2017 UPDATE

SECTOR SKILLS PLAN

SECTION E

SECTOR SKILLS PLAN

FOR THE HEALTH AND SOCIAL DEVELOPMENT SECTOR IN SOUTH AFRICA

SUBMITTED TO THE DEPARTMENT OF HIGHER EDUCATION AND TRAINING

BY THE HEALTH AND WELFARE SETA

2017 ANNUAL UPDATE

FOREWORD

The Health and Welfare Sector Education and Training Authority (HWSETA) is pleased to present its Draft HWSETA 2016/17-2021/22 Sector Skills Plan accompanied by the updated Continuous Improvement Plan, Synopsis Chapter and Top 10 Pivotal Skills List. Nothing has been done differently in the development of this current SSP. This SSP has responded positively to the Continuous Improvement Plan post the one-on-one session held between the HWSETA and DHET in 2014 as indicated below.

This SSP is a road map that details the path chosen by the HWSETA towards achieving the goals set by the Executive Authority, the Honourable Minister of Education and Training, Dr B.E. Nzimande. It is an annual update of the plans that are approved by the Board of the HWSETA, which comprises of representatives of government, labour and employers. Government departments that are key and have representatives on the Board are the Department of Social Development and the Department of Health.

This annual update 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 and the Medium Term Strategic Framework (MTSF).

The SSP meets the requirements set out by the Department of Higher Education and Training (DHET) in the National Skills Development Strategy (NSDS) III.

This SSP is a valuable tool for HWSETA stakeholders and a useful source of information for service providers and the community.

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

The HWSETA is committed to work with workers, employers, government departments and communities to move South Africa closer to the goal of 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 and the youth.

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 E.T. Confidence Moloko
Chairperson: HWSETA Board

____

Ms Elaine Brass
Acting Chief Executive Officer: HWSETA

ABBREVIATIONS AND ACRONYMS

AHPCSA	Allied Health Professions Council of South Africa
AIDS	Acquired Immune Deficiency Syndrome
APP	Annual Performance Plan
AQP	Assessment Quality Partner
ATR	Annual Training Reports
CBO	Community-Based Organisation
CDP	Community Development Practitioner
CDW	Community Development Worker
CESM	Classification of Education Study Material
CHE	Council on Higher Education
CHW	Community Health Worker
CPD	Continuous Professional Development
CYCW	Child and Youth Care Worker
DBE	Department of Basic Education
DBSA	Development Bank of South Africa
DHET	Department of Higher Education and Training
DoH	Department of Health
DSD	Department of Social Development
ECD	Early Childhood Development
FET	Further Education and Training
FETC	Further Education and Training Certificate
GDP	Gross Domestic Product
GET	General Education and Training
GETC	General Education and Training Certificate
GP	General Medical Practitioner
HASA	Hospital Association of South Africa
HEI	Higher Education Institution
HEMIS	Higher Education Management Information System
HET	Higher Education and Training
HIV	Human Immunodeficiency Virus
HPCSA	Health Professions Council of South Africa
HWSETA	Health and Welfare Sector Education and Training Authority
MLW	Mid-level Worker
MRC	South African Medical Research Council
MTEF	Medium Term Expenditure Framework
NC	National Certificate
NCV	National Certificate (Vocational)
NEI	Nursing Education Institution
NDP	National Development Plan
NGO	Non-Governmental Organisation
NGP	New Growth Path
NHA	National Health Act, 61 of 2003
NHI	National Health Insurance
NPO	Non-Profit Organisation
NQF	National Qualifications Framework
NSCA	National Senior Certificate for Adults
NSDS	National Skills Development Strategy
NSF	National Skills Fund
NT	National Treasury
OFO	Organising Framework for Occupations
PBSW	Professional Board for Social Work
PBCYC	Professional Board Child and Youth Care
PFMA	Public Finance Management Act
PHC	Primary Healthcare
PIVOTAL	Professional, Vocational, Technical And Academic Learning
PSETA	Public Service Sector Education Training Authority
QCTO	Quality Council for Trades and Occupations
QDP	Quality Development Partner
RPL	Recognition of Prior Learning
SACSSP	South African Council for Social Service Professions
SANC	South African Nursing Council
SAPC	South African Pharmacy Council
SASSA	South African Social Security Agency
SAVC	South African Veterinary Council
SAW	Social Auxiliary Worker
SDA	Skills Development Act
SDF	Skills Development Facilitator
SDL	Skills Development Levy
SIC	Standard Industrial Classification
SSACI	Swiss South African Cooperation Initiative
SSP	Sector Skills Plan
TB	Tuberculosis
TVET	Technical and Vocational Education and Training
UMALUSI	Council for Quality Assurance in General and Further Education and Training
WHO	World Health Organisation
WSP	Workplace Skills Plan

EXECUTIVE SUMMARY

The sector served by the 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, to veterinary services. The social development component of the sector consists of the government, NGOs and private social work practices. The health and social development sector is a heterogeneous sector, falling mainly under the Sector Industrial Classification (SIC) divisions 86 to 88. The HWSETA exercises jurisdiction over 19 SIC codes.

By April 2017 there were 332 654 filled positions in the Public Service health and social development departments and 266 466 in the private sector bringing total employment in the sector to 599 120. Professionals and technicians and associate professionals respectively formed 40% 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 the workers in the sector are living with disabilities. Labour and trade unions are well organised and mobilised within the formal health and social development sector.

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

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

Changes in the sector are driven by challenging socio-economic realities, the high burden of disease experienced in the country and high levels of interpersonal violence and other social crimes that increase the demand for public health and social welfare services. At the same time constitutional imperatives compel the state to be development orientated and to take progressive measures to grant everyone access to healthcare services, sufficient food and water, and social security.

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

Some of the statutory professional councils are introducing 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 and training providers.

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

The key skills issues that fall within the HWSETA ambit are: skills interventions needed to build the developmental state; the development and sustainment of a skills pipeline into the sector that provides for entry-level as well as higher level professional skills; the

development and sustainment of opportunities for work-integrated learning; the development of mid-level skills needed to strengthen health and social development service provision and addressing the skills gaps in the current workforce brought about by changes in policy and service delivery.

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

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

Poor management of the health workforce; and deficient leadership contribute to a high attrition rate from the health professions. Another labour market challenge relates to skills provision and skills absorption, e.g. social worker scholarships boosted graduate output in the last few years, but budget constraints in the public and private sector hampers employment of many of the newly qualified professionals.

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. Although some partnerships produced mixed results in the past, valuable lessons were learned, and the HWSETA has adopted corrective measures to advance skills production.

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

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

a) A sustainable skills pipeline into the health and social development sector;

b) Professionalisation of the current workforce and new entrants to the sector; and

c) Vital skills and skills sets required to enable the state to meet its service delivery obligations as a developmental state.

These skills development priorities are also viewed from a strategic perspective. First, a sustainable skills pipeline enables entry into employment in the health and social development sector at different entry points. Second, by prioritising the professionalisation of the workforce, the HWSETA can contribute to skills interventions required to improve service quality and efficiency, and also address changes to service provision. Third, 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.

In giving effect to these skills priorities, the HWSETA will not simply equip learners with the appropriate knowledge, but also with the practical skills, competencies, attitudes and behaviours to provide efficient and effective services. On a practical level, priority will be given to interventions that specifically address the scarce and critical skills as well as the particular skills sets required in the workplace. For the HWSETA and its stakeholders it is vital to nurture persons who are employable, competent, and work-ready and equipped with "Day One" skills when they enter employment in the sector.

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

TABLE OF CONTENTS

FOREWORD SSP-I

ABBREVIATIONS AND ACRONYMS SSP-II

EXECUTIVE SUMMARY SSP-III

LIST OF TABLES SSP-V

LIST OF FIGURES SSP-V

RESEARCH PROCESS AND METHODS SSP-VI

1 SECTOR PROFILE SSP-1
- 1.1 INTRODUCTION SSP-1
- 1.2 SCOPE OF COVERAGE SSP-1
- 1.3 KEY ROLE-PLAYERS SSP-2
- 1.4 ECONOMIC PERFORMANCE SSP-3
- 1.5 EMPLOYER PROFILE SSP-4
- 1.6 LABOUR MARKET PROFILE SSP-5
- 1.7 CONCLUSIONS SSP-13

2 KEY SKILLS ISSUES SSP-14
- 2.1 INTRODUCTION SSP-14
- 2.2 CHANGE DRIVERS SSP-14
- 2.3 ALIGNMENT WITH NATIONAL STRATEGIES AND PLANS SSP-16
- 2.4 IMPLICATIONS FOR SKILLS PLANNING SSP-18
- 2.5 CONCLUSIONS SSP-18

3 OCCUPATIONAL SHORTAGES AND SKILLS GAPS SSP-19
- 3.1 INTRODUCTION SSP-19
- 3.2 HARD-TO-FILL VACANCIES SSP-19
- 3.3 SKILLS GAPS SSP-22
- 3.4 EXTENT AND NATURE OF SUPPLY SSP-23
- 3.5 THE HWSETA PIVOTAL LIST SSP-31
- 3.6 CONCLUSIONS SSP-32

4 SECTOR PARTNERSHIPS SSP-33
- 4.1 INTRODUCTION SSP-33
- 4.3 EXISTING PARTNERSHIPS SSP-33
- 4.4 NEW PARTNERSHIPS SSP-36
- 4.5 CONCLUSIONS SSP-36

5 SKILLS PRIORITY ACTIONS SSP-37
- 5.3 INTRODUCTION SSP-37
- 5.4 FINDINGS FROM PREVIOUS CHAPTERS SSP-37
- 5.5 RECOMMENDED ACTIONS SSP-38
  - 5.5.1 SKILLS DEVELOPMENT PRIORITIES SSP-38
  - 5.5.2 STRATEGIC GOALS OF THE HWSETA SSP-40
  - 5.5.3 MEASURES TO SUPPORT NATIONAL PRIORITIES AND PLANS SSP-40
  - 5.5.4 HWSETA SKILLS PRIORITY ACTIONS FOR THE PERIOD 2017 TO 2022 SSP-41
- 5.6 CONCLUSION SSP-42

6 BIBLIOGRAPHY SSP-43

ANNEXURE A: CONTINUOUS IMPROVEMENT PLAN SSP-46

ANNEXURE B: PIVOTAL LIST SSP-47

LIST OF TABLES

Table 1-1 SIC codes and descriptions SSP-1
Table 1-2 Health expenditure in the public and private sectors: 2010 to 2017 . . . . . SSP-3
Table 1-3 Health and social development sector: Total employment 2013-2017 . . . . . SSP-5
Table 1-4 Public Service and private sector employment per occupational group: 2017 . . . . . SSP-6
Table 1-5 Health and social development sector: Total employment by population group 2013-2017 . . . . . SSP-7
Table 1-6 Population group distribution according to occupational-group 2017 . . . . . SSP-8
Table 1-7 Health and social development sector: gender distribution 2013-2017 . . . . . SSP-9
Table 1-8 Gender distribution according to occupational-group 2017 . . . . . SSP-10
Table 1-9 Health and social development sector: age distribution 2013-2017 . . . . . SSP-11
Table 1-10 Age distribution of employees in the Public Service and private health according to occupational group, 2017 . . . . . SSP-12
Table 2-1 Implications of NDP for skills planning in the health and social development sector SSP-17
Table 3-1 Hard-to-fill vacancies in the private health and social development sector according to OFO Unit Group: 2017 . . . . . SSP-19
Table 3-2 Priority and scarce skills reported in the public health and social development sector according to OFO Unit Group: 2017 . . . . . SSP-20
Table 3-3 Number of health-related and social work qualifications awarded by public HEIs: 2010 to 2015 . . . . . SSP-25
Table 3-4 Number of graduates at nursing colleges: 2010 to 2016 . . . . . SSP-27
Table 3-5 Number of selected professionals registered with the HPCSA as at 31 December of 2009 to 2016 . . . . . SSP-27
Table 3-6 Number of nurses registered with the SANC: 2009 to 2016 . . . . . SSP-28
Table 3-7 Number of registrations with the SAPC: 2010 to 2017 . . . . . SSP-29
Table 3-8 Total registrations with the AHPCSA: 2010 to 2016 . . . . . SSP-29
Table 3-9 Number of registrations with the SAVC: 2010 to 2016 . . . . . SSP-30
Table 3-10 Social workers and social auxiliary workers registered with the SACSSP: 2010 to 2015 . . . . . SSP-30
Table 4-1 New partnerships under development by the HWSETA SSP-36
Table 5-1Key challenges in the HWSETA skills development priority areas SSP-38
Table 5-2 The HWSETA strategic goals for the period 2017-2022 . . . . . SSP-40
Table 5-3 Alignment of NSDSIII goals and HWSETA skills development activities SSP-41

LIST OF FIGURES

Figure 1-1 The South African health and social development system SSP-2
Figure 1-2 Provincial distribution of employment in the Public Service and private health sector SSP-6

RESEARCH PROCESS AND METHODS

The research that informed this year's SSP update consisted of three projects, namely; policy analysis project, demand side analysis project and supply side analysis project. Each was designed to provide the information needed to fulfil the requirements of the five chapters of the SSP.

1) POLICY ANALYSIS PROJECT

This is a qualitative study that is focused on the health and social development-related aspects of the National Development Plan (NDP) and the way in which the NDP is interpreted and rolled out through the strategic plans of the National Department of Health (DoH) and the National Department of Social Development (DSD) and their provincial counterparts. It also included other policy documents such as white papers (e.g. the White Paper on the National Health Insurance (NHI) and white paper reviews (e.g. the Review of the White Paper on Social Welfare).

The projects specifically drew out the human resources implications of the respective policies and plans.

Information was collected through a literature survey. The most recent documents were systematically sourced from the respective departments' websites.

The study focused on policies and plans that had human resources implications in the fields of human and animal health.

- Strategic plans and legislation of the DoH, DSD, and the provincial departments of health and social development.
- National Treasury's budget documents. (Estimates of National Expenditure have specific budgets for DoH, DSD and the DoAFF.
- Policy documents such as white papers.
- Other relevant publications.

This research was conducted in May and June 2017.

2) DEMAND SIDE ANALYSIS PROJECT

This 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 uses study existing data sources.

The study covers the private and public health and social development sectors as well as a portion of animal health. NGOs and NPOs that are exempt from levy payments and who had not submitted WSPs are excluded.

The following datasets and data sources are analysed:

- The WSP submissions to the HWSETA
- The WSP submissions to the PSETA (health and social development departments)
- The Medpages database
- Discretionary grant applications submitted to the HWSETA in 2016 and 2017.

This study was conducted in June and July 2017..

3) SUPPLY SIDE ANALYSIS PROJECT

This study looks at the supply of skills to the Health and Social Development Sector. It tracks changes in the supply of skills over time and it investigates supply side blockages.

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

The study covers education and training from 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 Basic Education's website: EMIS - Education Management Information Systems for annual Grade 12 Senior Certificate output.
- Department of Higher Education and Training's website: HEMIS - Higher Education Management Information System for annual qualification output.
- Department of Higher Education and Training, HETIS office, for TVET data.

This study took place from May to July 2017.

After the first draft of the SSP was submitted to the DHET on 15 June 2017, the HWSETA engaged in a consultative workshop with stakeholders who were given the opportunity to make inputs with regards to the skills needs of the different components of the sector.

The SSP was also presented to the HWSETA Board on 10 July 2017 at their strategic planning session.

Comments from these consultative processes were included in the SSP where appropriate.

Topic	Nature (Design) of the study	Objectives of study	Data collection tool	Sample size and scope	List of data sources and datasets	Time frame
Policy Analysis Project	Qualitative	To obtain information on Government policies and strategic plans that impact the skills requirements of the Health and Social Development Sectors.	Desk top research.	All national and provincial departments of health and social development.	Published strategies, plans and policy documents	May – Jun 2017
Demand Analysis Project	Quantitative	To track trends in employment in the Health and Social Development Sector.	Analysis of existing data sources.	Levy-paying organisations in HW SETA – 7 883 WSP Submissions – 1 013 Individual employee records – 164 316 PSETA WSP Submissions – 20 Departments Medpages database – 156 545	HW Seta Levy Payers HW Seta WSP Submissions 2017 PSETA WSP Submissions 2017 Medpages Database	July 2017
Supply Analysis Project	Quantitative and qualitative	To track trends in the supply of qualifications relevant to the Health and Social Development Sectors and to track trends in professional registrations.	Analysis of existing data sources obtained from Internet searches and through email and telephonic contacts with professional councils.	20 Professional councils	HEMIS Data Professional council registers	May – June 2017
Skills needs of the non-profit making organisations:	Qualitative and quantitative.	To understand the skills needs of the NPOs operating within the health and welfare sectors: 1) Produce a detailed profile of the NPOs in the health and social development sectors. 2) Outline their skills needs.	Quantitative: Face-to-face Interviews by means of structured questionnaires Qualitative: In-depth interviews.	Quantitative: 267 randomly selected NPOs across SA. Interviews with managers/senior staff members Qualitative: 2 NPO's per province (11 interviews with senior representatives of NPOs).-	NPO database.	Published: 2015.
Revision of the health and social development occupations on the OFO.	Qualitative study.	To revise all the relevant occupations on the OFO and to bring them in line with the occupational titles, registration categories and designations used in South Africa.	Interviews and workshops with professional councils, assessment bodies and public and private sector employers.	32 Meetings and workshops	OFO	Finalised April 2017

1SECTOR 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.

1.2 SCOPE OF COVERAGE

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) –Table 1-1.

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 specialized stores
M	75000	Veterinary activities
O	84121	Regulation of the activities of providing health care, education, cultural services & other social services at National Government Level
	84122	Regulation of the activities of providing health care, education, cultural services & other social services, at Provincial Government level
	84123	Regulation of the activities of providing health care, education, cultural services & other social services, at Local Government level
	84220	Administration, supervision & operation of health activities for military personnel in the field
Q	86100	Hospital activities
	86201	Medical practitioner& specialist activities
	86202	Dentist & specialist dentist activities
	86209	Other medical & dental practice activities
	86900	Other human health activities e.g. nurses, paramedical practitioners, medical laboratories, blood banks, ambulances
	87100	Residential nursing care facilities
	87200	Residential care activities for mental retardation, mental health & substance abuse
	87300	Residential care activities for the elderly & disabled
	87900	Other residential care activities e.g. orphanages, temporary homeless shelters
	88100	Social work activities without accommodation for the elderly & disabled
	88900	Other social work activities without accommodation e.g. welfare, guidance, adoption.

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

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

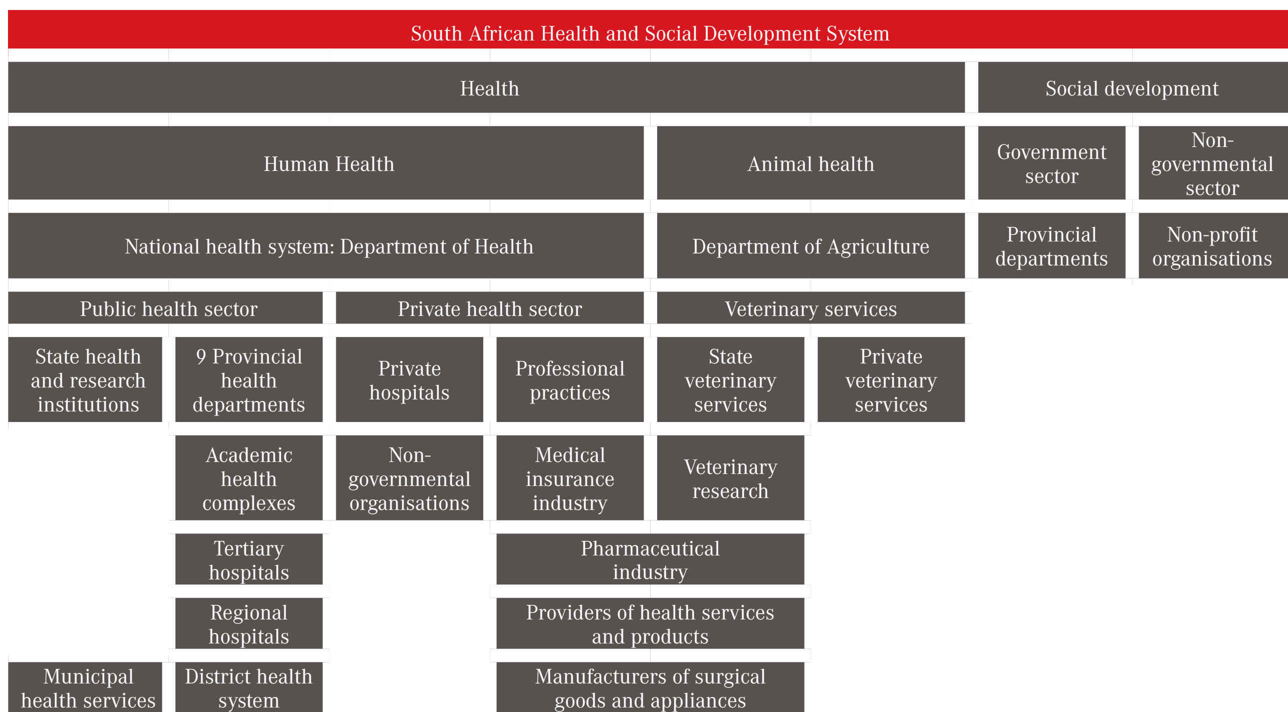


Figure 1-1 The South African health and social development system

1.3 KEY ROLE-PLAYERS

Public health services are provided at three tiers of government. The national Department of Health (DoH) is mainly responsible for policy, legislation, standard-setting, oversight and coordination of health services rendered by provinces (National Health Act 61 of 2003: Sec 21(2)). Provincial health departments deliver and monitor health services (NHA: Sec 25(2)) while municipal health services are assigned by provinces (NHA: Sec 34) and mainly involve environmental health (NT 2015a:52). Both the DoH and provinces have statutory responsibilities to develop human resources and skills. While the DoH has to "promote adherence to norms and standards for the training of human resources for health", the duty to "plan, manage and develop human resources for the rendering of health services" lies with the provincial departments (NHA Sec 21(2) (c) and 25(2) (i)).

In the social development sector, the DSD has a national responsibility to develop legislation, policies and standards to monitor the provision of welfare and community development services and the provincial departments are responsible for the implementation of a range of services to many different groups of beneficiaries (NT 2014:80). The South African Social Security Agency (SASSA) administers the payment of social protection grants to almost 16.5 million beneficiaries. NPOs are important service delivery agents for the state and provide the bulk of welfare and development services on behalf of provinces to children, families and communities; and persons affected by disease, disability and social ills (NT 2015:99). The National Development Agency (NDA) implements community-driven projects by supporting NGOs to create employment, income and development opportunities (DSD 2015b:42). Statutory professional councils regulate the various professions and also control standards for education and training. In the health sector these councils are the Health Professions Council of South Africa (HPCSA), the South African Nursing Council (SANC), the South African Pharmacy Council (SAPC), the Allied Health Professions Council of South Africa (AHPCSA) and the South African Dental Technicians Council (SADTC). Members of the veterinary and para-veterinary professions are registered with the South African Veterinary Council (SAVC) and practitioners using indigenous African healthcare techniques and medicines will soon be required to register with the Interim Traditional Health Practitioners Council of South Africa (ITHPCSA). Professionals and sub-professionals in the social development field are registered with the South African Council for Social Service Professions (SACSSP).

A number of institutions conduct sector-related research e.g. the South African Medical Research Council, the National Health Laboratory Service, the Human Sciences Research Council, and the Onderstepoort Veterinary Institute (HWSETA 2014:11). Several institutions are also mandated to advance the training and development of researchers, health professionals and technicians for the sector. Voluntary professional bodies promote the interests of specific professions, specialised fields of professional practice, and their members. Through advocacy, lobbying and negotiating these organisations seek to advance their members' positions and integrity as well as the standing and sustainability of their particular profession.

The Hospital Association of South Africa (HASA) is a major role-player and industry association representing the interests of 64 000 people employed by the majority of private hospital groups and independently owned private hospitals (HASA 2016). Labour and trade unions are well organised and mobilised within the sector. Trade unions play a formative role in shaping labour market policies, labour relations practices, and human resources management in the sector (HWSETA 2014:14).

1.4 ECONOMIC PERFORMANCE

1.4.1 SECTOR'S CONTRIBUTION TO THE ECONOMY

The health and social development sector contributes to growth in the South African economy by creating employment, income and economic value through the provision of infrastructure for service delivery. Both the public and private health sectors contribute health services infrastructure such as hospitals, out-patient clinics and pharmacies, and exist to serve the health needs of South Africans (NT 2014: 65; Econex 2013: 25). The animal health sector contributes the skills needed to prevent and treat diseases that pose a risk to animal and human health. Veterinary and para-veterinary services support profitable food production (including quality animal products for international markets) and food security required for economic growth (HWSETA 2014:55; NT 2014:147&153).

According to HASA (2016), economic activity generated by its 212 private hospital members directly and indirectly contribute R110 billion to the economy, with a contribution to the South Africa's Gross Domestic Product of R52.2 billion (2.2%). The major hospital groups that are members of HASA pay almost R6 billion in taxes and employ 64 000 people. The health and social development sector also indirectly generates further income streams by procuring goods and services from suppliers, which in turn, produces further tax revenues. The sector makes a significant contribution to train health professionals, nurses, and social workers. Provincial expenditure on health sciences education and training amounted to R4 billion in 2014, and another R4.6 billion in grant funding was allocated to develop health professionals and TVET and Nursing Colleges (NT 2014:63). A further R872 000 will be allocated to scholarships to train social work students (DSD 2015b:36) from 2015 to 2017. The large private hospital groups train nurses, pharmacist assistants and provide funding to develop medical specialists (Econex 2013:47).

1.4.2 CURRENT ECONOMIC PERFORMANCE

In 2013/14 healthcare (public and private) expenditure totalled R311 billion (National Treasury 2015:53). Expenditure for 2016/17 is estimated at R370 billion. Annual healthcare spending in South Africa averaged between 8.7% and 9% of GDP from 2010/11 to 2013/14 (Econex 2013:9; NT 2014:53). Healthcare expenditure comes from three sources. General tax revenues finance the public sector, while medical schemes and out-of-pocket payments finance private care. Table 1-2 shows outcomes or actual expenditure and medium term estimates of expenditure in the public and private sectors for the period 2010 to 2017.

Table 1-2 Health expenditure in the public and private sectors: 2010 to 2017

Public sector	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	AAG
	Outcome (Rand million)				Medium-term estimates (Rand million)			(%)
National DOH core	1 478	1 678	1 827	2 442	3 844	4 548	4 204	19
Provincial DOH	97 957	111 324	122 551	134 574	140 801	149 592	154 117	8
Department of Defence	3 150	3 400	3 460	3 762	3 849	4 059	4 325	5
Local government (own revenue)	1865	1 977	2 096	2 221	2 355	2 496	2 628	6
Department of Basic Education	3 993	4 929	5 274	5 561	5 873	6 133	6 458	8
Department of Correctional Services	508	519	584	657	694	748	780	7
Social insurance funds1	4 136	5 553	4 166	4 486	5 651	6 011	6 313	8
Total	113 088	130 379	139 958	153 703	163 068	173 587	178 825	8
Medical schemes	96 482	107 383	117 528	125 520	134 558	143 573	152 905	8
Out-of-pocket	17 172	18 202	19 294	20 452	21 679	22 980	24 198	6
Medical insurance	2 870	3 120	3 392	3 687	4 007	4 356	4 587	8
Employer private	1 372	1 491	1 621	1 762	1 915	2 081	2 192	8
Total	117 896	130 196	141 835	151 421	162 159	172 991	183 882	8
Donors or NGOs	5 787	5 308	5 574	5 852	6 145	6 452	6 794	3
TOTAL	236 771	265 884	287 367	310 977	331 372	353 030	369 501	8

Social insurance funds are the Compensation Fund for workmen's injuries on duty and the Road Accident Fund. Costs of private and public healthcare providers are included in the amounts paid. Source: National Treasury. 2015. Provincial Budgets and Expenditure Review 2010/11 -2016/17, p 53. http://www.treasury.gov.za/publications/igfr/2015/prov/04.%20Chapter%204%20-%20Health.pdf **(Accessed 19 April 2016).**

SECTOR SKILLS PLAN

In 2013/14 social development's expenditure totalled R14 billion (National Treasury 2015:85). Expenditure for 2016/17 is estimated at R18 billion. Information on social expenditure from donors and private sector organisations is not readily available. Transfers by national and provincial social development departments to NGOs for welfare services delivered on behalf of the state grew from R3.7 billion in 2010/11 to R5.1 billion in 2013/14 and is expected to increase to R6.5 billion in 2016/17 (NT 2015:90). Public veterinary services' expenditure totalled R749 million in 2013/14 and is expected to increase to R969 million in 2016/17 (NT 2015:154). The aim of these services is to reduce animal health risks and improve the hygiene management of animal products (NT 2015).

1.4.3 FUTURE OUTLOOK

Global and local economic contraction has impacted the health and social development sector directly. This sector is a component of the broader personal services sector where economic growth declined from 2.1% in 2012 to 1.2% in 2016 (StatsSA, 2017). Health and social development expenditure in provinces (i.e. the seats of service) is expected to slow down over the medium term, from above 10% p.a. in 2011-2014 to 5.6% p.a. and 8.2% p.a. respectively (NT 2014:54&85). Slower growth will also affect the allocation of human resources and training, as well as state subsidies and capacity building programmes for NGOs (HWSETA 2014:30; NT 2014:100).

Approximately 18% of South Africans access private healthcare as members of medical schemes, and the remaining 82% mostly use public health services. Some of the uninsured people also incur out-of-pocket expenses to consult doctors and dentists, and it is estimated that the private sector provides primary healthcare services to 28% – 38% of the population (Econex 2013:18). However, medical scheme coverage and people's ability to pay directly for private healthcare are closely linked to employment and when the labour market contracts, more people rely on the public health and social systems.

At a time when provincial health budgets are under more strain, the demand for public hospital services is growing (NT 2014:62), as is shown by the increase in out-patient visits, in-patients days and average length of stay. Demand for private healthcare continues to grow as is seen in the growth of medical scheme membership from 6.66 million in 2004 to 8.81 million beneficiaries by 2015, which accounts for an increase of 32% over the decade (Council for Medical Schemes 2016). Admission rates to private hospitals increased between 2006 and 2012, by around 2.7% to 6%, depending on the method of calculation used (Insight Actuaries and Consultants 2014:32). Expenditure for private health services is projected to grow by 7.7% p.a. until 2017 (NT 2014:53).

NGOs continue to face significant economic hardship due to financial challenges; problems to access donor funding; and weaknesses in governance and accountability procedures (O'Riordan 2014; HWSETA 2014:35; NT 2014:79&100). These factors, together with inadequate salary structures, have a direct impact on the availability of resources and professional skills to serve health- and social needs in communities.

Prior to the 2015 Budget, the National Treasury (2015a:12) reduced medium term spending plans by R25 billion, or by about one per cent of projected budgets. Slow economic growth impacts revenue sources, leading to reduced funding for public services. Overall, public sector budgets for 2015 to 2018 reflect that health and social spending programmes are given priority, despite pressure on resources (NT 2015a:55). There is a direct relationship between spending (in the public and private sectors) and the demand for workers. Public sector budgets are major determinants of both the number of positions created and salary levels and, consequently, of the ability of institutions to attract and retain staff. In the private sector the linkages are somewhat more complex, but equally significant.

1.5 EMPLOYER PROFILE

1.5.1 OVERVIEW

The health and social development sector is a heterogeneous sector in many ways. The size and type of organisations in the sector differ: Public health comprises large (150 or more employees) national and provincial departments of health and social development. In contrast, most of the organisations in private health are small. Sixteen per cent of organisations employ fewer than 10 people, 27% employ between 10 and 20 employees and 28% between 20 and 49 employees. This means that 70% 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 16% of the organisations in the private sector and the large organisations constitute 14%. However, large organisations such as hospital and pharmacy groups employ 85% 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 2016/2017 financial year a total of 8 904 organisations paid SDLs to the HWSETA. These are organisations with payrolls in excess of R500 000 per year. Small practices may be excluded from this number.

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 as a recent HWSETA study (2015a) shows that these organisations provide paid and unpaid employment to many workers in the sector. At the end-of March 2015, a total of 136 453 NPOs were registered with the DSD (2015e), 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. In 2015 there were 54 392 registered NPOs in social services, 11 966 in health and 1 577 in

the category "environment" (DSD 2015e:13). However, few of the NPOs are registered as employers with the HWSETA and they are therefore not included in the labour market profile. The HWSETA study indicated that NPOs work with relatively small numbers of full time staff and to a large extent rely on volunteers and part-time staff. Africans and women dominate the NPO workforce (HWSETA 2015a:87). The most common age group for full-time employees was 35 to 44 years, with part-time workers mostly older at 55 years and above, while casual workers were more evenly distributed across the age groups.

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 ESTIMATE OF TOTAL EMPLOYMENT

Three data sources were used to construct a profile of the labour force: Data from the workplace skills plans (WSPs) submitted by private sector employers to the HWSETA, data from such plans submitted by public sector employers to the Public Service SETA (PSETA) as well as data furnished to the HWSETA from the private MEDpages database. The data analysis provided information on 599 120 people who are formally employed in the health and social development sector. Of these, approximately 266 000 (44%) are employed in private sector organisations (referred to later as the "private sector") and levy-paying public sector organisations, while 333 000 (56%) work in the public service departments[1]. The private sector figures are underestimates of the total number of employees in the sector because of the exclusion of certain categories of workers (see Section 1.2).

Estimates of total employment in the health and social development sector can be seen in Table 1-3. Employment in the public service component of the sector decreased from 325 763 in 2013 to 310 256 in 2014. In 2015 it increased slightly by 0.8% to 312 884 and in 2016 it increased substantially to 330 015. In 2017 the figure increased only slightly to 332 654. The private sector component of the sector, on the other hand increased every year from 2013 to 2016, when it stood at 274 140. In 2017 employment dropped to 266 466 – a reduction of 3%.

Table 1-3 Health and social development sector: Total employment 2013-2017

	2013	2014	2015	2016	2017
Public	325 763	310 256	312 884	330 015	332 654
Private	262 503	276 513	269 244	274 140	266 466
Total	588 266	586 769	582 128	604 155	599 120

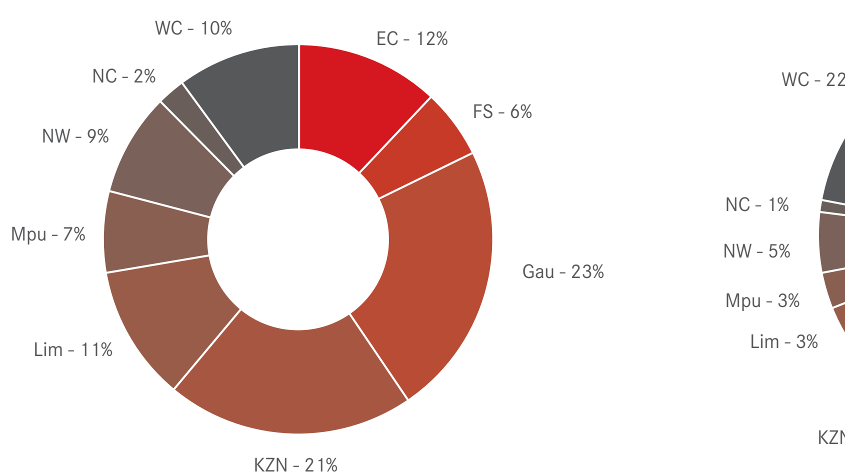
Sources: Calculated from HWSETA and PSETA WSP applications 2012 to 2017, MEDpages database,- July 2017.

1.6.2 PROVINCIAL DISTRIBUTION OF EMPLOYMENT

Figure 1-2 shows the provincial distribution of employees in the Public Service and the private sector. Compared to private health, the Public service has higher percentages of health workers in provinces with large rural, poor populations depending on public health services e.g. Limpopo and KwaZulu-Natal.

1. Note: No WSP's were received from the Western Cape Department of Health in 2014 and 2015. Their 2013 employment figures were used for calculations. The figure excludes medical personnel employed in the SANDF, NPOs, professionals not listed on any of the databases used and non-professional support staff employed in private professional practices.

PUBLIC SERVICE



PRIVATE SECTOR

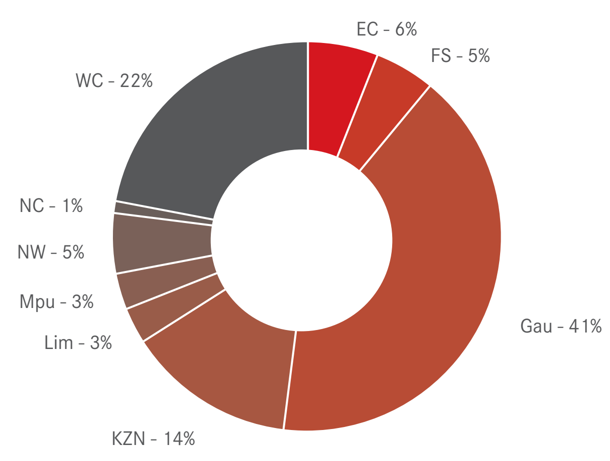


Figure 1-2 Provincial distribution of employment in the Public Service and private health sector.

Sources: Calculated from HWSETA and PSETA WSP applications 2017.

1.6.3 OCCUPATIONAL DISTRIBUTION OF EMPLOYMENT

Currently managers and professionals comprise 44% of total employment in the Public Service and 44% in the private sector (Table 1-4). In the health and social development sector, a large portion of managerial positions are filled by professionals. Professionals include medical and dental specialists and practitioners, registered nurses, pharmacists, veterinarians and other health-related occupations such as homoeopaths. Professionals in support functions such as human resource professionals, financial professionals and scientists also form part of this group. Technicians and associate professionals include occupations such as technicians, enrolled and veterinary nurses, ancillary health care workers, ambulance officers and pharmacy sales assistants as well as allied health workers such as chiropractors and administrative support workers such as office administrators.

Table 1-4 Public Service and private sector employment per occupational group: 2017

Occupational Group	Public Service		Private Sector		Total Sector	
	Number of employees	%	Number of employees	%	Number of employees	%
Managers	13 651	4	14 599	5	28 250	5
Professionals	134 567	40	104 076	39	238 643	40
Technicians and Associate Prof	67 758	20	64 893	24	132 651	22
Clerical Support Workers	39 112	12	34 341	13	73 453	12
Service and Sales Workers	34 799	10	28 863	11	63 662	11
Skilled Agricultural, Forestry, Fishery, Craft and Related Trades Workers	1 155	0	2 696	1	3 851	1
Plant and Machine Operators and Assemblers	4 309	1	4 251	2	8 560	1
Elementary Occupations	37 303	11	12 747	5	50 050	8
Total	**332 654**	**100**	**266 466**	**100**	**599 120**	**100**

Sources: Calculated from HWSETA and PSETA WSP applications 2016, MEDpages database, July 2017.

1.6.4 POPULATION GROUP

More than two thirds of the health and social development sector employees are African (Table 1-5). In the Public Service more than 80% of the work force is African and in the private sector this figure is around 50%. Whites form around 5% of the Public Service workforce and 28% of the private sector workforce.

Table 1-6 shows the population group distribution in the different occupational groups in 2017. In the Public Service, more than 80% of professionals, technicians and associate professionals, clerical support workers and elementary occupations were African, while less than 10% of the work force in these occupational groups were white. In private health, more than 50% of positions in the same occupational groups were filled by Africans and less than a third by whites. In the total sector 70% or more of managers, professionals, technicians and associate professionals and clerical support workers were black[2].

Table 1-5 Health and social development sector: Total employment by population group 2013-2017

	2013		2014		2015		2016		2017	
Public Service	N	%	N	%	N	%	N	%	N	%
African	263 174	80	251 905	81	256 564	82	269 571	82	271 926	82
Coloured	31 864	10	31 464	10	30 124	10	31 784	10	36 644	11
Indian	8 965	3	8 781	3	8 891	3	10 325	3	5 884	2
White	21 760	7	18 106	6	17 305	6	17 721	5	17 860	5
Non-South African							614	0	340	0
Total	325 763	100	310 256	100	312 884	100	330 015	100	332 654	100
Private sector	N	%	N	%	N	%	N	%	N	%
African	131 252	50	135 491	49	143 339	53	136 254	50	138 563	52
Coloured	39 375	15	44 242	16	37 651	14	44 378	16	37 605	14
Indian	15 750	6	16 591	6	16 146	6	17 253	6	16 188	6
White	76 126	29	80 189	29	71 402	27	76 255	28	74 110	28
Non-South African					706	0	0			
Total	262 503	100	276 513	100	269 244	100	274 140	100	266 466	100
Total sector	N	%	N	%	N	%	N	%	N	%
African	400 021	68	393 135	67	399 903	69	405 825	67	410 489	69
Coloured	70 592	12	76 280	13	67 775	12	76 162	13	74 249	12
Indian	23 531	4	23 471	4	25 037	4	27 578	5	22 072	4
White	94 123	16	93 883	16	88 707	15	93 976	16	91 970	15
Non-South African					706	0	614	0	340	0
Total	588 266	100	586 769	100	582 128	100	604 155	100	599 120	100

Sources: Calculated from HWSETA and PSETA WSP applications 2013 to 2017, MEDpages database, 2013 - July 2017.

2. African, coloured or Indian.

Table 1-6 Population group distribution according to occupational-group 2017

Occupational Group	African		Coloured		Indian		White		Non South African		Total	
Public Service	N	%	N	%	N	%	N	%	N	%	N	%
Managers	9328	68	2236	16	453	3	1574	12	60	0	13 651	100
Professionals	107586	80	11549	9	3553	3	11622	9	257	0	134 567	100
Technicians and Associate Prof	55273	82	9592	14	724	1	2151	3	18	0	67 758	100
Clerical Support	32518	83	4660	12	517	1	1417	4	0	0	39 112	100
Service and Sales	30620	88	3532	10	181	1	464	1	2	0	34 799	100
Skilled Agricultural, Forestry, Fishery, Craft and Related Trades	770	67	289	25	26	2	70	6	0	0	1 155	100
Plant and Machine Operators and Assemblers	3686	86	555	13	33	1	33	1	2	0	4 309	100
Elementary Occupations	32145	86	4231	11	397	1	529	1	1	0	37 303	100
Private sector												
Managers	4 222	29	1 230	8	980	7	8 167	56			14 599	100
Professionals	49 019	47	11 347	11	7 160	7	36 550	35			104 076	100
Technicians and Associate Prof	36 775	57	8 460	13	4 219	7	15 439	24			64 893	100
Clerical Support	14 550	42	6 390	19	2 658	8	10 743	31			34 341	100
Service and Sales	19 960	69	6 553	23	592	2	1 757	6			28 863	100
Skilled Agricultural, Forestry, Fishery, Craft and Related Trades	1 502	56	591	22	141	5	462	17			2 696	100
Plant and Machine Operators and Assemblers	3 031	71	717	17	183	4	320	8			4 251	100
Elementary Occupations	9 503	75	2 317	18	256	2	671	5			12 747	100
Total Sector												
Managers	13 550	48	3 466	12	1 433	5	9 741	34	60	0	28 250	100
Professionals	156 605	66	22 896	10	10 713	4	48 172	20	257	0	238 643	100
Technicians and Associate Prof	92 048	69	18 052	14	4 943	4	17 590	13	18	0	132 651	100
Clerical Support	47 068	64	11 050	15	3 175	4	12 160	17	0	0	73 453	100
Service and Sales	50 580	79	10 085	16	773	1	2 221	3	2	0	63 662	100
Skilled Agricultural, Forestry, Fishery, Craft and Related Trades	2 272	59	880	23	167	4	532	14	0	0	3 851	100
Plant and Machine Operators and Assemblers	6 717	78	1 272	15	216	3	353	4	2	0	8 560	100
Elementary Occupations	41 648	83	6 548	13	653	1	1 200	2	1	0	50 050	100

Sources: Calculated from HWSETA and PSETA WSP applications 2017

1.6.5 GENDER

Table 1-7 shows the gender distribution in the sector from 2013 to 2017. Men's share in employment in the sector varied between 26% and 30% while women formed between 70% and 74% of the workforce.

Table 1-7 Health and social development sector: gender distribution 2013-2017

	2013	2014	2015	2016	2017
Public Service	%	%	%	%	%
Male	28	27	27	28	32
Female	72	73	73	72	68
Total	100	100	100	100	100
Private sector	%	%	%	%	%
Male	27	30	25	25	28
Female	73	70	75	75	72
Total	100	100	100	100	100
Total sector	%	%	%	%	%
Male	27	28	26	27	30
Female	73	72	74	73	70
Total	100	100	100	100	100

Sources: Calculated from HWSETA and PSETA WSP applications 2013 to 2017, MEDpages database, 2013 - July 2017.

Women are in the majority in all occupation groups, except for the two groups: Skilled Agricultural, Forestry, Fishery, Craft and Related Trades, which includes artisans and Plant and Machine Operators and Assemblers, which includes occupations such as delivery drivers which are mostly filled by men.

Table 1-8 Gender distribution according to occupational-group 2017

Occupational Group	Male		Female		Total	
Public Service	N	%	N	%	N	%
Managers	5 867	43	7 784	57	13 651	100
Professionals	32 187	24	102 380	76	134 567	100
Technicians and Associate Prof	24 608	36	43 150	64	67 758	100
Clerical Support	13 410	34	25 702	66	39 112	100
Service and Sales	13 617	39	21 182	61	34 799	100
Skilled Agricultural, Forestry, Fishery, Craft and Related Trades	857	74	298	26	1 155	100
Plant and Machine Operators and Assemblers	3 295	76	1 014	24	4 309	100
Elementary Occupations	12 799	34	24 504	66	37 303	100
Private sector	**N**	**%**	**N**	**%**	**N**	**%**
Managers	5 881	37	8 718	63	14 599	100
Professionals	31 469	21	72 607	79	104 076	100
Technicians and Associate Prof	12 931	22	51 962	78	64 893	100
Clerical Support	9 031	22	25 310	78	34 341	100
Service and Sales	5 795	24	23 068	76	28 863	100
Skilled Agricultural, Forestry, Fishery, Craft and Related Trades	2 102	83	594	17	2 696	100
Plant and Machine Operators and Assemblers	3 802	84	449	16	4 251	100
Elementary Occupations	4 469	36	8 278	64	12 747	100
Total Sector	**N**		**%**		**N**	
Managers	11 748	42	16 502	58	28 250	100
Professionals	63 656	27	174 987	73	238 643	100
Technicians and Associate Prof	37 539	28	95 112	72	132 651	100
Clerical Support	22 441	31	51 012	69	73 453	100
Service and Sales	19 412	30	44 250	70	63 662	100
Skilled Agricultural, Forestry, Fishery, Craft and Related Trades	2 959	77	892	23	3 851	100
Plant and Machine Operators and Assemblers	7 097	83	1 463	17	8 560	100
Elementary Occupations	17 268	35	32 782	65	50 050	100

Sources: Calculated from HWSETA and PSETA WSP applications 2017, MEDpages database, July 2017.

1.6.6 AGE DISTRIBUTION

Table 1-9 shows the total age distribution in the Public Service, private health and the total sector from 2013 to 2017. The overall age profile remained relatively stable in the Public service over the five-year period with people under 35 forming around 30% of the workforce and people older than 55 constituting 10% or more of the workers. Private sector data is only available from 2014 to 2017. The percentage employees younger than 35 years in the private sector is markedly higher – around 40% of the total workforce.

Table 1-9 Health and social development sector: age distribution 2013-2017

	2013	2014	2015	2016	2017
Public Service	%	%	%	%	%
Younger than 35	33	30	31	32	29
35 to 55	57	59	57	58	61
Older than 55	10	11	12	10	10
Total	100	100	100	100	100
Private sector					
Younger than 35	No data	37	41	40	37
35 to 55	No data	54	50	49	49
Older than 55	No data	9	9	11	14
Total		100	100	100	100
Total sector					
Younger than 35		33	36	35	32
35 to 55		57	54	54	57
Older than 55		10	10	11	11
Total		100	100	100	100

Sources: Calculated from HWSETA and PSETA WSP applications 2013 to 2016, MEDpages database, 2014 - July 2017

The 2017 age distribution of employees in the health and social development sector by occupational group is given in Table 1-10. In the public sector 9% of the professionals are over the age of 55. In the private sector this figure is 19%. This is probably because people employed in the public sector retire when they reach retirement age of 60 or 65 while private practitioners continue working after this age.

The larger numbers of people under the age of 35 in the private sector are concentrated in the occupational groups Technicians and Associate Professionals, Clerical Support Workers and Service and Sales Workers.

Table 1-10 Age distribution of employees in the Public Service and private health according to occupational group, 2017

Occupational Group	Under 35		35 to 55		Older than 55		Total	
Public Service	N	%	N	%	N	%	N	%
Managers	2 890	21	8 597	63	2 154	16	13 641	100
Professionals	35 786	27	86 174	64	12 636	9	134 596	100
Technicians and Associate Prof	22 494	33	39 550	58	5 790	9	67 834	100
Clerical Support	13 974	36	22 696	58	2 599	7	39 269	100
Service and Sales	9 906	28	20 987	60	3 921	11	34 814	100
Skilled Agricultural, Forestry, Fishery, Craft and Related Trades	142	12	707	61	307	27	1 156	100
Plant and Machine Operators and Assemblers	1 406	33	2 361	55	541	13	4 308	100
Elementary Occupations	8 586	23	23 405	63	5 336	14	37 327	100
Private sector								
Managers	3 185	22	8 103	57	2 945	21	14 233	100
Professionals	29 971	29	54 469	52	20 447	19	104 887	100
Technicians and Associate Prof	31 399	49	27 836	43	5 285	8	64 520	100
Clerical Support	15 619	46	15 089	44	3 209	9	33 917	100
Service and Sales	12 288	43	14 169	49	2 252	8	28 709	100
Skilled Agricultural, Forestry, Fishery, Craft and Related Trades	1 136	42	1 204	45	350	13	2 690	100
Plant and Machine Operators and Assemblers	1 237	29	2 197	52	811	19	4 245	100
Elementary Occupations	4 342	34	6 760	53	1 606	13	12 708	100
Total sector								
Managers	6 075	22	16 700	60	5 099	18	27 874	100
Professionals	65 757	27	140 643	59	33 083	14	239 483	100
Technicians and Associate Prof	53 893	41	67 386	51	11 075	8	132 354	100
Clerical Support	29 593	40	37 785	52	5 808	8	73 186	100
Service and Sales	22 194	35	35 156	55	6 173	10	63 523	100
Skilled Agricultural, Forestry, Fishery, Craft and Related Trades	1 278	33	1 911	50	657	17	3 846	100
Plant and Machine Operators and Assemblers	2 643	31	4 558	53	1 352	16	8 553	100
Elementary Occupations	12 928	26	30 165	60	6 942	14	50 035	100

Sources: Calculated from HWSETA and PSETA WSP applications and Medpages database 2017.

1.6.7 DISABILITY

In 2017 0.5% of the people employed in the sector were living with disabilities. Of the 1 192 disabled employees in the Public Service, 116 (10%) were employed as managers, 303 (25%) as professionals, 130 (11%) as technicians and associate professionals and 454 (38%) as clerical support workers. In private health, 161 (9%) were employed as managers, 429 (25%) as professionals, 383 (22%) as technicians and associate professionals and 423 (25%) as clerical support workers.

1.7 CONCLUSIONS

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 the each of the components of the sector. The fact that the sector consists of a public and a private component and that these two components differ vastly in terms of resources, functioning and skills situations will be further illustrated in the chapters to come. Suffice to say at this stage that the skills situation in the public sector is intertwined with the availability, allocation and administration of public funds while the private sector is to a larger extent subject to market forces. The labour market situation of the total sector is therefore quite complex and quantitative expressions of current and future skills needs have to be interpreted with great care.

Healthcare and social service practitioners are regulated by a number of statutory professional councils. These bodies play a formative role in determining the scope of practice for professionals and specialist occupations, and also regulate the education and training standards required to work as healthcare or social service practitioners. For this reason, they form an integral part of the skills system and the HWSETA has to work in close co-operation with them.

NPOs play an essential role in service delivery for the health and social development sector as they are major providers of community development and care services for vulnerable target groups in South Africa but few NPOs are registered as employers with the HWSETA. Engaging with them and providing in their skills needs remains a major challenge for the SETA.

Seventy per cent of the organisations in private health are small (employ fewer than 50 people), but large organisations (150 and more employees) employ the majority of the work force. Formal employment in the health and social development sector is estimated at approximately 599 000, with 45% employed in private sector organisations and 55% 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.

2 KEY SKILLS ISSUES

2.1 INTRODUCTION

This chapter starts with a discussion of various change drivers that influence the demand for skills in the sector and the supply of skills to the sector. Some of the change drivers are generic to the health and the social development parts of the sector while others are specific to either one of them. The topics are grouped accordingly. The second part of the chapter deals with the implications of national strategies and plans for skills planning in the sector.

2.2 CHANGE DRIVERS

2.2.1 OVERALL CHANGE DRIVERS FOR HEALTH AND SOCIAL SERVICES

1. CHALLENGING SOCIO-ECONOMIC REALITIES

Challenging socio-economic realities drive the need for public health services and social development interventions. Poverty affects the majority of South Africans and vast social inequalities persist (NT 2014:79). Two-thirds of adults (67%) and 50% of children live in poverty and 79% of adults earn less than R50 000 p.a. At the end of 2016 the unemployment rate was recorded at 26.5% (StatsSA 2017), with youth unemployment much higher – the joblessness rate in the 15-34 year age cohort was recorded at 37.1% (TimesLive 2017). The number of social grant beneficiaries is expected to reach 17.5 million in 2018 (NT 2015a:67). These realities increase the demand for public health and social welfare services and contribute to the already excessive work loads of public health and social welfare workers.

2. HIGH BURDEN OF DISEASE

The high burden of disease hampers economic growth and development. More than 19% of adults (ages 15-49) in South Africa are living with HIV. South Africa has the world's largest HIV treatment programme, with 3.7 million people initiated on antiretroviral (ARV) treatment as of December 2016 (South African National AIDS Council 2017). Maternal and infant mortality rates remain high (DoH 2015b:19&36) while the burden of disease is exacerbated by factors such as an aging population, the rising incidence of chronic diseases, obesity and associated conditions and growth in detected cancer cases (Deloitte 2014; DSD 2015b:9&33). As the government is taking large responsibility for reducing the burden of disease, it is important to consider that these factors increase the demand for health services and the need for more healthcare workers at all levels.

3. HIGH LEVELS OF INTERPERSONAL VIOLENCE AND OTHER SOCIAL CRIMES

High levels of interpersonal violence have thrust the injury death rate of 158 per 100 000 populations to twice the global average, and necessitate the provision of wide-ranging and integrated preventative and remedial social services (DoH 2015b:20; DSD 2015b:19&32). Excessive substance abuse adds to the social burden (DSD 2015b:18&32). Skilled professionals are needed to provide these specialised services.

4. 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. As a result, existing practitioners require new skills sets to close current skills gaps. New occupations are emerging due to changing goals in social services; e.g. in community development and child and youth care, and new qualifications have been registered. 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 (DoH 2011b:42; HWSETA 2014:72). 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 (HWSETA 2014:51).

5. 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 2009; SACSSP 2010) are required to engage in mandatory accredited continuing professional development (CPD) in order to retain their registration status (i.e. the statutory authority to practice in a particular field). The DSD and DoH are setting national norms and service standards to advance the quality of social welfare services, and to improve both the safety in and quality of healthcare services (DoH 2015b:22; DSD 2015b:33; DSD 2013a). In the health sector, preparatory work is underway to implement and sustain compliance with internationally recognised norms and standards. In future, all private and public

health facilities will be subject to inspection, quality assurance and accreditation processes controlled by the Office of Health Standards Compliance (NT 2015a:69).

2.2.2 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 healthcare services, sufficient food and water, and social security. It is recognised that to achieve economic growth and a decent living standard, the country requires a high quality, accessible health system, and comprehensive and sustainable social development services to protect vulnerable persons (NPC 2012a:16; NT 2015b:265&293; Econex 2013:8). However, policy makers 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 (DoH 2015b:14; HWSETA 2014:28). As a result, these considerations necessitate that changes be made to the skills base and skills content of available human resources in the health and social development sector.

B) SOCIAL WELFARE POLICIES AND SERVICES BECOMING MORE DEVELOPMENT ORIENTATED

Service agendas aim to: promote social inclusion and strengthen social cohesion; enable families and individuals to access services and economic and social opportunities; reach out to vulnerable people and care for persons living with disabilities (DSD 2015b:3). Newly enacted legislation and social development programmes aim to progressively expand the reach of social security provision, and to care for children in particular. These measures have a major impact on the obligations, duties and skills mix of the social development workforce.

C) REVIEW OF THE WHITE PAPER FOR SOCIAL WELFARE

While the White Paper for Social Welfare originally served as a guideline document for the social development sector, a review of the White Paper was initiated by the Minister of Social Development and the review report was published in October 2016. The Review found that there are huge gaps in social welfare service provision in critical areas affecting the well-being of children, youth in trouble with the law, the elderly, people with disabilities and those who are experiencing substance addictions and violence. These gaps in services leave the poorest individuals and households in extreme distress and undermine the transformation and change agenda identified in the NDP Vision 2030. Social workers interviewed in the review reported high levels of stress, overwhelming workloads and burnout, as well as too few supervisors who are able to focus on the training and development of their teams. This often results in a high turnover of staff. Another area of concern was that many qualified personnel do not want to work in poverty-stricken and rural areas. A national bid by DSD to National Treasury to provide for rural allowances to attract personnel to these areas did not succeed. Allocated posts thus remain unfilled or have a high turnover, affecting the ability of the sector to adequately respond to social needs of the population (Department of Social Development 2016).

2.2.3 SPECIFIC CHANGE DRIVERS IN HEALTH

A) NATIONAL HEALTH INSURANCE

The first phase in implementing the National Health Insurance (NHI), which will provide citizens with universal access to a defined package of healthcare services, is underway, with eleven pilot programmes running in key districts around the country. 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 healthcare, to specialised secondary care and highly specialised tertiary levels of care (EE Research Focus 2017).

A very important driver of change will be the National Governing Body on Training and Development announced in July 2017 as part of Institutions, bodies and commissions that must be established for the implementation of the NHI. This body will be the main institution responsible for establishing a clear vision and for recommending policy related to health sciences student education and training. Body will coordinate and align strategy, policy and financing of health sciences education with co-responsibility between the Department of Higher Education and Training (DHET) and the National Department of Health (NDOH). (Department of Health, 2017.)

B) RE-ENGINEERING AND EXPANSION OF ACCESS TO PRIMARY HEALTHCARE

Primary healthcare (PHC) is being reengineered through four streams to improve timely access and to promote health and prevent disease. These streams are: municipal ward-based primary

health care outreach teams (WBPHCOTs), integrated school health programme (ISHP), district clinical specialist teams (DCSTs), and contracting of non-specialist health professionals. Each WBPHCOT team will be led by a nurse, and the process of strengthening the nursing colleges as the primary training platform is underway. An additional 20 000 community health workers that are part of the WBPHCOTs need to be deployed in municipal wards where at least 60% of the households are poor (EE Research Focus 2017).

C) HUMAN RESOURCES PLANNING FOR THE FUTURE

A study done by the Public Health Association of South Africa in 2013 revealed that South Africa falls well behind countries against which it is benchmarked in terms of the quantity of health workers relative to its population size (EE Research Focus 2017). The document Human Resources for Health – South Africa 2030 (DoH 2011b) outlines action plans for skills planning and three core themes are addressed:

- To improve the supply and distribution of health professionals and appropriately trained health workers;
- To strengthen education and training for the health sector; and
- To improve the work environment of the health workforce.

Five foundations (DoH 2011b:41-47) are outlined, which are to:

- Train and deploy a large community based workforce, i.e. community health workers who are skilled in health promotion and disease prevention;
- Strengthen the nursing profession, and grow the number of professional nurses and mid-level nurses (staff nurses) with clinical competencies for district health teams;
- Train mid-level workers to share or shift tasks performed by doctors and pharmacists;
- Train and deploy more doctors (general medical practitioners and specialists) and specialist nurses; and
- Expand public health specialists to lead public health strategy.

2.2.4 SPECIFIC CHANGE DRIVERS IN ANIMAL HEALTH, ENVIRONMENTAL AND PUBLIC HEALTH

The demand for veterinarians, para-veterinary professionals and primary animal healthcare workers is fuelled by policy goals to expand agricultural production and safe trade in animal products; maintaining food security; and improving livelihoods.

2.3 ALIGNMENT WITH NATIONAL STRATEGIES AND PLANS

2.3.1 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 2012d:68-69). Table 2-1 summarises 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 healthcare 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 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 healthcare
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
Social Development: Provide integrated social protection & enable citizens to live with dignity	
Expand basic social welfare services for vulnerable groups	Provide protection & care services for children, families, the elderly & disabled; Train more social service workers on all occupational levels; and Build management & governance capacity of NGOs to sustain service provision
Enable children to access social care, education safety & nutrition	Expand provision of early childhood development programmes & train ECD practitioners; Address the social impact of HIV/AIDS & other challenges on children; Strengthen child protection services, supervision & mentorship for youth & orphans; and Train caregivers & social work specialists (e.g. probation officers & registered counsellors)
Support communities with sustainable livelihoods & household food security	Train community development practitioners & enhance skills set of current workforce; and Build capacity of community-based organisations to provide effective community development
Reduce social crime & support victims	Increase social care & support to families & victims; and Train social workers to manage substance abuse & crime prevention programmes

Source: National Planning Commission 2012d; DoH 2015b and DSD 2015b.

2.3.2 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 all have rolled out programmes which are aligned to their national department's mandates, which to varying extents include the human resource and skills planning elements that will be required to ensure the successful achievement of the targets (EE Research Focus 2017).

2.3.3 WHITE PAPER FOR POST-SCHOOL EDUCATION AND TRAINING

The HWSETA must implement 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 (DHET 2013:30).

Of particular importance are measures to strengthen cooperation between education and training institutions and the workplace (DHET 2013:8-10). In future, more prominence will be given to work-integrated learning (DHET 2013:64-65) to better prepare learners for the labour market. The roles of SETAs are re-defined to "mediate between education and work" (DHET 2013:67), with their main focus on developing the

skills of the existing workforce and on providing a skills pipeline to existing workplaces. SETAs will support training programmes that lead to qualifications and awards recognised by industry, rather than on short courses (DHET 2013:61). Work-based learning such as learnerships and internships in the non-artisan fields will also be expanded, and SETAs are expected to facilitate work-based partnerships between employers and educational institutions. In order to increase the training capacity of workplace providers, SETAs are required to support the education and training system as a whole (DHET 2013:61).

2.4 IMPLICATIONS FOR SKILLS PLANNING

In a resource-constrained environment with enormous demands for healthcare and social services, South Africa needs to develop skills to deliver cost-effective healthcare 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's skills planning should contribute to a sustainable skills pipeline into the sector and address entry-level as well as higher level professional skills. Third, opportunities for work-integrated learning need to be strengthened in conjunction with HWSETA partners. Fourth, in order to support cost-effective skills interventions while also expanding service capacity, the HWSETA has to contribute to the development of mid-level skills needed to strengthen health and social development service provision. 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 as well as skills shortages driven by legislative changes and the human rights-based development agenda.

2.5 CONCLUSIONS

National and provincial policies and development agendas are aligned to the NDP and they are changing the way social services and human- and animal healthcare are accessed and delivered. Increasingly, government is looking at primary and community-based services to help vulnerable persons. The needs and service expectations of the primary healthcare and social development systems are expanding and have necessitated changes to the skills base of the workforce.

The HWSETA has a central role to play in the skills provision to meet the changing needs and requirements.

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 skills supply to the sector. This is followed by an explanation of the HWSETA's PIVOTAL list.

3.2 HARD-TO-FILL VACANCIES

One of the clearest indicators of skills shortages is vacancies that remain unfilled for long periods of time despite employers' active recruitment efforts. However, the monitoring of vacancies in the health and social development sector is problematic. The HWSETA collects vacancy data as part of their scarce skills questions in the WSP submissions. This information includes actual vacant positions that organisation had been trying to fill. The PSETA on the other hand requires employers to report on "priority skills" and quantify the need by filling in a field called "projected staff". The table that employers have to fill in also include "critical skills" which allows employers to list occupations in which the current incumbents need additional skills. This formulation of the questions make it impossible to distinguish between actual vacancies that may exist in the sector and occupations in which people have been appointed, but who don't have the prerequisite skills.

3.2.1 OCCUPATIONS WITH VACANCIES IN THE PRIVATE HEALTH AND SOCIAL DEVELOPMENT SECTOR

In the 2017 WSP submissions a total of 24% of the organisations that submitted WSPs reported on hard-to-fill vacancies. They reported a total of 4 194 vacancies. The vacancies were summarised to the OFO unit group level and are presented in Table 3-1. The table clearly shows that the greatest shortage is in nursing occupations as 70% of the hard-to-fill vacancies were for nurses, i.e. nursing professionals (60%), nursing associate professionals (8%) and midwifery professionals (2%). Pharmacists are also in short supply as 228 vacancies (5% of the reported vacancies were in this unit group. This is followed by Medical and Pathology Laboratory Technicians (177 vacancies – 4% of all the vacancies reported).

Table 3-1 Hard-to-fill vacancies in the private health and social development sector according to OFO Unit Group: 2017

Unit Group	Description	N	%	Average period vacant (months)
2221	Nursing Professionals	2 505	60	7.2
3221	Nursing Associate Professionals	317	8	10.5
2262	Pharmacists	228	5	6.8
3212	Medical and Pathology Laboratory Technicians	177	4	4.6
2222	Midwifery Professionals	91	2	5.6
4321	Stock Clerks	71	2	5.8
2131	Biologists, Botanists, Zoologists and Related Professionals	71	2	4.8
2635	Social Work and Counselling Professionals	60	1	6.5
2211	Generalist Medical Practitioners	54	1	8.0
3231	Traditional and Complementary Medicine Associate Professionals	52	1	5.3
3211	Medical Imaging and Therapeutic Equipment Technicians	48	1	10.3
5311	Child Care Workers	42	1	4.0
3258	Ambulance Workers	40	1	6.9

SECTOR SKILLS PLAN

Unit Group	Description	N	%	Average period vacant (months)
5322	Home-based Personal Care Workers	39	1	9.4
2212	Specialist Medical Practitioners	37	1	9.6
3141	Life Science Technicians (Excluding Medical)	35	1	6.0
1219	Business Services and Administration Managers not Elsewhere Classified	27	1	4.9
1344	Social Welfare Managers	25	1	6.9
1421	Retail and Wholesale Trade Managers	21	1	1.7

Only unit groups in which 20 or more vacancies were reported were included in this table.

Source: HW Seta WSP submissions, 2017

3.2.2 SKILLS NEEDED IN THE PUBLIC HEALTH AND SOCIAL DEVELOPMENT SECTOR

Although there is not sufficient information available to provide a list of hard-to-fill vacancies in the public sector, it is important, for the sake of completeness, to include information on the skills situation in the public service part of the health and social development sector. Table 3-2 summarises information submitted to the PSETA by the relevant national and provincial departments. The table indicates the unit groups that were identified by the employers as "priority skills". The second last column indicates the total number of people that the employers said they would need in those unit groups. It seems as if this may include people who are currently employed and who may need further training. The last column in the table indicates the number of people that employers who cited scarcity of skills as the reason for inclusion in the table, said they would need. This may not necessarily refer to existing vacancies. It must be noted that the last column's figures are a sub-set of the second last column.

It is important to note that nursing professionals are also at the top of the public sector list. The second unit group is social work and counselling professionals. General medical practitioners and specialist medical practitioners are also high up on the list.

Table 3-2 Priority and scarce occupations required in the health and social development sector: 2015 - 2017

OFO Code	OFO description	2017 Public	2017 Private	2016 Public	2016 Private	2015 Public	2015 Private
263507	Social Worker	3 573	5	3 531	9	10 646	55
2221	Registered Nurse	4 300	2 271	2 438	3 682	5 334	2 170
532903	Nursing Support Worker	2 375	0	353	4	3 861	4
221101	General Medical Practitioner	141	54	1 912	16	1 776	92
341201	Community Worker	290	0	0	0	1 055	46
322101	Enrolled Nurse	355	317	667	37	1 015	43
325802	Intensive Care Ambulance Paramedic	20	20	920	5	932	0
226201	Hospital Pharmacist	165	85	540	90	360	7
321101	Medical Diagnostic Radiographer	316	24	152	80	216	51
332208	Pharmacy Sales Assistant	178	12	172	0	183	6
226401	Physiotherapist	134	8	172	14	133	8
221210	Specialist Physician (General Medicine)	168	7	79	14	125	14
221211	Surgeon	23	0	87	0	114	0
321201	Medical Laboratory Technician	17	177	0	26	43	70
226501	Dietician	146	2	116	0	103	2
263401	Clinical Psychologist	103	7	77	10	103	1
226902	Occupational Therapist	111	7	102	22	66	19
226102	Dentist	14	1	65	93	48	0
222201	Midwife	83	90	189	27	26	9

OFO Code	OFO description	2017 Public	2017 Private	2016 Public	2016 Private	2015 Public	2015 Private
221207	Pathologist	29	0	47	1	9	14
671101	Electrician	20	11	10	5	7	12
321301	Pharmaceutical Technician	6	5	6	2	0	28
341203	Social Auxiliary Worker	2	1	0	5	0	0
226203	Retail Pharmacist	0	139	0	181	0	344
325801	Ambulance Officer	20	20	20	0		168
	Total	**12 589**	**3 263**	**11 655**	**4 323**	**26 155**	**3 163**

Source: Calculated from HWSETA and PSETA WSP applications 2015 to 2017.

As indicated earlier in this SSP, the NGO and NPO sector is not well represented in the data available to the HWSETA. For this reason targeted studies of this component of the sector are undertaken from time to time. An HWSETA research study conducted in 2015 (HWSETA 2015a) found that NPOs had unfilled vacancies at different occupational levels, with the highest in community and personal service, and clerical work. NPOs reported vacancies for social workers, nurses, teachers, caregivers, managers and information technology professionals and technicians.

3.2.3 REASONS FOR VACANCIES

Some of the reasons for vacancies are applicable to all occupational groups. They are first outlined before reasons specific to certain groups are discussed in more detail.

A) OCCUPATIONAL WAGES

Wage disparities within the Health and Social Development Sector and between the sector and other sectors of the economy have a direct bearing on organisations' ability to fill vacancies.

Wages in the public sector are affected by public policy and public spending patterns. As a result of slow economic growth and pressures on the fiscus, Government has been compelled to curtail spending on salaries and wages in the last few years. Measures to reduce the salary bill includes withholding money to appoint human resources, reviewing funded vacancies, and seeking sustainable cost-of-living adjustments (NT 2015a:40). These measures have a direct impact on skills provision and skills retention in the health and social development sector.

The DoH introduced the Occupation-Specific Dispensation (OSD) in the health sector for nurses in 2007/08, for doctors in 2009/10 and for therapeutic personnel in 2010/11 (PMG 2009; Fisher 2013; NT 2014:67). The remuneration model aimed to eliminate salary differentials between the private and public sectors, and to attract and to retain scarce professional skills. According to Government, the growth in staff numbers in the public health sector from 254 972 in March 2008 to 307 0423 in March 2014, can be partly attributed to the success of the OSD (NT 2014:69). Unfortunately, the arrangements were hampered by poor implementation, incapacity in provincial health departments and budget constraints (DoH 2011b:35; Bateman 2010; PMG 2009). Further, OSD was not made available to health professional groups, but on an individual basis following an evaluation process (PMG 2009). Over-spending on budgets to cover shortfalls in OSD provisions resulted in the non-filling of vacant posts. In nursing, OCD benefits are only paid for some, but not all areas of post-basic training. As a result, this incentive has diverted skills development away from much needed specialist areas that are excluded from OSD provisions (HWSETA 2014:114). A research study by Fisher (2013) showed that the introduction of the OSD dispensation did not decrease the vacancy rate of doctors at a large public sector hospital.

Since 2008/09 the DSD also applies an OSD model to attract and recruit social service professionals and related occupations (DSD 2013:107). Between 2010 and 2014 the number of filled positions in provincial social development departments increased by 7%, partly due to the OSD benefits (NT 2014:180-181). While the OSD has a positive effect on vacancies in the public sector, wage disparity between the public- and the NPO sector for social services contribute to the exodus of skills from the NPO sector to the public sector. (HWSETA 2015a:94)

NGOs struggle with unreliable sources of funding (NPC 2012c:337), and many lack the infrastructure and skills to access donor funding which is often linked to stringent requirements. NGOs rely on volunteers and persons who are willing to work at lower remuneration rates than in the public sector. Insecure funding and wide discrepancies in remuneration lead to high staff turnover and an exit of skills from the NGO sector.

B) CONDITIONS OF EMPLOYMENT

It is widely recognised (DoH 2013:27; DoH 2011b:8; DSD 2015c:117) that the availability of skills is determined by factors that shape work life, such as work practices and people management; the quality of workplaces, management and leadership; the condition of equipment and facilities; workloads; unsafe working conditions; remuneration and reward systems; and access to information, training, mentoring and career development opportunities. These aspects underlie the ability to attract and retain staff, and thus impact the current skills base. In South Africa there are vast differences in the working conditions of public servants and those in the private sector. In the public service the freezing of clinical posts leads to untenable burdens on the remaining clinical staff who are already stretched to breaking point. This in turn creates a 'domino effect' leading to

more resignations and eventually to the potential collapse of poorly staffed district hospitals and community health centres (Bateman 2016b). Poor working conditions also undermine the implementation of government policies. For example, it is reported that the DoH failed to attract a sufficient number of GPs from the private sector to do session work at NHI pilot sites (Khan 2015), with poor working conditions and remuneration levels among the reasons given (PMG 2014; NT 2015b:267).

Given the nature of the work environment, the health and social development workforce are exposed to major occupational health risks associated with serving members of communities with a high TB and HIV disease burden (Adams, Ehrlich, Ismail, Quail and Jeebhay 2013:67). As a result of HIV/AIDS, skilled workers leave the sector prematurely, either because they fear infection, become ill themselves, or need to care for others who fall ill. These risks impact directly on service provision, staff retention and employers' operational costs.

C) MIGRATION

Health professionals are highly mobile and are often attracted to better career opportunities in more resourced countries. Migration of health professionals from South Africa is conservatively estimated at 25% (Econex 2013:40; DoH 2011b:20). This mobility depletes the skills base locally, affects the quality of health services and the working conditions for the remaining workforce (HWSETA 2014:32).

In the animal health sector, the high emigration rate of newly qualified veterinarians (Department of Agriculture, Forestry and Fisheries 2012:10) has an adverse impact on the provision of regulated veterinary services.

D) VACANCIES FOR NURSES

Recent research found that it is common for nurses to hold multiple jobs (i.e. to be engaged in moonlighting) and to work excessive overtime (Rispel, Blaauw, Chirwa & de Wet 2014). More nurses are opting for temporary employment via nursing agencies that contracts the nurse to health providers in the public or private sector (Rispel et al. 2014). This has an effect on the filling of permanent positions.

E) THE NEED FOR SOCIAL WORKERS

In 2016 four of the provincial departments of social development that reported high numbers of social workers needed were visited and interviews were conducted with senior officials in an effort to develop an understanding of the situation. At the time the HWSETA was aware of the fact that the DSD had made available large numbers of bursaries for social work students and that the student output in social work had soared. It was also known that there were large numbers of unemployed social work graduates in the labour market. The interviews revealed that the needs reported by the respective provincial departments are largely unfunded vacancies or positions that the departments wish to have. The fact that they were (and still are) not filled was the result of a lack of state funding and not because of skills shortages. On the contrary, the people needed to fill those vacancies were available and were waiting to be appointed. It can thus be concluded that the need for social workers actually exists at another level and that it is not an expression of skills shortages. The provinces keep on reporting the need because they are scared that if they don't, it will be said that they haven't reported the need and that the funding will never be made available.

Some of the provinces reported a shortage of supervisors and specialist social workers in areas such as adoptions and clinical work, while others said that they have an abundance of veteran social workers who could be used to supervise and mentor new appointees.

F) TRAINING FOR OCCUPATIONS

In addition to the reasons outlined above, training related issues are amongst such factors. For example, the major factor for the high vacancy rates for nurses reported in the sector relates to the ongoing changes in the qualifications and registration requirements. The large hospital groups reported that the shortages of nurses that they are experiencing is a result of the fact that they don't train enough nurses to fill vacancies in their hospitals. The training regulations and facilities are a constrain to them should they wish to train more nurses. This in turn limits the number of professional nurses who qualify and a vicious circle is created. Overall, the ever changing educational landscape especially in Basic Education, affects the quality of enrolment and output, hence there is an ongoing shortage. The narrative below on institutional arrangements and capacity give further details on how training factors are proving to be a constraint.

3.3 SKILLS GAPS

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

3.3.1 SKILLS GAPS IN SOCIAL DEVELOPMENT

In social development the following gaps were identified:

A) MANAGERS

- Supervision, mentoring, coaching and management skills. Upskilling is needed to enable social service managers to oversee case management, and to prevent the collapse of service provision at district level (DSD 2015d; HWSETA 2014:73).
- Management, human resources management and computer skills in NPOs (HWSETA 2015a:91). Given that NPOs provide

the bulk of social services on behalf of the state, the skills void among NPOs is a skills crisis.

- Technical and operational skills to improve knowledge management within the national health information management system and work processes in the social services sector (HWSETA2 014: 42; DSD 2015d; DoH 2011b: 65).

B) PROFESSIONALS

- Induction programmes for social services professionals (DSD 2015d), to prepare new graduates to be work-ready and productive (HWSETA 2014:86). Stakeholders in the social development sector have expressed their concerns about the employability and work-readiness of newly qualified social workers and social auxiliary workers.
- Advanced, post-graduate level skills (HWSETA 2014:72). These skills are needed to improve interventions in cases of substance abuse; victim empowerment; child abuse and exploitation, forensic social work (i.e. knowledge of the criminal justice system); probation work; adoptions and other emerging areas of specialisation.
- Skills to deal with working in a community context (HWSETA 2014:72); and to adopt appropriate cultural sensitive and Afrocentric approaches in social work practice (DSD 2015d).
- Communication and writing skills within the ranks of social workers, and the need for structured CPD (DSD 2015d).

C) TECHNICIANS AND ASSOCIATE PROFESSIONALS

- All-round training for social auxiliary workers (SAWs) to produce work-ready and competent mid-level workers (HWSETA stakeholder interviews 2014). New norms and standards will require SAWs to allocate 80% of their workload to basic counselling and support to families (DSD 2013a:24), and so there is a need for training in grief- and trauma counselling, and psychosocial support, and cultural diversity (HWSETA 2014:72).
- Communication and writing skills of SAWs, and the need for structured CPD (DSD 2015d).

D) SERVICE WORKERS

- Caregiver training to work with persons infected with and affected by HIV/AIDS, the elderly and persons with disabilities.
- Formal training at above basic literacy levels for community caregivers "working for" NGOs and in the EPWP (Interviews DSD 2012&2014).

3.3.2 SKILLS GAPS HEALTH SERVICES

A) MANAGERS

- Management competency, leadership and governance capacity. These capabilities need to be strengthened across all levels of the health sector (DoH 2011b:50-62; NPC 2012b:336).

B) PROFESSIONALS

- Primary healthcare: more nurses need to be trained in primary healthcare, school health and at advanced level in most of the clinical specialisation areas (DoH 2013: 38).
- Clinicians need re-orientation in community health practice (DoH 2011b:47).
- Cuban-trained medical students need further academic and clinical training in SA, as well as other supporting interventions to prepare them for the local disease burden, practice environment and health practice standards (Bateman 2013).

C) SERVICE WORKERS

- Upskilling of community health workers and home-based carers (mostly volunteers) employed by NGOs (Interviews HWSETA 2012&2014). CHWs need formal, standardised training in health promotion and disease prevention, and HBCs require formal training in disability care, mental health care and end-of-life care (DoH 2015d: 23).

D) TOTAL WORKFORCE

- On-going training to advance good practice standards, practitioner ethics and quality of care for the entire workforce (DoH 2013: 11; DSD 2015d; DoH 2011b: 56).
- Quality of healthcare needs improvement i.e. the attitudes and behaviours to provide health services with care, compassion and cost effectively (DoH 2011b:37; DoH 2013:42).

3.4 EXTENT AND NATURE OF SUPPLY

Different elements of skills supply to the sector are described in this section. Education and training provision is discussed together with supply figures (where available) and supply-side constraints contributing to current skills shortages are highlighted.

3.4.1 EDUCATION AND TRAINING PROVISION

A) ENTRY INTO THE HEALTH AND SOCIAL DEVELOPMENT SECTOR

Prospective workers enter the health and social development sector at different levels: either directly from secondary school, or following post-school training, or with little or no formal school training. Output from the secondary school system underlies the greater part of skills supply to the sector. Grade 12 mathematics is an entry requirement for most of the tertiary-level study programmes providing access to the health sector. Prospective students in the fields of health sciences, nursing, pharmacy, veterinary science and the allied health sciences also need a solid Grade 12 pass in either physical- or life sciences, or both.

Although Grade 12 mathematics and science are not barriers to entry into the social development sector, the personal attributes of learners are important. Attributes such as well-developed communication skills, personal trustworthiness, and a desire to serve others are requirements.

B) INSTITUTIONAL ARRANGEMENTS AND CAPACITY TO TRAIN THE WORKFORCE

OVERVIEW

Post-school training for the nearly 100 registered health professions takes place at public and private HEIs, provincial training colleges, and nursing- and ambulance colleges. Health- and veterinary professional training also requires a clinical health service teaching platform to develop clinical skills, patient care, and delivery of care services. It takes many years to train and equip health professionals with the required knowledge, skills and competencies. Most prospective health professionals are trained in academic health complexes established under the National Health Act (Sec 51) that aim to provide comprehensive academic-, clinical- and in-service training at all levels of care, from primary- to tertiary level, and specialised care.

The private higher education sector has, to a large extent, been barred from producing certain health professionals, mainly due to regulatory constraints (HWSETA 2014:95 However, various learning centres 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 in the electrical field.

THE TRAINING OF DOCTORS

Historically the training of doctors was undertaken by eight South African medical schools which produced approximately 1 300 doctors per annum. In January 2016, a new medical school was opened at the University of Limpopo with 60 students as its first intake. This medical school is over the longer term linked to the presidential project of building an academic hospital in Limpopo (Quintal 2016). In April 2017, it was reported that the recruitment of rare medical specialists who will work at the medical school is underway (Mahopo 2017).

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 send them to Cuba for medical training. After completion of their studies they are contracted to work in these same areas.

The Cuban trained students are not ready for registration with the HPCSA. They need to be accommodated by the local medical schools for additional training before they can sit the final professional assessment.

THE TRAINING OF NURSES

Currently the institutional arrangements for the training of nurses are undergoing fundamental changes. The qualification requirements for entry into the nursing and midwifery professions have been increased to higher NQF levels. The following new qualifications have been introduced:

(a) The Certificate: Nursing Auxiliary at NQF Level 5 replaces the Certificate in Enrolled Nursing Auxiliary at NQF Level 3.

(b) The National Diploma: Staff Nurse at NQF Level 6 replaces the Certificate in Enrolled Nursing at Level 4.

(c) The Professional Nursing Degree at NQF Level 8 replaces the Comprehensive Diploma in Nursing (General, Psychiatry and Community) and Midwife at Level 6.

The implication of these changes is that the nursing colleges now become higher education institutions (HEIs) and as such they have to be accredited by the Council on Higher Education (CHE). Previously public and private nursing colleges that were not HEIs had agreements with Universities to provide oversight and mentoring on the quality and standards of education and training at their institutions. These agreements are no longer sufficient for the accreditation requirements for nursing institutions and for the offering of the new qualifications (DoH 2013).

NEW 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). All the unit-standard based qualifications that were registered on the NQF are in the process of being re-written into a new format as prescribed by the QCTO. The QCTO requires an Assessment Quality Partner (AQP) to

administer the external integrated summative assessments (EISAs) (the final exit exams) for the respective qualifications. The HWSETA has taken on this role for some of the occupational qualifications that lead into the sector. At this stage it is responsible for the Occupational Certificates: Social Auxiliary Worker (NQF Level 5), Child and Youth Care Worker (NQF Level 5) and Health Promotion Officer (NQF Level 3). Training institutions that are accredited by the QCTO offer the qualifications and upon completion of the knowledge, practical skills and work place components of the qualifications candidates write the HWSETA 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 capacity to seek accreditation to offer the formal qualifications registered on the NQF.

WORKPLACE TRAINING

Most of the occupations that are found in the health and social development sector require workplace training. In some instances they require work integrated learning (WIL) where the workplace components form part of the qualifications and in many instances health professionals have to complete an internship before they qualify for professional registration. This means that employers in the sector form a critical component of the institutional arrangements for education and training in the sector. Workplace training is also subject to norms and standards imposed by the professional councils.

C) STUDENT OUTPUT FROM THE PUBLIC HIGHER EDUCATION AND TRAINING SECTOR

The analysis of the supply of skills at HET level is based on information obtained from the Department of Education's Higher Education Management Information System (HEMIS). From 2010 HEMIS used revised Classification of Education Study Material (CESM) categories. In the absence of official information on correspondence between the two systems (mapping) only 2010 to 2015 output is shown in Table 3-3.

If all the health-related and social welfare fields of study are considered, the total output from the Higher Education and Training (HET) sector grew on average by 9.6% from 2010 to 2015 at first three-year B Degree level and at 7.5% at first four-year B degree level. Over the five-year period, professional (four-year) degrees in the following fields showed positive growth (if the average annual growth (AAG) figures are considered): communication disorders sciences and services (11.8%), medicine (5.9%), medical clinical sciences (2.1%), nursing (5.4%), pharmacy, pharmaceutical sciences and administration (15.3%), public health (7.4%), rehabilitation and therapeutic professions (6.2%) and medical radiologic technology/ science (radiography) (14.5%). Output in social work has grown on average by 15.1% per year and the total number of students who graduated each year doubled over the period. This increase can be largely ascribed to bursaries made available by the DSD.

In most of the study fields that show a negative AAG the student output tends to be small and the number of graduates fluctuate from year to year.

Table 3-3 Number of health-related and social work qualifications awarded by public HEIs: 2010 to 2015

CESM* Category	Qualification Type	2010	2011	2012	2013	2014	2015	AAG%**
Chiropractic	First Bdegree (3 yrs)				0			
	First Bdegree (4 yrs)	48	44	52	53	40	45	-1.1
Communications Disorders Sciences and Services	First Bdegree (3 yrs)				0			
	First Bdegree (4 yrs)	114	153	141	134	169	199	11.8
Dentistry, Advanced Dentistry and Oral Sciences	First Bdegree (3 yrs)	50	38	52	68	84	82	10.5
	First Bdegree (4 yrs)	212	157	201	177	212	166	-4.8
Dental Support Services and Allied Professions	First Bdegree (3 yrs)				0			
	First Bdegree (4 yrs)	46	36	24	44	30	28	-9.5
Health and Medical Administrative Services	First Bdegree (3 yrs)	200	179	230	271	235	235	3.3
	First Bdegree (4 yrs)	258	290	270	253	91	213	-3.8
Medicine	First Bdegree (3 yrs)	1	25	40	59	60	39	108.5
	First Bdegree (4 yrs)	637	704	660	542	557	847	5.9
Medical Clinical Sciences	First Bdegree (3 yrs)	55	65	102	141	93	74	6.2
	First Bdegree (4 yrs)	1 015	936	999	973	1 024	1 125	2.1

CESM* Category	Qualification Type	2010	2011	2012	2013	2014	2015	AAG%**
Nursing	First Bdegree (3 yrs)	302	271	278	395	364	415	6.6
	First Bdegree (4 yrs)	891	958	927	943	1 171	1 159	5.4
Optometry	First Bdegree (3 yrs)	1						
	First Bdegree (4 yrs)	127	115	90	81	81	120	-1.1
Pharmacy, Pharmaceutical Sciences and Administration	First Bdegree (3 yrs)	1			1			
	First Bdegree (4 yrs)	466	509	561	687	723	950	15.3
Podiatric Medicine/Podiatry	First Bdegree (3 yrs)							
	First Bdegree (4 yrs)	6	16	3	13	15	3	-12.9
Public Health	First Bdegree (3 yrs)	20	23	63	66	63	246	65.1
	First Bdegree (4 yrs)	172	201	210	231	236	246	7.4
Rehabilitation and Therapeutic Professions	First Bdegree (3 yrs)	57	52	41	83	90	123	16.6
	First Bdegree (4 yrs)	526	555	578	598	633	712	6.2
Veterinary Medicine	First Bdegree (3 yrs)	25	25					
	First Bdegree (4 yrs)	32	29	32	34	33	33	0.6
Veterinary Biomedical and Clinical Sciences	First Bdegree (3 yrs)	25	25					
	First Bdegree (4 yrs)	97	86	95	103	98	99	0.4
Dietetics and Clinical Nutrition Services	First Bdegree (3 yrs)	16	24	20	7	7	7	-14.8
	First Bdegree (4 yrs)	110	127	118	124	127	117	1.3
Alternative and Complementary Medicine and Medical Systems	First Bdegree (3 yrs)	10	6	7	16	19	10	0.0
	First Bdegree (4 yrs)	24	26	28	9	26	18	-6.1
Somatic Bodywork and Related Therapeutic Services	First Bdegree (3 yrs)	10	5	8				
	First Bdegree (4 yrs)	47	42	40	39	28	38	-4.2
Movement and Mind-Body Therapies And Education	First Bdegree (3 yrs)		14	20				
	First Bdegree (4 yrs)	7	6	6	11	4	15	16.5
Medical Radiologic Technology/ Science (Radiography)	First Bdegree (3 yrs)	29	41	33	43	39	52	12.2
	First Bdegree (4 yrs)	77	106	98	125	130	152	14.5
Health Professions and Related Clinical Sciences, Other	First Bdegree (3 yrs)	7			27	80		-100.0
	First Bdegree (4 yrs)	11	45	47	161	132	86	51.0
Social Work	First Bdegree (3 yrs)	65	85	48	107	126	96	8.1
	First Bdegree (4 yrs)	1 169	1 297	1 671	1,881	2 121	2 362	15.1
TOTAL	**First Bdegree (3 yrs)**	**872**	**878**	**941**	**1 282**	**1 261**	**1 379**	**9.6**
	First Bdegree (4 yrs)	**6 091**	**6 436**	**6 850**	**7 215**	**7 679**	**8 732**	**7.5**

***Classification of Education Study Material**

****Average annual growth**

Source: Calculated from DHET, HEMIS.

D) SKILLS SUPPLY THROUGH NURSING COLLEGES

Public and private nursing colleges are the primary training platforms for nurses. By August 2015, the SANC had accredited 121 public nursing education institutions (NEIs) (plus 28 sub-campuses) and 101 private institutions. These NEIs comprised: public sector nursing schools (attached to provincial- and military hospitals); universities and universities of technology; private hospital academies; private hospitals; training academies of mining companies; private academies and colleges; and institutional care facilities for the elderly and handicapped persons. The number of nurses who qualified at the various levels can be seen in Table 3-4. In 2016 a total of 22 110 nurses qualified at the nursing colleges. From 2010 to 2016 total output increased on average by 0.9% per year. The four-year programme showed a marked decrease from 5 903 in 2013 to 3 811 in 2014. The figures increased slightly in 2015 and 2016, but they remained far below the number of graduates produced between 2010 and 2013.

Table 3-4 Number of graduates at nursing colleges: 2010 to 2016

Programme	2010	2011	2012	2013	2014	2015	2016	AAG %
Four-year Programme	5 690	5 647	5 908	5 903	3 811	4 043	4 179	-5.0
Bridging Course*	2 655	2 964	3 929	3 291	2 889	4 136	3 326	3.8
Pupil Nurses	7 511	7 391	7 732	8 954	6 949	8 756	7 879	0.8
Pupil Auxiliaries	5 125	5 232	5 009	5 909	6 141	5 795	6 726	4.6
Total	**20 981**	**21 234**	**22 578**	**24 057**	**19 790**	**22 730**	**22 110**	**0.9**

*Bridging into professional nurse category.

Source: SANC, 2017. Published at http://www.sanc.co.za/stats.htm. (Accessed May 2017).

3.4.2 PROFESSIONAL REGISTRATION OF HEALTH PROFESSIONALS

Healthcare- and social services professionals are required to register with their respective professional councils in order to practise or work legally. Although the registers include those working abroad and in other sectors, as well as retirees and economically inactive persons (Day and Gray: 2014:286) they provide an indication of growth in the number of professionals available.

A) REGISTRATIONS WITH THE HEALTH PROFESSIONS COUNCIL OF SOUTH AFRICA (HPCSA)

The HPCSA controls 136 registration categories through twelve professional boards. Table 3-5 shows the registration figures for a number of key professions over the period 2009 to 2016. Since 2009 the number of registered dentists grew by 3.4% per year, medical interns (i.e. medical graduates in training) by 2.8%, and medical practitioners by 3.9%. The ranks of physiotherapists (4.9%), occupational therapists (6.7%) and radiographers (3.5%) also increased over the period. The number of registered medical technologists increased only slightly (by 0.7% per year) over the total period.

Table 3-5 Number of selected professionals registered with the HPCSA as at 31 December of 2009 to 2016

Registration category	2009	2010	2011	2012	2013	2014	2015	2016	AAG %
Dentist	5 015	5 296	5 423	5 652	5 787	6 062	6 126	6 331	3.4
Medical Intern	3 006	3 619	3 862	3 338	3 396	3 279	3 215	3 653	2.8
Medical Practitioner	33 800	36 633	37 289	38 652	40 258	42 146	42 550	44 145	3.9
Medical Technologist	5 311	5 383	5 552	4 948	5 045	5 350	5 331	5 576	0.7
Occupational Therapist	3 156	3 490	3 668	3 945	4 238	4 569	4 765	4 980	6.7
Optometrist	3 023	3 083	3 168	3 342	3 458	3 628	3 645	3 751	3.1
Physiotherapist	5 261	5 773	5 954	6 328	6 585	7 001	7 122	7 370	4.9
Psychologist	6 684	6 914	7 073	7 245	7 433	7 895	8 047	8 409	3.3
Radiographer	5 800	6 208	6 500	6 225	6 645	7 088	7 239	7 378	3.5
Speech Therapist and Audiologist	1 296	1 388	1 426	1 448	1 448	1 501	1 573	1 519	2.3

Source: HPCSA, 2017.

B) REGISTRATIONS WITH THE SOUTH AFRICAN NURSING COUNCIL (SANC)

The number of nurses registered with the SANC reached nearly 288 000 in 2016 (Table 3-6). In the period from 2009 to 2016 the average annual growth in registration for all nurses was 3.4%. Enrolled nurses increased on average by 6.3% per year and Auxiliaries by 2.3%. About 18% of nurses on the SANC registers are not working in South Africa (DoH 2013: 30).

By 2016, the registered nurse category which incorporates the professional nurse category only comprised 48.9% of the registered nurse practitioners. In 2013 the DoH reported that almost 44% of registered nurses are over 50 years old and will retire at a rate of 3 000 per annum over the next 10 to 15 years. Their ranks will decline from around 50% of the total pool in 2013 to about 37% in 2020. According to the DoH there is an urgent need to train nurses at a professional degree level. The attrition rate of nurses (i.e. the gap between those who graduate in one year and register with the SANC in the following year) is estimated at 40% (DoH 2013:30), while only 50% of learners who enter training, actually qualify.

The situation with regard to the nurses in training is reflected in the bottom part of Table 3-6. The total number of registered nurses in training had dropped from almost 49 000 in 2015 to just more than 35 000 in 2016. The number of student nurses (i.e. those enrolled on the four-year programme increased by 3.2% over the period 2009 to 2016. However, most of the growth took place between 2009 and 2010. From 2011 to 2016 the numbers remained almost stagnant. The number of pupil nurses and pupil nursing auxiliaries dropped substantially in 2016. This is the result of the changes in the nursing qualifications that are currently being implemented (see paragraph 3.4.1 (b)). All the old programmes are in their training out periods while the nursing colleges have to wait for accreditation before they can enrol students on the new qualifications.

Table 3-6 Number of nurses registered with the SANC: 2009 to 2016

Registration category	2009	2010	2011	2012	2013	2014	2015	2016	AAG %
Registered	111 299	115 244	118 262	124 045	129 015	133 127	136 854	140 597	3.4
Enrolled	48 078	52 370	55 408	58 722	63 788	66 891	70 300	73 558	6.3
Auxiliaries	62 440	63 472	64 526	65 969	67 895	70 419	71 463	73 301	2.3
Total	**221 817**	**231 086**	**238 196**	**248 736**	**260 698**	**270 437**	**278 617**	**287 456**	**3.8**
Student	17 167	19 778	20 581	20 920	20 956	21 303	20 549	21 339	3.2
Pupil	13 052	16 836	16 428	16 424	15 337	18 767	18 846	10 773	-2.7
Pupil Nursing Auxiliaries	3 753	6 711	5 744	5 910	6 747	8 549	9 312	2 990	-3.2
Total	**33 972**	**43 325**	**42 753**	**43 254**	**43 040**	**48 619**	**48 707**	**35 102**	**0.5**

Source: SANC, 2017. Published at http://www.sanc.co.za/stats.htm**. (Accessed May 2017).**

C) REGISTRATIONS WITH THE SOUTH AFRICAN PHARMACY COUNCIL (SAPC)

From 2010 to 2017 the annual growth in the ranks of registered pharmacists and pharmacist interns was 2.9% and 9.0% respectively (Table 3-7). The SAPC (2011:59) estimates that 96% of registered pharmacists are practising. The registration figures in the support staff categories showed higher growth, but from a low base. The number of people registered in the category Basic Pharmacist Assistant grew steadily from 2010 to 2015 but then it more than doubled between 2015 and 2016. In 2017 there was a slight decrease. Post-basic pharmacist assistants grew steadily by 16.7% per year.

Table 3-7 Number of registrations with the SAPC: 2010 to 2017

Registration category	2010	2011	2012	2013	2014	2015	2016	2017	AAG%
Basic Pharmacist Assistant	437	622	867	1 184	1 774	1 937	4 898	3 965	37
Learner Basic Pharmacist Assistant	3 637	3 858	3 807	4 372	3 500	3 510	3 166	3 080	-2.3
Post-basic Pharmacist Assistant	3 457	4 159	4 533	5 371	6 086	6 713	7 973	10 191	16.7
Learner Post-basic Pharmacist Assistant	1 507	1 757	1 693	1 956	1 849	2 098	2 642	2 084	4.7
Pharmacist	11 939	12 346	12 805	13 119	13 589	13 658	14 053	14 552	2.9
Pharmacist Intern	566	625	619	732	808	857	1 045	1 036	9
Community Service Pharmacist							642	806	25.5
B Pharm student							3 708	4 183	12.8

Source: SAPC, 2017. Published at http://www.pharmcouncil.co.za/B_Statistics.asp. **(Accessed May 2017).**

D) REGISTRATIONS WITH THE ALLIED HEALTH PROFESSIONS COUNCIL OF SOUTH AFRICA (AHPCA)

In 2016 a total of 2 637 people were registered with the AHPCSA (Table 3-8). Since 2010, the total number of registrations dropped by 3% per year. Generally, allied health professionals and complementary practitioners work in the private sector.

Table 3-8 Total registrations with the AHPCSA: 2010 to 2016

	Number of persons registered							
Registration category	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**	**AAG %**
Acupuncture	130	118	113	99	66	64	61	-11.8
Ayurveda doctor	14	12	14	15	15	17	17	3.3
Chinese medicine	160	153	156	152	155	156	160	0.0
Chiropractic	578	603	628	647	667	731	773	5.0
Homoeopathy	541	546	565	559	557	569	572	0.9
Naturopathy	92	91	95	89	91	92	88	-0.7
Osteopathy	46	48	49	47	46	40	40	-2.3
Phytotherapy	32	39	40	38	40	43	49	7.4
Therapeutic aromatherapy	396	342	306	242	222	179	157	-14.3
Therapeutic massage therapy	194	174	163	146	138	125	111	-8.9
Therapeutic reflexology	900	783	735	662	635	584	535	-8.3
Unani-Tibb	77	81	79	70	71	73	74	-0.7
Total	3 160	2 990	2 943	2 766	2 703	2 673	2 637	-3.0

Source: AHPCSA, March 2017.

E) REGISTRATIONS WITH THE SOUTH AFRICAN VETERINARY COUNCIL (SAVC)

The number of veterinarians registered with the SAVC grew by 2.6% from 2 769 in 2010 to 3 222 in 2016 (Table 3-9). Of the para-professionals registered, 1 013 were registered as animal health technicians, 640 as veterinary nurses, and 606 as veterinary technologists. The number of people registered as veterinary technologists more than doubled between 2015 and 2016.

Table 3-9 Number of registrations with the SAVC: 2010 to 2016

Number of persons registered								
Registration categories	2010	2011	2012	2013	2014	2015	2016	AAG %
Veterinarians	2 769	2 842	2 902	3 006	3 102	3 174	3 222	2.6
Veterinary specialists	135	139	147	157	164	167	163	3.2
Animal Health Technicians		1 008	1 043	1 039	1034	1 004	1 013	0.1
Laboratory Animal Technologists		21	21	21	20	17	19	-2.0
Veterinary Nurses		542	573	589	602	611	640	3.4
Veterinary Technologists		210	246	260	287	280	606	23.6
Professionals in training	650	1 693	1 926	2 077	2 221	1 635	1 411	13.8
Total	3 554	4 762	6 858	7 149	7 430	6 888	7 074	12.2

Source: SAVC, May 2017.

F) REGISTRATION WITH THE SOUTH AFRICAN COUNCIL FOR SOCIAL SERVICE PROFESSIONS

From 2010 to 2014, the total number of registered social workers increased on average by 9% (Table 3-10). The majority (87%) of currently registered social workers are women. Registered social auxiliary workers (NQF Level 4) increased on average by 24.9% per annum.

Table 3-10 Social workers and social auxiliary workers registered with the SACSSP: 2010 to 2015

Occupation	2010	2011	2012	2013	2014	2015	AAG (%)
Social Workers	14 904	15 866	16 164	16 682	18 213	22 973	9.0
Social Auxiliary Workers	2 729	2 980	3 243	4 489	5 239	8 293	24.9

Source: SACSSP, June 2015.

3.4.3 SUPPLY-SIDE CONSTRAINTS

A) READINESS OF CANDIDATES TO ENTER ACADEMIC TRAINING

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 (Interviews DSD 2012&2014; Ross 2012).

Academic criteria for admission to social work programmes are generally in the lower ranges, and students tend to under-estimate the training demands (HWSETA 2014:121). High drop-out rates at nursing colleges are a further indication that prospective learners are not prepared for training at post school level (HWSETA 2014:94).

Many volunteer workers enter the sector unskilled via government's EPWP and require basic literacy training prior to undergoing training to work as community caregivers and community health workers (Interviews DSD 2012&2014).

B) TRAINING CAPACITY

Training capacity for health professionals remains limited (DoH 2011b:26; DoH 2013:35) due to infrastructure constraints and restrictions on academic clinician posts, bed count, laboratories and other clinical teaching resources.

While the training of doctors in Cuba provides a solution to the skills shortages in the country, this is not without challenges. A significant challenge to the programme is that Cuba's medical schools focus more on preventative medical training while South Africa's focus more on curative training. The returning students need to be re-orientated towards South Africa's very different disease profile. It is said that local medical tutors spend 12-18 months re-orientating the Cuban-trained fifth-year students to English medical terminology, and better positioning them for the unique local 'diseased, injured and/or dying' patient profiles. They also need much preparation

before they can sit for the domestic final exam. One of the ways in which these challenges are overcome is by allowing the students to join their locally-trained counterparts at local medical schools for modules in their fourth, fifth and sixth years. However, this arrangement puts a huge amount of additional pressure on the local medical schools (Bateman, 2013).

Increased enrolment of social work students has put pressure on student-lecturer ratios at public HEIs (HWSETA 2014:120). 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 (Interviews HWSETA 2012&2014). Universities are challenged to place and maintain students in fieldwork training due to capacity and resource constraints of NGOs and employers, as well as the lack of supervision and mentorship (Ross 2012), which adversely affect training outcomes (DSD 2015d).

The DSD (2015:12) attributes the shortage of ECD workers to a shortage of teaching and training skills, as well as limited training capacity at TVET colleges, accredited private providers and NGOs.

The HWSETA's capacity to facilitate skills development for NGOs is hampered by funding constraints because the NGOs are levy-exempt organisations. Stakeholders emphasised the need to capacitate NGOs to provide accredited workplace training, and to enable them to involve external, experienced practice supervisors to oversee experiential learning (HWSETA 2014:97).

C) TRANSITION TO NEW QUALIFICATIONS

As explained earlier in this chapter, from 2016 onwards nursing education is placed in higher education. Auxiliary nurses and staff nurses require NQF level 5 and NQF level 6 qualifications respectively, midwives need advanced diplomas (NQF level 7), and professional nurses must attain professional degrees (NQF level 8). Public and private nursing colleges have to meet more stringent accreditation criteria, while clinical education has to be strengthened and qualified clinical preceptors and clinical supervisors have to be trained.

At this stage backlogs are experienced in the accreditation of nursing colleges. This has led to a drop in student enrolments which in turn will have an effect on the skills shortage position.

3.5 THE HWSETA PIVOTAL LIST

3.5.1 OVERVIEW

The professional, vocational, technical and academic learning (PIVOTAL) programmes are a combination of theoretical, practical and workplace training. PIVOTAL programmes therefore include internships, work integrated learning, apprenticeships, work experience placements that lead to a trade test or professional designation (candidacy), bridging course/ examinations of qualifications that lead to a designation.

SETAs are obliged to develop PIVOTAL lists as part of their sector skills planning processes. These lists are meant to align training programmes offered in and for the sector to the scarce skills or skills shortages experienced in the sector. The PIVOTAL lists are then used to guide funding decisions in the SETA.

In the preparation of a PIVOTAL list, the HWSETA has to take a holistic view of its sector, the skills composition and skills needs of the sector and the education and training pipelines that supply skills into the sector. It has to be borne in mind that the Health and Social Development Sector is a large and complex sector and that it does not only depend on core health and social service professions and occupations. There are support occupations that are relatively small in number, but that are critically important for the functioning of hospitals and other facilities, for example financial occupations and some of the trades.

Another factor that has to be borne in mind in the development of the list is the SETA's obligations in terms of national strategies. All SETAs have an obligation to assist with the alleviation of unemployment and poverty.

3.5.2 METHODOLOGY

The development of the PIVOTAL list starts with an analysis of the occupations in the sector and employment in those occupations. This is followed by an analysis of the vacancies in those 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 as well as the Medpages database 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 and to augment this list 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. As explained earlier in the chapter clarification is sometimes needed regarding the figures presented by employers in their WSP submissions (e.g. the situation regarding social workers and nurses).

The PIVOTAL list is ranked according to the number of people needed. However, this ranking does not necessarily signify preferential funding.

The type and nature of the learning programmes that lead into each identified occupation is identified in a further step. This in turn leads to the interventions indicated in the SETA PIVOTAL list. The number of interventions that the SETA can support depends on various considerations:

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

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

For the HWSETA PIVOTAL list please see Annexure C.

3.6 CONCLUSIONS

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 healthcare and social development services and changes in the way these services are delivered to the public. Evidently, high vacancy rates are reported for health and social service professionals.

It is evident from the foregoing analysis that the health and social development sector is challenged by significant occupational mismatches, especially in respect of the professional workforce. These mismatches are seen at a number of levels. First, there are imbalances between skills output versus the occupational demand in the workplace e.g. vacancies. Second, there are mismatches between skills provision (output) and actual skills absorption in the labour market. Skills absorption is determined by a variety of factors including workforce budgets, human resources practices, management of health and social welfare systems and working conditions. Third, mismatches exist when the education system fails to produce the package of skills required in the workplace, i.e. the combination of knowledge, clinical skill, capability, professional ethos and work-readiness needed when entering the profession on day one. 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 healthcare, and the new nurse practitioner categories and new qualifications.

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

The state's expanding development agenda referred to in Chapter 2 that is aimed at improving access to healthcare 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.

4 SECTOR PARTNERSHIPS

4.1 INTRODUCTION

Among the keystones in advancing the developmental state are to improve citizens' lives with accessible healthcare, adequate social protection and opportunities for socio-economic participation. On its own the HWSETA cannot meet these demands and therefore depends on the collaboration of many different entities. First, this Chapter provides an overview of the HWSETA's partnership model and existing partnerships. Second, successes and challenges with the partnership approach, as well as measures aimed at strengthening partnerships are considered. Third, potential new partnerships are identified and action plans to implement them are outlined.

4.2 HWSETA SUCCESSFUL PARTNERSHIP MODEL

The HWSETA enters into dedicated project-based partnerships, based on skills development needs where the partners have agreed deliverables and cooperate to achieve stated goals. The HWSETA uses a project-based partnership model as a mechanism to devise, design, develop, deliver and deploy the skills and competencies required in the sector. Typically, all the partners are involved in developing their capacity and aligning their resources to deliver the skills development interventions. Throughout the various stages, the HWSETA adopts different partnership roles and act as researcher, facilitator, Development Quality Partner (DQP), administrator, Assessment Quality Partner (AQP), funding provider, monitor and evaluator. The final stage concerns deployment of the skills and evaluation by the HWSETA.

4.3 EXISTING PARTNERSHIPS

The HWSETA participates in a range of partnerships so that it may offer different entry points into work in the health and social development sector.

4.3.1 STATE OF EXISTING HWSETA PARTNERSHIPS

A) PARTNERSHIPS WITH TVET COLLEGES AND SSACI

By the end of the 2014/15 financial year, the HWSETA had entered into partnerships with 11 public TVET colleges[3] that offer relevant programmes leading to artisan, vocational, technical and occupational health and social development related qualifications. Since then work has been extended to some of the satellite campuses of these colleges. In its work with the TVET colleges the HWSETA focuses on the NATED courses – especially on the 18 month internship required for the National Diploma. Another development is that the HWSETA has also entered into partnership with the Swiss-South African Cooperation Initiative (SSACI) which is a public-private partnership in development aimed at strengthening the public skills training system in South Africa. SSACI plays a pivotal role in the management of projects with TVET colleges and in the recruitment, selection and placement of learners. SSACI also provides learners with a six months work readiness programme before placement.

B) PARTNERSHIPS WITH AGRICULTURAL COLLEGES

The HWSETA provides funding for and works with agricultural colleges to train animal health technicians. These interventions also include provisions for lecturer development.

C) PARTNERSHIPS TO DEVELOP HIGH LEVEL SCARCE AND CRITICAL SKILLS

Through its eight partnerships with Universities, the HWSETA provides funding for post graduate research relevant to the health and welfare sector at Masters- and Doctorate level. The study areas cover both human and animal health, and welfare services.

Employed and unemployed undergraduate learners benefit from bursary funding to study towards a qualification in fields identified as scarce and critical skills (HWSETA partnership with NSFAS).

3 These are Umfolozi-, South West Gauteng-, East Cape Midlands-, King Hintsa-, Mnambithi-, Taeletso-, Northlink-, False Bay-, Tshwane South-, Letaba TVET College and the College of Cape Town.

The HWSETA entered into a partnership with the Walter Sisulu University to support the institutional turnaround strategy driven by the DHET to strengthen lecturer capacity and academic infrastructure to teach in fields relevant to the health and welfare sector.

A partnership with the Faculty of Veterinary Science at the University of Pretoria is multi-faceted and consists of: Financial support to equip the skills laboratory; funding for the establishment of two co-ops in the neighbouring community and the development of skills for the manufacturing of teaching aids in animal health; funding of work integrated learning for students; the establishment of partnerships between the Faculty and agricultural colleges for the training of animal health technicians; student bursaries; an "adopt a school" project whereby veterinarians teach school children about animal health; and research incentive bursaries to strengthen the lecturing capacity of the Faculty.

D) PARTNERSHIPS FOR OCCUPATIONAL QUALIFICATIONS

The HWSETA established the Qualification Development and Maintenance (QDM) sub-division which is dedicated to producing new industry-relevant qualifications, and to replace and re-curriculate legacy qualifications. All occupational qualifications are developed in partnerships and in accordance with the requirements of the Quality Council for Trades and Occupations (QCTO). At the time of writing, the HWSETA had served as development quality partner (DQP) for three new occupational qualifications and has taken the responsibility as assessment quality partner (AQP) for these qualifications. The SETA is currently working on the development of several new qualifications.

In its role as DQP and AQP the HWSETA works closely with the QCTO as well as with a group of expert practitioners sourced from the sector. These experts assist with the assessment of learners.

4.3.2 PARTNERSHIP SUCCESSES

The partnerships producing the most successful outcomes involve TVET Colleges with strong links to industry and with on-site practical training capacity. Guest lecturers from industry supplement the academic teaching offered by the TVET Colleges. Structured simulation training in workshops at the TVET colleges helps to prepare learners to enter apprenticeships.

The inclusion of the SSACI in the HWSETA work with TVET colleges has so far proved to be highly successful. SSACI brings strong project management skills to the partnership and has a far-reaching network of employers who are involved in the placement and training of learners. An important ingredient of this successful partnership is the relationship of trust that has been built between SSACI and employers.

4.3.3 FACTORS THAT WORK WELL IN PARTNERSHIPS

A) PARTNERSHIP STRUCTURE AND PARTICIPATION

The HWSETA involves multiple partners to optimise resources, address the actual skills needs of current and future employers, and to ensure community buy-in where this is required. For example, a HWSETA partnership with TVET colleges in the Western Cape involves community forums from Khayelitsha and Mitchell's Plain. Where additional preparatory work is required for successful skills provision, the HWSETA provides support.

B) LECTURER EXPOSURE TO THE FIELD OF TRAINING AND LEARNER SELECTION

Of the recent HWSETA partnerships with TVET Colleges to provide learners with training in entrepreneurship, the most successful programmes included learners and lecturers who had themselves participated in entrepreneurial pursuits. Both lecturer and learner had context for the learning programme, and such learners were more receptive to training, as 60% of them were successfully running their own businesses 12 months after completing their training.

C) NETWORKING

In order to meet its obligations as DQP and AQP with regard to occupational qualifications, the HWSETA has, for example, established networks of technical experts and practitioners to support qualification development in various occupational fields.

D) PRIVATE SECTOR INVOLVEMENT

An overall observation is that partnerships involving private sector employers are more successful that those involving public sector organisations. Greater efficiency and co-operation is experienced in the private sector.

E) GOOD PREPARATORY WORK FOR NEW QUALIFICATIONS

The development of new qualifications progress much easier if the preparatory work is done well. This includes research to establish the need for the qualification, the timeous involvement of all stakeholders and the early involvement of the QCTO.

4.3.4 PROBLEMS EXPERIENCED WITH PARTNERSHIPS

A) LIMITED FINANCE AND UNREALISTIC TARGETS

The HWSETA has to contend with a limited budget and it has to provide for multi-year interventions because the learning programmes required for employment in the sector are in some instances quite long. For partnerships to bear fruit in the long run, the SETA needs to commit funding over multiple years. At the same time it has to comply with targets set by the DHET – some of which are difficult to meet.

B) DIFFERENCES BETWEEN TVET COLLEGES

There are vast differences in the resources and the abilities of the different TVET colleges. Some are very well equipped and are able to provide the training at the standard required. Others are, however, under resourced and not able to perform at the required level.

C) FAILURE TO MEET TARGETS

Factors such as capacity problems at the TVET Colleges, as well as frequent changes to management and high turnover of academic staff hamper the roll-out and continuity of training programmes.

D) CONSTRAINTS ON THE PART OF NSFAS

Capacity constraints on the part of NSFAS to comply with HWSETA funding requirements as well as administrative bottlenecks at universities caused delays in the payment of the bursary funding. For this reason, the HWSETA aims to develop capacity in projects in order to facilitate timely deliverables.

E) LACK OF RESPONSIVENESS BY THE QCTO

At this stage it seems as if the QCTO doesn't have the capacity to deal with all the new developments that they are responsible for. This leads to a lack of responsiveness on their side which in some instances hinder the work of the SETA. On the other hand, this leaves room for the SETA to be creative and to find its own solutions to challenging situations.

F) LACK OF CAPACITY AMONG NGOS AND CBOS

The important role of NGOs and CBOs in the health and social development sector has been emphasised in earlier parts of this SSP. Partnerships with this component of the sector are important for the HWSETA. However, most of these organisations are small and they don't have the capacity to conceptualise partnership projects, to write funding proposals or to manage projects. This lack of capacity limits the HWSETA's ability to enter into meaning partnerships with them.

4.3.5 INTERVENTIONS TO STRENGTHEN PARTNERSHIPS

A) ADOPT A MORE STRATEGIC ROLE

In moving forward with the many HWSETA partnerships and improving their outcomes, the Research, Information, Monitoring and Evaluation (RIME) division of the HWSETA will monitor partners' performance throughout, validate partners' progress reports and performance to timely identify problems and risks requiring action. Learner progression will be monitored as well as the drop-out rate to develop a better understanding of learners' challenges. In-house capacity to monitor learners will be strengthened.

B) INCREASE UNDERSTANDING THROUGH RESEARCH

In addition to the continuous monitoring and evaluation of projects research and analysis will also focus on:

- The implementation of skills provision projects and the contributions of the various partners to projects.
- The constraints and limitations that employers experience in the implementation of learnerships.
- The placement and employment destinations of beneficiaries of HWSETA funding for learnerships, internships and workplace experience (tracer studies).
- Baseline studies of NSFAS (bursary) students and the impact of the skills development interventions.
- Partnership opportunities with NPOs to provide opportunities for young people who seek work experience, work exposure and entry into the sector.

4.4 NEW PARTNERSHIPS

The HWSETA will continue to engage with stakeholders and role-players in the health and welfare sector to develop new partnerships. Some of the partnerships that are in the process of development are listed in Table 4-1 below.

Table 4-1 New partnerships under development by the HWSETA

Planned partnerships	Projects
HWSETA and University of Witwatersrand	Partnership on the implementation of internships for Drama Therapy graduates. At this point the project has been implemented and still running.
HWSETA and Falsebay, College of Cape Town, and Northlink TVET College	ECD Training and artisan development for learners from the Mitchels Plain and Khayelitsha Area in the Western Cape.
HWSETA and Walter Sisulu University	Funding towards the turnaround strategy of the Health and Social Sciences Faculties of the university. Purchasing of Training aids, Training of lecturers **and** assistance in the re-accreditation of social work qualification. The implementation of this project has commenced.
HWSETA and King Hintsa TVET College	The project is based on the Social Auxiliary Learnership. The partnership also involves the DSD.
HWSETA and University of Pretoria	Multiple projects focusing on undergraduate bursaries, research incentives bursaries, executive leadership programme, teaching aid, cooperatives, adopt a school, agricultural college partnerships and work integrated learning have commenced.
HWSETA and University of Pretoria	Research Partnership into primary health care, specifically training and employment of carers.
HWSETA and Letaba TVET College:	Multiple projects focusing on capacity development and building, work integrated learning, teaching aid and bursaries.

4.5 CONCLUSIONS

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

The 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 success, progress was hampered by a lack of finance, poor stakeholder responses and participation, delays and labour market constraints that prevented learners from entering gainful employment. Moving forward, the HWSETA will continue to adopt corrective measures and different strategies to advance the successful production of skills. By increasing its capacity to track the progress of partners, providers and learners through research, the HWSETA will be able to respond to challenges sooner, in order to improve the outcomes of skills development partnerships. The HWSETA will continue to engage with its stakeholders and conduct research to keep abreast of changing skills needs in the sector.

5 SKILLS PRIORITY ACTIONS

5.1 INTRODUCTION

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

5.2 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 para professionals
- Statutory councils have a core role to regulate almost all aspects of professions and occupations
- NPOs are vital 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

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 be targeted, cost-effective and prioritised to

- build the developmental state
- enable a sustainable skills pipeline into the sector
- strengthen work-integrated learning
- expand service capacity via the production of mid-level skills, and to
- professionalise the workforce

Chapter 3:

- Employers face major complex and long-term skills challenges
- The skills needs of the public service component of the sector is 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 nursing profession
- Management and supervision skills are needed at all levels
- The skills gaps experienced across occupations are varied and plentiful
- A strategic priority is to strengthen education capacity and clinical- and practical training platforms
- Effective delivery of national healthcare initiatives and social services programmes depend on a skilled and professionalised workforce

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

5.3 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 begins with the HWSETA's processes put in place to set skills development priorities. This is followed by outlining strategic goals of the SETA in line with the identified skills development priorities, and aligning the HWSETA's strategic plans with national strategies and plans.

5.3.1 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 three overarching skills development priority areas:

a. A sustainable skills pipeline into the health and social development sector;

b. Professionalisation of the current workforce and new entrants to the sector; and

c. Vital skills and skills sets required to enable the state to meet its service delivery obligations as a developmental state.

These skills development priorities are viewed from a strategic perspective. Firstly, a sustainable skills pipeline enables entry into employment in the health and social development sector at different entry points. Secondly, by prioritising the professionalisation of the workforce, the HWSETA can contribute to skills interventions required to improve service quality and efficiency, and also address changes to service provision. Thirdly, the HWSETA can support the large-scale skills development interventions needed in for the state to enhance the lives, health, well-being and livelihoods of its citizens. Table 5-1 outlines the key challenges that exist in these three skills development priority areas.

Table 5-1Key challenges in the HWSETA skills development priority areas

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

Skills development priority area			Key challenges
Sustainable skills pipeline	Sustained employment: Up-skill in workplace	New entrants	Gap between graduation, professional registration & entry to work in 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 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 practice
			Skills distribution: urban v rural areas
			Health & social development information systems
Professionalisation of current workforce	In service and at work	New entrants	Work-ready with Day One Skills to serve
			On-boarding & orientation of social services professionals
			Mix of a 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 changed scope of practice requirements
			Up-skill to attain new & higher level qualifications
			Up-skill to meet new norms & standards for practice
			Articulation between vocational & other post-school occupational training
Grow developmental state	Public sector and NPO sector	Learners/students	Training at lower occupational levels often informal
			Service provision in rights-based context
			Candidate selection for large-scale scholarship programmes
		New entrants	Service provision in rights-based context
			Lack of posts to absorb new entrants into public service
		Employers	Weak governance and management systems in public sector & NGOs
			Sustainability of NPOs providing social services for state
			Scale & diversity of training interventions required
		Current employees	Service provision in rights-based context
			Large numbers of volunteers & part-time workers with poor/little skills
			Weak accountability

5.3.2 STRATEGIC GOALS OF THE HWSETA

Table 5-2 outlines the HWSETA's outcome orientated strategic goals for the period 2017 to 2022 which are critical for the achievement of the SETA's legislative and policy mandates. These goals also provide context for the HWSETA's skills development priorities over the medium to longer term. These HWSETA strategic goals are aligned to the NSDS III goals.

Table 5-2 The HWSETA strategic goals for the period 2017-2022

Strategic outcome orientated goals of the HWSETA
1. Skilled and work ready graduates in occupationally directed programmes join the health and social development fields of work
2. Work based skills development contribute to improved productivity and economic growth in the sector
3. College system expanded to offer pathways to occupations for school and post school youth
4. Demand-led skills development strengthened to implement the National Development Plan
5. A skilled workforce supporting an efficient administrative system for effective execution of skills development mandate

5.3.3 MEASURES TO SUPPORT NATIONAL PRIORITIES AND PLANS

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

- The NDP (NPC 2012e:268) requires of SETAs to focus on skills development for existing workplaces, the current workforce and unemployed persons who wish to enter employment in their sector. Training should take place across all the NQF qualification levels required in the sector. The HWSETA's skills programmes already address these requirements and will continue to do so in the future.
- The NDP (NPC 2012e:261) states that work experience improves productivity and enables a virtuous cycle that grows the economy. The NDP (NPC 2012e:287) requires of SETAs to increase linkages between post-school education and workplaces, to provide funding for work experience programmes and internships. The HWSETA works actively to provide funding for internships, work-integrated learning and work experience across many occupations.
- The NDP (NPC 2012e:266) calls for an expanded system of further education and training and skills development opportunities to young people who obtained a low pass in the NSC, as well as older people who wish to improve their skills, as well as people who had no or little access to education. The HWSETA will continue to support skills programmes that further these NDP goals.
- The NDP calls for the production of highly skilled professionals (NPC 2012e:289) to be expanded and for SETAs to provide more financial support to assist students from disadvantaged backgrounds (NPC 2012d:68). The NDP states that more people need to access post-school education and attain qualifications at intermediate or high level (NPC 2012e:286). The HWSETA funding provisions address these aspects.
- The NDP requires SETAs to build strong relationships between TVET colleges, other training institutions, industry and employers. The HWSETA works in partnership with such institutions to deliver vocational and occupationally-directed training.
- The NDP (NPC 2012e:288) calls for a strong quality assurance and qualification system to support public training provision and enable and regulate private training provision. The HWSETA is actively involved in the development of occupation qualifications for the health and social development sector and acts as AQP for some occupational qualifications.
- In line with calls in the NDP for increased access to career guidance (NPC 2012e:287), the HWSETA has a dedicated project in this regard.

In line with NSDS III priorities, all projects and funding programmes of the HWSETA target the participation of learners who are African, women, disabled, youth and residents of rural areas. Table 5-3 shows the link between the goals of the NSDSIII and the HWSETA's skills priorities.

Table 5-3 Alignment of NSDSIII goals and HWSETA skills development activities

NSDS III goals		HWSETA skills development activities
1	Establish a credible institutional mechanism for skills planning	Conduct extensive research to understand changing skills needs
		Engage with stakeholders, training providers, employers & key role-players
		Monitor and track performance of skills development partners & learners
2	Increase access to occupationally-directed programmes	Targeted funding to train artisans and learners in vocational occupations
		Form partnerships to develop occupational qualifications & fund learning programmes under those qualifications
		Support training via learnerships and internships
3	Grow capacity of public TVET colleges to respond to sector & national skills needs	Support learners in pre-apprenticeship training
		Support vocational training of unemployed learners at TVET colleges
4	Address low level of youth and adult language and numeracy skills to enable additional training	Support skills programmes to advance skills in sign language in the sector
		Support adult education & opportunities to enhance mobility of disabled persons
5	Encouraging better use of workplace-based skills development	Provide funding for experiential learning to produce work-ready graduates
		Improve work-place productivity by funding relevant skills programmes
		Support skills formation via learnerships and compulsory work experience
6	Supporting cooperatives, small enterprises, worker-initiated, NGO and community training initiatives	Provide funding to address skills development needs of NGOs and cooperatives
7	Enable public sector to improve service delivery and building of a developmental state	Use discretionary grant funding for targeted projects in public sector
		Fund development of critical and scarce skills at high-, medium- and low occupational levels
8	Building career and vocational guidance	Career guidance initiatives market occupations in the health and social development sector

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 sector. The skills issues identified in this SSP link into the Medium-Term Strategic Framework (MTSF); White Paper for Post-School Education and Training; National Health Insurance in South Africa (Green Paper); Human Resources for Health 2030; Pharmacy Human Resources in South Africa 2011; The National Nursing Strategic Plan for Nurse Education., Training and Practice 2012/13 – 2016/17; Draft Early Childhood Development Policy, Draft Policy for Social Service Practitioners; National Environmental Health Policy; Draft Municipal Ward-based Primary Healthcare Outreach Team Policy Framework and Strategy; Industrial Policy Action Plan (IPAP), the New Growth Plan (NGP) and the National Skills Accord (NSA).

5.3.4 HWSETA SKILLS PRIORITY ACTIONS FOR THE PERIOD 2017 TO 2022

A) THE SKILLS PIPELINE INTO THE HEALTH AND SOCIAL DEVELOPMENT SECTOR

The overriding priority for the HWSETA is to strengthen and sustain the inflow of skills to the health and social development sector at all qualification levels on the NQF. 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; and
- Promoting adult education and training and lifelong learning.

C) VITAL SKILLS REQUIRED FOR THE DEVELOPMENTAL STATE

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

- 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.

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.

5.4 CONCLUSION

This Chapter outlined the broad skills development priority areas and actions for the health and social development sector over the period 2017 to 2022. In designing and implementing skills programmes and skill projects, the HWSETA will be guided by three skills development priority themes:

- A sustainable skills pipeline into the health and social development sector;
- Professionalisation of the current workforce and new entrants to the sector; and
- Vital skills and skills sets required to enable the state to meet its service delivery obligations as a developmental state.

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

6 BIBLIOGRAPHY

Adams, S., Ehrlich, R., Ismail, N., Quail, Z. and Jeebhay, M.F., 2013, "Occupational Health Challenges Facing the Department of Health", A. Padarath, and R. English, (eds.), *South African Health Review 2012/13*, viewed 22 April 2015, from http://www.hst.org.za/publications/south-african-health-review-2012/13.

Bateman, C., 2016a, "Budget squeeze: Cutting clinicians hurts patients", *The South African Medical Journal*, 106(4), 321.

Bateman, C., 2016b, "PE hospital turmoil: CEO leaves, nurses snore in-patient beds", *The South African Medical Journal*, 106(4), 320.

Bateman, C., 2013, "Doctor shortages: Unpacking the 'Cuban solution'" *The South African Medical Journal*, 103, viewed 28 July 2015, from http://www.samj.org.za/index.php/samj/article/view/7323/5357.

Bateman, C., 2010, "Occupation-specific dispensation – a hapless tale". *South African Medical Journal,* May 2010, 100 (5), viewed August 2010, from http://www.scielo.org.za/pdf/samj/V100n5.

CARISA, 2014, *The South African Professional and Industry Bodies Sector – the 2014 Benchmark*, Johannesburg.

Council for Medical Schemes, 2014, *Annual Report 2013/14.*, viewed 17 April 2015, from https://www.medicalschemes.com/Publications.aspx.

Day, C. and Gray, A., 2014, "Health and Related Indicators", A. Padarath, and R. English, (eds.) *South African Health Review 2013/14,* viewed 22 April 2013, from http://www.hst.org.za/publications/south-african-health-review-201314.

Deloitte, *2014, South African Healthcare Outlook,* viewed 16 April 2015, from http://www.asaipa.co.za/Attachments/2014-South-African-Healthcare-Outlook.pdf.

Department of Agriculture, Forestry and Fisheries (Republic of South Africa), 2012, *Memorandum to the Veterinary and Para-Veterinary Professions Amendment Bill* 2012, viewed 23 April 2015, from http://pmg-assets.s3-website-eu-west-1.amazonaws.com/bills/120614b25-2012_0.pdf.

Department of Higher Education (Republic of South Africa), 2013, *White Paper for Post-School Education and Training*, viewed 29 April 2015, from http://www.dhet.gov.za/SitePages/Home.aspx.

Department of Health (Republic of South Africa), 2017. NHI Implementation:Institutions, bodies and commissions that must be established. Government Notice 660. July 2017.

Department of Health (Republic of South Africa), 2015a, *Annual Performance Plan 2016/17-2018/19*, viewed 20 April 2016, from file:///C:/Users/Elsje/Downloads/app%20%20inside%202016%208%20march%202016%20lowres.pdf.

Department of Health (Republic of South Africa). 2015b. *Strategic Plan 2015-2020*, viewed 20 April 2016, from http://www.health.gov.za/index.php/2014-03-17-09-09-38/strategic-documents/category/229-2015str.

Department of Health (Republic of South Africa), 2015c, *Health Priorities*, viewed 30 April 2015, from http://www.health.gov.za.

Department of Health (Republic of South Africa), 2015d, *Draft Municipal Ward Based Primary Health Care Outreach Team (Wbphcot) Policy Framework and Strategy*. Pretoria: Department of Health.

Department of Health (Republic of South Africa), 2013, *The National Nursing Strategic Plan for Nurse Education, Training and Practice 2012/13 – 2016/17*, viewed 7 July 2014, from http://www.sanc.co.za/archive/archive2013/NursingStrategy2013.html.

Department of Health (Republic of South Africa), 2011a, *National Health Insurance in South Africa: Policy Paper,* viewed 12 August 2011, from http://images.businessday.co.za/NHI.pdf.

Department of Health (Republic of South Africa), 2011b, *Human Resources for Health 2030*, viewed 22 April 2015, from http://www.hst.org.za/publications.

Department of Health (Republic of South Africa), 2011c, *National Environmental Health Policy. Government Gazette* No 34499, viewed 3 August 2011.

Department of Social Development (Republic of South Africa), 2015a, *Annual Performance Plan 2015-2016*, viewed 16 April 2015, from http://www.dsd.gov.za.

Department of Social Development (Republic of South Africa), 2015b, *Strategic Plan 2015-2020*, viewed 16 April 2015, from http://www.dsd.gov.za.

SECTOR SKILLS PLAN

Department of Social Development (Republic of South Africa), 2015c, *Draft Early Childhood Development Policy*, viewed 10 May 2015, from http://www.gov.za/sites/www.gov.za/files/38558_gon204.pdf.

Department of Social Development (Republic of South Africa), 2015d, Resolutions and Declaration – First Social Work Indaba, viewed 18 May 2015, http://www.dsd.gov.za/index.php?option=com_content&task=view&id=686&Itemid=1.

Department of Social Development (Republic of South Africa), 2015e, *State of South African registered Non-Profit Organisations 2014/15,* viewed 16 April 2016, from http://www.dsd.gov.za/npo/index2.php?option=com_docman&task=doc_view&gid=183&Itemid=116.

Department of Social Development (Republic of South Africa), 2014, *Policy for Social Service Practitioners,* 5th draft (internal working document): Pretoria: Department of Social Development.

Department of Social Development (Republic of South Africa), *2013 Annual Report*.

Department of Social Development (Republic of South Africa), 2013a, *Generic Norms and Standards for Social Welfare Service,* viewed 6 May 2015, from http://www.dsd.gov.za/index.php?option=com_docman&task=cat_view&gid=67&Itemid=39.

Department of Social Development (Republic of South Africa), 2016, Comprehensive Report on the Review of the White Paper for Social Welfare, 1997.

Development Bank of South Africa, 2008, *A Roadmap for the Reform of the South African Health System,* Report on a process convened and facilitated by the DBSA, Midrand.

Econex, 2013, *The South African Private Healthcare Sector: Role and Contribution to the Economy*, Stellenbosch: Econex, viewed 16 April 2015, from http://www.mm3admin.co.za/documents/docmanager/f447b607-3c8f-4eb7-8da4-11bca747079f/00060290.pdf.

Fisher, T. S. J., 2013, "*Impact of occupational specific dispensation on the vacancy rate and profile of doctors working at the Dr George Mukhari Hospital*", viewed 28 July 2015, from http://mobile.wiredspace.wits.ac.za/handle/10539/12302.

Health and Welfare SETA, 2014, *Sector Skills Plan 2015-2016*, Johannesburg.

Health and Welfare SETA, 2015a, *Skills needs of the Non-Profit making Organisations- Understanding the Skills Needs of the NPOs Operating within the Health and Welfare Sectors*, Johannesburg.

Health and Welfare SETA, 2015b, *Summative evaluation of the Ancillary Health Care qualification and its associated skills programmes*, Johannesburg.

Health Professions Council of South Africa, 2009, *Continuing Professional Development Guidelines for the Health Care Professionals*, viewed 5 May 2015, from http://www.hpcsa.co.za/Content/Docs/cpd_guidelines_april_2009.pdf.

Health Systems Trust, 2011, NHI: Behind the Proposals. From *Mail and Guardian*, 22 July 2011, viewed 18 May 2015, from http://www.hst.org.za/news/nhi-behind-proposals.

Hospital Association of South Africa, 2016, *Quick Facts*, viewed 15 May 2016, from http://www.hasa.co.za/.

South African Institute of Race Relations, 2012, "*Social worker shortage undermines effectiveness of social welfare legislation*". Press release dated 14 August 2012.

Kahn, T., 2015, "Lack of private GP buy-in is the Achilles heel of NHI", *Business Day*, 26 March 2015, viewed 24 May 2015, from http://www.bdlive.co.za/opinion/2015/03/26/lack-of-private-gp-buy-in-is-the-achilles-heel-of-nhi.

Insight Actuaries and Consultants, 2014, *Analysis of Medical Scheme Statutory Returns and Council for Medical Scheme Annual Reports over time,* Report for the Hospital Association of South Africa, viewed 8 June 2015, from http://www.hasa.co.za/research/1/.

MEDpages database, From http://www.medpages.co.za

Motsosi, K.S. and Rispel, L.C., 2012, *Nurses' perceptions of the implementation of occupational specific dispensation at two district hospitals in the Gauteng Province of South Africa*, viewed 28 July 2015, from http://uir.unisa.ac.za/bitstream/handle/10500/13018/ajnm_v14_n2_a11.pdf?sequence=1.

National Planning Commission (Republic of South Africa), 2012a, *National Development Plan 2030*, Executive Summary, viewed 16 April 2015, from http://www.gov.za/sites/www.gov.za/files/Executive%20Summary-NDP%202030%20-%20Our%20future%20-%20make%20it%20work.pdf.

National Planning Commission (Republic of South Africa), 2012b, *Promoting Health*, viewed 24 Aug 2012, from http://www.info.gov.za/issues/national-development-plan/index.html.

National Planning Commission (Republic of South Africa), 2012c, *Social Protection*, viewed 21 April 2015, from http://www.gov.za/sites/www.gov.za/files/devplan_ch11_0.pdf.

National Planning Commission (Republic of South Africa), 2012d, *Summary objectives and actions of the National Development Plan 2030*, viewed 24 Aug 2012, from http://www.info.gov.za/issues/national-development-plan/index.html).

National Planning Commission (Republic of South Africa), 2012e, *Improving Education, Training and Innovation*, viewed 4 June 2015, from http://www.gov.za/sites/www.gov.za/files/devplan_ch9_0.pdf.

National Treasury (Republic of South Africa), 2015a, *2015 Budget Review*, Pretoria.

National Treasury (Republic of South Africa), 2015b, *2015 Estimates of National Expenditure,* Pretoria.

National Treasury (Republic of South Africa), 2014, *Provincial Budgets and Expenditure Review: 2010/11 -2016/1,* Pretoria.

O'Riordan, A., 2014, *The End of Hope: SA Civil Society's Race to the Bottom,* The South African Civil Society Information Service, viewed 20 April 2015, from http://sacsis.org.za/site/article/2171.

PMG, 2014, Preparations for National Health Insurance (NHI) pilot districts: briefing by Minister of Health, viewed 18 May 2015, from http://www.samed.org.za/Filemanager/userfiles/MoH%20in%20Parliament%2026%20Feb%202014.pdf.

PMG, 2009, Occupational Specific Dispensation: Health Department briefing, 17 August 2009, viewed 28 July 2015, from https://pmg.org.za/committee-meeting/10658/.

Republic of South Africa, 2006, Children's Act 38 of 2005, Notice No. 610 of 19 June 2006, viewed 15 April 2015, from http://www.acts.co.za/childrens-act-2005/index.html.

Republic of South Africa. 2004, National Health Act, 61 of 2003, Notice No. 869 of 23 July 2004, viewed 15 April 2015, from http://www.acts.co.za/national-health-act-2003/index.html.

Republic of South Africa, 1996, Constitution of the Republic of South Africa, 108 of 1996, viewed 17 April 2015, from http://www.gov.za/documents/constitution-republic-south-africa-1996.

Rispel, L. C., Blaauw, D., Chriwa, T. & de Wet, K., 2014, Factors influencing agency nursing and moonlighting among nurses in South Africa, *Global Health Action*, (7), viewed 29 May 2015, from http://www.globalhealthaction.net/index.php/gha/article/view/23585.

Ross, E., 2012, "Social Work in South Africa", *Social Dialogue* 3 2013, viewed 10 June 2014, from http://data.axmag.com/data/201210/U42483_F151463/index.html.

South African Council for Social Service Professions, 2010, *Policy on Continuing Professional Development,* viewed 5 May 2015, from http://www.sacssp.co.za/Professionals/download/1.

SAIRR, 2012, "Social worker shortage undermines effectiveness of social welfare legislation", Press release 14 Aug 2012.

South African Nursing Council, 2014, *Annual Statistics*, viewed 21 April 2015, from http://www.sanc.co.za/stats/stat2013/...pdf

South African Pharmacy Council, 2011, *Pharmacy Human Resources in South Africa 2011,* Pretoria.

Statistics South African, *Key Statistics*, viewed 1 June 2016, from http://www.statssa.gov.za/?page_id=737&id=1.

Swan, G., 2011, Addressing the Veterinary Shortage. *Farmer's Weekly* 16 November, viewed 26 May 2015, from http://www.farmersweekly.co.za/article.aspx?id=10886&h=Addressing-the-veterinary-shortage.

The World Bank, 2015, Data, viewed 6 June 2015, from http://data.worldbank.org/.

Trading Economics, 2015, Health Indicators per Country, viewed 6 June 2015, from http://www.tradingeconomics.com/.

University of Pretoria, 2015, (Faculty of Veterinary Science) *One Health*, viewed 30 April 2015, from http://www.up.ac.za/en/faculty-of-veterinary-science/article/16412/one-health.

Versteeg-Mojanaga, M., 2015," Protecting critical posts at times of austerity", viewed 20 April 2016, from https://www.phasa.org.za/protecting-critical-posts-at-times-of-austerity/.

World Health Organisation, 2015a, Health Workforce, viewed 22 May 2015, from http://www.who.int/hrh/workforce_mdgs/en/.

World Health Organisation, 2015b, Global Health Observatory Data Repository, viewed 6 June 2015, from http://apps.who.int/gho/data/node.country.country-ZAF?lang=en.

ANNEXURE A: Continuous Improvement Plan

TABLE OF CONTENTS

1. Introduction SSP-48
2. Purpose SSP-48
3. Links to other plans SSP-48
4. CIP matters SSP-49
5. Follow up SSP-54
6. Conclusion SSP-54

1. INTRODUCTION

The Continuous Improvement Plan (CIP) is an ongoing improvement of processes through incremental and breakthrough improvements within the Health and Welfare SETA. It is based on the premise that these incremental changes will sum up to major improvements over time and it is as much about specific improvements as it is about changing the culture of the HWSETA to focus on opportunities for improvement rather than problems.

The HWSETA's CIP is based on a Four-step Quality Model- (i.e. Plan-Do-Check-Act [PDCA] Cycle). This is also known as Deming Cycle or Shewhart Cycle:

- Plan: Identify an opportunity and plan for change.
- Do: Implement the change on a small scale.
- Check: Use data to analyse the results of the change and determine whether it made a difference.
- Act: If the change was successful, implement it on a wider scale and continuously assess your results. If the change did not work, begin the cycle again.

The HWSETA's CIP model also emphasises the involvement of HWSETA employees and teamwork; measuring and systematising processes; reducing variation, defects and cycle times. The CIP covers the following areas which are integral to the HWSETA and its related sectors:

- The alignment of HWSETA priorities to the strategic plans and Government priorities.
- Involvement of Accounting Authority (Board, Chairperson and CEO) in the development of the Sector Skills Plan (SSP).
- The SETA collaboration/ partnerships with TVET colleges and universities.
- PIVOTAL skills list and programmes
- Usage of OFO codes in skills analysis and reporting.
- Development of research capacity
- Career Advice System
- Labour Market Intelligence Project
- Research Strategy and Agenda
- Improving data sources

This version of the HWSETA CIP covers the 2016/17 financial year and demonstrates continuous achievement in the above-mentioned areas. New partnerships with universities and TVET colleges have been established. The HWSETA is also in a process of reviewing its OFO codes for the health and welfare sectors. This project will involve mapping of OFO codes to occupations, occupational titles, and capture alternative titles amongst other things. A comprehensive report on CIP matters is detailed in the following section.

2. PURPOSE

The purpose of this document is to monitor and continuously update progress made on plans of the HWSETA. Furthermore, it eliminates ambiguity as it ensures that all employees have a clear understanding of the HWSETA plans and goals.

3. LINKS TO OTHER PLANS

The CIP presented herein is mainly linked to the HWSETA Strategic Plan, HWSETA Annual Performance Plan and Operational Plans of each division. The CIP is also linked to the risk management plan of the HWSETA and contributes towards the achievement of the targets in both the service level agreement and the annual performance plan.

4. CIP matters

MATTER	CURRENT STATUS	ACTION PLAN	PROGRESS MADE
Alignment of HWSETA priorities to strategic plans and other Government priorities	The HWSETA strategic objectives are drawn from the NSDS III and linked and guided by other government strategies such as HRDSSA 2030, New Growth Path, NDP, outcomes of the MTSF (especially outcomes 2,5 and 13), Rural Development Strategy, HRH Plan Human Resource for Pharmacy, NHI and the Skills accord and line government department strategic plans.	• Continuously review the HWSETA Strategic Plan to further improve its alignment to other government strategies,plans and priorities. • Scan the political, social and economic environment for emerging government and sectoral priorities to be aligned with the HWSETA's priorities. • Scan and infuse private sector growth plans into the HWSETA Strategic Plan.	Continuously Achieving: • This is evident in the current SSP and previous SSP Annual Updates. • These are also reflected in the strategic and annual plans of the HWSETA. • This is also evident in the programmes supported and impact made which is measured continuously
Involvement of Board in the development of the SSP	The HWSETA SSP is reviewed and approved by the Skills Development Standing Committee (sub-committee of the board) and finally by the HWSETA Board.	• Continuously review and approve SSP before submission to DHET. • Continuously review the approval of projects against priorities in the SSP and annual plans.	Continuously Achieving: • The SSP is presented to the Board strategic session together with the strategic plan, annual performance plan and budget. The SSP is again presented to the Board meeting as an annexure to the strategic plan and annual performance plan for adoption. • In the 2017 update, key stakeholders will present to the Board changes taking place in sub-sectors. All these will be incorporated into the SSP. This is part of the Board strategic plan session • The final approval of the SSP by Board is a standard practice at the HWSETA established through the Board Charter, delegation document and grant policies. • The Board is actively involved in the development and approval of the SSP.
SETA collaboration/ partnerships with TVET colleges and universities	Partnership is the key delivery mechanism of the HWSETA. Establishment of partnerships with TVET Colleges and Universities to facilitate skills development, is one of the HWSETA's strategic outcome oriented goals. Partnerships are aimed at enhancing workplace training and work integrated learning.	• Determine skills needs through research; • Establish partnerships with TVET Colleges and Universities through Cooperation Agreements and project based Memoranda of Agreement and Service Level Agreements; • Monitor projects at output, outcome and impact levels; • Resolve blockages and bottle necks through constant engagements; • Capacitate TVET Colleges to offer health and social development related programmes; and • Enforce partnerships between TVET Colleges and employers within a region.	Continuously achieving Partnerships with Universities and TVET Colleges: • North-West University • Sefako Makgatho Health Sciences University. • University of Fort- Hare • University of Pretoria-Faculty of Veterinary Sciences. • Tsolo Agriculture and Rural Development Institute • Walter Sisulu University – support to the department of social work to regain its accreditation with CHE Discussions underway to partner with the following institutions: • Research Chair in Antimicrobial Resistance-South African Poultry Association/NRF/HWSETA. • North-West University-Work Integrated Learning for the Nursing professionals. • Capacity building of TVET Colleges to offer HWSETA qualifications – This is a major project as very few TVET colleges offer HWSETA aligned qualifications • University of Venda – School of Social Work (capacity building of the school's library) • University of Zululand - support

MATTER	CURRENT STATUS	ACTION PLAN	PROGRESS MADE
PIVOTAL skills list and programmes	PIVOTAL programmes are identified and supported as highlighted in the SSP	• Identify PIVOTAL programmes linked to scarce and critical skills. • Identify employers and validate workplaces to offer quality workplace learning. • Link workplaces, employers, TVET Colleges and Universities. • Support PIVOTAL programmes as per the APP and budget	Continuously Achieving: • In the health sector most of the entry-level learning paths are be classified as pivotal programmes as prescribed by the relevant council/ statutory body. • Learning paths for a number of occupations in the social development sector are also - categorised as such. • The HWSETA intensified internships and Work Integrated Learning in selected high impact learning skills. Employers play an important role on these. • Employers have been identified for workplace learning for the implementation of pivotal programmes. In 2016/17, 364 employers were evaluated and particiape in work-based learning. • The HWSETA has adjusted its budget (per capita cost for unemployed persons) to respond to demand of PIVOTAL programmes.
Usage of OFO in skills analysis and reporting	SSP is reviewed to include the usage of the latest OFO version at six digit level.	• Change the usage of OFO code to 6 digits' level. • Workshop employers on the WSP submission requirements and use of OFO codes. • Draw scarce and critical skills and Pivotal List with OFO codes at 6 digits level	Achieved: • Problems with OFO codes for the sector have been reported by employers in the past • The SSP now incorporates the OFO six digit level in its narrative and tables A review of the OFO was conducted in 2016/17 and has been completed. • Submission to DHET on the revised codes is underway
Targets with budgets included in the SSP	SSP is reviewed to include the usage of the latest OFO version at six digit level.	• Change the usage of OFO code to 6 digits' level. • Workshop employers on the WSP submission requirements and use of OFO codes. • Draw scarce and critical skills and Pivotal List with OFO codes at 6 digits level	Achieved: • Problems with OFO codes for the sector have been reported by employers in the past • The SSP now incorporates the OFO six digit level in its narrative and tables A review of the OFO was conducted in 2016/17 and has been completed. • Submission to DHET on the revised codes is underway
Targets with budgets included in the SSP	SSP is reviewed to include the quantitative and qualitative targets and the budget	• Incorporate the budget to be utilised by the HWSETA in meeting its strategic objectives in the SSP annual update	Continuously achieving: • Detailed quantitative and qualitative targets and budget are constantly incorporated into the HWSETA SSP. • These are aligned to the strategic plan and the annual performance plan
Development of research capacity	The HWSETA has established the Research, Information, Monitoring and Evaluation (RIME) division in 2007 for the purpose of conducting research and M&E of projects and programmes.	• Build capacity for staff through coaching, skills transfer, and information sharing and training to improve internal skills. • Blind peer review of research reports and feedback.	Achieved: • The RIME research Unit is capacitated to 100% as approved by the Board. • The RIME Division has produced several research reports of high quality and integrity. These research reports are reviewed externally. • All staff have postgraduate degrees and have experience in research. • Peer review system has been introduced in the form of double blind reviews. • Capacity building workshop post peer review has also been introduced to strengthen and sharped reseach skills of researchers

MATTER	CURRENT STATUS	ACTION PLAN	PROGRESS MADE
Career Advice System	The HWSETA has established a Marketing division and one of the primary functions of this division is to develop and implement a Career Advice System for the health and social development sector.	The HWSETA has put a career guidance system in place and meets its career guidance mandate and targets through the following activities: • Career Guidance Events: Participation in these events is managed from the Marketing and Communications unit responsible for reporting on career guidance. Attendance at these events is covered either by the relevant Provincial Office or alternatively the Head Office personnel. Where Provincial Offices participate, feedback is sent to the Marketing and Communications unit for collation and reporting purposes. • Maintenance of the HWSETA website. • Use of mass media platforms such as commercial and community radio stations. • The HWSETA toll free helpline that is manned by the Stakeholder Relationship Officer. • Printed material in the form of brochures that are distributed to all Provincial Offices, as well as Satellite Offices. • Advertising in career guidance publications. • Placement of TVET graduates at TVET Colleges in rural areas and townships. One of the main functions of these graduates is to provide a help desk for in-school and post-school youth and adults to access information about the HWSETA, career advice, and processes on how communities can benefit from the HWSETA's funding.	Continuously achieving: • Through career guidance initiatives thhe HWSETA has reached 16 191 school going and out of school youth in 2016/17. • Targets are monitored by the Board quarterly and audited by the internal auditors and the Auditor General biannually. DHET also monitors and validates the achievements on a quarterly basis. • In the oncoming period the HWSETA plans to partner with educational psychologist and the Department of Basic Education to incorporate assessment tests into career development at school level • The HWSETA website has room for improvement and this has been relayed to the relevant department to work on it • Toll free helpline is working well and is properly manned • Brochures and career guidance publications are distributed in all provincial offices as well as satellite offices • The HWSETA targets placement of TVET college students on an annual basis and this is part of the annual performance plan. In 2017/18 800 TVET students will be placed with employers in the sector

MATTER	CURRENT STATUS	ACTION PLAN	PROGRESS MADE
Labour Market Intelligence Project	There are two Labour Market Intelligence Projects undertaken by the HWSETA namely: • Big Data Analytics and Curation (i.e. integrations of pieces of data into insight and intelligence and production of knowledge). • Student Progression Database System (i.e. monitoring of student progress) to inform insightful decision making.	• Source a variety of databases relevant to the health and welfare labour market. • Capacitate HWSETA internal staff to administer the IT systems quarterly. • Analyse data from the database systems to gain insight and intelligence for informed decision making. • Distribute knowledge to management and Board to make decisions.	Achieved: • The two LMI Projects have commenced and the two systems are in place and functional. • First set of reports have been presented to the Board to assist in making project approvals. • The analytics project has been expanded to include employers and private training colleges • The first expanded reports will be available in July 2017 • The HWSETA will also draw reports from the LMIP project of the DHET and incorporate this into the SSP. Board members will also be given an opportunity to look at the product so as to enable them to make informed decisions
Research Strategy and Agenda	The HWSETA has developed and implemented its research strategy and agenda over the years. The research agenda for the 2015/16 financial year as embedded in the Five Year Research Strategy, will produce evidence based health and social development research reports to inform planning in the strategic period 2013 t0 2018. The HWSETA Research Strategy and Agenda has been updated and submitted annually to DHET.	• Update Research Strategy and agenda. • Implement research agenda by conducting research that will inform skills planning. • Update policies relating to research, monitoring and evaluation. • Update M&E Framework based on new developments in the field. • Develop protocols applicable to the health and welfare sector from DPME and align framework appropriately.	Continuously achieving: • Research strategy and agenda was updated and approved for the period 2016 to 2020. • Information on the structures, systems and resources of the research division has been updated in the research strategy. • Research agenda for the year 2017/18 has been approved and is being implemented • Monitoring &Evaluation Framework will be updated in the fouth quarter of 2017/18 after the SAMEA conference to enable incorporation of developments discussed in the conference.
Improving data sources	The HWSETA employs triangulation of data sets from multiple data sources when conducting research and developing SSP for the health and welfare sector	• Source data sets from multiple data sources such as: • WSP data (HWSETA and PSETA Data) • Persal data • Independent research from the health and welfare sector • Professional Register from relevant councils • Sector strategies • Medpages database (comprehensive database for health professionals in the private sector) • Collect primary data from the sector.	Continuously achieving: • The HWSETA employed mixed methods approach for the development of the current SSP. • In addition to the mixed methods approach, the HWSETA utilised multiple data sets from multiple data sources. • All of the research work that will be conducted in this financial year will employ mixed methods approach and primary data will be collected from multiple respondents from the health and welfare sector. • There is still a concern on the credibility of data and data sources in the sector. This has been raised as a risk in the HWSETA risk register. The HWSETA has developed mitigation measures against the risk and progress is reported to Board quarterly

MATTER	CURRENT STATUS	ACTION PLAN	PROGRESS MADE
Alignment of strategic planning with sector skills research	The HWSETA's sector skills research agenda emanates from the strategic plans such as the APP and 5-year Strategic Plan. Therefore, sector skills research is embedded in the HWSETA strategic plans as a strategic outcome oriented goal of the HWSETA (refer to outcome oriented goal 2 of the Strat plan).	• Conduct evidence based health and social development research to inform skills planning. • Conceptualise research themes and topics based on the knowledge gaps of the HWSETA. • Conduct swift analysis to determine projects that are due for evaluations.	Continuously achieving: • In 2016/17 year, the HWSETA printed 2 volumes of evidence based research reports that have been externally reviewed • In the 2017/18 financial year, 8 sector skills research reports wwill be produced. The research reports mentioned are communicated to Board, staff and discussed with stakeholders where action and implorvement is needed on their side
Developing mechanisms for skills planning	• Establishment of an institutional mechanism for skills planning in the health and social development sector is one of the strategic outcome oriented goals of the HWSETA. • Skills Planning at the HWSETA is informed by sector skills research which is conducted internally with some of the research processes outsourced (e.g. data collection). • Sector skills research feeds into the development of the HWSETA SSP which informs skills planning. This has been the HWSETA's mechanism for skills planning.	• Conduct evidence-based health and asocial development research studies. • Incorporate research findings into the SSP to inform skills planning. • Implement projects and programmes based on the research findings.	Continuously achieving: • Skills planning is informed by evidence-based research. In that way, all projects and programmes are developed and implemented based on the needs of the sector emanating from the sector skills research findings.
Stakeholder engagement in preparation for the SSP	• Stakeholders are engaged in a form of semi-structured interviews. • Stakeholders are also engaged during WSP and SSP workshops to re-iterate the importance of capturing accurate information when populating their WSPs. This is done as a control measure to ensure that WSPs information is reliable and accurate. • Finally, stakeholders are engaged during the dissemination of the SSP for confirmation of findings and adoption.	• Conduct semi-structured interviews to feed into the SSP. • Organise and facilitate WSP and SSP workshops in nine provinces to encourage usage of reliable and accurate information. Furthermore, disseminate SSP findings	Continuously achieving: • Semi-structured interviews were conducted with different stakeholders from the public and private sector. This was done during the months of April and May 2016 and the qualitative findings have been included in the SSP Annual Update. These findings are still relevant in the 2017 SSP annual update but will be augmented by interviews with other stakeholders who could not be contacted in 2016 • Workshops held during the update of the OFO with employers and statutory bodies in the sectotr feed into the 2017 annual update of the SSP. • During WSP workshops employers are encouraged to use accurate and reliable information in the submissions of WSPs. Inaccurate information submitted in the previous year is highlighted to employers during these workshops

5. FOLLOW UP

The CIP will be reviewed and updated quarterly by the HWSETA. It will also be included in management meetings where management action is needed

6. CONCLUSION

The HWSETA CIP document has detailed 10 CIP matters indicating the current status, action plan and progress made thus far. Overall, the HWSETA has made significant progress in each area of the CIP over the years.

Areas of marked improvement to date include, but are not limited to, research capacity (i.e. Research, Information, Monitoring and Evaluation Division capacitated to 100%), university and TVET partnerships (i.e. over 20 partnerships established so far), and stakeholder engagements.

The HWSETA uses the WSP and SSP workshops as an important platform, not just to disseminate SSP findings, but more importantly to encourage the health and welfare sectors to incorporate accurate and reliable information in their WSPs. This initiative has yielded positive results and WSP data has improved in its quality, however there is still room for improvement.

Finally, it must be noted that there are no significant challenges that have been encountered thus far.

ANNEXURE B: HWSETA PIVOTAL LIST - 2018/19

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	2018/19	2015-222112	Registered Nurse	General Nurse/ Professional nurse	Bursary: Bachelor of Nursing Sciences	8	Y	8425	228
					Learnership: Diploma in General Nursing: Bridging	7	Y		650
HWSETA	2018/19	2015-263501	Social Counselling Worker	Adoptions Worker Clinical Social Worker School Social Worker	Bursary: Bachelor of Social Work Internships: As per the requirements of Bachelor of Social Work	8	Y	3578	66
					Internships: As per the requirements of Bachelor of Social Work		N		406
HWSETA	2018/19	2015-221101	General Medical Practitioner	Doctor General Practitioner	Bursary: Bachelor of Medicine and Bachelor of Surgery	8	Y	1495	87
HWSETA	2018/19	2015-325802	Intensive Care Ambulance Paramedic/ Ambulance Paramedic	Paramedic	Bursary: Bachelor of Emergency Medical Care	8	Y	1294	40
HWSETA	2018/19	2015-22108	Registered Nurse (Medical)	General Nurse	Learnership: Advanced Diploma in Medical and Surgical Nursing	6	Y	1213	300
HWSETA	2018/19	2015-226201	Hospital Pharmacist	Clinical Pharmacist/ Health Service Pharmacist/ Hospital Chemist/ Retail pharmacist Pharmacy assistant	Bursary: Bachelor of Pharmacy	8	Y	630	250
					FETC: Pharmacist Asistance	4	Y		1175
					Learnerships: NC: Pharmacist Assistance	3	Y		1175
HWSETA	2018/19	2015-321101	Medical Diagnostic Radiographer	Radiographer/ Medical Imaging Technologist/ Mammographer	Bursary: Bachelor of Diagnostic Radiography	8	Y	232	100
HWSETA	2018/19	2015-222201	Midwife	Midwife Practitioner/ Certified Midwife	Learnership: Diploma in Midwifery	6	Y	216	300

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	2018/19	2015-321201	Medical Laboratory Technician	Medical Bloodbank Technician/ Pathology Technician/ Clinical Microbiology Technician/ Phlebotomist/ Medical Laboratory Assistant	Bursary: Diploma in Biomedical Technology Learnership: As per the qualification and professional body requirements	5	Y	216	120
					Work Integrated Learning: As per the qualification and professional body requirements				353
					Learnership: FETC: Phlebotomy Techniques	4			250
HWSETA	2018/19	2015-226401	Physiotherapist	Physiotherapist/ Cardiothoracic Physiotherapist/ Paediatric Physiotherapist	Bursary: Bachelor of Physiotherapy	8	Y	186	22
HWSETA	2018/19	2015 - 222114	Nurse Educator	Staff Development Nurse Clinical Nurse Educator	Post-qualification (Bahcelor of Nursing Sciences): Nursing Education	7	Y	32	32

NOTES

higher education
& training
Department:
Higher Education and Training
REPUBLIC OF SOUTH AFRICA

Health and Welfare Sector
Education and Training Authority
HWSETA