909	100
Professionals	31 837	33	49 904	52	14 882	15	96 623	100
Technicians and Associate Prof	36 186	39	45 962	50	9 988	11	92 136	100
Clerical Support	21 859	40	27 299	50	5 380	10	54 539	100
Service and Sales	19 611	41	23 449	49	4 518	9	47 578	100
Skilled Agricultural, Forestry, Fishery, Craft, and Related Trades	1 032	26	2 027	51	888	22	3 947	100
Plant and Machine Operators and Assemblers	2 266	31	3 621	50	1 321	18	7 208	100
Elementary Occupations	8 539	33	14 067	55	2 903	11	25 509	100
Total sector	N	%	N	%	N	%	N	%
Managers	13 603	25	32 554	60	8 002	15	54 158	100
Professionals	69 031	30	134 228	58	27 884	12	231 143	100
Technicians and Associate Prof	57 474	35	88 392	54	18 510	11	164 376	100
Clerical Support	34 068	35	52 760	54	10 784	11	97 612	100
Service and Sales	29 810	30	59 580	60	10 568	11	99 958	100
Skilled Agricultural, Forestry, Fishery, Craft, and Related Trades	1 148	22	2 842	55	1 179	23	5 169	100
Plant and Machine Operators and Assemblers	2 915	30	5 047	51	1 903	19	9 865	100
Elementary Occupations	12 088	26	28 715	62	5 637	12	46 440	100

Sources: Calculated from HWSETA WSPs 2022, PSETA WSPs 2021, MedPages data 2022.

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

1.6.7 Disability

In 2022, 0.7% of the workers in the sector were people with disabilities. Of the 1 651 workers with disabilities in the Public Service, 102 (7%) were employed as managers, 380 (27%) as professionals, 206 (15%) as technicians and associate professionals, and 600 (42%) as clerical support workers. Of the 3 442 workers with disabilities in the private sector 464 (13%) were employed as managers, 865 (25%) as professionals, 560 (16%) as technicians and associate professionals, 940 (27%) as clerical support workers and 432 (13%) as service and sales workers.

1.7 CONCLUSION

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

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

A large proportion of the organisations in private health are small (employ fewer than 50 people), while large organisations (150 and more employees) employ the majority of the workforce. Formal employment in the health and social development sector is estimated at just over 778 000, with 55% employed in private sector organisations and 45% working in public service departments. For the HWSETA it is important to balance the needs of the small and the large organisations and those of the public and private sector components of its sector. The average annual growth for the total sector was 3.2% over the 2013-2022 period. The growth in employment in the sector from 2020 to 2022 was expected in light of the immediate COVID-19 demand for 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. However, the COVID-19 pandemic needs again special reference as it continues to pose major challenges to the sector. The second part of the chapter deals with the implications of national strategies and plans for skills planning in the sector. Because of the COVID-19 pandemic, the focus has been on the EERP, the Economic Reconstruction and Recovery Skills Strategy, and the revised MTSF. The data sources that were used in this chapter included a desktop review and interviews with key stakeholders in the sector.

2.2 CHANGE DRIVERS

2.2.1 COVID-19 pandemic

"The 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 Organization (ILO) estimated that nearly half of the global workforce is at risk of losing livelihoods (ILO 2020). The expanded unemployment rate of South Africa in the 4th quarter of 2021 confirms this; 42.6% (Stats SA 2022).

While the lockdown had a significant impact on many sectors of the economy's workforce, the findings of a study conducted by HWSETA in 2021 on the *'effects of COVID-19 in the health and Welfare Sector: A Descriptive Analysis on Job Losses and skills dynamics'* revealed that Covid-19 did not affect the health sector workforce in terms of retrenchment. This is explained by some organizations' ability to avoid layoffs and hire more people. This is also confirmed by another study conducted by HWSETA in partnership with Workers College on the *'effects of COVID-19 on shop stewards and workers in the SA'* Health and Social sector which revealed a similar trend that in the health sector covid-19 had no major effect on the workforce in terms of retrenchments. Even though the social sector has been impacted by major budget cuts and changes in funding initiatives. Covid-19 was also listed as the major change driver in both these studies as it came with certain changes in the regulations and subsequently affected organisational operations. Thus, the skilling and upskilling of the workforce remains crucial in the sector.

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

2.2.2 Overall change drivers for health and social services

a) Challenging socio-economic realities

Challenging socio-economic realities drive the need for public health services and social development interventions in South Africa. Poverty affects the majority of South Africans and vast social inequalities continue to persist (National Treasury 2021a). Despite a general decline in poverty between 2006 and 2011, poverty levels rose again in 2015. More than half of South Africans were poor in 2015, with the poverty headcount increasing to 55.5%. This means that over 30.4 million South Africans were living in poverty in 2015 (Stats SA 2017). 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 2022), showing the effect of the COVID-19 pandemic. DSD is going to pay over 18.6 million social grants to beneficiaries in 2022/2023, and it is expected that this number will reach 19.2 million in 2024/2025 (National Treasury 2022a). These realities increase the demand for public health and social welfare services and contribute to the already excessive workloads of public health and social welfare workers.

b) High burden of disease

Good health reduces poverty, improves educational performance, increases productivity, and as a result, stimulates economic growth. The high burden of disease in South Africa hampers economic growth and development. In 2021 an estimated 8.2 million people in South Africa were living with HIV/AIDS (Stats SA 2021). South Africa has one of the highest tuberculosis (TB) incidences in the world, with more than 360 000 new cases diagnosed in 2019 (WHO 2020). Maternal- and infant mortality rates remain high (Stats SA 2021) while the burden of disease is exacerbated by factors such as an aging population and the rising incidence of chronic diseases and obesity (CMS 2019). However, given the high mortality levels among the elderly during the COVID-19 pandemic, the growth rate among the elderly aged 60 and over drastically declined from 2.9% for the period 2019–2020 to 1.5% for the period 2020–2021 (Stats SA 2021). In addition, persons with existing diseases are very susceptible to COVID-19. These factors increase the demand for health services and the need for more healthcare workers at all levels. The strategies implemented by the government to counter the burden of disease are some of the major change drivers in the health and social development sector.

c) High levels of interpersonal violence and other social crimes

High levels of interpersonal violence have thrust the injury death rate of 1 393.2 per 100 000 populations to more than double the global average and necessitate the provision of wide-ranging and integrated preventative and remedial social services (IHME 2019). Excessive substance abuse adds to the social burden. The COVID-19 pandemic made the situation worse for women, especially during the lockdown period. Organisations such as Rise Up Against Gender-Based Violence (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). Skilled professionals are needed to provide these specialized services.

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

Shifting service demands and technological progress necessitate changes to the scopes of practice of some professions and occupations in the sector. As a result, existing practitioners require new 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. More health professionals require training in rural and community settings to meet local needs, while academics involved in health professional education need further training to teach on expanded training platforms (Stakeholder Interviews 2020, 2021).

e) Advanced professionalism and practice standards

The statutory councils controlling the health and social services professions are driving measures to advance professionalism and practice standards across the professions. Healthcare and social services practitioners (HPCSA 2017; SACSSP 2019) are required to engage in mandatory accredited continuing professional development (CPD) to retain their registration status (i.e. the statutory authority to practice in a particular field). 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). Legislation and social development programmes aim to progressively expand the reach of social security provision and to care for children in particular; the child grant, the new extended child support grant for orphans (National Treasury 2022a), and the focus on ECD is evident. These measures have a major impact on the obligations, duties, and skills mix of the social development workforce.

c) Review of the White Paper for Social Welfare

While the White Paper for Social Welfare originally served as a guideline document for the social development sector, a review of the White Paper was initiated by the Minister of Social Development, and the review report was published 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 has exacerbated this problem tremendously; although more social workers were recruited and deployed in 2020, the high levels of stress and heavy workloads continue amongst this group of professionals.

2.2.4 Specific change drivers in health

a) National Health Insurance

The first phase in implementing the NHI, which will provide citizens with universal access to a defined package of health care services, was pilot programmes running in key districts around the country since 2012. The White Paper was published in 2017, and the National Health Insurance Bill was approved by Cabinet in July 2019 and sent to Parliament to be tabled. It has since been subjected to an extensive public consultation process and is scheduled for further parliamentary debates before it is presented to the president for promulgation. The second phase includes the development of systems and processes for the effective functioning of the health system, and the third phase will be the introduction of mandatory prepayment for the NHI, contracting for accredited private hospital and specialist services, finalisation and implementation of the Medical Schemes Act and finalisation and implementation of the NHI Act. Progress has also been made in terms of the Health Patient Registration System (HPRS) with 57 million individuals registered in 3 111 public health facilities (DoH 2019a).

A very important driver of change will be the provision and maintenance of sufficient skills to implement the NHI. The success of the NHI will depend on the skills of health workers in general, who are trained to offer all levels of care, from primary health care to 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 (Stakeholder Interview 2019). The role of the HWSETA is crucial in this regard. Partnerships have already been established with all provincial governments to train their staff on the governance of the NHI. The COVID-19 pandemic has also shown that the public and private health sectors can cooperate, which is an important factor to ensure the success 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 2020). The DoH indicated that they underscored the importance of HRH in both the Reconstruction and Development Programme and the 1997 White Paper for the Transformation of the Health System and that HRH is critical in achieving global mandates such as Universal Health Coverage and the implementation of the NHI system (DoH 2020). The review focused on specific issues to address blockages within the education and training and skills development pipeline. Over the years several different HRH interventions were implemented addressing issues such as staffing norms and skills mix; recruitment and retention of staff; training and educational reforms; information for workforce planning; and leadership and organisational culture (van Ryneveld 2020). However, the HRH crisis remains and 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).

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 is 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) 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.

d) 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). Virtual care, which digitizes services to create a real-time healthcare system, has already been introduced in the private health sector, including telehealth services, remote patient monitoring, and virtual critical care unit solutions. Furthermore, a study conducted by HWSETA (2021 and 2022) confirms this, demonstrating that COVID-19 has increased the demand in the workplace for digital skills and emerging occupations such as telemedicine. This highlights the significance of continuing to upskill and reskill the existing workforce. Another study on the level of exposure and adoption of 4IR in the health sector conducted by HWSETA (2022) revealed that various organizations have made significant capital investments in 4IR. According to the study, the most used technologies in the health sector are, to name a few, telemedicine, E-patient, and computer-Aided dispatch systems. The findings also revealed that job losses in the health sector are unlikely to occur as a direct result of 4IR technology advancement. The study revealed that COVID-19 accelerated the adoption of 4IR technologies even though challenges such as financial constraints, legislative environment barriers, and lack of appropriate skills of the workforce persists. Further, the institutional reaction-time of Higher education and PSET institutions in incorporating technologies into curriculum has seen more non-accredited programmes and short courses to up-skill or provide top-up skills to staff.

e) Migration

The study conducted in 2022 assessing the current and historical trends of the internal and external migration of healthcare professions shows increasing levels of emigration from 2016 to 2019 before declining in 2020. The latter is explained by the COVID-19 lockdown regulations. The biggest proportion of those emigrating, according to the study survey sample, is specialist medical practitioners and general medical practitioners. These healthcare professionals, in the main, emigrate to UK, Australia, and New Zealand. Importantly, the two occupational categories 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.

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 Plan (APP) for 2021-2022; 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).

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

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

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

2.3.3 Provincial Plans and Programmes

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

2.3.4 White Paper for Post-School Education and Training

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

2.3.5 National Skills Development Plan 2030

The National Skills Development Plan (NSDP) 2030 derives from both the NDP and NGP with the mission "to ensure that South Africa has adequate, appropriate and high-quality skills that contribute towards economic growth, employment creation, and social development" (DHET 2019). The role of SETAs regarding the demand and supply of skills is again emphasised in the plan. The NSDP focuses on the following outcomes through the activities of the SETAs: (i) identifying and increasing 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.

2.3.6 2030 Human Resources for Health Strategy: The Case for Investing in the Health Workforce

The HRH strategy was already mentioned in section 2.3. However, the March 2020 version asks for a major mind shift; the need to appreciate that the health workforce is an investment, rather than an expenditure item. The strategy argues that a healthy workforce is the following: a key driver of inclusive economic growth; an investment, contributing to decent work and job creation, particularly for women and youth in rural and underserved communities; and at the heart of an efficient and well-functioning health system when empowered with the optimum skills mix, distribution, competencies, standards, support, and motivation to deliver essential services (DoH 2020). In terms of skills, the strategy states that there can be no delivery of universal health care and NHI without a skilled, enabled, and supported health workforce; it outlines a health workforce plan to ensure that HRH is aligned with current and future skills needs.

2.4 IMPLICATIONS FOR SKILLS PLANNING

In a resource-constrained environment with enormous demands for health care and social services, South Africa needs to develop skills to deliver cost-effective health care and social development interventions. The HWSETA cannot meet the vast spectrum of skills and has to prioritise skills development interventions. The key skills issues that fall within the HWSETA ambit are the following: First, the HWSETA has to support skills interventions needed to build the developmental state. In this regard, the HWSETA will assist national efforts to expand the numbers of health professionals needed to provide all levels of care under the NHI and facilitate skills development. Second, the HWSETA will continue to focus on skills development interventions required for 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 health and social development service providers. Fifth, the HWSETA also has a responsibility to respond to skills gaps in the current workforce brought about by changes in policy and service delivery; technological developments; skills shortages driven by legislative changes, the human rights-based development agenda, and health pandemics like COVID-19.

2.5 CONCLUSION

National and provincial policies and strategic development agendas are aligned with the NDP and in changing the way social services and human- and animal health care are accessed and delivered. The needs and service expectations of the primary health care and social development systems are expanding and have necessitated changes to the skills base of the workforce. Pandemics like COVID-19 emphasise the importance for government to include such occurrences in their strategic development planning. The ERRP will remain a primary driver in the sector for the next couple of years. 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 (PIVOTAL list). The data sources that were used are the PSETA and HWSETA WSP data, HEMIS data from DHET, and the data of the various professional bodies in the sector.

3.2 HARD-TO-FILL VACANCIES

One of the clearest indicators of skills shortages is vacancies that remain unfilled for long periods despite employers' active recruitment efforts. The employers that submitted WSPs to the HWSETA and the PSETA reported a total of 7 138 hard-to-fill vacancies. These vacancies were distributed over 213 occupations. Almost two-thirds (64.0%) of these vacancies were for professionals and almost a third (30.2%) for technicians and associate professionals (Table 3-1).

Table 3-1 Hard-to-fill vacancies according to Occupational Group

Occupational Group	Private	Public	Total	%
Managers	259	11	270	3.8
Professionals	3 307	1 264	4 571	64.0
Technicians and Associate Professionals	2 103	55	2 158	30.2
Clerical Support Workers	91	0	91	1.3
Service and Sales Workers	13	1	14	0.2
Skilled Agricultural, Forestry, Fishery, Craft, and Related Trades Workers	4	15	19	0.3
Plant and Machine Operators and Assemblers	1	12	13	0.2
Elementary Occupations	2	0	2	0.0
Total	5 780	1 358	7 138	100.0

Sources: Calculated from HWSETA and PSETA WSP submissions 2022.

The occupations, in which more than 20 vacancies were reported (as presented in Table 3-2), account for 18% (24/213) of all hard-to-fill vacancies reported by employers from HWSETA and PSETA WSP submissions. From the figures presented in the table, it is clear that both the public and private health sectors suffer from a severe shortage of registered nurses, medical doctors, specialists, and pharmacists. The national shortage of nurses remains a risk (Businesstech 2022). The reason for the huge shortage of nurses is due to the change in the nursing qualifications; the nursing training institutions only started training on the new qualifications in 2020. 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. In 2021 employers also reported that the reason for the scarcity of registered nurses (medical) and nursing support workers was the resignation of staff due to the COVID-19 pandemic; nurses in South Africa were battling under the strain of the pandemic and the effect is still visible. Other occupations where shortages are experienced are, for example, retail pharmacists in the private sector and hospital pharmacists in the public sector, radiographers and sonographers, clinical psychologists, and social service managers. It is interesting to note the need for some organisations to secure ECD teachers or practitioners; this is positive as it relates to the priority given to ECD in terms of the ERRP.

It should be noted that not all occupations listed below will have a SETA intervention aligned to them as the budget is limited to programmes where there are occupations with the highest vacancies and high-demand occupations are prioritised. Although, employers are encouraged to submit separate applications for training programmes they wish to implement within their organisations. Attraction and retention of scarce skills in the sector remains a critical imperative.

Table 3-2 Hard-to-fill vacancies according to occupation

OFO Occupation		Private	Public	Total	Reasons														
					Old qualification was terminated/ Pool became smaller	Limited numbers trained	Scarcity due to COVID-19	Scarcity of people with required qualifications	Unsafe working conditions	Lack of experience	High turnover rate	Scarcity in area/geographic location	Funds for training not available	ERRP intervention				
2021-222108	REGISTERED NURSE (MEDICAL)	2 255	49	2 304		X	X	X		X	X	X							
2021-322101	ENROLLED NURSE	1 572		1 572	X					X		X	X						
2021-226203	RETAIL PHARMACIST	437		437				X		X									
2021-221101	GENERAL MEDICAL PRACTITIONER	7	379	386				X				X							
2021-222101	CLINICAL NURSE PRACTITIONER	72	148	220		X						X							
2021-263508	CHILD AND YOUTH CARE WORKER		182	182								X							
2021-222101	CLINICAL NURSE PRACTITIONER		148	148				X				X							
2021-222105	REGISTERED NURSE (CRITICAL CARE AND EMERGENCY)	90	27	117				X		X									
2021-222104	REGISTERED NURSE (COMMUNITY HEALTH)	62		62				X											
2021-222111	REGISTERED NURSE (OPERATING THEATRE)	23	37	60				X				X							
2021-321101	MEDICAL DIAGNOSTIC RADIOGRAPHER	12	45	57				X		X		X							
2021-234201	PRIMARY SCHOOL AND EARLY CHILDHOOD TEACHERS	56		56										X					
2021-341202	DISABILITIES SERVICES OFFICER	55		55				X											
2021-134401	SOCIAL SERVICES MANAGER	39		39						X									
2021-222103	REGISTERED NURSE (CHILD AND FAMILY HEALTH)	2	35	37				X		X		X							
2021-122301	RESEARCH AND DEVELOPMENT MANAGER	36		36				X											
2021-263401	CLINICAL PSYCHOLOGIST	2	30	32				X				X							

OFO Occupation		Private	Public	Total	Old qualification was terminated/ Pool became smaller	Limited numbers trained	Scarcity due to COVID-19	Scarcity of people with required qualifications	Unsafe working conditions	Lack of experience	High turnover rate	Scarcity in area/geographic location	Funds for training not available	ERRP intervention
								Reasons						
2021-221210	GENERAL MEDICINE SPECIALIST PHYSICIAN	5	25	30				X				X		
2021-221103	PUBLIC HEALTH PHYSICIAN		29	29								X		
2021-222117	MIDWIFE	4	22	26				X		X		X		
2021-226201	HOSPITAL PHARMACIST	1	24	25						X		X		
2021-321104	SONOGRAPHER	24		24				X				X		
2021-221204	OBSTETRICIAN AND GYNAECOLOGIST	1	21	22				X				X		
2021-134101	CHILD CARE CENTRE MANAGER	21		21									X	

Sources: Calculated from HWSETA and PSETA WSP submissions 2022.

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 were identified.

3.3.1 Skills gaps in the social sector

Employers in the sector identified the following skills gaps at the high level (managers and professionals), mid-level (technicians, associate professionals, and service workers), and the lower level (elementary occupations) (Stakeholder interviews 2020, 2021). 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. The gaps in terms of work-from-home skills, especially the use of technology are applicable at all levels. However, it is important to note that most of the workers in the sector are working on site (hospitals, clinics, practices, etc.) and it is only the support staff that has the option to work-from-home; most organisations use a hybrid model in this regard (Stakeholder interviews 2021, 2022).

3.3.2 Skills gaps in the social development sector

a) **High-level (managers and professionals)**
- Leadership, team management, and conflict management skills.
- Industrial relations skills.
- Monitoring, evaluation, and impact assessment skills.
- Project management skills tailored to the social services sector.
- Virtual counselling.
- Data analytics.

b) **Mid-level (technicians, associate professionals, and service workers)**
- Communication and business report writing skills.
- Technical monitoring and evaluation skills.
- Time management skills.
- **Computer skills to utilise and maintain computerised information systems.**

c) **Lower level (elementary occupations)**
- Literacy and computer skills.
- Communication skills.
- Understanding of and compliance with policies.
- Occupational health and safety.

3.3.3 Skills gaps in the health sector

a) **High-level (managers and professionals)**
- Leadership and strategic planning skills.
- Business acumen.
- Change and crisis management skills.
- Managing diversity and managing millenniums.
- Emotional Intelligence (EQ) and self-management skills.
- Data analytics.

b) **Mid-level (technicians, associate professionals, and service workers)**
- Interpretation of and compliance with policies skills.
- Computer skills in order to utilise and maintain computerised information systems.
- Coding and Data analysis
- Customer (client) skills.
- Basic nursing skills i.e., focus on the patient and empathy; is found to be even more important now during the pandemic.
- Health and safety.
- Personal financial management.

c) **Lower level (elementary occupations)**
- Literacy and computer skills.
- Communication skills.
- Understanding of and compliance with policies skills.

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 is very positive in terms of skills development and the supply of skills (HWSETA 2020b).

3.4.1 Entry into the health and welfare development sector

Prospective workers enter the sector at different levels, either directly from secondary school, following post-school training, or with little or no formal school training. The positive or negative output from the secondary school system underlies the greater part of 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. 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 due to the COVID-19 pandemic must not be underestimated. One implication may be 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

a) Scope of institutional 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. However, various learning centers in the larger hospital groups are registered as private higher education institutions and TVET colleges. These institutions train nursing staff as well as professionals in emergency and critical care ranging from basic to undergraduate and postgraduate levels. Ancillary healthcare professionals are trained in infection control and as surgical technologists. Several hospital groups support technical training programmes to address shortages in technical skills, such as artisans.

The training of doctors

Historically the training of doctors was undertaken by eight South African medical schools which supply currently just over 1 000 doctors per annum. In January 2016, a new medical school was opened at the University of Limpopo with 60 students as its first intake; these students graduated in April 2022 and will commence their medical internships soon. 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 2019b). Another government intervention aimed at the training of doctors is known as the Nelson Mandela/Fidel Castro Medical Collaboration. This collaboration stems from the shortage of medical doctors in South Africa, in particular in the rural areas. The programme recruits students from rural areas that have a shortage of doctors and sends them to Cuba for medical training; about 5 000 have trained in Cuba since the inception of the programme.

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 higher education institutions (HEIs). The first group of nursing students on the new qualifications started in 2020. However, nursing colleges reported that the disruption of contact education also forced them to apply digital nursing education methods regarding the clinical components (practical); they have to work around the COVID-19 pandemic surges.

Occupational qualifications

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

Training offered by NGOs

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

Workplace training

Most of the occupations that are found in the health and social development sector require workplace training. In some instances, they require work-integrated learning (WIL) where the workplace components form part of the qualifications and in many instances, health professionals 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 or WBE 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.

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 2020 is shown in Table 3 3.

If all the health-related and social welfare fields of study are considered, the total output from the Public HET sector grew on average by 4.2% per annum from 2010 to 2020 at the first three-year B Degree level and 3.9% at the first four-year B Degree level. Over the ten years, most of the professional (four-year) degrees showed a positive average annual growth except for chiropractic, dentistry and oral sciences, somatic bodywork, and related therapeutic services and social work (3-year degree). The output of the first four-year degrees in medicine increased on average by 5.6% per annum over the ten years. Output in social work (4-year degree) has grown on average by 3.2% per year, with a decrease of 22.1% in graduate numbers from 2 049 in 2019 to 1 596 in 2020. The output of the four-year nursing degree has grown on average by 4.2% per annum over the same period, with a decrease of 11.7% in graduate numbers from 1 517 in 2019 to 1 340 in 2020. This is a good example of the interruption of contact education and training due to the COVID-19 pandemic. Many students were not able to meet the clinical/practical requirements of the respective programmes, depending on the duration of the academic interruption.

Table 3-3 Number of health-related and social work qualifications awarded by public HEIs: 2010 to 2020

HEMIS Study Fields	Qualifications	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	AAG (%)
Chiropractic	First Bdegree (4 years)	48	44	52	53	40	45	60	24	44	56	18	-9.3
Communications Disorders Sciences and Services	First Bdegree (3 years)											31	
	First Bdegree (4 years)	114	153	141	134	169	199	202	232	243	256	243	7.9
Dentistry, Advanced Dentistry and Oral Sciences	First Bdegree (3 years)	50	38	52	68	84	82	55	33	36	46	32	-4.4
	First Bdegree (4 years)	212	157	201	177	212	166	205	199	207	210	189	-1.1
Health and Medical Administrative Services	First Bdegree (3 years)	200	179	230	271	235	235	220	212	253	265	334	5.3
	First Bdegree (4 years)	258	290	270	253	91	213	158	358	364	377	257	0.0
Medicine	First Bdegree (3 years)	1	25	40	59	60	39	81	58	51	51	113	60.4
	First Bdegree (4 years)	637	704	660	542	557	847	996	843	1 039	1002	1 097	5.6
Medical Clinical Sciences	First Bdegree (3 years)	55	65	102	141	93	74	72	122	85	57	158	11.1
	First Bdegree (4 years)	1 015	936	999	973	1 024	1 125	941	1162	1 103	1185	1 090	0.7
Nursing	First Bdegree (3 years)	302	271	278	395	364	415	454	316	323	260	320	0.6
	First Bdegree (4 years)	891	958	927	943	1 171	1 159	1 200	1379	1 354	1517	1 340	4.2
Optometry	First Bdegree (3 years)	1											
	First Bdegree (4 years)	127	115	90	81	81	120	127	116	94	160	136	0.7
Pharmacy, Pharmaceutical Sciences and Administration	First Bdegree (3 years)	1			1	0	0	11	11	5	2	0	
	First Bdegree (4 years)	466	509	561	687	723	950	834	878	972	955	961	7.5
Podiatric Medicine/Podiatry	First Bdegree (3 years)												
	First Bdegree (4 years)	6	16	3	13	15	3	31	29	23	37		22.4
Public Health	First Bdegree (3 years)	20	23	63	66	63	246	256	316	97	89	118	19.4
	First Bdegree (4 years)	172	201	210	231	236	246	256	316	254	293	208	1.9
Rehabilitation and Therapeutic Professions	First Bdegree (3 years)	57	52	41	83	90	123	147	124	149	123	122	7.9
	First Bdegree (4 years)	526	555	578	598	633	712	742	728	769	693	758	3.7
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										
	First Bdegree (4 years)	97	86	95	103	98	99	125	125	165	169	145	4.1
Dietetics and Clinical Nutrition Services	First Bdegree (3 years)	16	24	20	7	7	7	4	6				
	First Bdegree (4 years)	110	127	118	124	127	117	166	184	184	160	198	6.1
Alternative and Complementary Medicine and Medical Systems	First Bdegree (3 years)	10	6	7	16	19	10	23	11	26	32	34	13.0
	First Bdegree (4 years)	24	26	28	9	26	18	16	16	31	21	39	5.0
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	-7.7
Movement and Mind-Body Therapies And Education	First Bdegree (3 years)		14	20									
	First Bdegree (4 years)	7	6	6	11	4	15						
Medical Radiologic Technology/Science (Radiography)	First Bdegree (3 years)	29	41	33	43	39	52	44	48	49	84	30	0.3
	First Bdegree (4 years)	77	106	98	125	130	152	192	231	252	378	411	18.2
Clinical Technology	First Bdegree (3 years)												
	First Bdegree (4 years)										10		
Medical Laboratory Sciences	First Bdegree (3 years)												
	First Bdegree (4 years)											1	
Health Professions and Related Clinical Sciences, Other	First Bdegree (3 years)	7			27	80			62				36.6
	First Bdegree (4 years)	11	45	47	161	132	86	80	22	114	126	102	24.9
Social Work	First Bdegree (3 years)	65	85	48	107	126	96	123	125	64	49	30	-7.4
	First Bdegree (4 years)	1 169	1 297	1 671	1 881	2 121	2 362	2 618	2815	2 518	2049	1 596	3.2
Total	**First Bdegree (3 years)**	**874**	**878**	**942**	**1 282**	**1 261**	**1 379**	**1 490**	**1 444**	**1 138**	**1 057**	**1 322**	**4.2**
	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**	**3.8**

Source: HEMIS 2020.

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 17 universities and universities of technology (SANC 2022). 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 2021 can be seen in Table 3-4. A total of 37 257 Professional Nurses qualified with a four-year qualification over the ten years, showing an average annual growth of 1.8%, while another 38 545 Nurses completed the Bridging Programme between 2011 and 2021, showing an average annual growth of 1.9%. The Nursing Education Association (NEA) warns that there is going to be a significant decrease noticeable in output in 2024 at this level due to the phasing-out of the old qualifications (Interview 2022). 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).

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 hospitals in the sector (Interview 2021).

Table 3-4 Number of graduates at NEIs: 2011 to 2021

Program	Number of graduates											
	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	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	1.8
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	-36.8
Pupil Auxiliaries	5 232	5 009	5 909	6 141	5 795	6 726	587	39	29	32	34	-39.6
Total	18 553	19 895	21 415	19 200	21 978	21 459	12 924	8 381	9 029	5 946	7 220	-9.0

**Bridging into the professional nurse category.*

Source: SANC 2022.

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 2021 over 29 400 candidates qualified in qualifications such as Child and Youth Care Work, Social Auxiliary Work, and Community Health Work (Table 3-5).

Table 3-5 Student output in some qualifications overseen by HWSETA: 2013 to 2021

Qualification	Number of students									
	2013	2014	2015	2016	2017	2018	2019	2020	2021	Total
L4: Child and Youth Care Work	521	344	1 113	1 405	376	480	866	899	1119	7 123
L4: Social Auxiliary Work	2 476	1 209	844	713	471	279	979	454	353	7 778
L4: Community Health Work	352	463	644	361	280	191	1279	274	353	4 197
L2: Community Health Work	629	2 418	2 786	1 744	230	584	872	61		9 324
L4: Health Promotion Officer				558	477					1 035
Total	3 978	4 434	5 387	4 781	1 834	1 534	3 996	1 688	1 825	29 457

Source: HWSETA MIS May 2022.

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 indicate growth in the number of professionals available.

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

The HPCSA controls 136 registration categories through twelve professional boards. Table 3-6 shows the registration figures for several key professions over the period 2011 to 2021. Since 2011, the number of registered dentists grew on average by 1.9% per year, medical interns (i.e. medical graduates in training) by 2.0%, and medical practitioners by 2.8%. The ranks of physiotherapists (3.7%), occupational therapists (5.1%), radiographers (2.7%), and psychologists (2.6%) also increased per annum over the period. The number of registered medical technologists increased only slightly (by 1.1% per year) over the total period. The same counts for speech therapists and audiologists; the number only increased by 1.4% per annum.

Table 3-6 Number of selected professionals registered with the HPCSA as at 31 December of 2011 to 2021

Registration category	Number of persons registered											
	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	AAG %
Dentist	5 423	5 652	5 787	6 062	6 126	6 331	6 409	6 430	6 530	6 472	6 553	1.9
Medical Intern	3 862	3 338	3 396	3 279	3 215	3 653	3 780	3 745	4 430	5 370	4 713	2.0
Medical Practitioner	37289	38652	40258	42146	42550	44145	44858	46014	46839	46516	49087	2.8
Medical Technologist	5 552	4 948	5 045	5 350	5 331	5 576	5 616	5 793	5 975	6 088	6 219	1.1
Occupational Therapist	3 668	3 945	4 238	4 569	4 765	4 980	5 174	5 410	5 682	5 718	6 041	5.1
Optometrist	3 168	3 342	3 458	3 628	3 645	3 751	3 773	3 812	3 837	3 899	3 990	2.3
Physiotherapist	5 954	6 328	6 585	7 001	7 122	7 370	7 665	7 856	8 153	8 185	8 536	3.7
Psychologist	7 073	7 245	7 433	7 895	8 047	8 409	8 449	8 770	8 881	8 978	9 106	2.6
Radiographer	6 500	6 225	6 645	7 088	7 239	7 378	7 729	7 794	8 168	8 121	8 489	2.7
Speech Therapist & Audiologist	1 426	1 448	1 448	1 501	1 573	1 519	1 547	1 594	1 612	1 582	1 641	1.4

Source: HPCSA 2022.

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 276 819 in 2021 (Table 3-7). In the period from 2011 to 2021, the average annual growth in registration for all these categories was only 1.5%. Registered nurses increased on average by 2.9%, enrolled nurses by 0.2%, and auxiliaries by -0.2% per year. The decrease in registrations for auxiliaries from 2016 to 2021 (over 9 500, a drop of 24.2%) and enrolled nurses from 2017 to 2021 (over 18 000, a drop of 13.3%) can be expected due to the change in the qualification framework and teach out period of the legacy qualifications; this will even be more noticeable in the next few years. The NEA warns 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 about 24 500 nurses in training at different levels (SANC 2022). 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).

Table 3-7 Number of nurses registered with the SANC: 2011 to 2021

Registration category	Number of persons registered											
	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	AAG %
Registered	118 262	124 045	129 015	133 127	136 854	140 597	142 092	146 791	153 095	154 024	156 784	2.9
Enrolled	55 408	58 722	63 788	66 891	70 300	73 558	74 556	70 552	64 638	61 033	56 490	0.2
Auxiliaries	64 526	65 969	67 895	70 419	71 463	73 301	70 431	68 361	67 104	65 187	63 545	-0.2
Total	238 196	248 736	260 698	270 437	278 617	287 456	287 079	285 704	284 837	280 244	276 819	1.5

Source: SANC 2022.

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

From 2012 to 2022, the average annual growth for registered pharmacists and pharmacist interns was 2.9% and 7.8% respectively (Table 3-8). The registration figures in the support staff categories showed higher growth over this period; Basic Pharmacist Assistants grew by 14.8% annually over the period. The number of people registered in this category grew steadily from 2012 to 2015, more than doubled between 2015 and 2016, and slightly decreased again between 2019 and 2022. Post-basic pharmacist assistants grew at an annual average of 13.1% per year.

Table 3-8 Number of registrations with the SAPC: 2012 to 2022

Registration category	Number of persons registered											
	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	AAG %
Basic Pharmacist Assistant	867	1 184	1 774	1 937	4 898	3 965	4 367	4 293	3 877	4 111	3 457	14.8
Learner Basic Pharmacist Assistant	3 807	4 372	3 500	3 510	3 166	3 080	3 326	3 208	3 110	3 152	3 603	-0.5
Post-basic Pharmacist Assistant	4 533	5 371	6 086	6 713	7 973	10191	11681	13103	13481	14863	15494	13.1
Learner Post-basic Pharmacist Assistant	1 693	1 956	1 849	2 098	2 642	2 084	2 431	2 173	2 170	2 208	2 184	2.6
Pharmacist	12805	13119	13589	13658	14053	14552	15231	15722	16020	16541	17113	2.9
Pharmacist Intern	619	732	808	857	1 045	1 036	1 086	1 082	1 171	1 260	1 316	7.8
Specialist pharmacist	13	13	13	13	13	13	13	11	10	10	10	-2.6
Community Service Pharmacist*					642	806	758	807	813	855	871	5.2
B Pharm student*					3 708	4 183	4 287	4 520	4 013	3 331	3 727	0.1

*Source: SAPC 2022. *From 2016*

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

In 2022 a total of 2 511 people were registered with the AHPCSA (Table 3-9). Since 2012, the total number of registrations dropped on average by 1.6% per year. Generally, allied health professionals and complementary practitioners work in the private sector.

Table 3-9 Total registrations with the AHPCSA: 2012 to 2022

Registration category	Number of persons registered											
	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	AAG %
Acupuncture	113	99	66	64	61	57	54	53	52	44	44	-9.0
Ayurveda doctor	14	15	15	17	17	13	13	12	12	12	10	-3.3
Chinese medicine	156	152	155	156	160	157	153	157	158	146	146	-0.7
Chiropractic	628	647	667	731	773	808	835	877	897	917	930	4.0
Homoeopathy	565	559	557	569	572	581	584	580	573	573	572	0.1
Naturopathy	95	89	91	92	88	86	80	80	77	68	68	-3.3
Osteopathy	49	47	46	40	40	36	37	38	37	33	33	-3.9
Phytotherapy	40	38	40	43	49	51	48	48	49	45	46	1.4
Therapeutic aromatherapy	306	242	222	179	157	131	121	105	98	83	79	-12.7
Therapeutic massage therapy	163	146	138	125	111	103	102	95	94	94	93	-5.5
Therapeutic reflexology	735	662	635	584	535	501	491	446	437	403	427	-5.3
Unani-Tibb	79	70	71	73	74	67	66	69	69	65	63	-2.2
Total	2 943	2 766	2 703	2 673	2 637	2 591	2 584	2 560	2 553	2 483	2 511	-1.6

Source: AHPCS 2022.

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

The number of veterinarians registered with the SAVC grew on average by only 1.9% from 2902 in 2012 to 3 500 in 2022 (Table 3-10). The average annual growth for animal health technicians was 4.0% over this period, veterinary nurses 2.4%, and veterinary technologists 4.8%.

Table 3-10 Number of registrations with the SAVC: 2012 to 2022

Registration category	Number of persons registered											
	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	AAG %
Veterinarians	2 902	3 006	3 102	3 174	3 222	3 340	3 548	3 658	3 718	3 720	3 500	1.9
Veterinary specialists	147	157	164	167	163	184	207	206	205	212	217	4.0
Compulsory Community Veterinary Service											323	
Animal Health Technicians	1 043	1 039	1034	1 004	1 013	1 041	1 205	1 281	1 283	1 372	1 549	4.0
Laboratory Animal Technologists	21	21	20	17	19	17	16	15	19	15	14	-4.0
Veterinary Nurses	573	589	602	611	606	640	709	732	769	719	727	2.4
Veterinary Technologists	246	260	287	280	279	311	334	354	349	358	395	4.8
Veterinary Physiotherapists*										60	65	
Professionals in training	1 926	2 077	2 221	1 635	1 411	1 411	1 655	1 415	1 415	1 252	1 207	-4.6
Total	6 858	7 149	7 430	6 888	6 713	6 944	7 674	7 661	7 758	7 708	7 997	1.5

**New para-veterinary profession*
Source: SAVC 2022.

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

From 2016 to 2022, (Table 3-11), the average annual growth for registered Social Workers, and Social Auxiliary Workers were 6.0% and 5.5% respectively, compared to 8.5% for Child, and Youth Care Workers. There are currently 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. These are positive trends in terms of supplying human resources for the delivery of much-needed social services in South Africa.

Table 3-11 Social Service Professionals and students with the SACSSP. 2016 to 2022

Registration category	Number of persons registered							
	2016	2017	2018	2019	2020	2021	2022	AAG %
Social Workers	27 130	20 017	32 657	33 404	34 569	35 328	38 443	6.0
Social Auxiliary Workers	9 235	10 142	11 182	11 589	11 824	11 954	12 716	5.5
Child & Youth Care Workers	5 113	6 303	7 503	8 122	9 071	7 467	8 358	8.5
Total	41 478	36 462	51 342	53 115	55 464	54 749	59 517	6.2
Student Social Workers	10 807	13 366	15 411	16 938	14 582	14 636	14 894	5.5
Student Social Auxiliary Workers	8 528	10 081	11 247	12 276	11 715	15 279	12 540	6.6
Students Child & Youth Care Workers	15	132	0	0	198	263	282	63.0
Student Auxiliary Child and Youth Care Workers	131	214	742	1 245	2 421	3 206	3 773	75.1
Total	19 481	23793	27400	30 459	28 916	33 384	31 489	8.3

Source: SACSSP 2022.

3.4.5 Summary of the supply-side constraints and HWSETA interventions

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

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

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

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

High drop-out rates at nursing colleges are a further indication that prospective learners are not prepared for training at the post-school level (Stakeholder interviews 2019, 2020, 2021, 2022).

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

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

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

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

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

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

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

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

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

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

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

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.

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

3.5 THE HWSETA SECTOR PRIORITY OCCUPATIONS LIST (PIVOTAL LIST)

3.5.1 Overview

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

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 SPO list is then used to guide funding decisions in the SETA.

In the preparation of a SPO 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. All SETAs have an obligation to assist with addressing skills shortages in the country through skills development initiatives.

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

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

The PIVOTAL list is ranked according to the reasons for HTFV and 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 level in relation to HWSETA's mandate and control. However, this ranking does not necessarily signify preferential funding. The type and nature of the learning programmes that lead to each identified occupation are identified in a further step. The finalisation of the list from the financial year concerned updates the 4-year trends of HTFV to account for variations that arise from 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 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 in output at HEIs because of the disruption of contact education; the challenges regarding the new nursing qualifications; and the decrease in enrolments due to fewer learners obtaining an NSC with mathematics and science. However, the fact that a large proportion of employers and skills development providers in the sector made a huge effort to continue training during the COVID-19 pandemic showed that they are committed to sustaining skills development in the sector (HWSETA 2020b).

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. Last year the HWSETA established extraordinary new partnerships to address the ongoing COVID-19 pandemic and its effects. 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 sees 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; building NHI capacity; stimulating economic activity and cooperative development; developing artisans and technicians; and providing opportunities for pharmacist and assistants to work optimally in the course of the COVID-19 pandemic. 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 and Universities)	Higher Health	• Build the capacity of HEIs and TVET colleges' academic and support staff as well as students in health and hygiene matters to advance their wellness • Assist clinics with their staff needs • Support Gender Based Violence (GBV), mental health and wellness programmes for PSET through Skills Development	March 2020 to March 2023	To contribute towards the prevention and management of; • mental health problems of students and staff; • other general health problems; • gender-based violence within PSET institutions	Large gatherings were not allowed due to Covid regulations which posed a challenge to face-to-face engagements. To mitigate this challenge virtual tools were used for gathering.	• Collaboration across PSET institutions • Development of tools, frameworks, and guidelines for distance contact which can be used continuously • Support services of post-school institutions were able to identify other needs that can be supported by the HWSETA • More than 2 500 persons in the TVETs were imparted with skills and capacity development on GBV & mental health
	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 do not meeting the accreditation requirements of quality assurance bodies. To mitigate this challenge colleges were advised on processes to follow for accreditation.	Build a relationship with and support Centres of Specialisation
Work Integrated Learning	TARDI	To enable students who are enrolled with the college to gain workplace experience in line with the 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	To enable students who are enrolled with universities to gain workplace experience in line with the university's curriculum for them to graduate	August 2020 – August 2022			
	• Central University of Technology • Mangosuthu University of Technology • Durban University of Technology • Nelson Mandela University • Vaal University of Technology					
Lecturer Development	• East Cape Midlands TVET College • TARDI • Central Johannesburg TVET College • South-West Gauteng TVET College • Northern Cape Rural TVET College • Northlink College • Boland College • College of Cape Town	Improve the capacity of lectures which contributes to the quality of education To improve lecturers' skills for conducting assessments	August 2021 – August 2022	Skilling and upskilling to improve the quality of education and productivity	• Accreditation challenges experienced by colleges • There is also low reporting of completions because the training is quality assured by other SETAs which causes delays	• Support in planning for lecturer development • Secure stability of the project by ensuring continuity beyond one financial year
Vocational Bursaries	• TARDI • Umfolozi TVET College • Majuba TVET College	• To increase SETA-TVET College partnerships • To fund more students towards occupationally directed qualifications • To contribute to work opportunities	September 2021 – September 2024	Increase the production of occupationally directed programmes to broaden South Africa's intermediate (mid-level) skills base, especially in the health sector	• Low completion rates • Poor planning and administration from TVET Colleges • None of the TVETs used to offer HWSETA-related qualifications	• Efficient implementation and delivery to supply the knowledge-intensive economy with relevant skills • Partner with many public TVETs to broaden access: socially, geographically, and financially • Guide TVETs to deliver HWSETA qualifications

Priority	Partners	Objectives	Duration	Impact (value-add)	Challenges	Success factors
NGO/NPO worker education	Institute for Justice and Reconciliation	To train leaders and managers, front-line workers, and volunteers from NGO/NPO on self-transformation with a focus on anti-racism, discrimination, and all forms of bias	November 2021 – November 2023		Incomplete documentation regarding agreements which causes delays in project commencement	• information regarding the agreement • Constant communication is maintained to ensure that partners understand the requirements and their respective roles
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 the 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 the required knowledge on labour issues	Incomplete documentation resulted in delays in the commencement of the project	• The project has not started due to a lack of information regarding the agreement • 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	To increase the number of workers and unemployed persons that enter, re-enter, and complete bursary programmes on qualifications funded by the HWSETA UL; CPU; WSU; RU; Netcare College; UJ; UKZN; UCT; DUT; UP; NMU; UFS; Heldernburg University; NWU	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 restricts funding for many students as per demand • Low re-entries due to slow submission of documentation from universities as the staff were working from home	• 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

Priority	Partners	Objectives	Duration	Impact (value-add)	Challenges	Success factors
	• University of Free State • Heldernburg University • North-West University					
Post-Graduate Bursaries	• Cape Peninsula University of Technology • University of Pretoria • Sefako Makgatho University • University of Witwatersrand • University of KwaZulu-Natal	• To increase access to 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 restricts funding for many students as per demand • Low re-entries due to slow submission of documentation from universities as the staff were working from home	• Efficient use of available funds to supply pipeline for higher level qualifications • Contributes to post-graduate bursary funds available for post-graduate studies
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	• Rural development, only recruiting from rural areas • The first cohort completed the trade test • Working closely with rural communities
Training of Pharmacists and assistants demanded during the COVID-19 pandemic	Northern Cape DoH Northwest DoH	Training of basic- and post-basic pharmacist assistants	June 2021 -December 2022	Meet the labour market demand of occupations in high demand within the pharmaceutical sector	Departments do not keep a record of the registration certificates which is required by the HWSETA	• Engaging with departments • The departments can now deliver on their mandates • The departments can now deliver on their mandates
Supporting skills development initiatives of small and micro enterprises (SMEs) and levy-exempt organisations	159 SMEs and 179 levy-exempt businesses (NGOs &NPOs) operating with less than 50 employees	• To increase the number of entry-level employment/workplace experiences for the youth • To expand the production capacity of rural cooperatives • To provide workplace experiential learning for the youth within SMEs and NPOs/NGOs	Varies according to partnership: MoA signature dates (February & March 2022)	Increased capacity of SMEs and NGOs/NPOs to meet social and rural development needs Direct business growth, sustainability, and professionalisation	Limited budget to support all the applicants	• The needs of the approved enterprises will be discussed with statutory bodies and associations for proper budgeting • The method of advertisement is a success factor given the high demand received from the EOI

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 the University of KwaZulu Natal to supply psychological support to people after the floods in the area; a partnership with Universities offering Social Entrepreneurship to capacitate unemployed Social Service Professionals to pursue self-employment and thus offer their skills to address the social ills that plague the South African Society; and partnerships with organisations to provide and manage training interventions in rural areas.

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. There is also a focus on SMEs, NGOs, and NPOs. 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, and most recently COVID-19 conditions 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[3] , where accurate, quality data and precise analysis inform strategic planning, decision-making, and prioritisation of interventions. This enhances strategic corporate learning and empowers the accounting authority with credible data to critically reflect, respond quicker, justify their actions, and account for expenditure. The Performance Monitoring Plan as defined in the M&EP for HWSETA has been designed with several objectives in mind. It provides a tool to:

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

5.3 APPROACH AND INSTITUTIONALISATION OF MONITORING AND EVALUATION

HWSETA has established the Research, Information, Monitoring, and Evaluation (RIME) unit 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 evaluation5 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.

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[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).

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

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

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 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 decreased its budget allocation towards the WBL programmes to support workplace capacity both at partnership and student levels by 24% in 2021/22 compared to the budget of 2020/21 (Table 5-1). Consequently, the performance of the set target of WBL student placement decreased by 15% in 2021/22 from the 2020/21 baseline. In terms of increasing the workplace capacity through partnerships with employers, the performance achievement against set targets was exceeded by 28%. Cumulatively, workplace capacity has been overachieved by 41% between 2020 to 2022. These partnerships also yielded substantial progress (87%) in the actual number of unemployed learners entering the WBL programme, which is an important focus in terms of the ERRP. Cumulatively, the actual number of unemployed workers entering the WBL: the programme is at the performance level of good progress between 2020 to 2022. This level of performance is partly explained by the relaxed COVID-19 regulations in terms of lower lockdown levels during 2021/22 financial. The assessment of outcomes of performance of the WBL programme shows moderate success (42%) in the financial year 2021/22. These findings illustrate that the employers in the sector may experience the delayed negative economic effect of COVID-19. Thus, low absorption (25%) of the work-ready graduates by the labour market in 2021/22 as employers try to adjust under difficult economic circumstances. This confirms that employment is dependent on both supply and demand side factors. Cumulatively, good progress (70%) has been achieved from 2020 to 2022 against the five-year target.

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.

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

Table 5-1 M&E of skills priority 1: The skills pipeline, 2021/22

Result Chain Level	Indicator	Target 5yrs	Achievement 2021/2022	Cumulative Achievement 2020-2022	Comments
Impact statement 2 *"The HWSETA contributes to the development of the post-school system that produces increasing productive workers and work-ready graduates for the health and welfare sector by 2030 To be conducted after 5 years*					
<u>Outcome</u> *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% Indicator was changed in 2020/21 thus no baseline	25% 42%	42% 70%	2021/2022: [26% to 50%] Moderate Success 2020-2022: [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% Indicator was changed in 2020/21 thus no baseline	40% 50%	39% 49%	2021/22 & 2020-2022 [26% to 50%] Moderate Success
Result Chain Level	**Indicator**	**Target 2021/2022**	**Achievement 2021/2022**	**Cumulative Achievement 2020-2022**	**Comments**
<u>Output</u> *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	2 882 (31% decrease from the 2020/21 baseline)	3 146 109%	4220 60%	2021/2022: [>=100%] Achieved/ Exceeded 2020-2022: [51%-75%] Good Progress
<u>Activity</u> *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	Number of unemployed students entered into WBL programmes (TVET, & university WIL, internships, learnerships, and apprenticeships)	5 910 (15% decrease from the 2020/21 baseline)	5 136 87%	9521 74%	2021/22: [76%-99%] Substantial Progress 2020-2022: [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 (0% increase from 2020/21 baseline)	348 128%	762 141%	2021/22 & 2020-2022: [>=100%] Achieved/ Exceeded

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

In 2021/22 HWSETA decreased its budget allocation to PIVOTAL programmes for upskilling workers by 18% from that of 2020/21 while decreasing its set target for a number of workers by 39%. In terms of implementation performance, Table 5-2 below shows that the HWSETA underachieved against the set targets of the number of workers in PIVOTAL programmes for upskilling but showed good progress (67%) for 2021/22. This level of performance, underachieving but with good progress, is attributed to most learning programmes being offered on a full-time basis which means workers must be out of operations. With increased operational targets being pursued by employers after restrictive protocols of the COVID-19 pandemic, most workers could not be released to attend learning programmes. Similarly, skills programmes offered through conferences and workshops were restricted in terms of the volume of attendees, which means that the HWSETA could not reach its targets. As such, the more employers adopt the use of e-learning and offering of part-time learning programmes, the more likely the achievement levels will increase against set targets. However, the HWSETA has overachieved and exceeded the cumulative target by 2%.

The achievement of the set output targets (completions) were also underachieved but showed good progress at 62% against set targets due to restrictions on entries imposed by COVID-19 protocols. HWSETA overachieved and exceeded the cumulative target by 82%. This is indicative of the extent to which delayed negative effects of the COVID-19 pandemic are now being experienced by employers in the sector.

The first evaluation of outcomes for the employed took place in 2021/22. As shown in the table below, the set target for 2021/22 of the training of workers that directly leads to productivity after completion was overachieved and exceeded by 46%. This is the baseline performance level given that the tracer study was conducted for the first time on employed beneficiaries. 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, 2021/2022

	Target	Realised	%	Rating of performance
Impact Statement 3 "The HWSETA contributes to the improved level of skills for 80% of the workforce within the health and welfare sector by 2030, which is evidenced by higher productivity of employers, and/or career progression either through promotion within the same organization or appointment in a higher position or appointment in a higher position by another organization." *To be conducted after 5 years*				
	Indicator	Achievement 2021/2022	Cumulative Achievement 2020-2022	Comments
Result Chain Level	Target 5yrs			
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*	50%	73% 146%	73% 146%	2021/22 & 2020-2022: [>=100%] Achieved/ Exceeded
Result Chain Level	Target 2021/2022	Achievement 2021/2022	Cumulative Achievement 2020-2022	Comments
Output Statement *Number of employed students who complete the artisan,/Learnership, bursary, skills, AET, lecturer development, and RPL programmes funded by the HWSETA*	5 557	3 421 62%	24 055 182%	2021/2022: [51%-75%] Good Progress 2020-2022: [>=100%] Achieved/ Exceeded
Activity *Number of employed students who enrolled to the artisan, learnership, bursary, skills, AET, lecturer development, and RPL programmes funded by the HWSETA*	12 444 (39% decrease from 2020/21 baseline)	8 349 67%	33 333 102%	2021/2022: [51%-75%] Good Progress 2020-2022: [>=100%] Achieved/ Exceeded
Input	Discretionary Grand Budget for the professionalisation of the workforce			

Source: HWSETA PIR, 2022

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 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. The HWSETA decreased its budget and targets by 43% and 19% respectively from 2020/21 to 2021/22 as the COVID-19 pandemic risks decreased and regulations were relaxed. In terms of implementation performance, HWSETA overachieved at 176% against set targets for 2021/22 on the number of projects aimed at public sector education and training in the reporting period. Cumulatively, HWSETA has overachieved at 144% between 2020 to 2022. At learner/ student level intervention, HWSETA overachieved at 116% against the set target of the number of learners supported in TVET colleges, other public colleges, and AET (unemployed). The support speaks to TVETs and CETs capacity through expansion of education and training. This was despite an 83% decrease in budget allocation from the 2019/20 budget. Accumulatively, HWSETA has overachieved at 119% between 2020 to 2022.

Table 5-3 M&E of skills priority 3: Vital skills required for the developmental state, 2021/22

Indicator	Target 2021-2022	Achievement 2021-2022	Achievement 2020-2022	Rating of performance
Institutional level: Number of education and training projects aimed at the public sector (DoH & DSD)	17 (19% decrease from 2020/21 baseline of 21)	30 176%	46 144%	[>=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	1 340 (3% increase from the 2020/21 baseline)	1 604 116%	3156 119%	[>=100%] Achieved/ Exceeded

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. HWSETA should 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 program 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.

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 both the commitment of resources and performance levels toward the sector priority areas. Cumulatively between 2020 and 2022, HWSETA's performance is an overachievement for vital skills required for the developmental state and professionalisation of the workforce while it is an underachievement but with substantial progress 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 2023/24, 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.
- Serious budget constraints due to the effect of COVID-19 and poor economic circumstances.
- The demand for certain workers such as nurses remains a concern.

Chapter 2:

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

Chapter 3:

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

Chapter 4:

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

Chapter 5:

- An M&E framework adopted by HWSETA is demonstrated as a management tool to assess decisions and actions
- An assessment of 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. Skills needs and gaps in the time of the COVID-19 pandemic.

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

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

Table 6-1 Key challenges in the HWSETA skills development priority areas

S kills 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
			Transform to teach under new qualifications set in higher education
			Set academic & clinical training capacity in higher education
			Nursing training capacity of private hospitals limited by SANC
	NQF levels 5 to 7/8	Post-school to first degree	Financial assistance & bursary funding
			Limited academic & clinical training capacity
			Practical 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
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 2022/2023 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 2022/2023

Strategic outcome-orientated goals of the HWSETA
1. 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.
2. The HWSETA delivers its mandate efficiently and effectively through its well-capacitated organisational structure and business processes that are automated and integrated in the strategic period.
3. The HWSETA promotes linkages between education and the workplace to increase work-based learning opportunities in the health and welfare sector in the strategic period.
4. The HWSETA provides quality assurance services for the health and welfare sector that ensures quality in occupational education and training during the strategic period.
5. 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
6. The HWSETA supports career development services related to the health and welfare sector and makes them accessible to rural and targeted youths in the strategic period.
7. The HWSETA 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, and focal areas in the NSDP and ERRP, which shape skills planning by the HWSETA. Through its multi-dimensional agenda, the NDP gives prominence to three vital areas: economic growth and job creation; education and skills; and building a capable and developmental state. The NDP offers a long-term strategy to grow employment and expand opportunities through education, vocational training, and work experience; strengthen health and nutrition services, and increase social security and community development (NPC 2012a).

In 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 6 3 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 activities
1	Identifying and increasing the production of occupations in high demand	N/A	• Conduct extensive research to understand changing skills needs in general, as well as the effect of the COVID-19 pandemic on skills needs and gaps • Engage with stakeholders, training providers, employers & key role-players • Monitor and track the performance of skills development partners & learners
2	Increase access to occupationally-directed programmes	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
3	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
4	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
5	Supporting skills development for entrepreneurship and cooperative development	N/A	• Provide funding to address the skills development needs of NGOs and cooperatives
6	Improving the level of skills	Increased access to programmes resulting in qualifications in priority sectors (intervention 3)	• Support skills programmes to advance skills in sign language in the sector • Support adult education & opportunities to enhance the mobility of disabled persons • Use discretionary grant funding for targeted projects in the public sector • Fund development of critical and scarce skills at high-, medium- and low occupational levels
7	Supporting career development services	N/A	• Career guidance initiatives market occupations in the health and social development sector
8	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 2022/2023

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; and
- Addressing the changes in skills needed due to the COVID-19 pandemic.

c) Vital skills required for the developmental state

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

- Support for skills development needed to implement the National Health Insurance system;
- Support for public TVET colleges to improve on-site practical and vocational training capacity.
- Advancing the production of health professionals, nurses, ECD workers, and a spectrum of social services practitioners.
- Building skills to advance social- and community development.
- Funding skills development interventions for persons who serve or provide care to persons with disabilities.
- Targeted funding to enable skills development in NPOs, NGOs, and Community-based Organisations.
- Funding skills projects aimed at offering youth and older persons a second chance to enter employment in the health and social development sector.
- Addressing the changes in skills needed due to the COVID-19 pandemic.

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

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 2022/2023. 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
- Skills needs and gaps in the time of the COVID-19 pandemic.

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ANNEXURE C

SECTORAL PRIORITY OCCUPATIONS AND INTERVENTION LIST 2023/2024

SETA NAME	PERIOD	OCCUPATION CODE	OCCUPATION	SPECIALISATION/ ALTERNATIVE TITLE	INTERVENTION PLANNED BY THE SETA	NQF LEVEL	NQF ALIGNED	QUANTITY NEEDED	QUANTITY TO BE SUPPORTED BY SETA
HWSETA	2023/24	2021-222108	REGISTERED NURSE (MEDICAL)	Prison nurse/ Hospital nurse/ Nursing prison officer/General nurse	Learnership: Advanced Diploma in Medical and Surgical Nursing	6	Y	1584,00	784
HWSETA	2023/24	2021-222105	REGISTERED NURSE (CRITICAL CARE AND EMERGENCY)	REGISTERED NURSE (CRITICAL CARE AND EMERGENCY)	Learnership: Higher Certificate in Critical Care and Emergency Nurse	5	Y	358,00	177
HWSETA	2023/24	2021-22603	Retail Pharmacist	Pharmacist assistant/ Community pharmacist/ Dispensing Chemist/	Learnership: FETC Pharmacist Assistance	4	Y	175,00	87
					Learnership: NC Pharmacist Assistance	3	Y		0
HWSETA	2023/24	2021-222111	REGISTERED NURSE (OPERATING THEATRE)	REGISTERED NURSE (OPERATING THEATRE)	Bursary: Bachelor of Nursing Science	7	Y	149,00	74
HWSETA	2023/24	2021-321101	Medical Diagnostic Radiographer	Medical/Diagnostic Radiation Technologist/Radiographer	Bursary: Diploma in Diagnostic Radiography	5	Y	87,00	43
HWSETA	2023/24	2019-332208	PHARMACY SALES ASSISTANT	Pharmacy Cosmetics Salesperson/Pharmacy Salesperson/Retail Dispensary / Pharmacy Assistant	Learnership: FETC Pharmacist Assistance	4	Y	29,00	14
HWSETA	2023/24	2019-213110	MEDICAL SCIENTIST	Biomedical Technologist/ Public Health Scientist/ Medical Laboratory Scientist/Immunologist (Medical Research)/Medical Technologist/Transfusion Scientist/Clinical Biochemist/Haematologist (Medical Research)/ Histologist/Medical Scientific Officer/	Bursary: Bachelor of Biomedical Sciences	7	Y	24,00	12
HWSETA	2023/24	2021-263508	CHILD AND YOUTH CARE WORKER	Child and Youth Counsellor	FETC: Child and Youth Care Work	4	Y	55,00	27
HWSETA	2023/24	2021-234201	EARLY CHILDHOOD DEVELOPMENT PRACTITIONER	Early intervention teacher/ Nursery teacher/ Pre-school coordinator/ Early childcare teacher	Occupational Certificate: Early Childhood Development practitioner	4	Y	26,00	13
HWSETA	2023/24	2021-225101	VETERINARIAN	VETERINARIAN	Bursary: Bachelor of Veterinary Sciences	8	Y	28,00	14

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