# SECTOR SKILLS PLAN
# 2025-2030

FOR THE HEALTH AND SOCIAL DEVELOPMENT SECTOR IN SOUTH AFRICA

Health and Welfare Sector
Education and Training Authority
HWSETA

# SECTOR SKILLS PLAN

2025-2030

Approved 31/03/2025

# Foreword.

DR NOMFUNDO MNISI
CHAIRPERSON OF
THE HWSETA BOARD

AND MS ELAINE BRASS, CA (SA)
CHIEF EXECUTIVE OFFICER:
HWSETA

The Health and Welfare Sector Education and Training Authority (HWSETA) is pleased to present its 2025-2030 Sector Skills Plan (SSP) accompanied by the updated Continuous Improvement Plan (CIP), updated Research Agenda, and Top 10 OFO-based Sector Priority Occupations List (Pivotal). This SSP has been developed in adherence to the provisions and alignment with the Department of Higher Education and Training (DHET) 2025-2023 SSP Framework. It responds positively to the Continuous Improvement Plan post the one-on-one session held between the HWSETA and the DHET as indicated below.

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

Current sector skills development needs as set out in the HWSETA Five Year Sector Skills Plan are a key consideration in this plan. Its purpose is also to align sector-based skills needs and programmes with the socio-economic development priorities of government and the country as stated in the New Growth Path (NGP), the National Development Plan (NDP) 2030, the Medium-Term Development Plan (MTDP), the National Skills Development Plan (NSDP), the National Human Resources Development Strategy South Africa (2010-2030), the Economic Reconstruction and Recovery Plan (ERRP), and the Economic Reconstruction and Recovery Skills Strategy. The SSP also endeavours to showcase the post-COVID-19 effects in the sector as the health and social development sector was on the frontline of fighting the pandemic. The Sectoral Priority Occupations and Interventions (SPOI) list for this year's update will therefore aim to support the sector in addressing the post-COVID-19 effects in the sector.

DHET's requirements as set out in the NSDP have been addressed and the document serves as a valuable tool for HWSETA stakeholders and a useful source of information for service providers and the community.

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

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

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

Dr. N.V. Mnisi
Chairperson: Health and Welfare SETA Board

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

# Executive Summary.

MS ELAINE BRASS, CA (SA)
CHIEF EXECUTIVE OFFICER: HWSETA

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

There are currently 332 045 filled positions in the Public Service health and social development departments and 411 665 in the private sector bringing total employment in the sector to approximately 743 710. From 2020 to 2024, employment in the public service reflected negative growth, i.e. an average annual rate of -1,5%, while the private sector saw an average annual growth rate of 2,4% over the same period. Overall, the entire sector, encompassing both public and private components, experienced an average annual growth of 0,6% during this period. Professionals form 37% of the total workforce, whereas technicians and associate professionals make up 22%. The majority of people working in the sector are female and the vast majority are black. Only a small percentage of workers in the sector are living with disabilities. Labour and trade unions are well organised and mobilised within the formal health and social development sector.

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

The NGOs play a very important role in the sector. The government relies on these organisations to offer social services on its behalf. However, they struggle to attract and retain social services professionals. Many NGOs are exempt from paying skills development levies, which means their workers fall outside the SETA levy-grant system for skills development. Changes in the sector are driven by challenging socio-economic realities, the high burden of disease experienced in the country, high levels of gender-based violence, and other social crimes that increase the demand for public health and social welfare services. At the same time, constitutional imperatives compel the state to be developmentally orientated and to take progressive measures to grant everyone access to health care services, sufficient food and water, and social security. The effects of the COVID-19 pandemic added to the stress factors already mentioned. One of the most important change drivers is the NHI, especially the provision and maintenance of sufficient skills to implement

the Act. The success of the NHI will depend on the skills of health workers in general, who are trained to offer all levels of care, from primary health care to specialised secondary care and highly specialised tertiary levels of care.

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

Interventions are needed to address the considerable gaps in the management of public health operations, its employees, and technology, as well as its capital and financial resources. In the social development sector, managers and supervisors require training in leadership and team management, special fund-raising, and project management skills tailored to the social services sector. In the health sector, leadership and strategic planning skills are also high on the list for managers. Both sectors experience a lack of data analytical skills at this level.

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

Market forces, working conditions, remuneration, and career advancement opportunities are all factors that determine where and for how long people work in a particular workplace. The health and social development sector is grappling with serious human resources- and labour market challenges. These are reflected in high vacancy rates, especially among health service professionals, nurses in particular. The high vacancy rates are caused by, among others, inadequate occupational wages, and wage differentials between different components of the sector, poor working conditions, inequitable distribution of resources, and the emigration of professionals and other workers to countries with better health systems and in-migration of professionals from rural to urban areas. The COVID-19 pandemic increased the demand for certain workers in the sector, such as community health workers, nurses, lab technicians, and social workers considerably. The government made more funds available during the COVID-19 pandemic to employ additional social workers and community health workers. Unfortunately, these human resources were not all retained after the COVID-19 pandemic ended.

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

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

The institutional capacity for the education and training of health and social service professionals has been boosted in the past few years. A new medical school opened at the University of Limpopo in 2016, followed shortly by the tenth at Nelson Mandela University in the Eastern Cape. The eleventh medical school is scheduled to open at North West University in 2028. Large numbers of medical students have been sent for training to Cuba, the training of nurses has been moved to a higher education platform and new qualifications for mid-level workers have been developed under the QCTO. Although these new developments are not without challenges and in some instances disruptions, they are expected to help alleviate the skills shortages experienced in the sector.

The establishment of partnerships with training institutions, employers, and statutory bodies lies at the heart of HWSETA skills development operations. The partnerships are structured to provide multiple entry points into work in the health and social development sector and focus on increasing work-based learning (WBL) opportunities. Although some partnerships produced mixed results in the past, valuable lessons were learned, and HWSETA has adopted corrective measures to advance skills produc-

tion. The circumstances during the COVID-19 pandemic asked for extraordinary strategies and partnerships. The HWSETA's proactive reaction to the pandemic has resulted in several life-saving partnerships and job creation initiatives. HWSETA saw its mandate reaching beyond a skills development responsibility during the COVID-19 pandemic.

HWSETA is only one of several institutions tasked with the funding and provision of skills development for the sector and has set skills development priorities to guide it with skills planning and skills provision. Identification of the skills priorities also takes place in the context of informed research. National strategies give prominence to skills development at all qualification levels to advance health, social development, employment, and economic growth. Against these considerations, HWSETA identified the following overarching skills development priority areas:

a) A sustainable skills pipeline into the health and social development sector enables entry into employment at different entry points;

b) The professionalisation of the current workforce and new entrants to the sector to improve service quality and efficiency and address changes in service provision;

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

d) Skills development initiatives linked to the ERRP and MTDP 2024-2029.

A key focus is the escalation of WBL opportunities for learners. For the HWSETA and its stakeholders, it is vital to nurture persons who are employable, competent, work-ready, and equipped with appropriate skills when they enter employment in the sector. Since the COVID-19 pandemic, the focus continues to be on the ERRP and the linked skills strategy. The action plan of the HWSETA for 2023-2024 in terms of the ERRP looks as follows: A total of 2 963 students were funded to support the ERRP skills strategy. However, implementation of ERRP takes place within the limitation of financial resources generated through the skills development levy. Yet, the Human Resources for Health Strategy very importantly states that a major mind-shift is needed to appreciate that the health workforce is an investment, rather than an expenditure item. To this end, HWSETA continues to pursue a health and welfare workforce that has an optimum skills mix; equitable distribution of resources; and excellent competencies.

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

# Abbreviations and Acronyms.

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

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# RESEARCH PROCESS AND METHODS.

# RESEARCH PROCESS AND METHODS

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

The research that informs this year's SSP update consists of three projects, each designed to provide the information needed to fulfill the requirements of the six chapters of the SSP. These projects are conducted simultaneously and culminate in the chapters of the SSP. The projects commence in May each year and continue until the end of July.

## 1. Policy Analysis Project

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

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

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

## 2. Demand Side Analysis Project

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

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

This study is mainly based on existing data sources. The DHET also requires SETAs to do personal interviews with a selected number of employers according to an interview schedule developed by the Department. Occupation-focused studies were also conducted in 2022/23, 2023/24, and 2024/25 including medical practitioners, pharmacists, and pharmacist assistants, and social service professionals such as social workers, social auxiliary workers, and child and youth care workers. The findings from interviews with stakeholders in the medical, pharmacy, and social service professions, including relevant councils, voluntary associations, employers, medical and pharmacy schools, and training institutions for social service professionals, are incorporated into the SSP update where applicable. The demand-side study covers the private and public health and social development sectors, as well as a portion of animal health. The following datasets and data sources are analysed in the demand-side analysis project:

- The Workplace Skills Plan (WSP) submissions to the HWSETA (2024)
- The WSP submissions to the PSETA (health and social development departments) (2024)
- The Medpages database (2024)
- Discretionary grant applications submitted to the HWSETA (2023-2024)
- DHET employer interviews (2019-2024)
- HWSETA interviews with specific stakeholders (2019-2024)

This study is conducted every year from May to July and the results are usually incorporated in the second submission of the SSP. A significant number of large public and private organisations requested an extension for the submission of WSPs which means that the demand data was only available in June and updated in the second submission end of July 2024. Over the years, the HWSETA has assisted the NGOs and NPOs through different initiatives which has improved the submission rate of the NPOs as reported by the HWSETA NPO training needs analysis for skills planning research study. This saw an increase in the share of NPOs predominantly classified as levy-exempt organisations submitting their WSPs from 5% in 2015/16 to 47% in 2022/23.

## 3. Supply Side Analysis Project

This study looks at the supply of skills to the Health and Social Development Sector. It tracks changes in the supply of skills over time and investigates supply-side blockages. The study is quantitative and qualitative in nature and existing data sources were analysed. Professional councils that do not publish their registration figures are contacted by email or telephonically to request registration figures. In addition to this data on supply, interviews were also conducted with all the medical and pharmacy schools, councils, voluntary associations, and employers as part of the occupation-focused research (medical practitioners, pharmacists, and pharmacist assistants) in 2022/23, 2023/24, and 2024/25. The study covers education and training from the post-school level to professional registration. It includes higher education and professional qualifications, as well as occupational qualifications. The following data sources and datasets are analysed:

- Department of Higher Education and Training HEMIS database - Higher Education Management Information System for annual qualification output (2022)[1]
- HWSETA's information on occupational qualifications (2023)
- Databases of all the relevant Councils i.e., HPSCA, SANC, SAPC, AHPCSA, SAVC, and SACSSP (2023-2024).

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

## 4. Supplementary research on key issues

In 2022, a study was conducted between March and September on the effect of COVID-19 on shop stewards in the South African health and social development sectors. This study's main findings highlighted the need to use workplaces as training spaces for workers to improve on their capabilities. Other research projects conducted in the 2022-2023 cycle that informed the HWESTA with skills planning, relate to the following topics: determining the level of exposure and adoption of 4IR in the health sector and how it created skills gaps; identifying appropriate skills intervention responses to the identified skills gaps emanating from the current and historical trends in the migration of health care professionals in South Africa; and determining (through tracer studies) the employability of students after completion of graduate and post-graduate studies funded by the HWSETA. In terms of the supply and demand of specific health workers, studies focused on medical practitioners, pharmacists, and pharmacist assistants (2022-2023). For the social development sector, supply and demand studies were conducted on social workers, social auxiliary workers, and child and youth care workers (2023-2024). These types of studies are ongoing during the year. After the first submission of the SSP to the DHET in mid-June each year, the HWSETA engages in consultative workshops with stakeholders who are then given the opportunity to make inputs concerning the skills needs of the different components of the sector. The SSP is also presented to the HWSETA Board at their strategic planning session. Comments from these consultative processes are included in the updates of the SSP where applicable.

*1 This is the most recent data available from DHET.*

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

| TOPIC | NATURE (DESIGN) OF THE STUDY | OBJECTIVES OF THE STUDY | DATA COLLECTION METHODS | LIST OF DATA SOURCES AND DATASETS | SAMPLE SIZE AND SCOPE | TIME-FRAME | CHAPTER IN-FORMED? |
|---|---|---|---|---|---|---|---|
| **Primary and secondary research** | | | | | | | |
| 1. Trends analysis of employment in the Health and Social Development Sector: SSP Demand Analysis Project | Quantitative, cross-sectional (descriptive) | To track employment trends in the Health and Social Development Sector. | Document review,<br>systematic review of administrative databases | Secondary data:<br>HWSETA levy payers (2024)<br>HWSETA WSPs submissions (2024)<br>PSETA WSP submissions 2023<br>Medpages database June 2024 | Levy-paying organisations in HWSETA – 12 573,<br>WSP submissions – 1961,<br>Individual employee records – 218 299,<br>PSETA WSP submissions – 20 departments<br>Medpages database – 95 707 records | Mar – Jun 2024 | 1 |
| 2. Trends analysis of the supply of qualifications relevant to the Health and Social Development Sectors: SSP Supply Analysis Project | Mixed Method | To track trends in the supply of qualifications relevant to the Health and Social Development Sectors and to track trends in professional registrations. | Document Review,<br>Systematic review of administrative databases | Secondary data :<br>HEMIS Data (DHET) 2021 (most recent)<br>Professional council registers (May-June 2023)<br>SAPC, HPCSA, SACSSP, and Colleges of Medicine data | 1 individual from each of the six statutory professional councils interviewed<br>1 individual from a Voluntary Professional Body | May - Jun 2024 | 1 & 3 |
| | | Focused occupational research on medical practitioners, pharmacists, pharmacist assistants, social workers, and child and youth care workers. | Quantitative and Qualitative,<br>Explanatory Sequential Design<br>Closed-ended questionnaires and interviews | Secondary data and primary data:<br>Same data sources as above but also includes primary data from key informants (experts) in the sector | 49 semi-structured stakeholder interviews<br>HPCSA,SAPC, and SACSSP register data (2022-2024)<br>Mid-year population data (2022) | Nov 2023 - May 2024 | 1 & 3 |
| 3. Trend analysis of the migration of healthcare professionals | Mixed Method | 1) To establish the current and historical trends in the migration of the health care professionals in South African<br>2) To establish the extent to which the current and historical trends in the migration of health care professionals in South African health sector created skills gaps as either opportunities or threats<br>3) To identify appropriate skills intervention responses to the identified skills gaps emanating from the current and historical trends in the migration of the health care professionals in the South Africa. | Quantitative and Qualitative:<br>Structured survey (web-based)<br>In-depth face-to-face interviews and computer assisted telephonic interviews (CATI<br>Document analysis | Primary data:<br>Training providers<br>Key informants<br>Enrolled students | 3 Training providers<br>7 Key Informants<br>Qualification development process<br>236 qualification beneficiaries | Mar - Jun 2022 | 2 & 3 |
| 4. Alignment of occupational qualifications developed by the HWSETA to sectoral needs and demand | Mixed Method | 1) To assess the internal and external factors that inform the HWSETA's process of qualification development<br>2) To determine the alignment of the qualifications developed by the HWSETA to sectoral needs<br>3) To determine the outcomes of these occupational qualifications on employment by measuring and mapping exit pathways after completion of training | Quantitative and Qualitative:<br>Structured survey (web-based)<br>In-depth face-to-face interviews and computer assisted telephonic interviews (CATI<br>Document analysis | Primary data:<br>Training providers<br>Key informants<br>Enrolled students | 3 training providers<br>7 key informants<br>Qualification development process<br>236 qualification beneficiaries | Jul 2022 - Sep 2023 | 3 |

| TOPIC | NATURE (DESIGN) OF THE STUDY | OBJECTIVES OF THE STUDY | DATA COLLECTION METHODS | LIST OF DATA SOURCES AND DATASETS | SAMPLE SIZE AND SCOPE | TIME-FRAME | CHAPTER IN-FORMED? |
|---|---|---|---|---|---|---|---|
| 5. Investigating the effects of COVID-19 on shop stewards in the health and social development sector | Quantitative Method | 1) To investigate the resultant effects of COVID-19 on shop stewards from trade unions in the health and social development sector.<br>2) To obtain the perceptions of shop stewards from the trade unions in the health and social development sector about the skills gaps in trade unions considering the direct and indirect challenges posed by COVID-19.<br>3) To explore the experiences of shop stewards from trade unions in the health and social development sector regarding the barriers to accessing required skills to respond to COVID-19.<br>4) To determine the barriers for shop stewards to access the skills they require to offer effective responses towards the control of COVID-19 | Quantitative: Online Survey Monkey | Primary data from shop stewards | 440 Shop stewards from 5 different unions | Mar 2022 - Sep 2022 | 2 |
| 6. The level of exposure and adoption of 4IR in the health sector | Mixed Method | 1) To determine the level of exposure and adoption of 4IR among four occupation groups within the health sector.<br>2) To what extent has the exposure and adoption of 4IR created skills gaps as either opportunities or threats.<br>3) To determine the extent to which 4IR changes the nature of work in terms of tasks and occupations.<br>4) To determine occupations at risk of being replaced by automation or 4IR technologies from the four occupation groups.<br>5) To determine the potential impact of 4IR on employment within the four occupation groups. | Quantitative and qualitative:<br>Online survey<br>Semi structured Interviews with key informants<br>Focus groups with key informants | Primary data:<br>from key informants (associations and statutory bodies) and healthcare professionals | 33- Focus group participants<br>123 online surveys (healthcare professionals)<br>6- semi structured interviews with key informants | Mar 2022 - Sep 2022 | 2 |
| 7. Eight-year review of WSP submissions and actual training needs | Mixed Method | 1) To determine how many levy and non-levy paying organisations have submitted their WSPs over the last eight years.<br>2) To determine the size of organisations that have submitted WSPs over the last eight years.<br>3) To determine if the planned training identified by employers over the eight years were implemented as intended under the actual training.<br>4) To identify employer organisations who submit WSP/ATR and participate in HWSETA's discretionary grant programmes as expressed through our expression of interest. | Quantitative (WSP datasets) and one interview with HWSETA Skills Development Division | 2016- 2017 to 2022-2023 WSP and ATR Submissions | 1835 Organisations | Oct 2022 - Feb 2023 | 1 & 3 |

| TOPIC | NATURE (DESIGN) OF THE STUDY | OBJECTIVES OF THE STUDY | DATA COLLECTION METHODS | LIST OF DATA SOURCES AND DATASETS | SAMPLE SIZE AND SCOPE | TIME-FRAME | CHAPTER IN-FORMED? |
|---|---|---|---|---|---|---|---|
| 8. Employment trends and the determining factors within the health and social sector | Mixed Method | 1) To establish if there were any job losses/gains within the health and social sector as of 2022<br>2) To establish which occupations contributed towards the job losses/gains within the health and social sector as of 2022<br>3) To explore the primary reasons for job losses/gains as of 2022<br>4) To establish the common skills gaps in 2022<br>5) To establish the emerging occupations and skills gaps in 2022 | Computer assisted telephonic interviews (CATI)<br>(Sample framework: SETA Quarterly Management Reporting database (SQMR) and SETMIS | Primary data collection from organisations belonging to health and social development sector<br>Secondary data: 2016- 2022 WSP/ATR submissions | 36 824 Registered Organisations on the WSP<br>462 Organisations that participated in Survey Monkey | Oct 2022 - Feb 2023 | 1 |
| 9. HWSETA Track and Tracer Study: Employed (Artisans, Learnership, Under-graduate, and Post-graduate Bursary) 2022/23 Cohort | Quantitative | 1) To determine whether the qualification has provided a career progression<br>2) To determine the change in salary/wage after obtaining the qualification<br>3) To determine the utilisation of skills after completion<br>4) To determine learner perceptions towards the programme | Computer assisted ielephonic interviews (CATI) | Primary data:<br>Sample frame from SETA Quarterly Management Reporting database (SQMR) and SETMIS | 188 learners who completed HWSETA learning or work experience in bursaries and learnerships | Apr -Jun 2023 | 4 & 5 |
| 10. HWSETA Track and Tracer Study: TVET WIL and University WIL 2022/23 Cohort | Quantitative | 1) To determine the attainment of full qualification after completion of the WIL programme<br>2) To determine learners' experiences towards the WIL programme<br>3) To determine learner employability after completion of the WIL programme | Computer Assisted Telephonic Interviews (CATI) | Primary data:<br>Sample frame from SETA Quarterly Management Reporting database (SQMR) and SETMIS | 429 learners who completed HWSETA TVET and University WIL Programmes | Apr - May 2023 | 4 & 5 |
| 11. Trade Unions Officials Relevance Evaluation Study 2022/23 Cohort | Quantitative | 1) Have the trade unions officials received training that was prescribed in their training plans?<br>2) How many training needs have trade union officials fulfilled against what had been planned in the previous two years?<br>3) To what extend have trade union officials utilised the skills developed through the support of the HWSETA for union agenda.<br>4) What other skills needs do Trade Unions have which may require support from the HWSETA in the near future. | Surveys conducted via an online platform and telephonically. | Primary data:<br>Sample frame from SETA Quarterly Management Reporting database (SQMR) and SETMIS | 175 Beneficiaries | Apr-Jul 2023 | 4 & 5 |

| TOPIC | NATURE (DESIGN) OF THE STUDY | OBJECTIVES OF THE STUDY | DATA COLLECTION METHODS | LIST OF DATA SOURCES AND DATASETS | SAMPLE SIZE AND SCOPE | TIME-FRAME | CHAPTER IN-FORMED? |
|---|---|---|---|---|---|---|---|
| 12. TVET and University Work Integrated Learning Tracer Study 2022/23 Cohort | Quantitative | 1) To determine students' experiences towards the WIL programme.<br>2) To determine students' perception of their work-readiness after completing the WIL programme.<br>3) To determine attainment of full qualification after completion of the WIL programme.<br>4) To determine student employability after completion of the qualification for which work integrated programme was funded | Survey conducted telephonically | Primary data:<br>Sample frame from SETA Quarterly Management Reporting database (SQMR) and SETMIS | 399 Beneficiaries | April-February 2023 | Chapter 4 & 5 |
| 13. Unemployed Adult Education Training (AET) Track and Tracer Study 2022/23 Cohort | Quantitative | 1) To determine the destinations of learners who have completed the AET programme.<br>2) To determine the nature of the employment of learners who received employment.<br>3) To determine type of skills development initiatives that yield positive employment outcomes.<br>4) To assess progression to further learning after completing the AET programme. | Survey conducted telephonically | Primary data:<br>Sample frame from SETA Quarterly Management Reporting database (SQMR) and SETMIS | 320 Beneficiaries | April-July 2023 | Chapter 4 & 5 |
| 14. Levy-Exempt Organisations and Small and Emerging Businesses 2022/23 Cohort | Quantitative | 1) Have the levy-exempt organisation and SMEs received training that was prescribed in their plans?<br>2) How many training needs have the levy- exempt organisations and SMEs received from what they have planned in the past two years?<br>3) To what extent has the HWSETA-funded interventions improved the governance of levy exempt organisations?<br>4) Is there a continuation of benefits since the receipt of HWSETA SME support initiatives?<br>5) Which types of support led to the sustainability (continuation of benefits) of SMEs and addressed the constraints to sustainability? | Survey conducted telephonically | Primary data:<br>Sample frame from SETA Quarterly Management Reporting database (SQMR) and SETMIS | 220 Beneficiaries | April-June 2023 | Chapter 3 & 5 |

| TOPIC | NATURE (DESIGN) OF THE STUDY | OBJECTIVES OF THE STUDY | DATA COLLECTION METHODS | LIST OF DATA SOURCES AND DATASETS | SAMPLE SIZE AND SCOPE | TIME-FRAME | CHAPTER IN-FORMED? |
|---|---|---|---|---|---|---|---|
| 15. Employment trends and the determining factors within the health and social sector | Quantitative | 1) To establish if there were any job losses/gains within the health and social sector as of 2022<br>2) To establish which occupations contributed towards the job losses/gains within the health and social sector as of 2022<br>3) To explore the primary reasons for job losses/gains as of 2022<br>4) To establish the common skills gaps in 2022<br>5) To establish the emerging occupations and skills gaps in 2022 | Surveys conducted via an online platform and telephonically. | Primary data sample frame from 2016- 2017 to 2022-2023 WSP and ATR Submissions | 2993 Organisations that reported on total employment profile from WSP.<br>462 Organisations that participated in the survey | Oct 2022 - Feb 2023 | 1 |
| 16. A survey on WSP/ ATR non-submissions by employers in the health and social development sector | Quantitative | 1) To find out the reasons for the non-submission of the WSP/ATR by the HWSETA SDL paying organisations<br>2) To propose measures that can be taken to improve the submission of WSP/ATR by the SDL paying organisations | Surveys conducted via an online platform and telephonically. | Primary data:<br>Sample from SARS database of employers classified under HWSETA | A sampled of 441 organisations reached by the study | Sep 2023 - Jan 2024 | 1 |
| 17. Investigating the association between employee wellness (physical and mental health) and the working | Mixed Methods | 1) To investigate the role of the working environment and physical health on mental health of persons registered with the South African Pharmacy Council<br>2) To investigate the role of demographic and socio-economic factors on the mental health of persons registered with the South African Pharmacy Council<br>3) To establish if any of the health cases attended by the committee are representative of the prevalence of mental health problems in the profession<br>4) To establish possible intervention options available for council other than current health processes, to prevent or manage mental health problems within the profession. | Online Survey Monkey and Focus group interviews | Primary data:<br>Same frame from SACP register dataset<br>Key informants from SACP council committee, pharmacy associations | 3977 human personnel in SACP register dataset<br>Three Pharmacy associations | Oct 2023 - Jan 2024 | 2 |

# 1. SECTOR PROFILE.

# 1 SECTOR PROFILE

## 1.1 INTRODUCTION

This chapter provides an overview of the scope of coverage of the health and social development sector, the key role players in the sector, and the economic performance of the sector. The chapter also includes an employer and labour market profile of the sector. The data sources that were used are the Budget Review (2024) and Estimates of National Expenditure of National Treasury (2024), the PSETA and HWSETA WSP data (May 2023 and 2024 submissions), and data from Medpages (May 2023 and 2024).

## 1.2 SCOPE OF COVERAGE

The HWSETA's sector comprises economic activities from five sections of the Standard Industrial Classification of all Economic Activities (SIC) i.e., manufacturing (C), wholesale and retail trade (G); Professional, scientific, and technical activities (M), public administration, and defence and compulsory social security (O) and human health and social work activities (Q). The table below shows the applicable SIC Codes and their descriptions. Broadly, the sector includes the following activities: Traditional healing; provision of equipment and appliances; therapeutic health and skin care; pharmacies; medical aid schemes; research and development; employment services for health professionals; pharmaceutical and drug information services; rehabilitation; residential care; environmental services; hospitals; hospices; doctors; dentistry services; laboratory services; veterinary activities; health NGOs; and social and community services.

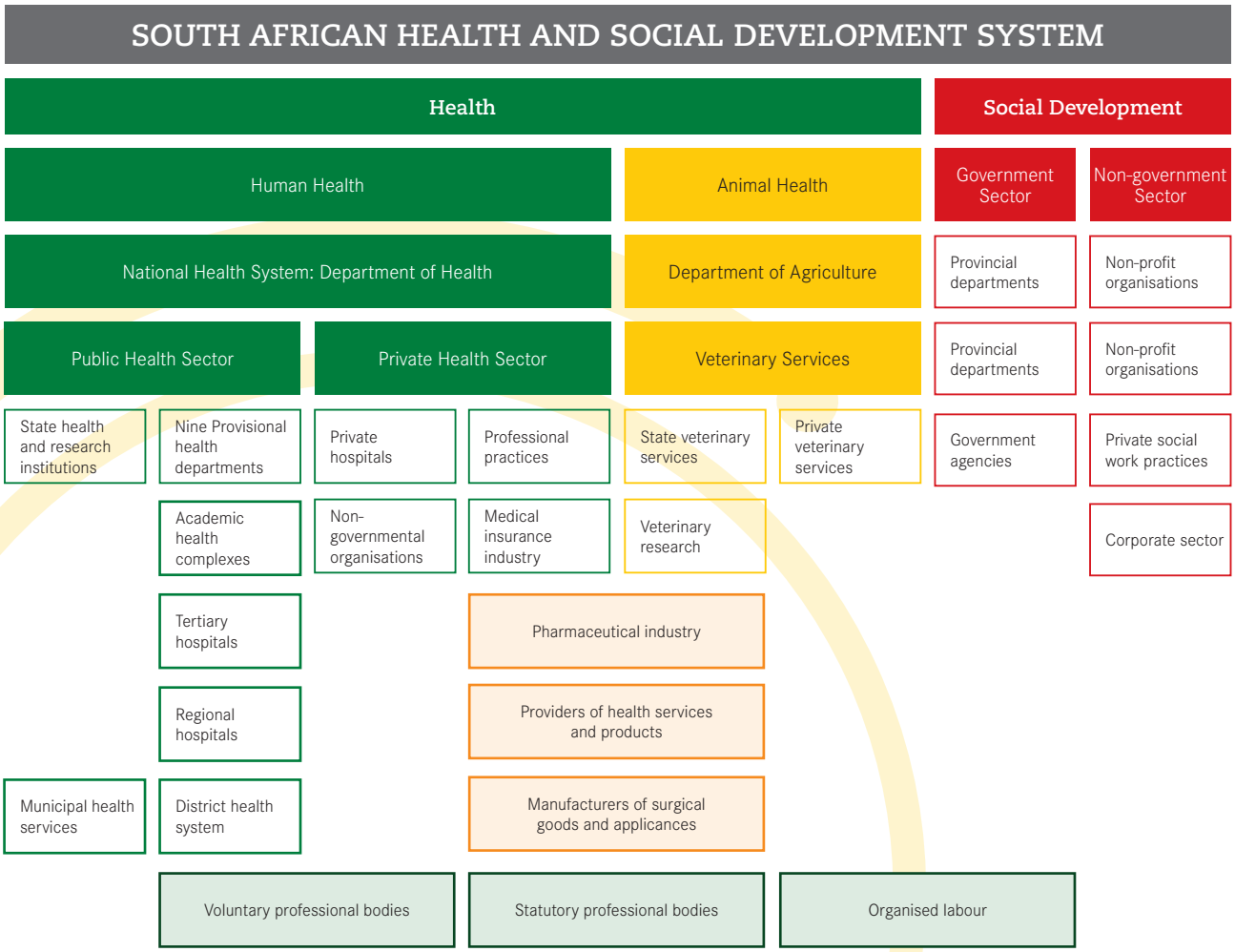
**Table 1-1 SIC codes and descriptions**

| SECTION | SIC CODE | SIC DESCRIPTION |
|---|---|---|
| C | 21000 | Manufacture of pharmaceuticals, medicinal chemical and botanical products |
| | 32500 | Manufacture of medical and dental instruments and supplies |
| G | 47620 | Retail sale of pharmaceutical and medical goods, cosmetic and toilet articles in specialised stores |
| M | 75000 | Veterinary activities |
| O | 84121 | Regulation of the activities of providing health care, education, cultural services and other social services at the National Government level |
| | 84122 | Regulation of the activities of providing health care, education, cultural services and other social services, at the Provincial Government level |
| | 84123 | Regulation of the activities of providing health care, education, cultural services and other social services, at the Local Government level |
| | 84220 | Administration, supervision and operation of health activities for military personnel in the field |
| | 84121 | Regulation of the activities of providing health care, education, cultural services & other social services at the National Government level |
| Q | 86100 | Hospital activities |
| | 86201 | Medical practitioner and specialist activities |
| | 86202 | Dentistry and specialist dentist activities |
| | 86209 | Other medical and 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 and substance abuse |
| | 87300 | Residential care activities for the elderly and disabled |
| | 87900 | Other residential care activities e.g., orphanages, temporary homeless shelters |
| | 88100 | Social work activities without accommodation for the elderly and disabled |
| | 88900 | Other social work activities without accommodation |

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

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

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



## 1.3 KEY ROLE-PLAYERS

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

**Table 1-2 Key role-players in the sector**

| ROLE PLAYER | KEY ROLES IN RELATION TO THE NSDP OUTCOMES |
|---|---|
| **National Departments of Health and Social Development** | Review and develop policies, legislation, standard-setting, and oversight coordination of services rendered by provinces including skills development and capacity building. These departments play a critical role in NSDP outcome 2 (linking education and the workplace) and outcome 4 (increase access to occupationally directed programmes) |
| **Accounting Authority** | The HWSETA Accounting Authority is responsible for governing and managing the SETA in accordance with the PFMA and other legislations. The Accounting Authority delegates some of its responsibilities and functions to one or more committees for practical purposes. These committees are mechanisms to help the Accounting Authority in fulfilling its duties and responsibilities, in accordance with the implementation of the NSDP 2030. |
| **TVET Colleges, Nursing Colleges, Community Colleges and Public Universities** | TVET Colleges, Nursing Colleges, Community Colleges and Universities are an important part of the PSET system's skills development ecosystem. They serve as a vital link between the HWSETA and the industry by expanding provision of mid-level technical and occupational qualifications as per outcome 5 of the NSDP: support the growth of the public college institutional type as a key provider of skills required for socio-economic development. In developing their capacity, the HWSETA collaborates closely with the TVET Colleges, Nursing Colleges, Community Colleges and DHET. Public Universities provide the HWSETA with critical research capacity. |
| **Provincial Departments of Health and Social Development**<br>**Municipal Health Services**<br>**Government Agencies** | Implement policies and regulations at different levels. Another key role is to facilitate and support training and capacity development aligned with outcome 3 of the NSDP: Improving the level of skills development. This is also attained through linking education and the workplace (Outcome 2 of the NSDP). |
| **NGOs, CBOs, and NPOs** | Serves as agents of advocacy for delivering health and social services, as well as provision for skills development in the sector. This is aligned with outcome 4 of the NSDP: Skills development support for entrepreneurship and cooperative development. |
| **The Hospital Association of South Africa (HASA)**<br>**Statutory professional bodies**<br>**Voluntary professional bodies** | Represents the interests of members, provide the registered practitioner's database, ensures adherence to professional conduct and continued professional development through NSDP outcome 7: encourage and support worker-initiated training. |
| **Labour and trade unions** | The shaping of labour market policies, labour relations practices, and human resources management in the sector. This includes ensuring that employers invest in skills development which is linked to the NSDP outcome 7: encourage and support worker-initiated training. |
| **Research institutions; Medical Research Council; Human Sciences Research Council; National Health Laboratory Service; and Onderstepoort Veterinary Institute** | Conducting sector-relevant, related research which results in high levels of skills development - aligned with outcome 3 of the NSDP. |

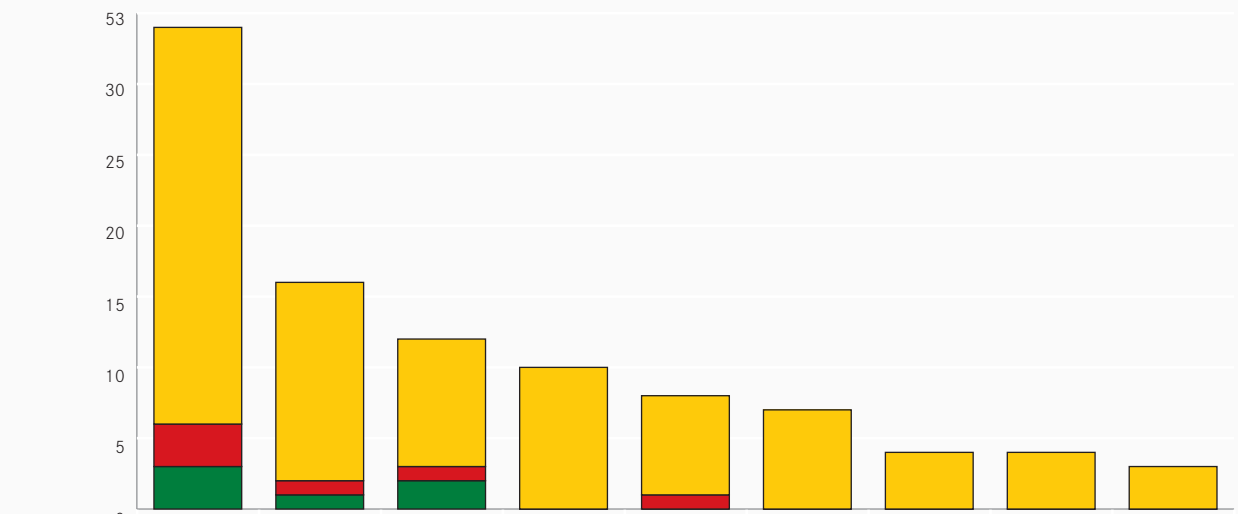
## 1.4 EMPLOYER PROFILE

### 1.4.1 Public and Private Sector

The health and social development sector is highly diverse. Public health includes large national and provincial departments across all the provinces, typically employing 150 or more people. Each province has its own Department of Social Development and Department of Health, with the national departments headquartered in Gauteng. Thus, in total 20 large employer public departments account for the public health sector.

In contrast, the private health sector is predominantly made up of small organisations. Over the past five years, 81% of private health organisations have been classified as small; these are mostly health professionals in private practices. Medium-sized organisations, with 50 to 149 employees, and large organisations that constitute 11% and 9% of the sector respectively. Despite their smaller numbers, large organisations like hospitals and pharmacy groups employ 83% of the private health workforce, with the majority of these employees being nurses (see Figure below).

**Figure 1-2 Provincial distribution of employers in the private sector[2] by organisational size**




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

*Source: HWSETA WSP submissions 2024.*

Private health employers can be categorised into hospitals and clinics, doctors and specialists, dental services, other health-related services, laboratory services, medical aid schemes, complementary health services, veterinary services, community services, and research and development institutions. The geographical distribution of private health employers[3] has remained consistent over the last couple of years. Gauteng province dominates followed by Western Cape while the Northern Cape has the smallest spread of employers for all different sizes (Figure 1-2). Similarly, the workforce distribution in the private sector follows this trend. As such, private sector investment in health is biased towards metropolitan-based areas.

In the 2023/2024 financial year, 12 573 (27%) out of 45 735[4] organisations registered under the HWSETA domain by SARS paid skills development levies to the HWSETA. This represents an increase of 1 830 organisations since 2019/2020, reflecting an average annual growth of 4,0%. Of the 12 573 organisations paying their skills development levies, only 1 941 submitted WSPs in 2023/2024. However, the number of WSP submissions has shown an average annual growth of 23,4% since 2019/2020. Recognising these low WSP/ATR submission rates, HWSETA has commissioned a study on non-submissions in the 2023/24 research agenda to gain insight for strategies that should be adopted to improve submission rates.

2 *Since the public sector departments are equally represented across all provinces and all have large size departments, the distribution of employers by province and organisation size in the private sector is not affected and thus applicable to the overall sector distribution.*

3 *For the public sector, each province has its own Department of Social Development and Department of Health, with the national departments headquartered in Gauteng. Thus, each province is represented.*

4 *This figure as per HWSETA ERP system on the 15th of May 2024.*

### 1.4.2 Non-Profit Organisations

The Social Sector Framework Agreement forms a partnership between the state and civil society to tackle poverty, inequality, unemployment, and gender-based violence. It highlights the essential role of NPOs in achieving the National Development Plan and the 2030 Agenda for Sustainable Development, as well as their significant contribution to skills development and job creation, especially for women and youth affected by high unemployment in South Africa (DSD 2023). However, NPOs face challenges such as limited funding, capacity constraints, and regulatory burdens, which have been exacerbated by the COVID-19 pandemic, forcing many to adapt their operations and service delivery models under financial pressure (Stakeholder Interviews 2023).

NPOs provide a variety of social services, including homes and specialised services for individuals with disabilities, geriatric care, in-home services, and specialised youth services. In the health sector, NPOs are involved in research, education, policy advocacy, and development and care for issues such as HIV/AIDS, emergency care, mental health, public health, cancer, support for orphans and vulnerable children, and palliative care. In the animal health sector, NPOs offer veterinary services, animal protection, and animal welfare services. As of September 2023, there were 280 329 registered NPOs in South Africa, up from 266 531 in September 2022 (DSD 2023). Few of these NPOs are registered as employers with the HWSETA and they are therefore not included in the labour market profile. However, a study conducted by the HWSETA (2015) showed that these organisations provide paid and unpaid (volunteer) employment to many workers in the sector.

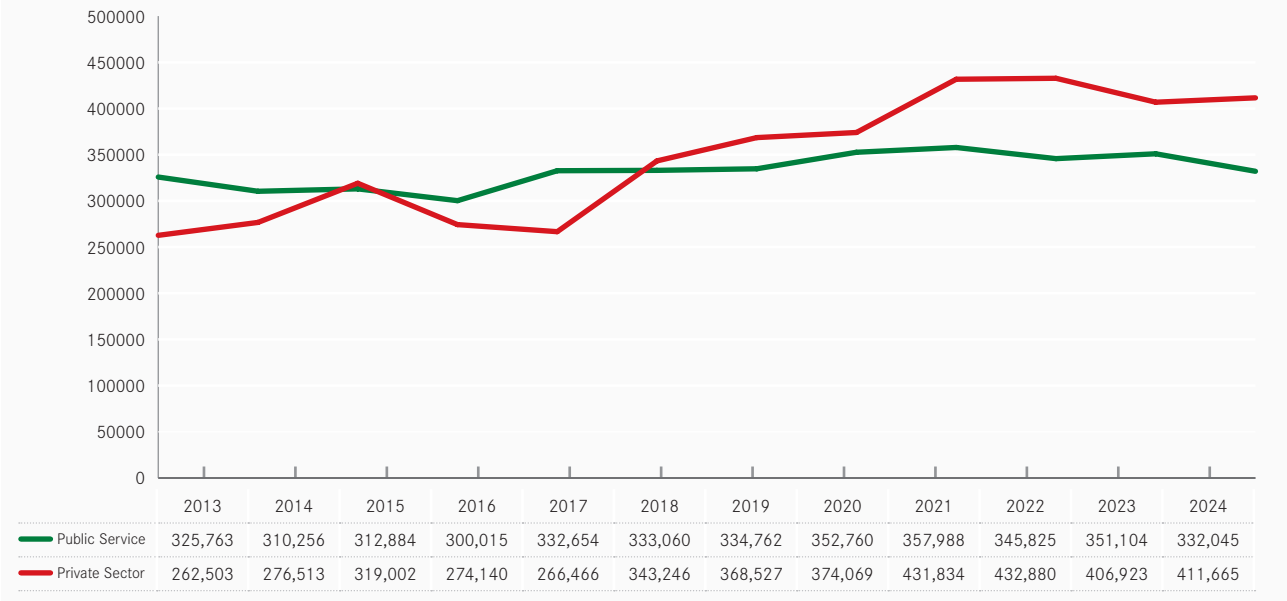
## 1.5 LABOUR MARKET PROFILE

### 1.5.1 An estimate of total employment

Three data sources were used to construct a profile of the labour force: data from WSPs submitted by private sector employers to the HWSETA, data from public sector employers submitted to the PSETA, and data provided to the HWSETA from the private Medpages database. The analysis covered 743 710 people in 2024 formally employed in the health and social development sector, ranging from managers, professionals, technicians and associate professionals, clerical support workers, service and sales workers, craft and trades workers, plant and machine operators, and elementary workers.

Approximately 411 655 (55%) are employed in private sector organisations, while 332 045 (45%) work in public service departments. This distribution has remained relatively constant over the past five years (2019-2024). Employment in the public service component of the sector decreased from 352 760 in 2020 to 332 045 in 2024, with an average annual growth of -1,5% over the period. The private sector component of the sector showed an average annual growth of 2,4% over the same period. The total sector (public and private) showed an average annual growth of 0,6% over the 2020-2024 period. This includes all occupational categories as mentioned in the previous paragraph.

**Figure 1-3 Total employment in the health and social development sector, 2013-2024**



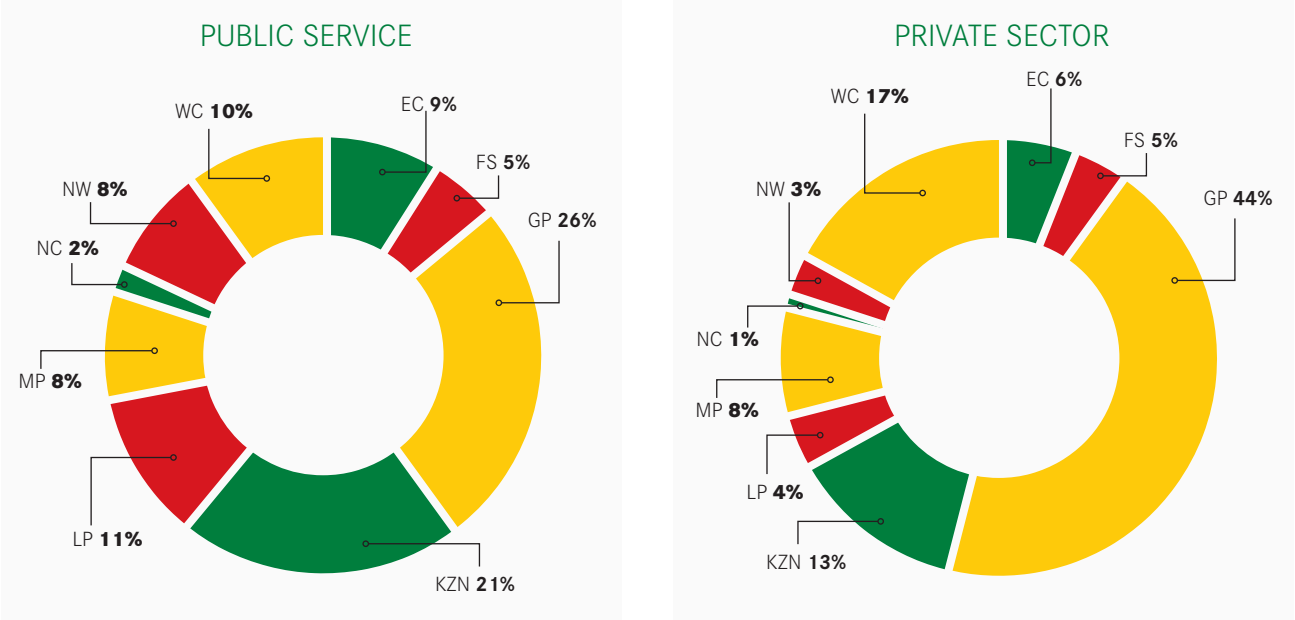

| | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 | 2020 | 2021 | 2022 | 2023 | 2024 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Public Service | 325,763 | 310,256 | 312,884 | 300,015 | 332,654 | 333,060 | 334,762 | 352,760 | 357,988 | 345,825 | 351,104 | 332,045 |
| Private Sector | 262,503 | 276,513 | 319,002 | 274,140 | 266,466 | 343,246 | 368,527 | 374,069 | 431,834 | 432,880 | 406,923 | 411,665 |

*Source: Calculated from HWSETA and PSETA WSPs 2013 -2024, Medpages data 2013 -2024.*

## 1.5.2 Provincial distribution of employment

The figure below shows the provincial distribution of employees in the public service and the private sector. Compared to private health, the public service has higher percentages of health workers in provinces with large rural, poor populations depending on public health services. The provincial distribution has remained constant over the last five years.

**Figure 1-4 Provincial distribution of employment in the public service and private health sector, 2024**




*Sources: Calculated from HWSETA and PSETA WSPs 2024, Medpages data 2024.*

## 1.5.3 Occupational distribution of employment

From 2019 to 2024, 54% and 46% of total employment was from the private sector and public service respectively. In the same period, the share of professionals, technicians and associate professionals has remained consistent at 55% of total employment (Table 1-3). With a 7% share of managers in total employment from 2019 to 2024, this makes the skilled[5] category share 62% of total employment in the sector while semi-skilled[6] and low-skilled[7] categories account for 30% and 8% respectively.

In the health and social development sector, a large portion of managerial positions are filled by professionals. In the health sector, professionals include medical and dental specialists and practitioners, registered nurses, pharmacists, veterinarians, and other health-related occupations such as homeopaths. Professionals in support functions such as human resource professionals, financial professionals, and scientists also form part of this group. Technicians and associate professionals include occupations such as technicians, enrolled and veterinary nurses, ancillary healthcare workers, ambulance officers, and pharmacy sales assistants as well as allied health workers such as chiropractors and administrative support workers such as office administrators.

5 *Skilled occupations refers to OFO major groups namely; managers, professionals, and technicians and associate professionals.*

6 *Semi-Skilled occupations refers to OFO major groups namely: clerical support, skilled agricultural, forestry, fishery, craft and related trades, plant and machine operators and assemblers.*

7 *Low-skilled occupations refers to elementary occupations as an OFO major group.*

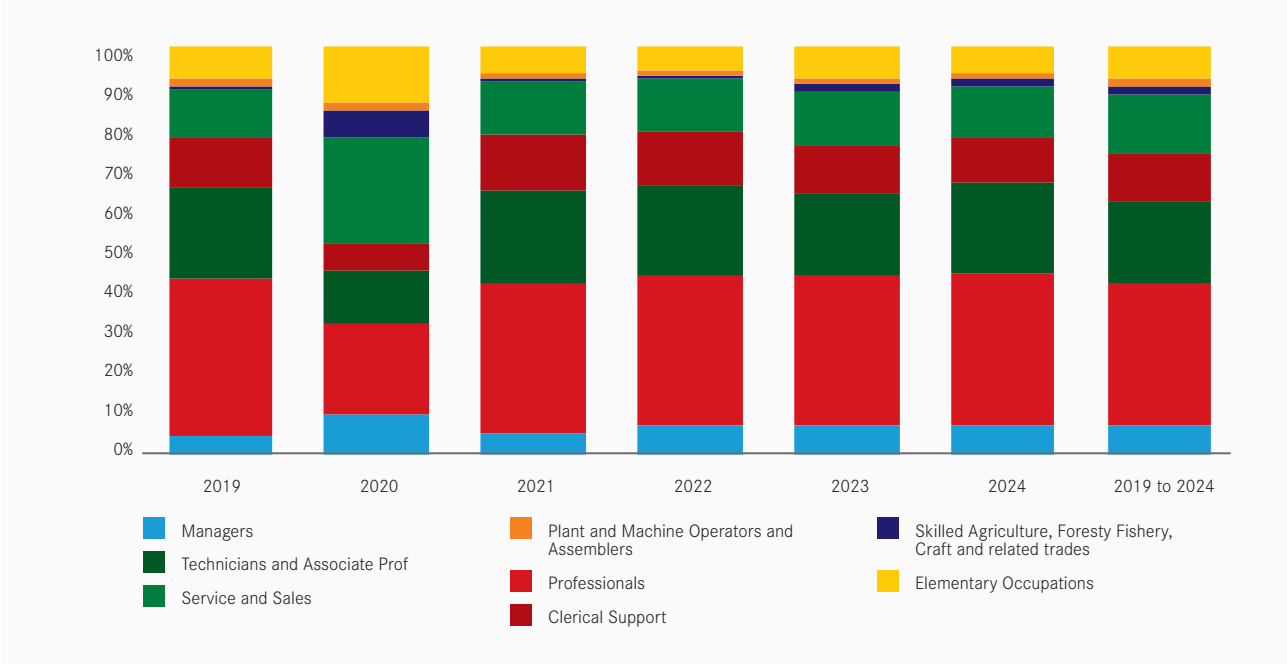
**Table 1-3 Public service and private sector employment per occupational group, 2024**

| OCCUPATIONAL GROUP | PUBLIC SERVICE | | PRIVATE SECTOR | | TOTAL SECTOR | |
|---|---|---|---|---|---|---|
| | NUMBER OF EMPLOYEES | % | NUMBER OF EMPLOYEES | % | NUMBER OF EMPLOYEES | % |
| Managers | 11 803 | 4 | 40 142 | 10 | 51 945 | 7 |
| Professionals | 135 676 | 41 | 142 977 | 35 | 278 653 | 37 |
| Technicians and Associate Professionals | 74 448 | 22 | 88 009 | 21 | 162 457 | 22 |
| Clerical Support Workers | 32 953 | 10 | 49 809 | 12 | 82 762 | 11 |
| Service and Sales Workers | 48 215 | 15 | 45 564 | 11 | 93 779 | 13 |
| Skilled Agricultural, Trades Workers | 2 180 | 1 | 12 017 | 3 | 14 197 | 2 |
| Plant and Machine Operators | 2 617 | 1 | 6 714 | 2 | 9 331 | 1 |
| Elementary Occupations | 24 153 | 7 | 26 433 | 6 | 50 586 | 7 |
| **Total** | **332 045** | **100** | **411 665** | **100** | **743 710** | **100** |

*Sources: Calculated from HWSETA and PSETA WSPs 2024, Medpages data 2024.*

A graphical representation of the distribution of employment per occupational group from 2019 to 2024 is shown below. While the distribution of employment per occupational group has remained constant over the five-year period, the graph below displays rapid shifts in employment trends during the COVID-19 pandemic year in 2020. Service and sales, managers, and elementary occupations doubled their share during this period while the skilled agricultural, forestry, fishery, craft, and related trades category increased its share seven times. These shifts are notable given that the healthcare system in the country was stretched to its limits due to rapid increase in demand for health services. The shifts reflect both increased demand and government response in terms of its resource allocation towards human personnel in the health sector. These rapid shifts in trends should be seriously considered going forward since the successful implementation of the NHI is likely to increase the same demand for health services.

**Figure 1-5 Distribution of total sector employment per occupational group from 2019 to 2024**




*Sources: Calculated from HWSETA and PSETA WSPs 2019-2024, Medpages data 2019-2024.*

With an annual average growth rate of 1.9% employment from 2019 to 2023, semi-skilled occupations' annual growth rate is 1.2% above that of the total sector with services and sales at a rapid annual growth rate (5.1%). Plant and machine operators and assemblers have the most negative annual average growth rate of -7.2%. This indicates that, over the 2019

to 2023 strategic period, the health and social labour market demand increased towards semi-skilled occupations driven by services and sales while low-skilled occupations grew at the overall sector growth rate. Skilled occupations were the only exception with a growth rate below (1.4%) the total sector annual growth rate at 1.9%. The table below displays the distribution of occupational groups from 2020 to 2024, with the distributions remaining constant across the different groups throughout this period.

**Table 1-4 Public Service and private sector occupational group distribution, 2020-2024**

| SKILL LEVEL | TOTAL SECTOR | 2020 % | 2021 % | 2022 % | 2023 % | 2024 % | 2020-2024 (AAG) % | 2020-2024 (AAG) % |
|---|---|---|---|---|---|---|---|---|
| Skilled | Managers | 5 | 5 | 7 | 7 | 7 | 2,9 | 0,9% |
| | Professionals | 38 | 36 | 37 | 37 | 37 | -1,1 | |
| | Technicians and Associate Professionals | 22 | 23 | 22 | 20 | 22 | -1,3 | |
| Semi-Skilled | Clerical Support Workers | 12 | 14 | 13 | 12 | 11 | -7,0 | -,05% |
| | Service and Sales Workers | 13 | 13 | 13 | 13 | 13 | 1,0 | |
| | Skilled Agricultural, Trades Workers | 1 | 1 | 1 | 2 | 2 | 10,0 | |
| | Plant and Machine Operators | 2 | 1 | 1 | 1 | 1 | -4,6 | |
| Low-skilled | Elementary Occupations | 7 | 7 | 6 | 8 | 7 | -2,7 | 1,2% |

*Sources: Calculated from HWSETA and PSETA WSPs 2020-2024, Medpages data 2020-2024.*

Regarding the demand for professionals, HWSETA recently conducted occupation-focused studies on pharmacists, pharmacist assistants, medical practitioners, and social workers. The findings revealed that the output of medical student graduates and pharmacy human personnel, while noting improvements, is insufficient to meet the needs of the population (HWSETA 2023a). Thus, more intake and funding are needed to increase the capacity of the existing supply institutions in terms of staff, infrastructure, and facilities. Lack of posts for internship and community service of medical practitioners was flagged as one of the biggest concerns. Thus, the successful implementation of the NHI has the potential to address these system challenges appropriately. For social workers, the study highlighted that demand is influenced by various factors such as demographic trends, social welfare policies, the prevalence of social issues, and non-competitive salaries.

However, the main factor affecting the demand for social workers is funding and budget cuts, particularly in the public sector, which limit hiring enough social workers to provide the necessary services (HWSETA 2024). Thus, skilled occupations remain in demand by the labour market even though at a slower pace compared to semi-skilled and low-skilled occupations.

### 1.5.4 Population group

Currently, Africans make up 76% of the employees in the health and social development sector, public and private sector combined (Table 1-5). In the public sector, the proportion of Africans remained relatively constant between 2020 and 2024, ranging from 79% to 86%. In the private sector, however, the proportion of African employees increased significantly, from 58% in 2020 to 70% in 2023, decreasing to 67% in 2024. Meanwhile, the proportion of White employees decreased from 23% in 2020 to 14% in 2023, increasing again to 17% in 2024.

Table 1-6 shows the proportion of African employees across the different occupational groups over the 2020-2024 period. In the public sector, the proportion of African managers was just below two thirds (62%) in 2020, dropping to 58% in 2022, but increasing again to more than three quarters (78%) in 2024. In the private sector, the proportion of African managers increased significantly, from 50% in 2020 to 63% in 2024. The proportion of African professionals and associate professionals in the public sector remained relatively constant over the period but showed a sharp increase to 88% for associate professionals in 2024. The private sector witnessed significant increases for Africans in these occupational groups, increasing from 48% (2020) to 61% (2024) for professionals and for associate professionals from 58% in 2020 to 72% in 2023, decreasing to 68% in 2024.

**Table 1-5 Health and social development sector: Total employment by population group, 2020-2024**

| | 2020 | | 2021 | | 2022 | | 2023 | | 2024 | |
|---|---|---|---|---|---|---|---|---|---|---|
| **PUBLIC SERVICE** | **N** | **%** | **N** | **%** | **N** | **%** | **N** | **%** | **N** | **%** |
| African | 279 945 | 79 | 286 150 | 80 | 276 011 | 80 | 299 039 | 85 | 284 833 | 86 |
| Coloured | 43 878 | 12 | 42 853 | 12 | 43 655 | 13 | 26 564 | 8 | 22 807 | 7 |
| Indian | 9 058 | 3 | 9 145 | 3 | 7 411 | 2 | 8 457 | 2 | 8 010 | 2 |
| White | 19 879 | 6 | 19 840 | 6 | 18 748 | 5 | 17 044 | 5 | 16 395 | 5 |
| Total | 352 760 | 100 | 357 988 | 100 | 345 825 | 100 | 351 104 | 100 | 332 045 | 100 |
| **PRIVATE SECTOR** | **N** | **%** | **N** | **%** | **N** | **%** | **N** | **%** | **N** | **%** |
| African | 214 272 | 58 | 266 087 | 62 | 265 325 | 61 | 285 727 | 70 | 277 387 | 67 |
| Coloured | 54 685 | 15 | 51 646 | 12 | 56 443 | 13 | 43 293 | 11 | 42 786 | 10 |
| Indian | 20 208 | 5 | 30 826 | 7 | 24 765 | 6 | 19 768 | 5 | 23 091 | 6 |
| White | 84 904 | 23 | 83 276 | 19 | 86 347 | 20 | 58 135 | 14 | 68 400 | 17 |
| Total | 374 069 | 102 | 431 834 | 100 | 432 880 | 100 | 406 923 | 100 | 411 665 | 100 |
| **TOTAL SECTOR** | **N** | **%** | **N** | **%** | **N** | **%** | **N** | **%** | **N** | **%** |
| African | 494 217 | 70 | 552 237 | 70 | 541 336 | 70 | 584 766 | 77 | 562 220 | 76 |
| Coloured | 98 563 | 14 | 94 499 | 12 | 100 098 | 13 | 69 857 | 9 | 65 593 | 9 |
| Indian | 29 266 | 4 | 39 971 | 5 | 32 176 | 4 | 28 225 | 4 | 31 101 | 4 |
| White | 104 783 | 15 | 103 116 | 13 | 105 095 | 13 | 75 179 | 10 | 84 795 | 11 |
| Total | 726 829 | 103 | 789 822 | 100 | 778 705 | 100 | 758 027 | 100 | 743 710 | 100 |

*Sources: Calculated from HWSETA and PSETA WSPs 2020-2024, MedPages data 2020-2024.*

**Table 1-6 Proportion African employees across the occupational groups, 2020-2024**

| | 2020 | 2021 | 2022 | 2023 | 2024 |
|---|---|---|---|---|---|
| **PUBLIC SERVICE** | % | % | % | % | % |
| Managers | 62 | 62 | 58 | 74 | 78 |
| Professionals | 76 | 76 | 77 | 82 | 81 |
| Technicians and Associate Professions | 77 | 79 | 77 | 83 | 88 |
| Clerical Support | 80 | 80 | 83 | 84 | 84 |
| Service and Sales | 91 | 92 | 92 | 95 | 95 |
| Skilled Agricultural, Forestry, Fishery, Craft, and Related Trades | 81 | 82 | 82 | 89 | 91 |
| Plant and Machine Operators and Assemblers | 83 | 85 | 83 | 89 | 88 |
| Elementary Occupations | 87 | 87 | 84 | 93 | 92 |
| **PRIVATE SECTOR** | % | % | % | % | % |
| Managers | 50 | 49 | 59 | 63 | 63 |
| Professionals | 48 | 54 | 55 | 61 | 61 |
| Technicians and Associate Professions | 58 | 61 | 59 | 72 | 68 |
| Clerical Support | 49 | 57 | 54 | 61 | 59 |
| Service and Sales | 71 | 75 | 74 | 78 | 78 |
| Skilled Agricultural, Forestry, Fishery, Craft, and Related Trades | 58 | 69 | 72 | 94 | 94 |
| Plant and Machine Operators and Assemblers | 77 | 73 | 69 | 83 | 82 |
| Elementary Occupations | 79 | 86 | 87 | 88 | 88 |
| **TOTAL SECTOR** | % | % | % | % | % |
| Managers | 54 | 52 | 59 | 65 | 66 |
| Professionals | 63 | 65 | 65 | 72 | 71 |
| Technicians and Associate Professions | 67 | 69 | 66 | 77 | 77 |
| Clerical Support | 64 | 66 | 68 | 70 | 69 |
| Service and Sales | 81 | 83 | 84 | 87 | 87 |
| Skilled Agricultural, Forestry, Fishery, Craft, and Related Trades | 64 | 73 | 74 | 94 | 94 |
| Plant and Machine Operators and Assemblers | 78 | 76 | 73 | 85 | 84 |
| Elementary Occupations | 84 | 87 | 86 | 90 | 90 |

*Sources: Calculated from HWSETA and PSETA WSPs 2020-2024, MedPages data 2020-2024.*

### 1.5.5 Gender

The gender distribution stayed constant in the sector over the 2020-2024 period. The sector is represented by 28% to 30% males, whilst females continue to make up the majority of the workforce in the health and social development sector.

**Table 1-7 Gender distribution in the health and social development sector, 2020-2024**

| | 2020 | 2021 | 2022 | 2023 | 2024 |
|---|---|---|---|---|---|
| **PUBLIC SERVICE** | % | % | % | % | % |
| Male | 27 | 26 | 28 | 27 | 27 |
| Female | 73 | 74 | 72 | 73 | 73 |
| Total | 100 | 100 | 100 | 100 | 100 |
| **PRIVATE SECTOR** | % | % | % | % | % |
| Male | 28 | 29 | 29 | 33 | 32 |
| Female | 72 | 71 | 71 | 67 | 68 |
| Total | 100 | 100 | 100 | 100 | 100 |
| **TOTAL SECTOR** | % | % | % | % | % |
| Male | 28 | 28 | 29 | 30 | 30 |
| Female | 72 | 72 | 71 | 70 | 70 |
| Total | 100 | 100 | 100 | 100 | 100 |

*Sources: Calculated from HWSETA and PSETA WSPs 2020-2024, MedPages data 2020-2024.*

Females are in the majority in all occupation groups, except for the groups that are related to plant and machine operations and trades. This trend was consistent over the last five-years.

**Table 1-8 Gender distribution according to the occupational group, 2024**

| | MALE | | FEMALE | | TOTAL | |
|---|---|---|---|---|---|---|
| **PUBLIC SERVICE** | **N** | **%** | **N** | **%** | **N** | **%** |
| Managers | 4 517 | 38 | 7 286 | 62 | 11 803 | 100 |
| Professionals | 29 043 | 21 | 106 633 | 79 | 135 676 | 100 |
| Technicians and Associate Professions | 20 953 | 28 | 53 495 | 72 | 74 448 | 100 |
| Clerical Support | 10 800 | 33 | 22 153 | 67 | 32 953 | 100 |
| Service and Sales | 13 033 | 27 | 35 182 | 73 | 48 215 | 100 |
| Skilled Agricultural, Forestry, Related Trades | 1 205 | 55 | 975 | 45 | 2 180 | 100 |
| Plant and Machine Operators and Assemblers | 1 923 | 73 | 694 | 27 | 2 617 | 100 |
| Elementary Occupations | 7 556 | 31 | 16 597 | 69 | 24 153 | 100 |
| **PRIVATE SECTOR** | **N** | **%** | **N** | **%** | **N** | **%** |
| Managers | 15 184 | 38 | 24 958 | 62 | 40 142 | 100 |
| Professionals | 26 059 | 20 | 101 959 | 80 | 128 018 | 100 |
| Technicians and Associate Professions | 21 746 | 21 | 81 222 | 79 | 102 968 | 100 |
| Clerical Support | 16 461 | 33 | 33 348 | 67 | 49 809 | 100 |
| Service and Sales | 11 437 | 25 | 34 126 | 75 | 45 564 | 100 |
| Skilled Agricultural, Forestry, Related Trades | 10 810 | 90 | 1 207 | 10 | 12 017 | 100 |
| Plant and Machine Operators and Assemblers | 5 865 | 87 | 849 | 13 | 6 714 | 100 |
| Elementary Occupations | 10 899 | 41 | 15 534 | 59 | 26 433 | 100 |
| **TOTAL SECTOR** | **N** | **%** | **N** | **%** | **N** | **%** |
| Managers | 19 701 | 38 | 32 244 | 62 | 51 945 | 100 |
| Professionals | 55 102 | 21 | 208 592 | 79 | 263 694 | 100 |
| Technicians and Associate Professions | 42 699 | 24 | 134 717 | 76 | 177 416 | 100 |
| Clerical Support | 27 261 | 33 | 55 501 | 67 | 82 762 | 100 |
| Service and Sales | 24 470 | 26 | 69 308 | 74 | 93 779 | 100 |
| Skilled Agricultural, Forestry, Related Trades | 12 015 | 85 | 2 182 | 15 | 14 197 | 100 |
| Plant and Machine Operators and Assemblers | 7 788 | 83 | 1 543 | 17 | 9 331 | 100 |
| Elementary Occupations | 18 455 | 36 | 32 131 | 64 | 50 586 | 100 |

*Sources: Calculated from HWSETA and PSETA WSPs 2024, MedPages data 2024.*

### 1.5.6 Age distribution

Table 1-9 shows the total age distribution in the public sector, private health, and the total sector from 2020 to 2024. The overall age profile in the public sector remained relatively stable over the period, with individuals under 35 years old comprising 24-26% of the workforce and those over 55 years old making up 10-12%. In the private sector, the percentage of employees younger than 35 was significantly higher, ranging from 33-40%, while those over 55 constituted 11-15% of the workforce during the same period.

**Table 1-9 Age distribution of all employees in the health and social development sector, 2020-2024**

| | 2020 | 2021 | 2022 | 2023 | 2024 |
|---|---|---|---|---|---|
| **PUBLIC SERVICE** | % | % | % | % | % |
| Younger than 35 | 26 | 26 | 26 | 24 | 24 |
| 35 to 55 | 63 | 63 | 63 | 65 | 64 |
| Older than 55 | 11 | 11 | 11 | 10 | 12 |
| Total | 100 | 100 | 100 | 100 | 100 |
| **PRIVATE SECTOR** | % | % | % | % | % |
| Younger than 35 | 38 | 35 | 40 | 33 | 35 |
| 35 to 55 | 50 | 50 | 49 | 54 | 55 |
| Older than 55 | 12 | 15 | 11 | 13 | 11 |
| Total | 100 | 100 | 100 | 100 | 100 |
| **TOTAL SECTOR** | % | % | % | % | % |
| Younger than 35 | 32 | 31 | 30 | 29 | 29 |
| 35 to 55 | 56 | 56 | 57 | 59 | 59 |
| Older than 55 | 12 | 13 | 13 | 12 | 12 |
| Total | 100 | 100 | 100 | 100 | 100 |

*Sources: Calculated from HWSETA and PSETA WSPs 2020- 2024, MedPages data 2020-2024.*

The table below highlights the age distribution of managers, professionals, and associate professionals in the health and social development sector for 2020-2024. The proportion of managers under 35 decreased from 31% in 2020 to 28% in 2024. Notably, the proportion of professionals and associate professionals under 35 also decreased over the same period.

**Table 1-10 Age distribution of managers, professionals, and associate professionals in the health and social development sector, 2020-2024**

| | 2020 | 2021 | 2022 | 2023 | 2024 |
|---|---|---|---|---|---|
| **MANAGERS** | % | % | % | % | % |
| Younger than 35 | 31 | 25 | 25 | 31 | 28 |
| 35 to 55 | 57 | 57 | 60 | 56 | 58 |
| Older than 55 | 12 | 18 | 15 | 13 | 14 |
| **PROFESSIONALS** | % | % | % | % | % |
| Younger than 35 | 31 | 28 | 30 | 26 | 29 |
| 35 to 55 | 54 | 58 | 58 | 59 | 58 |
| Older than 55 | 15 | 14 | 12 | 15 | 13 |
| **ASSOCIATE PROFESSIONALS** | % | % | % | % | % |
| Younger than 35 | 39 | 34 | 35 | 29 | 29 |
| 35 to 55 | 50 | 54 | 54 | 62 | 60 |
| Older than 55 | 11 | 12 | 11 | 9 | 11 |

*Sources: Calculated from HWSETA and PSETA WSPs 2020-2024, MedPages data 2020-2024.*

## 1.5.7 Disability

The proportion of workers with disabilities in the health and social development sector remained the same (1%) between 2020 and 2024 (Table 1-11).

**Table 1-11 Disability distribution across occupational groups in the health and social development sector, 2020-2024**

| | 2020 | 2021 | 2022 | 2023 | 2024 |
|---|---|---|---|---|---|
| **DISABILITY** | % | % | % | % | % |
| Managers | 7 | 8 | 11 | 9 | 9 |
| Professionals | 23 | 21 | 24 | 21 | 29 |
| Technicians and Associate Professions | 14 | 18 | 15 | 16 | 16 |
| Clerical Support | 34 | 34 | 29 | 31 | 25 |
| Service and Sales | 12 | 11 | 13 | 13 | 15 |
| Skilled Agricultural, Forestry, Fishery, Craft, and Related Trades | 2 | 1 | 1 | 2 | 2 |
| Plant and Machine Operators and Assemblers | 1 | 2 | 1 | 1 | 1 |
| Elementary Occupations | 6 | 6 | 5 | 6 | 4 |
| **% of total employment** | **1** | **1** | **1** | **1** | **1** |

*Sources: Calculated from HWSETA and PSETA WSPs 2020-2024.*

## 1.6 LABOUR MARKET ANALYSIS

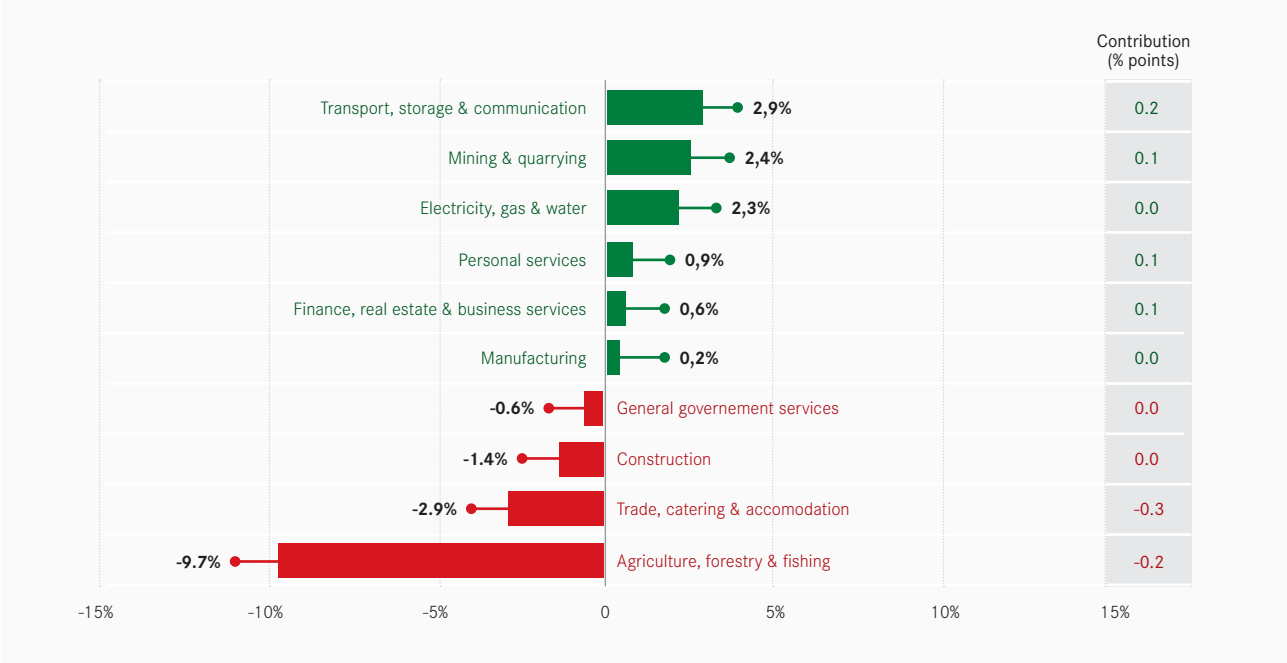
### 1.6.1 Sector's contribution to the economy

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

As anticipated by the Economic Reconstruction and Recovery Plan (ERRP) policy document (2020, p.2) that "COVID-19 pandemic deepened the economic crisis" in South Africa, in the first quarter of 2024, the unemployment rate was still high, standing at 32,9%, equating to 8,2 million people (Stats SA 2024b). The increase in unemployment and income losses have entrenched existing inequalities (Stats SA 2024b). The ERRP, as a post-COVID-19 recovery strategy, focused on job creation and skills innovation, while the COVID-19 social relief of distress grant focuses on income support. The latter, which was initiated to provide short-term support for low-income households in 2020, has now been extended to the end of March 2025 and a further R33,6 billion has been allocated in 2024/25 to this end (National Treasury 2024a).

Figure 1-6 shows industry growth in South Africa for the fourth quarter of 2023 in comparison to the third quarter of 2023 (Stats SA 2024a). Public health and social development services form part of the Government sector, private health, and social development services are part of the sector called personal services, retail pharmacies fall under trade while manufacturing of pharmaceuticals, medicinal chemicals, and botanical products form part of the manufacturing sector. In terms of public health and social development activity, the Government sector contracted by 0,6%. Personal services, which include private health-related activities, showed increased activity of 0,9% when the South African economy grew by 0,1%.

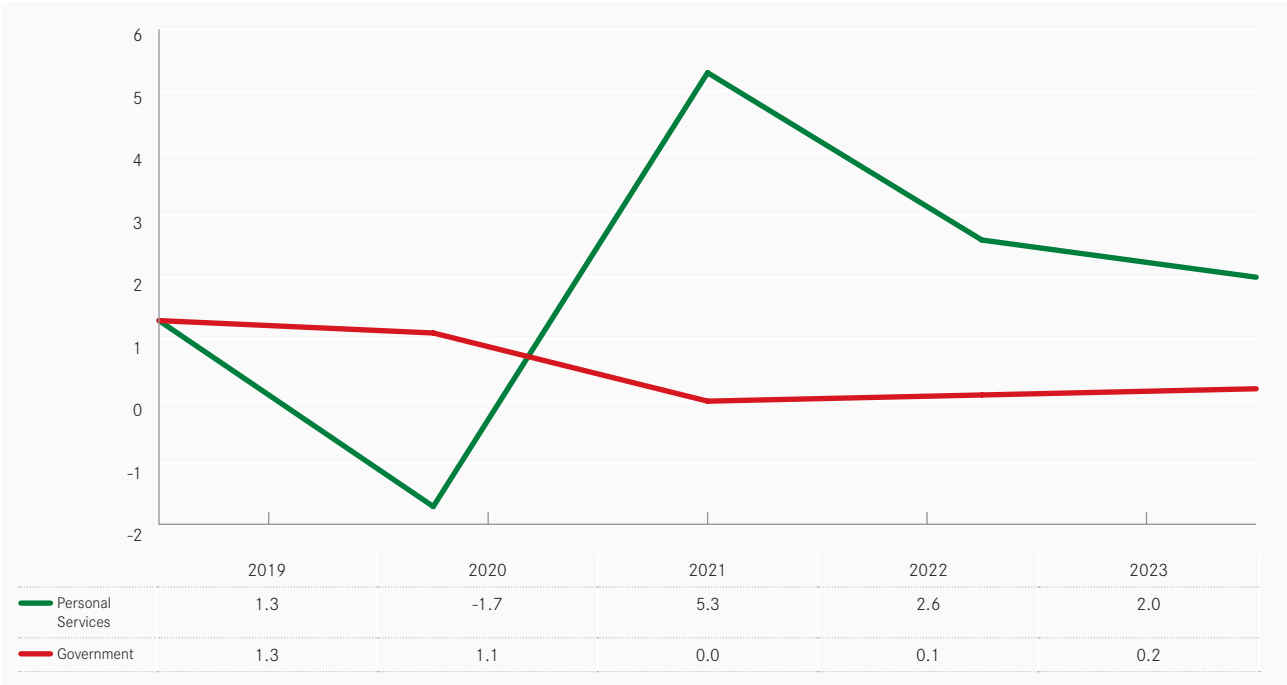
**Figure 1-6 Industry growth in the 4th quarter of 2023 in comparison with the 3rd quarter in 2023**




*Source: Stats SA 2024a.*

The figure below illustrates the growth rates in industry value added and GDP (constant 2015 prices) for Government and personal services from 2019 to 2023. The growth rate for Government remained consistently low throughout the period. Notably, the impact of the pandemic is evident in 2020 (personal services that include private health related activities), when only essential medical services were allowed. The implication is that the health and social development sector (personal services) is linked to the growth trajectory of the country both from productivity and employment trends.

**Figure 1-7 Growth rates in industry value added and GDP, 2019-2023.**



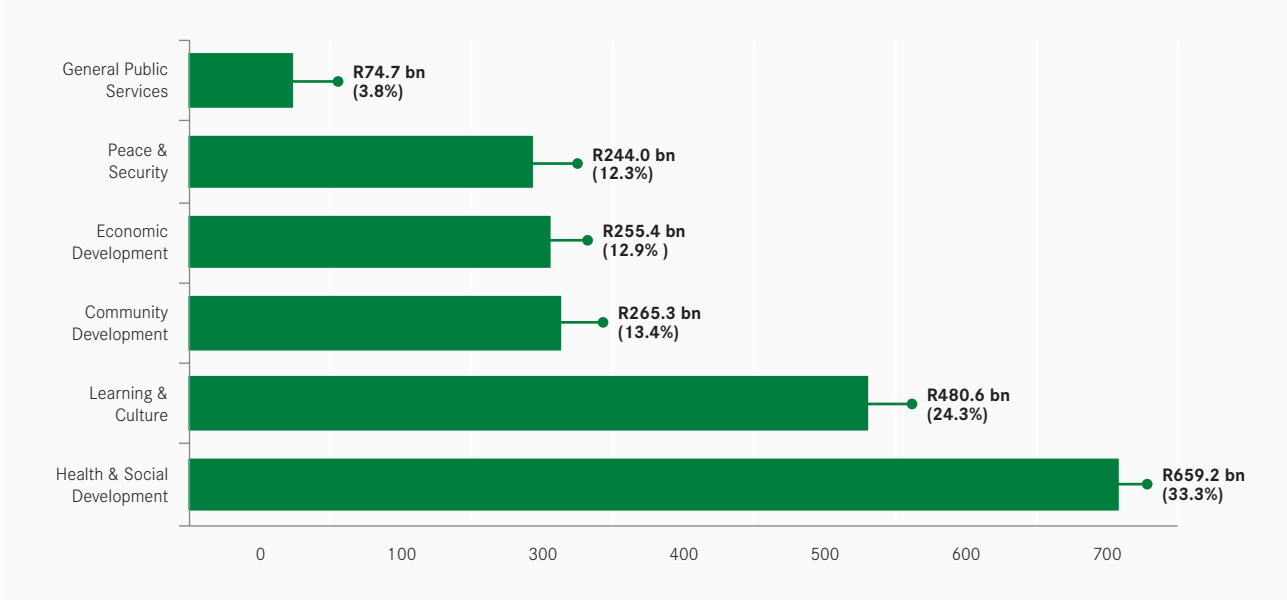

| | 2019 | 2020 | 2021 | 2022 | 2023 |
|---|---|---|---|---|---|
| Personal Services | 1.3 | -1.7 | 5.3 | 2.6 | 2.0 |
| Government | 1.3 | 1.1 | 0.0 | 0.1 | 0.2 |

*Source: Stats SA 2024a.*

## 1.6.2 Economic performance

Healthcare expenditure comes from three sources; general tax revenues finance the public sector, while medical schemes and out-of-pocket payments finance private care. Public sector health and social development budgets respectively account for 13,7% (R271,9 billion) and 219,6% (R387,3 billion); in total 33,3% (R659,2 billion) of government expenditure in 2024/25 (see figure below for comparison with other key sectors in the public domain) (National Treasury 2024a).

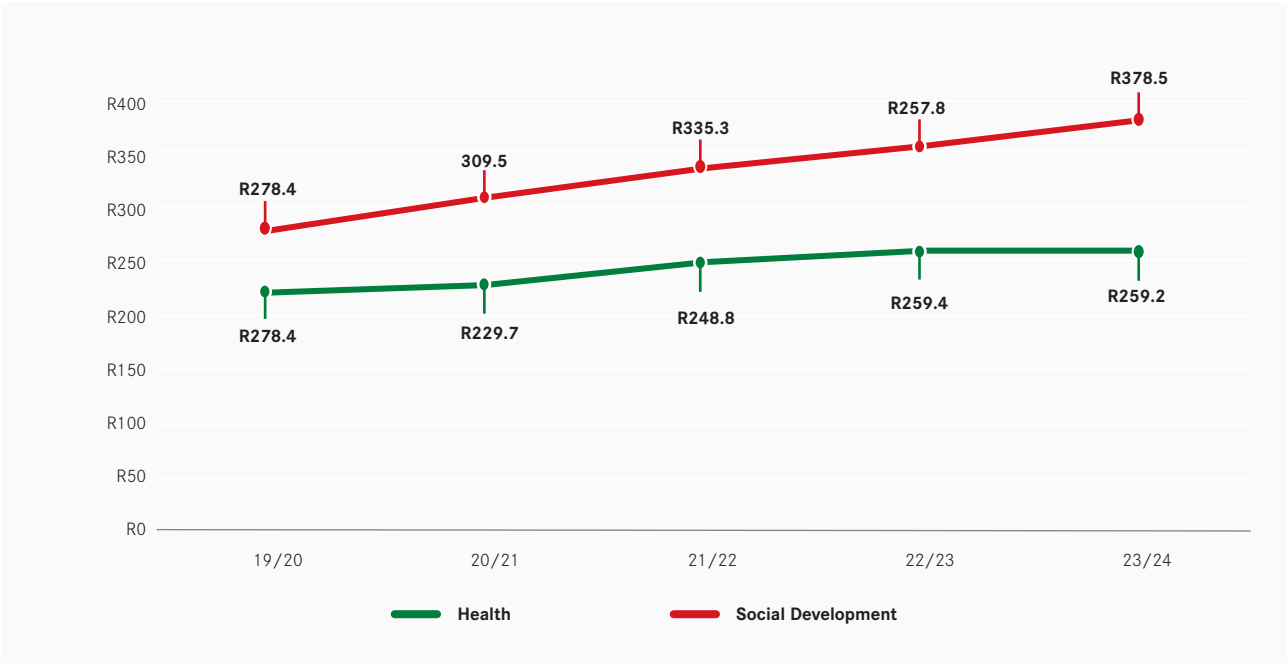
**Figure 1-8 Health and Social Development proportion of the budget (public sector), 2024**




*Source: National Treasury 2024a, 2024b.*

The figure below displays the health and social development MTEF budgets from 2019/20 to 2023/24. The share of budget allocation for health and social development remains unchanged from 33% over the 5-year strategic period despite the high demand for services from the population. The increase in the social development budget is linked to the rise in grant beneficiaries. In 2019, 17 million social grants were paid monthly to needy South Africans, and this number is expected to reach 19,6 million by March 2026.

**Figure 1-9 Health and Social Development MTEF budget allocation (public sector), 2019/20-23/24**




*Source: National Treasury 2020-2025.*

During the COVID-19 period in 2020, the medical scheme industry experienced a slight decline in membership. However, data from 2021 indicates a marginal increase, reflecting beneficiary patterns similar to those seen before the pandemic (CMS 2023). In 2022, medical aid beneficiaries made up about 15,8 percent of the total population, which translates to approximately 9,7 million people out of the country's 61 million residents (Statista 2024). This may all change once the NHI is active and possibly funded through taxes paid by all employed South Africans.

In 2021, the total gross relevant healthcare expenditure incurred by medical schemes increased by 14.5% to R205.80 billion from R179.70 billion in 2020. In 2021, medical schemes incurred a surplus of R12.18 billion compared with R24.84 billion in 2020, representing a decrease of 50.9% (CMS 2021). South Africa's private hospital groups reported increased activity again after the pandemic, including expansion initiatives (Moneyweb 2022, Daily Maverick 2022).

### 1.6.3 Future outlook

The government estimates that health expenditure will increase at an average annual rate of 4,3%, between 2023/24 and 2026/27. Social development expenditure is expected to increase by an average growth rate of 1,0% over the period, from R260,9 billion in 2023/24 to R269,2 billion in 2026/27 (National Treasury 2024b).

There will be an ongoing focus on implementing the NHI, preventing and treating communicable and non-communicable diseases, investing in health infrastructure, supporting tertiary health care services, and developing the health workforce. Preparatory work in terms of the NHI includes capacity building that is largely funded through the national health insurance indirect grant, which has an allocation of R6,9 billion over the MTEF period (2024/25-2026/27). The grant now combines its non-personal and personal services components into a single health systems component, allocated R2,4 billion with an annual spending increase of 4,6%. This aims to strengthen health systems, improve information systems, address compliance issues, enhance clinic initiatives, and pilot primary healthcare contracting units. The remaining R4,6 billion is for health facility revitalisation, including R1,6 billion for building the Limpopo Academic Hospital. In essence, the implementation of the NHI will see a rise in both training investment and employment in the sector. The latter is due to public sector budgets prioritisation of the health and social spending programmes despite pressure on resources (National Treasury 2024a). There is a direct relationship between spending (in the public and private sectors) and the demand for workers. Public sector budgets are major determinants of both the number of positions created and salary levels and, consequently, the ability of institutions to attract and retain staff. In the private sector, the linkages are somewhat more complex but equally significant.

## 1.7 CONCLUSION

The employer profile and labour market analysis 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 for the specific needs of each of the components of the sector. The sector consists of a public and a private component and these two components differ vastly in terms of resources, functioning, and skills situations. The skills situation in the public sector is intertwined with the availability, allocation, and administration of public funds while the private sector is to a larger extent subject to market forces. The labour market situation of the total sector is therefore quite complex and quantitative expressions of current and future skills needs must be interpreted with great care.

Healthcare and social service practitioners are regulated by several statutory professional councils. These bodies play a formative role in determining the scope of practice for professionals and specialist occupations and regulate the education and training standards required to work as healthcare or social service practitioners. For this reason, they form an integral part of the skills system and the HWSETA must work in close cooperation with them. At an occupational level, the demand for nurses remains a critical issue as they form the majority of the sector's workforce and form the backbone of most services offered.

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

Formal employment in the health and social development sector is estimated at about 758 000, with 54% employed in private sector organisations and 46% working in public service departments. For the HWSETA, it is important to balance the needs of the small and the large organisations and those of the public and private sector components of its sector. The average annual growth for the total sector was 0,6% over the 2020-2024 period. The growth in employment in the sector from 2020 to 2022 was expected considering the immediate COVID-19 demand for extra workers to assist the population with health and social development services.

# 2. KEY SKILLS CHANGE DRIVERS.

# 2 KEY SKILLS CHANGE DRIVERS

## 2.1 INTRODUCTION

It is important to note that all change drivers in this sector are significant and noteworthy, as they may have an impact on the health and wellbeing of the majority of the population. This chapter therefore starts with a discussion of various change drivers that influence the demand for skills in the sector and the supply of skills to the sector. Some of the change drivers are generic to the health and the social development segments of the sector while others are specific to either one of them. Although COVID-19 is now classified as endemic, it is still an underlying factor to the economic challenges (effect) and technology (a response to the effect). The second part of the chapter deals with the implications of national strategies and plans for skills planning in the sector. The data sources that were used in this chapter included a desktop review and interviews with key stakeholders in the sector.

## 2.2 FACTORS AFFECTING SKILLS DEMAND AND SUPPLY

The top three factors affecting skills demand and supply in the health and social development sector have been consistent over the five-year period. These factors are, in their order of importance (see Table below).

a) Shortage of human capital of clinical staff and specialist registered nursing personnel

b) Economic challenges

c) Technology

**Table 2-1 Top three factors affecting skills demands and supply, 2020-2024**

| | | IMPLICATIONS FOR SKILLS PLANNING | |
|---|---|---|---|
| CHANGE DRIVER | DESCRIPTION | DEMAND-RELATED IMPLICATIONS | SUPPLY-SIDE RELATED IMPLICATIONS |
| 1. **Shortage of human capital of clinical staff and specialist registered nursing personnel** | There is a shortage of clinical, specialist registered nursing personnel, medical specialists and radiologists (Employer interviews 2024, 2023, and Lifehealthcare annual report 2023) | Increased salary competition on the market due to scarcity | Decreasing trend of pupils from basic education passing Maths with bachelors and/or choosing STEM fields or specifically health sciences in their post-schooling |
| | Limited training capacity for the training of registered nurses due to low capped training capacity with respect to intakes and numbers (Employer interviews 2024, 2023, and Netcare integrated report 2023) | Demand anticipated to continue to outpace or outstrip the pace of supply | This has seen persistence of specialist nurses as hard-to-fill-vacancies i.e. registered nurse in medical, critical care and emergency, and operating theatre etc. |
| | Aging rather than emigration of nurses as the immediate threat to nurses particularly specialities against decreasing trend of learners passing matric with bachelor's and choosing health sciences | Sustained and increasing demand for specialist nurses increasing salary competition | Sustained and increasing demand for specialist nurses and clinical staff as hard-to-fill-vacancies. |
| 2. **Economic Challenges** | Low economic growth negatively affects both public and private sector, and the population as consumers | • Increased salary competition on the market due to scarcity<br>• Limited budgets in the public sector and NPOs making it difficult to appoint skilled staff thus putting increased workload burden on current existing staff | Limited budgets constrain the investment in skills training thus low supply persists |

| CHANGE DRIVER | DESCRIPTION | IMPLICATIONS FOR SKILLS PLANNING<br>DEMAND-RELATED IMPLICATIONS | IMPLICATIONS FOR SKILLS PLANNING<br>SUPPLY-SIDE RELATED IMPLICATIONS |
|---|---|---|---|
| **3. Technology** | Exacerbated by COVID-19 pandemic, organisations are now adopting digitisation and automation for their business model, front and back-end services | • Increased demand for adoption of technologies for changing business models to improve efficiencies and service experience need to virtual technology since the pandemic | • Increased need for training or upskilling staff to complement new technologies<br>• Increased needs for digital and data analytics for analysis of big data |
| | Technology posing new risks with respect to cyber and ransomware attacks resulting in unauthorised access to customer or patient data (i.e. NHLS, Lifehealthcare etc.) | • Demand for highly skilled IT speciality to ensure data security and integrity | |

Other factors considered as change drivers in the health and social development sector are considered below.

## a) Challenging socio-economic realities

Challenging socio-economic realities drive the need for public health services and social development interventions in South Africa. The challenge of poverty and unemployment are significant factors that shape the health and social development sector in South Africa. Poverty affects the majority of South Africans and vast social inequalities continue to persist (National Treasury 2023a). The latest Household Affordability Index by the Pietermaritzburg Economic Justice and Dignity group (PMBEJD) showed that an estimated 30,4 million people are living below the upper-bound poverty line of R1 558 a month; this is about half of the population. In terms of the food poverty line of R760 a month, the estimation is some 13,8 million people (PMBEJD April 2024). Although the unemployment rate has dropped a bit, it still stands at a high 32,9% (8,2 million people) for the first quarter of 2024. Particularly alarming is the 45,5% unemployment rate among young individuals (aged 15-34 years) (Stats SA 2024b). These persistently high unemployment levels are expected to increase the number of social grant beneficiaries to 19,6 million by March 2026 (National Treasury 2023a).

## b) High burden of disease

Good health reduces poverty, improves educational performance, increases productivity, and as a result, stimulates economic growth. The high burden of disease in South Africa hampers economic growth and development. Although the Sixth South African National HIV Prevalence, Incidence, and Behaviour survey (SABSSM VI) found that the percentage of all people living with HIV in South Africa has decreased from 14,0% in 2017 to 12,7% in 2022, it remains a high burden. This translates to approximately 7,8 million people living with HIV in South Africa in 2022 compared to 7,9 million in 2017 (HSRC 2023). South Africa has one of the highest tuberculosis (TB) incidences in the world, with more than 214 295 new cases diagnosed in 2022; the national TB incidence rate per 100 000 population was 468 (WHO 2023). These factors increase the demand for health services and the need for more healthcare workers at all levels.

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

Shifting service demands and technological progress necessitate changes to the scopes of practice of some professions and occupations in the sector. As a result, existing practitioners require new skill sets to close current skills gaps. New occupations have emerged due to changing goals in health and social services. For example, qualifications in community health, community development, and child and youth care have been registered in the last couple of years. The need is growing for work-ready and well-trained mid-level workers to share tasks and extend service capacity in the resource-constrained environments of healthcare and social development; a case in point was the high demand for community health workers in 2020 and 2021 to assist with tracking and tracing of potential COVID-19 cases. Fortunately, a cohort of about 50 000 community health workers was ready to be deployed nationally to assist with the COVID-19 pandemic. Another example is the current demand from the Department of Basic Education (DBE) for placing child and youth care workers in schools (HWSETA 2024b).

## e) Inequity in public-private and urban-rural distributions

Only about 15% of the population is covered by a medical aid therefore the public sector health facilities are stretched to attend to about 85% of the population's healthcare needs, with insufficient numbers of health professionals, especially medical practitioners and nurses working in the public sector. Interviews with stakeholders (2023) conveyed that medical practitioners who are working in the public sector for example, are very disillusioned because of the huge disparity in working conditions and facilities compared to the private sector. Improving these areas could make a positive difference in addressing the shortage, especially since many of them are vocationally driven and do want to work in the public sector. In addition, shortages in rural areas remain an ongoing challenge; posts in rural areas can be vacant for years. Stakeholders expressed hope in the NHI to resolve these challenges (Stakeholder Interviews 2023). In terms of the availability of HRH in the rural areas, and in line with the rural district development model, the HWSETA reacted and prioritised 18 of the 44 rural districts as zones of targeted skills development initiatives (HWSETA 2023c).

## h) Migration

The HWSETA study conducted in 2022 assessing the current and historical trends of the internal and external migration of healthcare professionals shows increasing levels of emigration from 2016 to 2019 before declining in 2020 and increasing again in 2021 and 2022. The decrease in 2020 is explained by the COVID-19 lockdown regulations. The biggest proportion of those emigrating, according to the study survey sample, is specialist medical practitioners, general medical practitioners, nurses, dentists, and psychologists. These healthcare professionals, in the main, emigrate to UK, Australia, and New Zealand. Reasons for emigration are predominantly push factors which relate to the following: economic instability; safety and security concerns; heavy workload in the sector; and the introduction of the NHI.

SAMA conducted a survey in 2021, showing that more than a third (38%) of its members are considering emigrating from South Africa, due to the introduction of the NHI (Businesstech 2023). Yet over the five-year strategic period (2019 to 2023), Medpages datasets accounting for the private sector show a decreasing trend of health professionals[8] emigrating at a negative annual average growth rate of -39,3%. Importantly, all the health professionals selected in the private sector have a negative annual average growth rate of emigration in the same period. This signals that in the health sector, emigration is a decreasing trend thus not a major factor explaining demand and supply dynamics in the sector. Employer interviews (2024) confirmed this trend when it was stated that "most people are not going outside the country but are leaving the health service instead". It was further emphasised that aging of healthcare professionals was more of a major concern than emigration.

8 *This refers to selected health professionals analysed for emigration namely, General practitioner (GP), nurses, surgeon, physician, pharmacist, paediatrician, obstetrician and gynaecologist.*

## 2.3 POLICY FRAMEWORKS AFFECTING SKILLS DEMAND AND SUPPLY

### 2.3.1 National Health Insurance (NHI) and human resources for health

South Africa has committed to attaining universal health care (UHC) by 2030 as part of the United Nation's Sustainable Development Goals. The main strategy to attain UHC is to implement it through a National Health Insurance system which will provide citizens with universal access to a defined package of health care services. With the White Paper published in 2017, the National Health Insurance Bill was signed by the President on 15 May 2024. The intent of government is shown in the 2024/25 budget allocation of funds to the NHI. The funding is earmarked to enhance infrastructure and health systems, particularly information systems, address findings from the Office of Health Standards and Compliance, advance the implementation of the ideal clinic initiative, improve medication dispensing through the central chronic medication dispensing and distribution programme, and provide proof of concept by piloting contracting units for primary health care. However, final implementation may be slow as there are several legal challenges to the Act from various organisations.

The skills implication of the NHI will be the provision and maintenance of sufficient skills to implement the NHI with intention to match-up to the rapid increase of demand for health service triggered by universal access. Both supply and demand for health services and human personnel in the sector will be increased rapidly considering the re-engineering and expansion of access to primary healthcare. The latter would drive-up demand through its municipal ward-based primary healthcare outreach teams (WBPHCOTs). The Human Resources for Health (HRH) strategy responds to staff shortages and unequal distribution of skilled health professionals between public and private sectors, and between urban and rural areas exacerbating public health sector shortages.

### 2.3.2 White paper for Social Development and Sector Strategy for the Employment of Social Service practitioners

The Review of the White Paper (2016) found that there were huge gaps in social welfare service provision in critical areas affecting the well-being of children, youth in trouble with the law, the elderly, people with disabilities, and those who are experiencing substance addictions and violence. These gaps in services leave the poorest individuals and households in extreme distress and undermine the transformation and change agenda identified in the NDP Vision 2030. Social workers interviewed in the review reported high levels of stress, overwhelming workloads, and burnout, as well as too few supervisors who can focus on the training and development of their teams. The COVID-19 pandemic exacerbated this problem tremendously during 2020 and 2021. Currently, high levels of stress and heavy workloads continue amongst this group of professionals due to difficult socio-economic conditions in South Africa (HWSETA 2024b).

As a response, the Cabinet approved the Sector Strategy for the Employment of Social Service Practitioners on 28 February 2024, reflecting South Africa's commitment to the National Development Plan's goal of 55 000 social service practitioners by 2030. This strategy involves all government spheres to address the high demand for social services and the limited supply of trained social service practitioners. As of the 2023/24 financial year, the government employs 23 561 social service practitioners across various departments. The strategy aims to enhance planning, recruitment, deployment, and management of practitioners for a more effective social protection system. It considers both primary settings i.e. the social development sector, and secondary settings such as education, health, and justice, where social service professionals support core business activities (DSD News 2024). Thus, the strategy's skills implication is increased demand for social service professionals (social workers, child and youth care practitioners, and community development practitioners) for service provisioning in the most vulnerable communities.

### 2.3.3 The Economic Reconstruction and Recovery Plan and the linked Skills Strategy

The ERRP and a linked strategy were put into place to support both the management of the COVID-19 pandemic and the economic and social recovery in relation to skills development. It is a short-term plan designed to create a balance between the short- and long-term skills needs of the country and ensure that the skills system is strengthened. The focus was the immediate rollout of skills development interventions to make sure that the ERRP is supported in all regards. The focus of the HWSETA is on the implementation of the strategy as well as the revised MSTF. In response to the immediate requirements, the HWSETA revised the Annual Performance Plans (APPs) for 2021-2022 and thereafter; prioritised funding for skills development interventions required for the ERRP and aligned the strategic and sector skills planning to the strategy and revised MSTF. Interventions two, three, five, and seven of the ERRP are applicable to the sector updating or amending technical and vocational education programmes; increased access to programmes resulting in qualifications in priority sectors; access to workplace experience; and retraining/up-skilling of employees to preserve jobs (HWSETA 2021). The action plan of the HWSETA for 2023-2024 in terms of the ERRP looks as follows: A total of 2 963 students were funded to support the ERRP skills strategy (HWSETA 2023).

### 2.3.4 National Skills Development Plan 2030

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

### 2.3.5 Medium-term Development Plan 2024-2029

The Medium-term Development Plan (MTDP), with a 5-year horizon from 2024 to 2029, draws its goals and priorities from the National Development Plan with more focus on development outcomes to reduce unemployment while increasing economic growth. The MTDP is premised on three strategic priority areas namely, inclusive growth and job creation, reduce poverty and tackling the high cost of living, and a capable, ethical and developmental state.

The MTDP strategic priorities are aligned to the existing National Skills Development Plan (NSDP) for the SETA landscape. MTDP strategic priority 1: inclusive growth and job creation is aligned to NSDP's outcome 1 "identify and increase production of occupations in high demand" which seeks to improve responsiveness to the demand-side of the economy by determining occupations in high demand. The MTDP strategic priority 1 sub-outcomes of working with the private sector to protect existing jobs and optimising public employment programmes is aligned to the NSDP's outcome 4 "improving the levels of skills in the South African workforce" and outcome 3 "linking education and the workplace" which ensures training for employment.

MTDP strategic priority 2: reduce poverty and tackle the high cost of living includes optimisation of social protection, improved access to affordable and quality healthcare, skilling for outcomes, and social cohesion and nation-building. MTDP strategic priority 3: build a capable, ethical, and developmental state seeks to improve governance and performance of public entities through a capable and professional public service which will improve delivery of basic services. These MTDP strategic priorities are aligned to the NSDP outcomes which prioritise increasing the supply training capacity of human personnel (i.e. healthcare and social professional practitioners) crucial for service delivery within the health and social development sector.

## 2.4 IMPLICATIONS FOR SKILLS DEMAND AND SUPPLY

In a resource-constrained environment with enormous demands for health care and social services, South Africa needs to develop skills to deliver cost-effective health care and social development interventions. The HWSETA cannot meet the vast spectrum of skills and has to prioritise skills development interventions. The key skills issues that fall within the HWSETA ambit are the following:

- First, the HWSETA must support skills interventions needed to build the developmental state. In this regard, the HWSETA will assist national efforts to expand the number of health professionals needed to provide all levels of care under the NHI and facilitate skills development as per the MTDP 2024-2029.
- Second, the HWSETA will continue to focus on skills development interventions required for the Presidential Youth Employment Initiative and the ERRP skills strategy such as: updating technical and vocational education programmes; increasing access to programmes resulting in qualifications in priority sectors; providing access to workplace experience opportunities, and retraining/up-skilling of employees to preserve jobs.
- Third, the HWSETA's skills planning should continue contributing to a sustainable skills pipeline into the sector and address entry-level as well as higher-level professional skills.
- Fourth, to support cost-effective skills interventions while also expanding service capacity, the HWSETA has to contribute to the development of mid-level skills needed to strengthen the health and social development, service providers.
- Fifth, the HWSETA also has a responsibility to respond to skills gaps in the current workforce brought about by changes in policy and service delivery, technological developments, skills shortages driven by legislative changes and other factors, the human rights-based development agenda, and health pandemics like COVID-19.

Lastly, the implications for skills supply with renewed focus from the MTDP 2024-2029 relates to the aspect of promoting social cohesion and nation-building which seeks to promote the rights of women, youth, children and persons with disabilities.

In essence, the MTDP implications for skills supply will be in the increase of skills development initiatives to protect existing jobs, create new jobs, and training and capacity building of human personnel for various initiatives such as NHI. The alignment of MTDP to the NSDP outcomes emphasizes timelines and attainment of strategic objectives.

## 2.5 CONCLUSION

Several change drivers, including socio-economic challenges leading to high poverty levels, a high disease burden, the recent pandemic, the implementation of the NHI, and critical shortages of nurses and medical practitioners, will significantly impact the demand for skills in the health and social development sector in the coming years. National and provincial policies are aligning with the NDP to transform the access and delivery of social services and healthcare. The expanding needs and service expectations of primary healthcare and social development systems require an updated skills base in the workforce. The COVID-19 pandemic highlighted the necessity for government strategic planning to include such occurrences. The ERRP will continue to be a primary driver in the sector for the next few years, with HWSETA committed to its 2024/25 action plan as per the MTDP 2024-2029 strategic priorities. Addressing skills shortages and inequities in human resource distribution remains a major concern in the sector.

# 3. OCCUPATIONAL SHORTAGES AND SKILLS GAPS.

# 3 OCCUPATIONAL SHORTAGES AND SKILLS GAPS

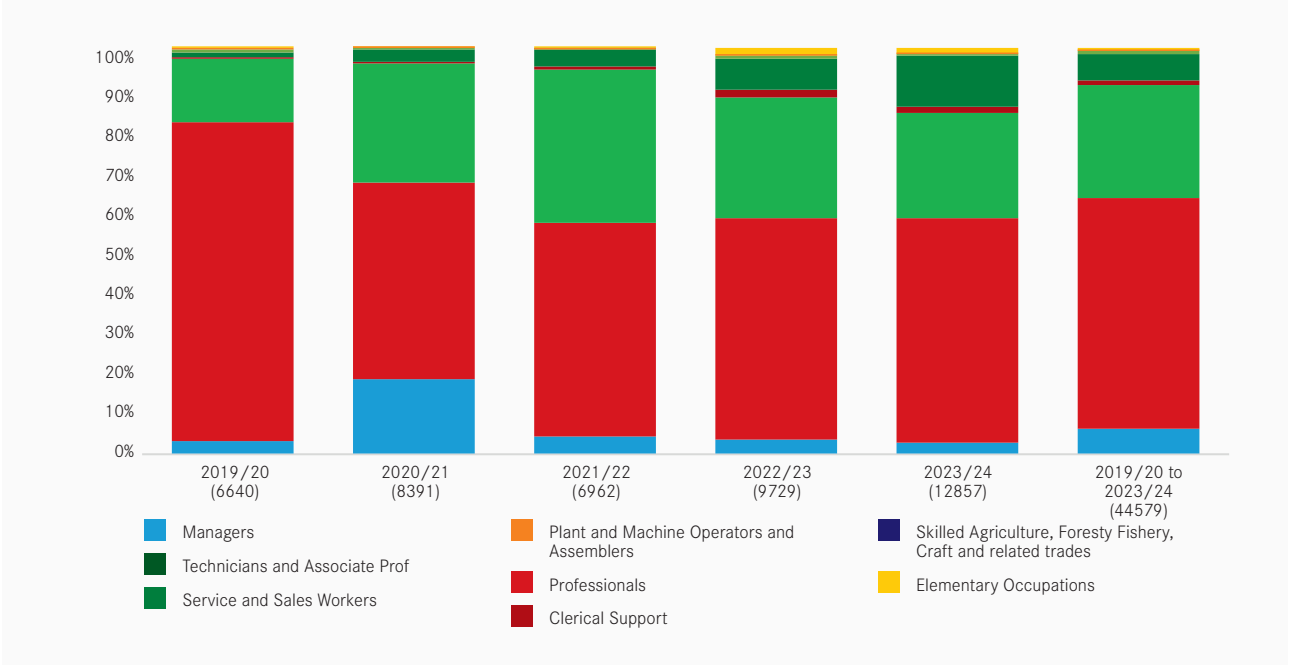
## 3.1 INTRODUCTION

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

## 3.2 HARD-TO-FILL VACANCIES

One of the clearest indicators of skills shortages is vacancies that remain unfilled for long periods despite employers' active recruitment efforts. The graph below shows the distribution of HTFV by OFO major groups as reported by organisations through WSP submissions from 2019/20 to 2023/24 irrespective of the number of months each occupation had taken. The graph below shows an increasing trend of technicians and associate professionals increasing its HTFV share by 11% from 2019/20 to 2023/24. Another increasing trend shown in the graph is of service and sales workers increasing its HTFV share by 12% from 2019/20 to 2023/24. Professionals are shown to be the only category with a decreasing trend losing 24% of its HTFV share from 2019/20 to 2023/24. Accumulatively, professionals remain the most dominant category (57%) of the HTFV from 2019/20 to 2023/24 followed by technicians and associate professionals (28%), service and sales workers (7%), and managers (6%). From 2019/20 to 2023/24, managers share of the HTFV remained stable with exception of 2020/21 when there was COVID-19 pandemic crisis.

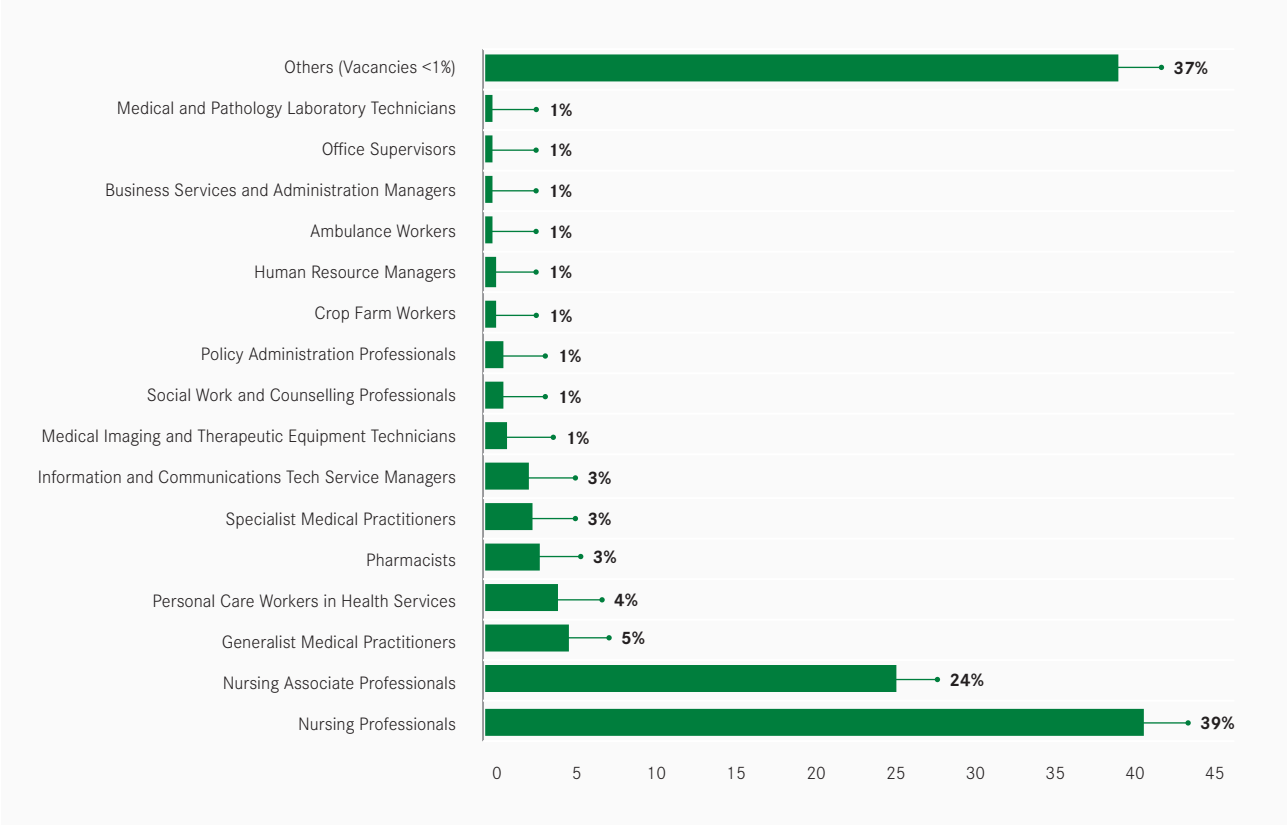
**Figure 3-1 Hard-to-fill vacancies according to Occupational Group from 2019/20 to 2023/24**




*Sources: Calculated from HWSETA (2019/20 -2023/24) and PSETA (2019/20 -2023/24) WSP submissions.*

When using the OFO Unit Group clustered under the fourth level, figure 3-2 below shows that seven unit groups account for 81% of all the HTFVs from 2019/20 to 2023/24. In their order of importance, these unit groups consist of nursing professionals (39%), nursing associate professionals (24%), general medical practitioners (5%), personal care workers in health services not elsewhere classified, pharmacists (3%), specialist medical practitioners (3%), and information and communication technology service managers (3%). This confirms that the national shortage of nurses remains a critical issue. There is also a shortage of nursing support workers classified as personal care workers in health services by OFO minor group, which encompasses roles such as hospital and paramedical aides and nursing assistants.

**Figure 3-2 Distribution of HTFV by OFO Unit Groups from 2019/20 to 2023/24**




*Sources: Calculated from HWSETA (2019/20 -2023/24) and PSETA (2019/20 -2023/24) WSP submissions.*

Further analysis indicates six unit groups whose positive annual average growth rates (AAG) pre and during the COVID-19 pandemic year had negative growth rates post-COVID-19. The need for occupations in these unit groups peaked during COVID-19 but have changed trajectory and become less in demand post-COVID-19. These unit groups, especially those in the health sector, imply that they are likely to peak when demand for healthcare services increases rapidly as it happened during the COVID-19 pandemic. As such, the NHI once fully phased in through the district model is more than likely to trigger the same demand for occupations in these unit groups. These six unit groups are as follows.

1) Information and communications technology service managers
2) Generalist medical practitioners
3) Specialist medical practitioners
4) Social work and counselling professionals
5) Medical imaging and therapeutic equipment technicians
6) Ambulance workers

Further analysis confirms two unit groups whose AAG were negative pre and during the COVID-19 pandemic year but changed to positive AAG post-COVID-19. This indicates that the need for occupations in these unit groups only peaked post-COVID-19 due to them becoming more in demand. These unit groups imply that they are more than likely to have occupations in demand for the next strategic period of 2025 to 2030. These two-unit groups are as follows.

1) Medical and pathology laboratory technicians (i.e. medical technician and medical technologist in their order of importance)
2) Office supervisors (i.e. office administrators)

Lastly, analysis shows that other unit groups continue to have a positive AGG even though with a notable decreasing rate except for unit group policy administration professionals and pharmacists which have positive AAG at an increasing rate. The policy administration professionals primarily consist of business administrators, intellectual property special advisors, regulatory affairs officers, internal auditors, and policy analysts. The unit group pharmacists primarily consist

of retail and hospital pharmacists in their order of importance. Thus, both policy administration professionals and pharmacists are more than likely to have occupations in demand for 2025 to 2030.

It is noted in table 3-1 that private sector has a predominant share of HTFV from 2019/20 to 2023/24 accounting for about (66%) two-thirds. Table 3-1 also summarises the reasons why some jobs are difficult to fill from 2019/20 to 2023/24[9]. The main reasons are listed in their order of importance:

1) **Limited supply**: there simply isn't enough pool (volumes) of qualified people available to fill all the open positions. [supply-side reason].
2) **Scarcity of required qualifications**: candidates lack required qualifications for the occupation which is also essential to qualify for practice within a specific scope of practice. [supply-side reason].
3) **General scarcity of specialised skills**: candidates lack a combination of skills set especially at specialised levels. [supply-side reason].
4) **Competitive salaries** in the market [demand-side reason].
5) **Scarcity of people with experience**: candidates lack sufficient experience necessary for the occupation and as per requirement by the regulation bodies for practice. [supply-side reasons].
6) **Limited training**: inadequate training capacity [supply-side reason].
7) **Geographic location**: remote location with less infrastructure and amenities less desirable [supply-side reason].
8) **Poor remuneration**: employers cannot afford to match market related salary scales. [demand-side reason].
9) **Budget constraint**: lack or limited funds restrict the ability of employers to fill vacancies. [demand-side reason].

Overall, occupational shortages are primarily caused by problems on the supply side of the labour market, meaning there aren't enough training facilities with sufficient capacity to produce (supply) at the pace of labour market demand in the sector. Consequently, the limited supply from limited training results in increased demand for salaries of occupations essential for service provisioning thus employers fail to match the market related salary scale. In this phenomena, remote locations suffer the most from limited supply given less infrastructure and budget to match labour market demand for occupations in need for service provisioning.

Limited training also negatively affects the supply-side in the sense that few candidates with required qualifications are produced. According to employer interviews (2024), occupational shortages in areas of specialisation is mainly due to universities being the only training institutions thus constraining the numbers of training uptake that an institution can train. These factors limit training uptake.

*9 This is only confined HTFV vacancies with a minimum accumulative number of 20 vacancies from 2019/20 to 2023/24.*

**Table 3-1 Hard-to-fill vacancies according to occupation from 2019/20 to 2023/24**

| OCCUPATION | | PRIVATE | PUBLIC | TOTAL | BUDGET CONSTRAINT | CHANGE IN QUALIFICATION | POOR REMUNERATION | COMPETITIVE SALARIES IN THE MARKET (HEAD HUNTED) | EQUITY CONSIDERATIONS | GENERAL SCARCITY OF SPECIALIZED SKILLS | GEOGRAPHIC LOCATION | LIMITED SUPPLY | LIMITED TRAINING | SCARCITY OF PEOPLE WITH EXPERIENCE | SCARCITY OF REQUIRED QUALIFICATIONS |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 222105 | Registered Nurse (Critical Care And Emergency) | 921 | 424 | 1345 | | | | X | | X | X | X | X | X | X |
| 222111 | Registered Nurse (Operating Theatre) | 346 | 236 | 582 | | | | | | | | | X | X | X |
| 222113 | Paediatrics Nurse | 10 | 101 | 111 | | | | | | | | | X | X | X |
| 134201 | Medical Superintendent | 52 | 92 | 144 | | | | | | X | | | | X | X |
| 222108 | Registered Nurse (Medical) | 5622 | 306 | 5928 | | | | X | | X | | X | X | X | X |
| 221101 | General Medical Practitioner | 80 | 1841 | 1921 | | | | | | | X | X | | | X |
| 532903 | Nursing Support Worker | 840 | 139 | 979 | | | | X | | | | X | | | X |
| 226203 | Retail Pharmacist | 547 | 0 | 547 | | | | | X | X | X | X | | X | |
| 226201 | Hospital Pharmacist | 144 | 244 | 388 | | | | | | | X | X | | | |
| 222117 | Midwife | 35 | 296 | 331 | | | | | | | | X | X | | X |
| 263508 | Child And Youth Care Worker | 46 | 182 | 228 | | | | | | | | | | X | X |
| 222112 | Registered Nurse (Surgical) | 4 | 212 | 216 | | | | | | | | X | X | X | X |
| 221208 | Psychiatrist | 15 | 110 | 125 | | | X | X | | X | | X | | | X |
| 263401 | Clinical Psychologist | 11 | 114 | 125 | | | | X | | | | | | | |
| 221203 | Emergency Medicine Specialist | 95 | 23 | 118 | | | | | | X | | | | | |
| 225101 | Veterinarian | 117 | 0 | 117 | | | | X | | | X | X | | X | |
| 226902 | Occupational Therapist | 19 | 86 | 105 | | | | X | | | | X | | | |
| 221204 | Obstetrician And Gynaecologist | 0 | 103 | 103 | | | | | | | | | | | X |
| 213110 | Medical Scientist | 98 | 2 | 100 | | | | | | | | X | | X | |
| 263501 | Social Counselling Worker | 80 | 6 | 86 | | | | | | | | X | | | |
| 134101 | Child Care Centre Manager | 78 | 0 | 78 | X | | | | | X | | | | | |
| 321201 | Medical Technician | 73 | 0 | 73 | | | | X | | | | X | | X | |
| 122101 | Sales And Marketing Manager | 73 | 0 | 73 | X | | | | | X | | | | | |
| 226501 | Dietician | 14 | 55 | 69 | | | | | | | | | | | X |
| 221212 | Forensic Pathologist | 0 | 59 | 59 | | | X | | | X | | | | | X |
| 321206 | Medical Technologist | 48 | 9 | 57 | | | | X | | | | X | | X | |
| 263507 | Adoption Social Worker | 39 | 16 | 55 | X | | | X | | | | X | | X | |
| 221206 | Paediatrician | 0 | 48 | 48 | | | | | | | | | | | X |
| 134402 | Community Development Manager | 45 | 0 | 45 | | | | | | | | | | X | |
| 221103 | Public Health Physician | 0 | 44 | 44 | | | | | | | | | | | X |
| 325701 | Environmental And Occupational Health Inspector | 30 | 6 | 36 | X | | | | | | | | | | |
| 221224 | Orthopaedic Surgeon | 0 | 34 | 34 | | | | | | X | | | | | X |
| 226601 | Audiologist | 0 | 34 | 34 | | | | | | | | | | | |

| OCCUPATION | | PRIVATE | PUBLIC | TOTAL | BUDGET CONSTRAINT | CHANGE IN QUALIFICATION | POOR REMUNERATION | COMPETITIVE SALARIES IN THE MARKET (HEAD HUNTED) | EQUITY CONSIDERATIONS | GENERAL SCARCITY OF SPECIALIZED SKILLS | GEOGRAPHIC LOCATION | LIMITED SUPPLY | LIMITED TRAINING | SCARCITY OF PEOPLE WITH EXPERIENCE | SCARCITY OF REQUIRED QUALIFICATIONS |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 341203 | Social Auxiliary Worker | 33 | 0 | 33 | | | | | | X | | | X | | |
| 134401 | Social Services Manager | 32 | 0 | 32 | X | | | | | X | | X | | | |
| 122301 | Research And Development Manager | 25 | 1 | 26 | | | | X | | | X | X | | | |
| 321301 | Pharmacy Technician | 20 | 5 | 25 | | X | | | | | X | X | | | |
| 221213 | Radiation Oncologist | 1 | 23 | 24 | | | X | X | | X | | X | | | X |
| 221211 | Surgeon | 5 | 19 | 24 | | | X | X | | X | | X | | | |
| 321114 | Health Technical Support Worker | 24 | 0 | 24 | | | | | | | | | | | |
| 222106 | Registered Nurse (Developmental Disability) | 8 | 15 | 23 | | | | | | | | | | | X |
| 221225 | Neurosurgeon | 2 | 20 | 22 | | | X | X | | X | | X | | | |
| 251203 | Developer Programmer | 20 | 0 | 20 | | | | X | | X | | | | | |
| 321121 | Cardiothoracic Perfusion Clinical Technologist | 0 | 20 | 20 | | | | | | | | X | | | X |
| **Total** | **44 occupations with 20 or more HTFVs** | **9652** | **4925** | **14577** | | | | | | | | | | | |
| | | **66%** | **34%** | **100%** | | | | | | | | | | | |

*Sources: Calculated from HWSETA private sector WSP submissions (2023/24) and PSETA public sector WSP submissions (2023/24).*

## 3.3 SKILLS GAPS

The difference in the skills required for the job and the actual skills possessed by the employees is called a skills gap. In the research for the SSP and during engagements with stakeholders in the sector, skills gaps at different levels were identified.

### 3.3.1 Skills gaps in the health and social sector

Employers in the sector identified the following skills gaps at a high level (managers and professionals), mid-level (technicians, associate professionals, and service workers), and the lower level (elementary occupations) (DHET employer interviews 2021, 2022, 2023). A gap that has been noticed recently is data analytical skills for professionals in the sector. Many employers indicated that the roles that professionals fulfil these days require data analytical skills (DHET employer interviews 2021, 2022, 2023). Predominant skills gaps by level of occupations were identified by DHET employer interviews over the last five years as follows.

#### a) High-level (managers and professionals)

- Leadership and strategic planning skills.
- People and team management skills.
- Conflict management skills.
- Industrial relations skills.
- Emotional intelligence skills (EQ).
- Data analytical skills.

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

- Computer skills to utilise and maintain computerised information systems.
- Occupational health and safety skills.
- Customer/client service skills.
- Stress management skills.

#### c) Lower level (elementary occupations)

- Communication skills.
- Occupational health and safety skills.

According to HWSETA's planned training from 2020 to 2024, a dataset that forms part of the WSP submissions, employers planned for training as shown in tables 3-2 and 3-3. These findings highlight that even within the same sector or organisations, in the main, training is occupation-specific.

**Table 3-2 Skill gaps at OFO major group, 2020 to 2024**

| OFO CODE | OFO MAJOR GROUP | TOP THREE SKILLS GAPS [2020-2023] | TOP THREE SKILLS GAPS [2024] |
|---|---|---|---|
| **2021-1** | **Managers** | First aid | Management development |
| | | Health and safety | POL QA 04-06 |
| | | Ergonomics & wellbeing | Health and Safety |
| **2021-2** | **Professionals** | Continuing professional development (occupation-based) | Continuing professional development (occupation-based) |
| | | Customer service training | Soft skills training |
| | | Diversity and inclusion training | Basic life support (BLS) |
| **2021-3** | **Technicians and Associate Professionals** | Basic life support (BLS) | Continuing professional development (occupation-based) |
| | | Patient assessment and patient records | Customer experience training |
| | | Continuing professional development (occupation-based) | Soft skills training |
| **2021-4** | **Clerical Support Workers** | Family and friends CPR | Computer skills |
| | | Time management | Courier training |
| | | Ergonomics & wellbeing | Customer experience training |
| **2021-5** | **Service and Sales Workers** | Standard operating procedure (SOP) training | Standard operating procedure (SOP) training |
| | | Healthcare basics | Manual handling of elderly and vulnerable |
| | | Clinical appointments | Basic life support (BLS) |
| **2021-6** | **Skilled Agricultural, Forestry, Fishery, Craft and Related Trades Workers** | Basic computer skills | Standard operating procedure (SOP) training |
| | | Product awareness training | Occupational health and safety |
| | | Family and friends CPR | Supervisory skills |
| **2021-7** | **Plant and Machine Operators and Assemblers** | Computer skills | Advanced driving skills |
| | | First aid skills | Standard operating procedure (SOP) training |
| | | Equipment training | Transporting dangerous goods |
| **2021-8** | **Elementary Occupations** | Workplace and classroom development | CPR in-service |
| | | POPIA training (legislation) | Workplace bullying workshop |
| | | Basic computer skills | Advanced cardiovascular life support (ACLS) |

*Source: HWSETA WSP 2020-2024*

**Table 3-3 Skill gaps at the most dominant occupation planned for training in each OFO Major Group**

| 2020-2023 | | | 2024 | | |
|---|---|---|---|---|---|
| OFO CODE | OCCUPATION | TOP THREE SKILLS GAPS | OFO CODE | OCCUPATION | TOP THREE SKILLS GAPS |
| 2021-134402 | **Community Development Manager** | Health and safety | 2021-121908 | **Quality Systems Manager** | Continuing professional development (CPD) |
| | | Fire fighting | | | POL Q04-06 |
| | | First aid | | | Good laboratory practice |
| 2021-222108 | **Registered Nurse (Medical)** | Basic life support (BLS) | 2021-222108 | **Registered Nurse (Medical)** | Nursing CPD modules 1-4 |
| | | In service nephrology | | | Basic infection prevention and control for healthcare practitioners |
| | | Advanced cardiac life support (ACLS) | | | Supervision and leadership training |
| 2021-322101 | **Enrolled Nurse** | Basic life support (BLS) | 2021-322101 | **Enrolled Nurse** | Nursing CPD modules 1-4 |
| | | Nursing CPD modules 1-4 | | | Customer experience training |
| | | Patient assessment and patient records | | | Wellness: Money/debt management |
| 2021-431101 | **Accounts Clerk** | Time management | 2021-411101 | **General Clerk** | Computer skills |
| | | Basic Excel functions and Power BI | | | Customer experience training |
| | | Telephone and email etiquette and billing rules | | | Wellness: Money/debt management |
| 2021-532903 | **Nursing Support Worker** | Basic life support (BLS) | 2021-532903 | **Nursing Support Worker** | Basic nursing procedures workshop |
| | | Early warning adult observation | | | Early warning adult observation |
| | | Patient records made practical | | | Basic life support (BLS) |
| 2021-671101 | **Electrician** | Fire fighting and rescue | 2021-661502 | **Optical Mechanic** | Standard operating procedures |
| | | Family and friends CPR | | | Management course |
| | | Basic computer skills | | | First aid |
| 2021-732203 | **Emergency Vehicle Drivers** | PRF fundamentals training | 2021-732101 | **Delivery Driver** | Advanced driving skills |
| | | Radio communications and etiquette | | | Transporting dangerous goods |
| | | Basic anatomy and physiology | | | POPIA training |
| 2021-811202 | **Healthcare Cleaner** | Basic infection prevention | 2021-833402 | **Store Person** | CPR in-service |
| | | CSSSD training | | | Workplace bullying workshop |
| | | Cleaning procedures and chemical safety | | | Advanced cardiovascular life support (ACLS) |

*Source: HWSETA planned training data, 2020 to 2024.*

Implications for skills has translated into the following six emerging occupations

**Table 3-4 Distribution of six Emerging occupations, 2020-2024**

| SETA NAME | PERIOD | OCCU-PATION CODE | OCCUPATION | INTERVENTION(S) PLANNED | NQF LEVEL | NQF ALIGNED (Y/N) | QUANTITY NEEDED | QUANTITY TO BE SUP-PORTED | RATIONALE (DIGITIZATION OR NATIONAL STRATEGY AND SPECIFY THE NATION-AL STRATEGY) |
|---|---|---|---|---|---|---|---|---|---|
| HWSETA | 2025/26 | 251102 | Data Scientist | Occupational Certificate: Data Science Practioner | **5** | **Y** | **U** | **U** | Technology |
| HWSETA | 2025/26 | 212103 | Statistician | Bachelor of Science in Mathematical Statistics | **7** | **Y** | **U** | **U** | Technology |
| | | | | Diploma in Mathematics Sciences | **6** | **Y** | | | |
| HWSETA | 2025/26 | 226302 | Safety, Health, Environment and Quality (SHE&Q) Practitioner | Occupational Certificate: Safety, Health and Quality Practitioner (Occupational Health and Safety Practitioner) | **5** | **Y** | **15** | **15** | ERRP Skills Strategy |
| HWSETA | 2025/26 | 134901 | Environmental Manager | Bachelor of Arts Honours in Environmental Management | **8** | **Y** | **11** | **11** | ERRP Skills Strategy |
| HWSETA | 2025/26 | 133103 | Data Management Manager | Postgraduate Diploma in Science in the field of Data Science | **8** | **Y** | **U** | **U** | Technology |
| HWSETA | 2025/26 | 221212 | Forensic Pathologist | Master of Medicine in Forensic Pathology | **9** | **Y** | **59** | **11** | Shortage of human capital of clinical staff personnel |

KEY: **U** = Unknown

## 3.4 EXTENT AND NATURE OF SUPPLY

Supply can be influenced by a range of factors such as the number and geographic distribution of healthcare providers, the production, recruitment, retention, and throughput of students, availability, and quality of healthcare educators, as well as the licensing, regulation, scope of practice, migration, and employment status of health care workers. This section outlines some of the identified critical elements of supply to the sector. These include education and training provision, training capacity, training output, and a summary of the supply-side constraints. Along with the identified constraints, there is also a brief indication of how the HWSETA seeks to respond to these constraints. The training of healthcare professionals is a topic that impacts us all. The goal of health professional education is to deliver a cadre of well-trained and appropriately skilled health workers who are responsive to the needs of the communities in which they work. This can be done through an appropriate health science education model that includes education from further education and training, undergraduate and postgraduate education through to the maintenance of professional competence.

The HWSETA conducted a study in 2020 to determine if employers and skills development providers had resumed training during the COVID-19 level 3 lockdown period. Three quarters (290/388) of all the employers and 82% (84/103) of the skills development providers who participated in the survey indicated that they had resumed training during this period. This was very positive in terms of skills development and the supply of skills at the time (HWSETA 2020b); it shows that the health sector may not have been affected as much as the other sectors by the pause in contact education. In 2022/23 the HWSETA conducted in-depth studies on medical practitioners and pharmacists, looking at the challenges that medical and pharmacy schools experience in the education and training of these professionals and in providing the output needed to meet the health care needs of the population. Challenges that relate to shortages of academic and clinical staff and insufficient infrastructure seemed to be the main themes (see section 3.4.2). A similar study is currently being conducted relating to social service professionals such as social workers and child and youth care workers.

### 3.4.1 Entry into the health and social development sector

Prospective workers enter the sector at different levels, either directly from secondary school or following post-school training. The positive or negative output from the secondary school system underlies the greater part of skills supply to the sector. For example, a good Grade 12 pass, in mathematics, physical- and life sciences is a basic entry requirement into most of the tertiary-level study programmes which enable access to the health sector. Such programmes include health sciences, nursing sciences, pharmacy, optometry, radiography, veterinary sciences, and other allied health sciences to mention a few.

Between 2018 and 2021 the participation has increased by an annual average growth rate of 3,5% and 4,6% for those writing mathematics and physical sciences (NSC level) respectively. However, the distribution in comparison with other subjects has been on the decline by 7% (from 46% to 37%) and 6% (34% to 28%) for those writing mathematics and physical sciences (NSC) respectively. This indicates that more and more students are not choosing the STEM fields within the basic education sub-system.

Although Grade 12 mathematics and science are not barriers to entry into the social development sector, a well-developed level of non-cognitive skills is essential. Much attention is paid to increasing the quality of basic education (NPC 2020). The DBE is currently engaged in a curriculum strengthening exercise (2023). A strategy to get more entrants into education in the health professions is to encourage individuals to obtain qualifications in fields in which there are more opportunities for employment (DHET 2020). However, the effect of the disruption of contact education at secondary school level due to the COVID-19 pandemic must still not be underestimated; the implication is that there will be fewer learners with an NSC in mathematics and science. This will have an impact on the intake of students in the health sciences field.

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

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

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

#### The training of medical practitioners

Historically, the training of medical practitioners was undertaken by eight South African medical schools which supply just over 1 400 doctors per annum. In January 2016, the ninth medical school was opened at the University of Limpopo and the first group of students started with their internships recently. This medical school is in the longer term linked to the presidential project of building an academic hospital in Limpopo, namely the Limpopo Central Hospital (DoH 2019). A tenth medical school was opened in 2021 at the Nelson Mandela University in the Eastern Cape; their first output will only be seen closer to 2030. Most recent planning ensures that an 11th medical school is set to open in 2028 at North-West University (NWU).

Another government intervention targeting the training of doctors is the Nelson Mandela/Fidel Castro Medical Collaboration. This initiative addresses the shortage of medical practitioners in South Africa, particularly in rural areas. The programme recruits students from these underserved rural regions and sends them to Cuba for medical training. Additionally, the need for private sector involvement in training medical practitioners has been emphasised. However, medical schools have stated that they cannot increase their intake of medical students due to a current lack of internship and community service posts. These issues must be resolved before expanding student intake (Stakeholder Interviews 2023).

All medical schools reported struggles with staffing and infrastructure. Many of their teaching staff are joint appointees who are also practicing clinicians, burdened with their regular hospital duties alongside teaching and conducting research. To alleviate this, schools need more permanent staff to share the workload and assist with administrative tasks. (Stakeholder Interviews 2023).

#### The training of pharmacists

Currently, nine pharmacy schools offer training for pharmacists, and they face similar challenges to those of medical schools. There is an increasing shortage of academic pharmacists because most prefer to work in the industry, where they earn significantly higher salaries compared to university lecturers. All pharmacy schools reported difficulties with staff shortages and infrastructure. To meet lecturing needs, some rely on contract or temporary staff, such as postgraduate students. However, these positions should be permanent due to the ongoing demand. Additionally, some institutions have to reallocate funds from other budgets to pay these contract staff, which strains their capacity and resources in other areas (Stakeholder Interviews 2023).

#### The training of nurses

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

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

### Occupational qualifications

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

### Training offered by NGOs

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

### Workplace training

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

In line with the skills strategy linked to the ERRP, the focus since 2021 is on providing sufficient WIL opportunities to learners in the sector. However, the effect of the interruption of contact education and training due to the COVID-19 pandemic was seen in some of the supply data; many students were not able to meet the clinical/practical requirements of their training and had to extend their training. In addition, the lack of internship positions for medical and pharmacy students remains a concern regarding the supply of these professionals; training hospitals mentioned the lack of funding as the major issue (Stakeholder Interviews 2023). There is also evidence that employers find it currently difficult to release employees for longer-term training such as learnership programmes. Stakeholder interviews (2024) indicate that for a clinical training programme to occur for an employed, a replacement for a year is required. This has become a significant barrier to upskilling the workforce in areas of specialisation. The HWSETA has therefore initiated an alternative model that involves learnership programmes being offered in parts over a longer period than usual (HWSETA 2023).

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

The analysis of the supply of skills at the HET level is based on information obtained from the DHET's Higher Education Management Information System (HEMIS). Student enrolments and output in selected fields of study relevant to the health and social development sector over the period 2013 to 2022 is shown in tables 3-5 and 3-6 respectively.

If the selected health-related and social welfare fields of study are considered, the total output from the public higher education and training sector for the selected study fields grew on average by -2,1% per annum from 2013 to 2022 at the first three-year B Degree level, and 1,7% at the first four-year B Degree level. Over the period, most of the professional (four-year) degrees showed a positive average annual growth except for dentistry, advanced dentistry, and oral sciences, somatic bodywork, and related therapeutic services, health professions and related clinical sciences, and social work.

Over the shorter period between 2018 and 2022, the total output of the selected health and social welfare fields showed the following trend: On average, the first four-year degrees in the selected fields saw a decline of 2,1% annually. This decrease can be seen in several study fields: dentistry, advanced dentistry, and oral sciences decreased at a rate of 2,8%; medical clinical sciences at a rate of 0,4% per annum; pharmacy, pharmaceutical sciences, and administration at a rate of 0,9%; and for veterinary sciences the growth stagnated at a meagre average annual rate of 0.5%.

The output of the four-year nursing degree also showed a negative trend, an average annual growth of -1,8% over the same period, with a decrease of 17,6% in graduate numbers from 1 354 in 2018 to 1 151 in 2022. The COVID-19 pandemic's disruption of in-person learning and ongoing challenges with the new nursing education framework likely contributed

to this decline. Output in social work has decreased on average by 8,2% per year over the five-year period, from 2 518 in 2018 to 1 169 in 2022. This sharp decline highlights a potential shortage of social workers at a time when their services are highly sought after.

**Table 3-5 Number of health-related and social work qualifications enrolments by public HEIs, 2018-2022**

| HEMIS STUDY FIELDS | Qualifications | 2018 | 2019 | 2020 | 2021 | 2022 |
|---|---|---|---|---|---|---|
| Chiropractic | First BDegree (4 years) | | | 62 | 263 | 280 |
| Communications Disorders Sciences and Services | First Bdegree (3 years) | | | 99 | 200 | 76 |
| | First Bdegree (4 years) | 1 237 | 1 254 | 1 193 | 1 224 | 1 378 |
| Dentistry, Advanced Dentistry and Oral Sciences | First Bdegree (3 years) | 124 | 127 | 127 | 135 | 170 |
| | First BDegree (4 years) | 1 149 | 1 141 | 1 111 | 1 213 | 1 212 |
| Health and Medical Administrative Services | First BDegree (3 years) | 1 742 | 1 965 | 1 509 | 1 085 | 830 |
| | First BDegree (4 years) | 1 924 | 1 968 | 1 373 | 1 077 | 617 |
| Medicine | First BDegree (4 years) | 6 555 | 7 141 | 7 757 | 8 140 | 8 068 |
| Medical Clinical Sciences | First BDegree (3 years) | 519 | 580 | 620 | 621 | 640 |
| | First BDegree (4 years) | 5 215 | 5 432 | 5 219 | 5 784 | 6 304 |
| Nursing | First BDegree (3 years) | 1 531 | 1 628 | 1 180 | 581 | 400 |
| | First BDegree (4 years) | 3 777 | 4 023 | 3 954 | 3 870 | 3 674 |
| Optometry | First BDegree (4 years) | 480 | 463 | 599 | 631 | 677 |
| Pharmacy, Pharmaceutical Sciences and Administration | First Bdegree (4 years) | 4 466 | 4 362 | 4 342 | 4 332 | 4 219 |
| Podiatric Medicine/Podiatry | First BDegree (4 years) | | | 20 | 168 | 168 |
| Public Health | First BDegree (3 years) | 745 | 683 | 649 | 528 | 1 346 |
| | First BDegree (4 years) | 892 | 1 147 | 1 314 | 1 457 | 1 669 |
| Rehabilitation and Therapeutic Professions | First BDegree (3 years) | 611 | 579 | 467 | 541 | 671 |
| | First BDegree (4 years) | 3 195 | 3 228 | 3 420 | 3 532 | 3 700 |
| Veterinary Biomedical and Clinical Sciences* | First BDegree (4 years) | 1 043 | 1 008 | 1 077 | 1 112 | 1 160 |
| Dietetics and Clinical Nutrition Services | First BDegree (4 years) | 640 | 628 | 815 | 838 | 856 |
| Alternative and Complementary Medicine and Medical Systems | First BDegree (3 years) | 64 | 53 | 48 | 30 | 14 |
| | First BDegree (4 years) | 116 | 142 | 216 | 283 | 304 |
| Somatic Bodywork and Related Therapeutic Services | First BDegree (4 years) | 12 | 13 | 13 | 23 | 18 |
| Medical Radiologic Technology/Science (Radiography) | First BDegree (3 years) | 192 | 239 | 72 | 42 | 4 |
| | First BDegree (4 years) | 686 | 826 | 1 120 | 1 166 | 1 425 |
| Clinical Technology | First BDegree (4 years) | | | 89 | 118 | 130 |
| Medical Laboratory | First BDegree (4 years) | | | 75 | 98 | 159 |
| Health Professions and Related Clinical Sciences, Other | First BDegree (3 years) | 21 | 3 | 58 | 112 | 161 |
| | First BDegree (4 years) | 169 | 287 | 258 | 329 | 159 |
| Social Work | First BDegree (4 years) | 10 416 | 8 332 | 7 373 | 7 227 | 7 082 |
| **Total** | **First BDegree (3 years)** | **5 549** | **5 857** | **4 829** | **3 875** | **4 312** |
| **Total** | **First BDegree (4 years)** | **41 972** | **41 395** | **41 400** | **42 885** | **43 259** |

**Table 3-6 Number of health-related and social work qualifications awarded by public HEIs, 2013-2022**

| HEMIS STUDY FIELDS | Qualifications | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 | 2020 | 2021 | 2022 | AAG 2013-2022 % | AAG 2018-2022 % |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Chiropractic | First BDegree (4 yrs) | 53 | 40 | 45 | 60 | 24 | 44 | 56 | 18 | 41 | 54 | 0,2 | 2,3 |
| Communications Disorders Sciences and Services | First BDegree(3 yrs) | 134 | 169 | 199 | 202 | 232 | 243 | 256 | 243 | 246 | 239 | 6,6 | -0,2 |
| Dentistry, Advanced Dentistry and Oral Sciences | First BDegree(3 yrs) | 68 | 84 | 82 | 55 | 33 | 36 | 46 | 32 | 30 | 27 | -9,8 | -3,1 |
| | First BDegree(4 yrs) | 177 | 212 | 166 | 205 | 199 | 207 | 210 | 189 | 211 | 160 | -1,1 | -2,8 |
| Health and Medical Administrative Services | First BDegree (3 yrs) | 271 | 235 | 235 | 220 | 212 | 253 | 265 | 334 | 282 | 220 | -2,3 | -1,5 |
| | First BDegree (4 yrs) | 253 | 91 | 213 | 158 | 358 | 364 | 377 | 257 | 281 | 281 | 1,2 | -2,8 |
| Medicine | First BDegree (4 yrs) | 542 | 557 | 847 | 996 | 843 | 1 039 | 1002 | 1 097 | 1 144 | 1 229 | 9,5 | 1,9 |
| Medical Clinical Sciences | First BDegree (3 yrs) | 141 | 93 | 74 | 72 | 122 | 85 | 57 | 158 | 159 | 57 | -9,6 | -4,3 |
| | First BDegree (4 yrs) | 973 | 1 024 | 1 125 | 941 | 1162 | 1 103 | 1185 | 1 090 | 966 | 1060 | 1,0 | -0,4 |
| Nursing | First BDegree (3 yrs) | 395 | 364 | 415 | 454 | 316 | 323 | 260 | 320 | 251 | 251 | -4,9 | -2,8 |
| | First BDegree (4 yrs) | 943 | 1 171 | 1 159 | 1 200 | 1379 | 1 354 | 1517 | 1 340 | 1 013 | 1 151 | 2,2 | -1,8 |
| Optometry | First BDegree (4 yrs) | 81 | 81 | 120 | 127 | 116 | 94 | 160 | 136 | 134 | 157 | 7,6 | 5,9 |
| Pharmacy, Pharmaceutical Sciences and Administration | First BDegree(4 yrs) | 687 | 723 | 950 | 834 | 878 | 972 | 955 | 961 | 1006 | 899 | 3,0 | -0,9 |
| Podiatric Medicine/Podiatry | First BDegree (4 yrs) | 13 | 15 | 3 | 31 | 29 | 23 | 37 | | 37 | 39 | 13,0 | 6,0 |
| Public Health | First BDegree (4 yrs) | 231 | 236 | 246 | 256 | 316 | 254 | 293 | 208 | 236 | 232 | 0,0 | -1,0 |
| Rehabilitation and Therapeutic Professions | First BDegree (3 yrs) | 83 | 90 | 123 | 147 | 124 | 149 | 123 | 122 | 76 | 76 | -1,0 | -7,2 |
| | First BDegree (4 yrs) | 598 | 633 | 712 | 742 | 728 | 769 | 693 | 758 | 714 | 826 | 3,7 | 0,8 |
| Veterinary Biomedical and Clinical Sciences* | First BDegree (4 yrs) | 103 | 98 | 99 | 125 | 125 | 165 | 169 | 145 | 158 | 172 | 5,9 | 0,5 |
| Dietetics and Clinical Nutrition Services | First BDegree (4 yrs) | 124 | 127 | 117 | 166 | 184 | 184 | 160 | 198 | 190 | 216 | 6,4 | 1,8 |
| | First BDegree (3 yrs) | 16 | 19 | 10 | 23 | 11 | 26 | 32 | 34 | 23 | 46 | 12,5 | 6,5 |
| Alternative and Complementary Medicine and Medical Systems | First BDegree (4 yrs) | 9 | 26 | 18 | 16 | 16 | 31 | 21 | 39 | 29 | 29 | 13,9 | -0,7 |
| Somatic Bodywork and Related Therapeutic Services | First BDegree (4 yrs) | 39 | 28 | 38 | 41 | 46 | 48 | 45 | 21 | 10 | 8 | -16,1 | -18,1 |
| Medical Radiologic Technology/Science (Radiography) | First BDegree (3 yrs) | 43 | 39 | 52 | 44 | 48 | 49 | 84 | 30 | 39 | 39 | -1,1 | -2,5 |
| | First BDegree (4 yrs) | 125 | 130 | 152 | 192 | 231 | 252 | 378 | 411 | 238 | 267 | 8,8 | 0,6 |
| Health Professions and Related Clinical Sciences, Other | First BDegree (4 yrs) | 161 | 132 | 86 | 80 | 22 | 114 | 126 | 102 | 110 | 89 | -6,4 | -2,7 |
| Social Work | First BDegree (4 yrs) | 1 881 | 2 121 | 2 362 | 2 618 | 2815 | 2 518 | 2049 | 1 596 | 1 349 | 1 169 | -5,1 | -8,2 |
| **Total** | **First BDegree(3yrs)** | **1151** | **1093** | **1190** | **1217** | **1098** | **1164** | **1123** | **1273** | **1106** | **955** | **-2,1** | **-2,2** |
| **Total** | **First BDegree(4yrs)** | **6 020** | **6 421** | **7 333** | **7 847** | **8 309** | **8 432** | **8 248** | **7 476** | **6 901** | **6 978** | **1,7** | **-2,1** |

*Source: HEMIS 2021.. *Veterinarian output*

## a) Skills supply through nursing

As from 2020 all undergraduate new nursing qualifications are offered by public and private Nursing Education Institutions (NEIs) in the higher education setting. The qualifications are: (i) one-year Higher Certificate in Auxiliary Nursing (NQF Level 5) leading to registration as a Nursing Auxiliary; (ii) three-year Diploma in Nursing (NQF Level 6) leading to registration as a General Nurse; and (iii) four-year Bachelor's Degree in Nursing Sciences (NQF Level 8) leading to registration as a Professional Nurse and Midwife. There are currently 22 private NEIs that are accredited to offer the new nursing qualifications, 54 public NEIs, and 19 universities and universities of technology (SANC 2023). There are still a few institutions that are accredited to deliver the legacy qualifications during the phasing-out period.

It is important to look at the output of nurses over a longer period due to the changes in the qualification framework. The number of nurses who qualified at various levels between 2011 and 2022 can be seen in Table 3-7. A total of 40 577 Professional Nurses qualified with a four-year qualification over the 11 years, showing an average annual growth of 1,0%, while another 38 545 nurses completed the bridging programme between 2011 and 2021, showing an average annual growth of 1,9%. However, the Nursing Education Association (NEA) already warned in 2022 that there is going to be a significant decrease noticeable in output at this level due to the phasing-out of the old qualifications (Interview 2022). This is highly noticeable in the 2022 output data reflected in the table below; there were no graduates under the bridging course programme. This programme contributed significantly to the supply of nurses until 2021. Another challenge is that for the past three years, no post-basic (specialist) training took place; only a few universities started in 2022 with small numbers of students, which contributes to serious shortages (interviews 2022, 2023, 2024). This is one of the reasons why the HWSETA has prioritised post-graduate qualifications (specialisations) for nurses as a key action in 2023/24 and onwards (HWSETA 2023c).

The decrease in pupil nurses and pupil auxiliaries is due to the phasing out of legacy qualifications. These courses were terminated in 2015, which means that the numbers below reflect the phasing-out period of the programmes. The data on the first output on the new qualifications is still awaited; the SANC has not released the data yet.

The Hospital Association of South Africa (HASA) emphasised that the output of nurses can increase significantly if the SANC allows private hospitals to train more nurses (HASA 2019). This was confirmed by interviews with big private hospital groups in the sector (interviews 2021, 2022 and 2023).

**Table 3-7 Number of graduates at NEIs, 2011-2022**

| PROGRAM | 2011 | 2012 | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 | 2020 | 2021 | 2022 | AAG % |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Four-year Programme | 2 966 | 3 225 | 3 261 | 3 221 | 3 291 | 3 528 | 3 322 | 3 564 | 3 736 | 3 608 | 3 535 | 3 320 | 1,0 |
| Bridging Course* | 2 964 | 3 929 | 3 291 | 2 889 | 4 136 | 3 326 | 3 014 | 3 953 | 5 169 | 2 298 | 3 576 | | 1.9 |
| Pupil Nurses | 7 391 | 7 732 | 8 954 | 6 949 | 8 756 | 7 879 | 6 001 | 825 | 95 | 8 | 75 | 85 | -33,4 |
| Pupil Auxiliaries | 5 232 | 5 009 | 5 909 | 6 141 | 5 795 | 6 726 | 587 | 39 | 29 | 32 | 34 | 39 | -35,9 |
| **Total** | **18 553** | **19 895** | **21 415** | **19 200** | **21 978** | **21 459** | **12 924** | **8 381** | **9 029** | **5 946** | **7 220** | **3 444** | **-42,9** |

**Bridging into the professional nurse category.*
*Source: SANC 2023.*

## b) Skills supply through occupational qualifications

As indicated earlier, the HWSETA plays an important role in terms of the quality assurance of a range of qualifications. These qualifications play a key role in the supply of important skills to the sector and in the period 2013 to 2022 over 29 900 candidates qualified in qualifications such as Child and Youth Care Work, Social Auxiliary Work, and Community Health Work (Table 3-8). Community health has become a key area in the domain of primary health care. As shown in table 3-7 below, the occupational qualifications overseen by HWSETA had a negative annual average growth rate from 2013 to 2022 except for community health work (L4) and health promotion Officer (L4). The latter signals successful rollout of a new national occupational qualification.

**Table 3-8 Student output in some qualifications overseen by HWSETA, 2013-2022**

| PROGRAMME | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 | 2020 | 2021 | 2022 | AAG 2013-2022 % |
|---|---|---|---|---|---|---|---|---|---|---|---|
| L4: Child and Youth Care Work | 3 261 | 3 221 | 3 291 | 3 528 | 3 322 | 3 564 | 3 736 | 3 608 | 3 535 | 3 320 | 1,0 |
| L4: Social Auxiliary Work | 3 291 | 2 889 | 4 136 | 3 326 | 3 014 | 3 953 | 5 169 | 2 298 | 3 576 | | 1.9 |
| L4: Community Health Work | 8 954 | 6 949 | 8 756 | 7 879 | 6 001 | 825 | 95 | 8 | 75 | 85 | -33,4 |
| L2: Community Health Work | 5 909 | 6 141 | 5 795 | 6 726 | 587 | 39 | 29 | 32 | 34 | 39 | -35,9 |
| L4: Health Promotion Officer | | | | | | | | | | | |
| **Total** | **21 415** | **19 200** | **21 978** | **21 459** | **12 924** | **8 381** | **9 029** | **5 946** | **7 220** | **3 444** | **-42,9** |

*Source: HWSETA MIS May 2023.*

## 3.4.4 Professional registration of health professionals

Healthcare and social services professionals are required to register with their respective professional councils to practice or work legally. Although the registers include those working abroad and in other sectors, as well as retirees and economically inactive persons they both indicate growth in the number of professionals available and number of student enrolments as a proxy for supply capacity.

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

The HPCSA controls over 130 registration categories through twelve professional boards. Table 3-9 shows the registration figures for several key professions over the period 2014 to 2023. Since 2013, the number of registrations for key professions across categories grew by 2.2% on average per year. Of these ten key professions, only three grew above the 2.2% average per year. These were medical interns (i.e., medical graduates in training) which grew by 5,9%, occupational therapists by 3.2%, and physiotherapists by 2.3% per year. Prior to and during the COVID-19 pandemic year (2014-2020), the same professions with the addition of radiography had an annual average growth rate above the overall average of 2.2%.

Over the shorter period from 2020 to 2023, it is noteworthy that the average annual registration growth for all the mentioned health professionals remained positive, except for speech therapists and audiologists, who experienced a negative growth (-0,3%).

**Table 3-9 Number of selected professionals registered with the HPCSA as of 31 December, 2014-2023**

| PROGRAMME | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 | 2020 | 2021 | 2022 | 2023 | AAG 2014-2020 % | AAG 2020-2023 % | AAG 2014-2023 % |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Dentist | 6 062 | 6 126 | 6 331 | 6 409 | 6 430 | 6 530 | 6 472 | 6 553 | 6 481 | 6 624 | 1,1 | 0,8 | 1,0 |
| Medical Intern | 3 279 | 3 215 | 3 653 | 3 780 | 3 745 | 4 430 | 5 370 | 4 713 | 5 016 | 5 500 | 8,6 | 0,8 | 5,9 |
| Medical Practitioner | 42 146 | 42 550 | 44 145 | 44 858 | 46 014 | 46 839 | 46 516 | 49 087 | 49 108 | 51 470 | 1,7 | 3,4 | 2,2 |
| Medical Technologist | 5 350 | 5 331 | 5 576 | 5 616 | 5 793 | 5 975 | 6 088 | 6 219 | 6 269 | 6 320 | 2,2 | 1,3 | 1,9 |
| Occupational Therapist | 4 569 | 4 765 | 4 980 | 5 174 | 5 410 | 5 682 | 5 718 | 6 041 | 5 825 | 6 063 | 3,8 | 2,0 | 3,2 |
| Optometrist | 3 628 | 3 645 | 3 751 | 3 773 | 3 812 | 3 837 | 3 899 | 3 990 | 4 031 | 4 245 | 1,2 | 2,9 | 1,8 |
| Physiotherapist | 7 001 | 7 122 | 7 370 | 7 665 | 7 856 | 8 153 | 8 185 | 8 536 | 8 309 | 8 571 | 2,6 | 1,5 | 2,3 |
| Psychologist | 7 895 | 8 047 | 8 409 | 8 449 | 8 770 | 8 881 | 8 978 | 9 106 | 9 112 | 9 365 | 2,2 | 1,4 | 1,9 |
| Radiographer | 7 088 | 7 239 | 7 378 | 7 729 | 7 794 | 8 168 | 8 121 | 8 489 | 8 387 | 8 621 | 2,3 | 2,0 | 2,2 |
| Speech Therapist & Audiologist | 1 501 | 1 573 | 1 519 | 1 547 | 1 594 | 1 612 | 1 582 | 1 641 | 1 586 | 1 566 | 0,9 | -0,3 | 0,5 |

*Source: HPCSA 2024.*

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

The number of registered, enrolled and auxiliary nurses registered with the SANC reached 287 456 in 2016 but decreased gradually to 271 431 in 2022 (Table 3-10). Between 2013 and 2022, registrations across all categories experienced a low average annual growth of 0,4%. Registered nurse registrations saw a comparatively higher average increase of 2,2%, while registrations for enrolled and auxiliary nurses both declined, with rates of -2,2% and -1,1% respectively. The decline in registrations for auxiliaries from 2016 to 2022 (over 11 700, a decrease of approximately 17%) and enrolled nurses from 2017 to 2022 (over 22 200, a decrease of about 30%) can be attributed to changes in the qualification framework and the teach-out period of legacy qualifications. This trend is expected to become even more pronounced in the coming years if the issues surrounding the training of nurses are not fully addressed. The latter is evident when considering the post-COVID-19 period (2020-2022) which shows a negative 1,6% average annual growth of registrations across all categories.

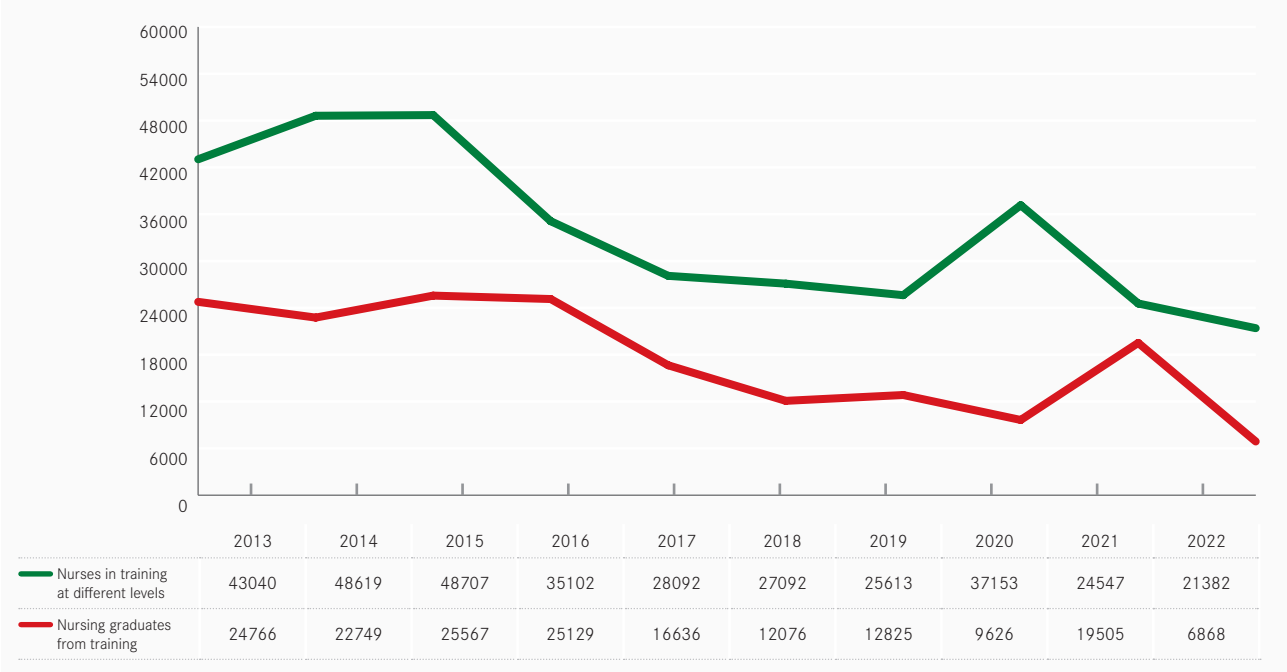
**Table 3-10 Number of nurses registered with the SANC, 2013-2022**

| | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 | 2020 | 2021 | 2022 | AAG 2014-2020 % | AAG 2020-2023 % | AAG 2014-2023 % |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Registered | 129 015 | 133 127 | 136 854 | 140 597 | 142 092 | 146 791 | 153 095 | 154 024 | 156 784 | 157 516 | 2,6 | 1,1 | 2,2 |
| Enrolled | 63 788 | 66 891 | 70 300 | 73 558 | 74 556 | 70 552 | 64 638 | 61 033 | 56 490 | 52 350 | -0,6 | -7,4 | -2,2 |
| Auxiliaries | 67 895 | 70 419 | 71 463 | 73 301 | 70 431 | 68 361 | 67 104 | 65 187 | 63 545 | 61 565 | -0,6 | -2,8 | -1,1 |
| **Total** | **260 698** | **270 437** | **278 617** | **287 456** | **287 079** | **285 704** | **284 837** | **280 244** | **276 819** | **271 431** | **1,0** | **-1,6** | **0,4** |

*Source: SANC 2023.*

The NEA warned already in 2022 that there is going to be a significant decrease noticeable in the registration numbers due to the drop in output at NEIs. There were only about 21 300 nurses in training at different levels at the time. All the old programmes are in their phasing out periods while the nursing colleges only started to deliver the new qualifications in 2020. The delay in the accreditation process of nursing colleges as HEIs affected the new enrolments considerably (Interview 2021, 2022, 2023, 2024). Figure 3-12 shows that nurses in training and nursing graduates across all post-schooling education and training institutions had a negative average growth of -7% and -13% respectively

**Figure 3-12 Number of nurses in training, 2013-2022**




| | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 | 2020 | 2021 | 2022 |
|---|---|---|---|---|---|---|---|---|---|---|
| Nurses in training at different levels | 43040 | 48619 | 48707 | 35102 | 28092 | 27092 | 25613 | 37153 | 24547 | 21382 |
| Nursing graduates from training | 24766 | 22749 | 25567 | 25129 | 16636 | 12076 | 12825 | 9626 | 19505 | 6868 |

*Source: SANC 2022.*

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

From 2015 to 2024, the average annual growth rate for registered pharmacists and pharmacist interns was 3,1% and 4,9% respectively (Table 3-11). The registration figures in the support staff categories showed higher growth over this period; basic pharmacist assistants grew on average by 7,5% annually over the period. The number of people registered in this category more than doubled between 2015 and 2016, and slightly decreased again between 2019 and 2024. Post-basic pharmacist assistants grew at an annual average of 11,3%; the number of people registered in this category almost doubled between 2015 and 2019, and then showed a steady increase over the shorter period from 2020 to 2024. This growth is significant because both categories of support staff play a crucial role in assisting pharmacists.

During the shorter period (2020-2024), encompassing the COVID-19 era, registrations for basic pharmacist assistants saw a marginal yearly decrease of 1,0%. Conversely, registrations for post-basic pharmacist assistants demonstrated steady growth, averaging 6,9% annually.

**Table 3-11 Number of registrations with the SAPC, 2015-2024**

| REGISTRATION CATEGORY | 2015 | 2016 | 2017 | 2018 | 2019 | 2020 | 2021 | 2022 | 2023 | 2024 | AAG 2015-2024 % | AAG 2020-2024 % |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Basic Pharmacist Assistant | 1 937 | 4 898 | 3 965 | 4 367 | 4 293 | 3 877 | 4 111 | 3 457 | 3 430 | 3 726 | 7,5 | -1,0 |
| Learner Basic Pharmacist Assistant | 3 510 | 3 166 | 3 080 | 3 326 | 3 208 | 3 110 | 3 152 | 3 603 | 4 051 | 4 130 | 1,8 | 7,3 |
| Post-basic Pharmacist Assistant | 6 713 | 7 973 | 10 191 | 11 681 | 13 103 | 13 481 | 14 863 | 15 494 | 16 528 | 17 576 | 11,3 | 6,9 |
| Learner Post-basic Pharmacist Assistant | 2 098 | 2 642 | 2 084 | 2 431 | 2 173 | 2 170 | 2 208 | 2 184 | 2 303 | 2 531 | 2,1 | 3,9 |
| Pharmacist | 13 658 | 14 053 | 14 552 | 15 231 | 15 722 | 16 020 | 16 541 | 17 113 | 17 531 | 18 029 | 3,1 | 3,0 |
| Pharmacist Intern | 857 | 1 045 | 1 036 | 1 086 | 1 082 | 1 171 | 1 260 | 1 316 | 1 412 | 1 313 | 4,9 | 2,9 |
| Specialist pharmacist | 13 | 13 | 13 | 13 | 11 | 10 | 10 | 10 | 11 | 10 | -2,9 | 0,0 |
| Community Service Pharmacist | | 642 | 806 | 758 | 807 | 813 | 855 | 871 | 810 | 922 | 4,6 | 3,2 |
| B Pharm student | | 3 708 | 4 183 | 4 287 | 4 520 | 4 013 | 3 331 | 3 727 | 4 028 | 4 663 | 2,9 | 3,8 |

*Source: SAPC 2024. *From 2016*

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

Since 2015, the total number of registrations for allied health professionals declined by an average of 0,7% per year until 2023, dropping from 2 673 in 2015 to 2 591 in 2023 (Table 3-12). However, in 2024, registrations surged to 3 399, resulting in an average annual growth rate of 2,7% over the ten-year period (2015-2024) and 3,2% over the five-year period (2020-2024). This increase primarily reflects growth in the registrations of chiropractors, homeopaths, phytotherapists, and acupuncturists. Typically, allied health professionals and complementary practitioners operate in the private sector.

**Table 3-12 Total registrations with the AHPCSA, 2015-2024**

| REGISTRATION CATEGORY | 2015 | 2016 | 2017 | 2018 | 2019 | 2020 | 2021 | 2022 | 2023 | 2024 | AAG 2015-2024 % | AAG 2020-2024 % |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Acupuncture | 64 | 61 | 57 | 54 | 53 | 52 | 44 | 44 | 54 | 85 | 3,2 | 5,6 |
| Ayurveda doctor | 17 | 17 | 13 | 13 | 12 | 12 | 12 | 10 | 10 | 9 | -6,8 | -3,1 |
| Chinese medicine | 156 | 160 | 157 | 153 | 157 | 158 | 146 | 146 | 145 | 155 | -0,1 | -0,2 |
| Chiropractic | 731 | 773 | 808 | 835 | 877 | 897 | 917 | 930 | 975 | 1511 | 8,4 | 6,0 |
| Homoeopathy | 569 | 572 | 581 | 584 | 580 | 573 | 573 | 572 | 596 | 830 | 4,3 | 4,2 |
| Naturopathy | 92 | 88 | 86 | 80 | 80 | 77 | 68 | 68 | 73 | 77 | -2,0 | 0,0 |
| Osteopathy | 40 | 40 | 36 | 37 | 38 | 37 | 33 | 33 | 33 | 29 | -3,5 | -2,7 |
| Phytotherapy | 43 | 49 | 51 | 48 | 48 | 49 | 45 | 46 | 49 | 74 | 6,2 | 4,7 |
| Therapeutic aromatherapy | 179 | 157 | 131 | 121 | 105 | 98 | 83 | 79 | 75 | 69 | -10,1 | -3,8 |
| Therapeutic massage therapy | 125 | 111 | 103 | 102 | 95 | 94 | 94 | 93 | 91 | 116 | -0,8 | 2,4 |
| Therapeutic reflexology | 584 | 535 | 501 | 491 | 446 | 437 | 403 | 427 | 425 | 374 | -4,8 | -1,7 |
| Unani-Tibb | 73 | 74 | 67 | 66 | 69 | 69 | 65 | 63 | 65 | 70 | -0,5 | 0,2 |
| **Total** | **2 673** | **2 637** | **2 591** | **2 584** | **2 560** | **2 553** | **2 483** | **2 511** | **2 591** | **3 399** | **2,7** | **3,2** |

*Source: AHPCS 2024.*

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

Of the registration categories with the SAVC, the animal health technicians have the highest annual average growth of 7,1% from 2015 to 2024 followed by veterinary technologist (4,7%), veterinary specialists (3,2%), and veterinary nurses (2,4%). The number of veterinarians registered with the SAVC grew on average by only 1,7% from 3174 in 2015 to 3 699 in 2024 (Table 3-13). Veterinary physiotherapist is a new para-veterinary profession which has grown by an annual average growth of 17% but only from 2021 to 2024; 96 have been registered to date. Since 2022, it is also compulsory for veterinarian graduates to commit themselves to one year of community veterinary service. There are currently 278 vets in community service in the country.

During the shorter period from 2020 to 2024, which includes the COVID-19 era, registrations for veterinarians experienced a slight annual decline of 0,1%, while veterinary nurses saw a decline of 0,2%. A survey by the SAVA found that an alarming high number of vets are leaving the country, and that a considerable number are planning to leave. The profession is critical to ensure food safety and security in South Africa and skills shortages in this field needs to be addressed urgently. The SAVC records show that South Africa is losing up to 150 vets a year to emigration; this figure is based on the number of vets a month requesting letters of good standing from the SAVC to enable them to practise abroad (SAVC 2023).

**Table 3-13 Number of registrations with the SAVC, 2015-2024**

| REGISTRATION CATEGORY | 2015 | 2016 | 2017 | 2018 | 2019 | 2020 | 2021 | 2022 | 2023 | 2024 | AAG 2015-2024 % | AAG 2020-2024 % |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Veterinarians | 3 174 | 3 222 | 3 340 | 3 548 | 3 658 | 3 718 | 3 720 | 3 500 | 3 491 | 3 699 | 1,7 | -0,1 |
| Veterinary Specialists | 167 | 163 | 184 | 207 | 206 | 205 | 212 | 217 | 216 | 221 | 3,2 | 1,9 |
| Community Veterinary Service | | | | | | | | 323 | 382 | 278 | | -7,2 |
| Animal Health Technicians | 1 004 | 1 013 | 1 041 | 1 205 | 1 281 | 1 283 | 1 372 | 1 549 | 1 599 | 1 867 | 7,1 | 4,3 |
| Laboratory Animal Technologists | 17 | 19 | 17 | 16 | 15 | 19 | 15 | 14 | 13 | 13 | -2,9 | -4,1 |
| Veterinary Nurses | 611 | 606 | 640 | 709 | 732 | 769 | 719 | 727 | 723 | 757 | 2,4 | -0,2 |
| Veterinary Technologists | 280 | 279 | 311 | 334 | 354 | 349 | 358 | 395 | 394 | 422 | 4,7 | 2,1 |
| Veterinary Physiotherapists* | | | | | | | 60 | 65 | 73 | 96 | | 17,0 |
| **Total** | **6 888** | **6 713** | **6 944** | **7 674** | **7 661** | **7 758** | **7 708** | **7 997** | **6 891** | **7 353** | **3,8** | **4,8** |

**New para-veterinary profession*
*Source: SAVC 2024.*

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

Of the registration categories with the SACSSP, as shown in Table 3-14, child and youth care workers have the highest annual average growth of 9,2% from 2016 to 2023 followed by social workers (7,2%), and social auxiliary workers (6,9%). Over a short period from 2020 to 2023, social workers have the highest annual average growth of 8,5% followed by social auxiliary workers (7,6%), and child and youth care workers (1,4%). The latter is mainly explained by the phasing out of the level 4 qualification.There are just over 29 136 students preparing to become social workers, social auxiliary workers, child and youth care workers, or auxiliary child and youth care workers in the next couple of years. These are positive trends in terms of supplying human resources for the delivery of much-needed social services in South Africa, especially with the national focus on children.

**Table 3-14 Social Service Professionals and students with the SACSSP, 2016-2023**

| REGISTRATION CATEGORY | 2017 | 2018 | 2019 | 2020 | 2021 | 2022 | 2023 | 2024 | AAG 2020-2023 % | AAG 2016-2023 % |
|---|---|---|---|---|---|---|---|---|---|---|
| Social Workers | 27 130 | 20 017 | 32 657 | 33 404 | 34 569 | 35 328 | 38 443 | 44 106 | 8,5 | 7,2 |
| Social Auxiliary Workers | 9 235 | 10 142 | 11 182 | 11 589 | 11 824 | 11 954 | 12 716 | 14 749 | 7,6 | 6,9 |
| Child and Youth Care Workers | 5 113 | 6 303 | 7 503 | 8 122 | 9 071 | 7 467 | 8 358 | 9 460 | 1,4 | 9,2 |
| **Total** | **41 478** | **36 462** | **51 342** | **53 115** | **55 464** | **54 749** | **59 517** | **68 315** | **7,0** | **7,4** |
| Student Social Workers | 10 807 | 13 36 | 15 411 | 16 938 | 14 582 | 14 636 | 14 894 | 14 154 | 3,9 | 3,9 |
| Student Social Auxiliary Workers | 8 528 | 10 081 | 11 247 | 12 276 | 11 715 | 15 279 | 12 540 | 11 756 | 4,7 | 4,7 |
| Student Child and Youth Care Workers | 15 | 132 | 0 | 0 | 198 | 263 | 282 | 366 | 57,8 | 57,8 |
| Student Auxiliary Child and Youth Care Workers | 131 | 214 | 742 | 1 245 | 2 421 | 3 206 | 3 773 | 2 860 | 55,3 | 55,3 |
| **Total** | **19 481** | **23793** | **27400** | **30 459** | **28 916** | **33 384** | **31 489** | **29 136** | **5,9** | **5,9** |

*Source: SACSSP 2024.*

### 3.4.5 Summary of the supply-side constraints and HWSETA interventions

The readiness of candidates for education and training required to work in the sector is a major constraint identified in the sector. Stakeholders are concerned about the high drop-out rate of undergraduates and the number of learners who seem under-prepared for tertiary-level studies and grapple with language and cultural barriers. Academic criteria for admission to social work programmes are generally in the lower ranges, and students tend to underestimate the training demands (Stakeholder interviews 2019, 2020, 2021, 2022, 2023). In terms of the training of nurses, the decline in output is a critical issue, exacerbating the nursing shortage. The HWSETA focus on prioritising post-graduate nursing qualifications since 2023 is a positive step towards addressing the shortage.

NGOs offer non-accredited training to volunteers, CHWs, and community caregivers. Most of these organisations lack the capacity to seek accreditation to offer the formal qualifications registered on the NQF. Training capacity for health professionals remains limited due to infrastructure constraints, shortages of academic clinician posts, bed count, laboratories, and other clinical teaching resources (Stakeholder interviews 2019, 2020, 2023). The interruption of contact education and training due to the COVID-19 pandemic in 2020 had an impact on the clinical/practical requirements of the respective programmes, depending on the duration of the academic interruption. Enrolment figures have dropped as expected in 2021 but increased again in 2022. Similarly, there is limited training capacity at TVET colleges, accredited private providers, and NGOs in certain areas that are important to the health sector. The role that the HWSETA plays is therefore important in terms of the quality assurance of a range of qualifications such as child and youth care work, social auxiliary work, and community health work, a key area in the domain of primary health care; these qualifications play a key role in the supply of important skills to the sector.

## 3.5 THE HWSETA SECTOR PRIORITY OCCUPATIONS AND INTERVENTIONS (SPOI) LIST

### 3.5.1 Overview

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

In the preparation of a SPOI list, the HWSETA takes a holistic view of its sector as per the SIC code distribution assigned, the skills composition and skills need of the sector, and the education and training pipelines that supply skills into the sector. It bears in mind that the Health and Social Development Sector is large and complex and that it does not only depend on core health and social service professions and occupations. There are support occupations that are relatively small in number, but that are critically important for the functioning of hospitals and other facilities, for example, financial occupations and some trades. Another factor that must be borne in mind in the development of the list is the SETA's obligations in terms of national strategies; a good example is the NHI.

### 3.5.2 Methodology

The development of the Sectoral Priority Occupations and Interventions (SPOI) List (formerly known as PIVOTAL list) starts with an analysis of the occupations in the sector and employment trends in those occupations. This is followed by an analysis of the Hard-To-Fill-Vacancies (HTFV) reported by organisations in the public and private sector. This analysis, which is based on one-on-one employer interviews, and the WSPs submitted to the HWSETA, as well as the PSETA provides a basic list of occupations in which scarcity (unable to fill vacancies within twelve months) is experienced, with employment and vacancy information on each occupation.

A second step in the process is a systematic analysis of the quantities of each identified occupation based on the people required to fill vacancies. This informs the ranking of occupations in terms of priority. Stakeholder engagements around the SPOI List take the form of interviews conducted with key role players in the sector. Clarification is sometimes needed regarding the figures presented by employers in their WSP submissions.

The occupations on the SPOI List are ranked according to the reasons for HTFV and the duration that HTFVs have taken (12 months or more), and minimum number of people needed per occupation. Amongst many reasons for the HTFV, scarcity of people with experience, required qualifications, and specialised skills are used to rank priority levels in relation to

HWSETA's mandate and control and as per Sector Skills Plan framework and guidelines which emphasises that SPOI list be based on skills-related reasons. However, this ranking does not necessarily signify preferential funding. The type and nature of the learning programmes that lead to each identified occupation are addressed in a further step. The finalisation of the SPOI list is based on the HTFV list but with specific focus occupations that become HTFV due to skills-related reasons. The estimate of the quantity of need in the sector is formulated from the 5-year average of HTFV to account for variations that arise from the changing number of employer organisations submitting their WSPs. The 5-year average is also crucial to identify consistent HTFV patterns over the five-year strategic period so as to best anticipate the coming strategic period for planning.

This, in turn, leads to the interventions indicated in the SETA SPOI list. The number of interventions that the SETA can support depends on various considerations:

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

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

### 3.5.3 Approval of the Sectoral Priority Occupational and Interventions list

The process of organising the SPO list culminates in the submission of it for consideration and approval by the Board. Upon approval, the SPOI list is then signed by the Board's Chairperson.

## 3.6 CONCLUSION

The demand for skills in the health and social development sector continues to outstrip supply in many areas. This is largely due to the state's agenda to improve access to adequate health care and social development services, changes in the way these services are delivered to the public, and the COVID-19 pandemic. The following is evident:

- There are imbalances between skills output versus the occupational demand in the workplace as indicated by the vacancies data, especially for nurses and medical practitioners.
- There are mismatches between skills provision 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.
- The education system does not always 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. Therefore, in line with the ERRP Skills Strategy, the focus will be on the provision of WBL opportunities to ensure the work readiness of entrants to the sector.
- Mismatches exist due to changes in the work environment, service delivery models, and the scopes of professional responsibility, e.g., the re-engineering of primary health care, and the new nurse practitioner categories and new qualifications.

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

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

Over the last five years the following factors had an effect on the supply of skills to the sector: the consequences of the COVID-19 pandemic, increasing the demand for certain workers in the sector such as general medical practitioners (specifically in the public sector) and nurses; the decrease and delayed output at HEIs because of the disruption of contact education during 2020 and 2021; and the challenges regarding the new nursing qualifications disrupting the output of nurses.

# 4. SETA PARTNERSHIPS.

# 4 SETA PARTNERSHIPS

## 4.1 INTRODUCTION

Among the keystones in advancing the developmental state are the improvement of citizens' lives through accessible healthcare, adequate social protection, and opportunities for socio-economic participation. On its own, the HWSETA cannot meet these demands and therefore depends on collaborations with many different entities. Since 2020, the HWSETA established extraordinary new partnerships to address the effects of the COVID-19 pandemic. The HWSETA saw its mandate reaching beyond a skills development responsibility during the pandemic. This chapter reports on existing and planned partnerships.

## 4.2 APPROACH TO PARTNERSHIPS

As per the SSP framework, HWSETA partnerships are official and legally approved documents of collaboration between two or more parties in pursuit of strategic objectives which are mutually beneficial with respect to skills priorities. In essence, partnerships expand HWSETA capabilities through collaboration with partners from the PSET ecosystem towards realisation of the NSDP's vision which is to attain "an educated, skilled and capable workforce for South Africa" (NSDP 2019).

HWSETA partnerships are encoded in NSDP principles. For greater inclusivity that fosters ownership and participation among stakeholders, collaborative partnerships are forged across different key stakeholders (i.e. employers, providers, and labour) within public sector, and between public and private sector. HWSETA partners with training providers to steer supply of qualifications particularly those in the public sector (i.e. TVETs and CETs) through large-skills development training to expand state capacity. This also extends to the NPO sector. This prioritisation ensures the realisation of the HWSETA's skills priority called vital skills required for the developmental state.

To understand skills demand in the sector, collaboration with higher education and research institutions, and professional bodies are prioritised for analysis of trends in the sector. This extends to partnerships with employers that are key in the sector for gathering of credible information about the changing nature of work and needs (demand and supply) associated with it. Partnerships with employers are of utmost importance to the HWSETA for purposes of credible information gathering, broadening of workplace capacity for work-based training, and absorption of beneficiaries from work-based training upon completion. As such, partnerships with employers ensures realisation of HWSETA's skills priority called sustainable skills pipeline which enables entry into employment through access to workplace experience. Further, partnerships with employers support the realisation of the HWSETA's skills priority called professionalisation of the workforce which closes skills gaps and upskills the workforce for service quality, efficiency, and service provisioning.

## 4.3 EXISTING PARTNERSHIPS

The table below provides information on current partnerships and covers the objectives and duration of partnerships; the impact (value-add); and challenges and success factors. The priorities of these partnerships relate to the following: supporting post-school institutions to be able to supply skills to the sector; providing work-based experience opportunities such as WIL or internships to new entrants to the sector; building the mid-level skills base in the health sector; providing undergraduate and post-graduate bursary opportunities for unemployed youths and also workers; developing post-school education lecturers; building skills of leaders of trade unions and those of the NGO/NPO sector; stimulating economic activity and cooperative development; and developing artisans and technicians. These partnerships are linked to the priorities of the NSDP and/or the ERRP.

The HWSETA's partnerships are administered through Memorandum of Agreements (MoAs) or Memorandum of Understandings (MoUs) with the objective of establishing and outlining collaborative agreements including service partnerships. This contract usually follows a certain format that includes, although not limited to the following key sections: definitions of terms; purpose of the agreement; scope of work; obligations of each party; a detailed description of roles and responsibilities; duration; and breach and termination. Whilst entering into an agreement clearly expresses mutual obligations for the HWSETA and the partners, it is often found that most of the partnerships pose some challenges; some

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

The table below accounts for the HWSETA existing partnerships by strategic partnerships, education and training delivery partnerships, industry and professional bodies partnerships.

**Table 4 1 Existing partnerships**

| | | IMPLICATIONS FOR SKILLS PLANNING | |
|---|---|---|---|
| **INSTITUTION/PARTNER ORGANISATION** | **NATURE OF PARTNERSHIP** | **DEMAND-RELATED IMPLICATIONS** | **SUPPLY-SIDE RELATED IMPLICATIONS** |
| **Netcare Hospitals** | **Strategic partnership**<br>Learnership: Higher Certificate in Nursing.<br>(Start date: 30 Aug 2023 End date: 30 Mar 2025) | 1) To give exposure to occupational work<br>2) To acquire occupational competence through structured components of theory and practical work experience. | • These strategic partnerships have contributed towards employability given the work-readiness after completion of the learnership. This claim is evident from the tracer studies conducted over the years by HWSETA which have confirmed the work-based training through learnership as a legitimate training-for-employment model. Learnership programmes in the health sector had better prospects of employment upon completion than those in the social sector. Importantly, evaluation studies showed that learnership programme had more resilience during the COVID-19 period in terms of absorption to employment of beneficiaries upon completion.<br>• Employment of beneficiaries confirm acquisition of occupational competence and evidence of demand for it by the labour market.<br>• Challenges and mitigating factors: While the learnership programme is effective in its outcomes (value-add) it has implementation challenges of not achieving all its planned targets due to employers not having appetite to take workers from the areas of employment for longer periods. HWSETA's implementing division has commissioned a research study on this aspect for consideration in its review of how learnerships can be more responsive to this concern by employers to find a conducive balance for being at work and at training at a reasonable level. |
| **Environment and Language Educational Trust** | **Strategic partnership**<br>Learnership: FETC: Early Childhood Development<br>(Start date: 23 Jul 2023 End date: 23 Jul 2025) | | |
| **Wits Health Consortium (PTY) LTD** | **Strategic partnership**<br>Learnership: Pharmacist Assistant Learners (Basic) & Pharmacist Assistant Learners (Post Basic)<br>(Start date: 23 Jun 2023 End date:23 Jun 2025) | | |

| | | IMPLICATIONS FOR SKILLS PLANNING | |
|---|---|---|---|
| **INSTITUTION/PARTNER ORGANISATION** | **NATURE OF PARTNERSHIP** | **DEMAND-RELATED IMPLICATIONS** | **SUPPLY-SIDE RELATED IMPLICATIONS** |
| **Higher Education Training Health Wellness Development Centre (Higher Health)** | **Strategic partnership**<br>(Non-credit bearing skills programme bundle: Psycho-social support and mentoring programme for GBV and mental health support)<br>Start date: 30 Aug2023<br>End date: 30 Mar 2025 | 1) To introduce a new skill<br>2) To acquire additional knowledge<br>3) To improve productivity<br>4) To improve service provisioning | • Strategic partnerships from skills programmes have contributed towards introduction of new skills and knowledge contributing towards productivity and service provisioning. Importantly, HWSETA's commitment towards the non-credit bearing programmes from planning and resource allocation as an indicator illustrates adaptability and responsiveness to sectoral and context-specific needs which are demand-led. As such, the value is these programmes affords HWSETA sufficient flexibility to detect new needs as they emerge in the sector.<br>• Thus, HWSETA's skills programme has contributed towards professionalization of the sector by closing skills gaps or skills deficiencies.<br>• Challenges and mitigating factors: While the skills programmes are effective, the programme implementation challenges in terms of slow implementation due to non-availability of workers for training because of the demands of their jobs. As such, the programme has not been able to achieve its planned targets.<br>• HWSETA's implementing division has commissioned a research study on this aspect for consideration in its review of how skills programmes can be more responsive to this concern of employers. |
| **University of KwaZulu-Natal** | **Strategic partnership**<br>(Non-credit bearing skills programme bundle: Training of traditional health practitioners on leadership in primary healthcare, principles in traditional medicine, and project implementation)<br>Start date: 22 Sep 2022<br>End date: 22 Sep 2024 | | |
| **Wits Health Consortium (PTY) LTD** | **Strategic partnership:**<br>A broad outline for the provision and support of skills development activities<br>Start date: 03 Jun 2024<br>End date: 03 Jun 2027 | | |
| **Durnacol Skills Hub** | **Strategic partnership**<br>Artisans/Apprenticeship Training: Millwrights<br>Start date: 30 Jan 2024<br>End date: 30 Sep 2028 | • To support the training of students in trades that are in demand to increase the number of qualified artisans in the country<br>• To acquire occupational competence through structured components of theory and practical work experience. | • The strategic partnerships from artisanship have contributed positively towards employability in the past as confirmed by evaluation studies. The latter is premised on the work-readiness after completion of the artisanship and technical and occupational competence confirmed by the trade test and absorption to employment.<br>• Absorption to employment is evidence of demand from the labour market. Thus, the existing partnership has the high likelihood to produce the same positive results.<br>• Challenges and mitigating factors: The artisanship programme is both effective and efficient given its achievement of targets in the recent past emanating from monitoring of implementation and timeous reporting by employers. Thus, the current existing benefits stand to benefit positively from the implementation model that has been adopted for artisanship programme.<br>• Given the national vision of the artisan of the decade which aims to produce 30 000 artisans annually by 2030, these artisan development partnerships offer added value to the HWSETA's contributions. |
| **Air Conditioning and Refrigeration Academy** | **Strategic partnership**<br>Artisans/Apprenticeship Training: Refrigeration Mechanic (Commercial)<br>Start date: 13 Sep 2023<br>End date: 13 Sep 2025 | | |

| | | IMPLICATIONS FOR SKILLS PLANNING | |
|---|---|---|---|
| **INSTITUTION/PARTNER ORGANISATION** | **NATURE OF PARTNERSHIP** | **DEMAND-RELATED IMPLICATIONS** | **SUPPLY-SIDE RELATED IMPLICATIONS** |
| • **University of Limpopo**<br>• **Cape Peninsula University of Technology**<br>• **Rhodes University**<br>• **University of Johannesburg**<br>• **University of KwaZulu-Natal**<br>• **University of Cape Town**<br>• **Durban University of Technology**<br>• **University of Pretoria**<br>• **Nelson Mandela University**<br>• **North-West University**<br>• **Stellenbosch University** | **Strategic partnership**<br>Undergraduate Bursaries<br>Start date: 01 Apr 2022<br>End date: 31 Mar 2026 | • To increase the number of workers and unemployed persons that enter, re-enter and complete bursary programmes on qualifications funded by the HWSETA | • The strategic partnerships supporting undergraduate bursaries have increased the supply of a skilled workforce towards high-end skills by opening doors to further learning from undergraduate to post graduate studies. The partnership's value-add is also in its specific targeting of the 'missing middle' students who do not qualify for NSFAs bursary funding.<br>• Evaluation studies have also confirmed that undergraduate bursaries lead to a reasonable level of absorption to employment.<br>• Challenges & mitigating factors: Completions remain a challenge given that students ordinarily take more time to complete their studies. Thus, aspect of the programme still needs continuous improvement in efficiencies. 15 public TVET colleges |
| **15 public TVET colleges** | TVET vocational bursaries and experiential learning<br>Start date: 01 Apr 2022<br>End date: 31 Mar 2026 | • Establish schools of health and social development within TVET Colleges<br>• Support artisan training programmes<br>• Support work-readiness programmes<br>• Support animal health technicians training programmes | • Facilitates the delivery of HWSETA qualifications within TVET colleges<br>• Contributes towards the maintenance of hospital equipment.<br>• Improves the employability of graduates<br>• Secures animal health for food production<br>• Challenges and mitigating factors: Accreditation standards not evenly met across TVET colleges. Thus, standardisation has been adopted by the HWSETA for uniformity of the intervention. |
| **TARDI** | Animal Health Technicians<br>Start date: 01 Apr 2022<br>End date: 31 Mar 2026 | • To enable students who are enrolled with the college to gain workplace experience in line with curriculum for them to graduate | • Linking the world of work and education through training for employment.<br>• Challenges and mitigating factors: whilst this programme is effective a solution needs to be found in terms of articulation from animal health Technicians to Bachelor of Veterinary Sciences. More consultation with relevant stakeholders is required for better articulation pathways. |
| • **University of Cape Town**<br>• **Cape Peninsula University of Technology**<br>• **Rhodes University**<br>• **University of KwaZulu Natal**<br>• **University of Western Cape**<br>• **University of North-West**<br>• **University of Limpopo**<br>• **University of Sefako Makgatho**<br>• **University of Johannesburg**<br>• **University of Venda**<br>• **University of Pretoria**<br>• **Nelson Mandela University**<br>• **Durban University of Technology**<br>• **Stellenbosch University**<br>• **University of Fort Hare**<br>• **University of South Africa** | Postgraduate Research Bursary programme Bursaries<br>Start date: 20 Oct 2023<br>End date: 20 Oct 2028 | • To increase access into post-graduate higher education programmes<br>• To create a pipeline of candidates that qualify to enter into Master's degrees and PhDs | • Increases the number of people with high-level skills in the sector to qualify to become lectures at higher education institutions<br>• To fill hard-to fill vacancies that require high-level and/or specialised skills<br>• Recent evaluation studies confirm that postgraduate degrees facilitate progression which saw most beneficiaries change their jobs and nature of employment towards permanent positions upon completion. These outcomes confirm value of the programme to the sector and country thus presenting a logical basis for the success of the current and future partneships under postgraduate research bursary programme.<br>• Challenges and mitigating factors: While the completions have ordinarily taken longer, in 2023/24 financial year monitoring and follow-ups saw more reporting on completions.<br>• Thus, partnerships on this programme are both effective and efficient. Given effectiveness of the partnerships for this programme, resourcing and budgeting is to be improved at disaggregated level for desired outcomes. |

| | | IMPLICATIONS FOR SKILLS PLANNING | |
|---|---|---|---|
| **INSTITUTION/PARTNER ORGANISATION** | **NATURE OF PARTNERSHIP** | **DEMAND-RELATED IMPLICATIONS** | **SUPPLY-SIDE RELATED IMPLICATIONS** |
| • **East Cape Midlands TVET College**<br>• **TARDI**<br>• **Central Johannesburg TVET College**<br>• **South-West Gauteng TVET College**<br>• **Northern Cape Rural TVET College**<br>• **Northlink College**<br>• **College of Cape Town** | Lecturer Development<br>Start date: 01 Apr 2023<br>End date: 31 Mar 2026 | • Improve capacity of lectures which contribute to the quality of education<br>• To improve lecturers' skills for conducting assessments | • Skilling and upskilling to improve quality of education and productivity<br>• Challenges nd mitigating factors: Accreditation challenges experienced by colleges. Going forward verification of accreditation requirements will be conducted.<br>• There is also low reporting of completions because the training is quality assured by other SETAs which causes delays. Going forward, more collaboration for sharing of data to report performance will be advanced. |
| • **NPSWU**<br>• **NEHAWU**<br>• **HOSPERSA** | Worker Leader Training (Trade Unions)<br>Start date: 01 Apr 2023<br>End date: 31 Mar 2025 | • To support workers to access credit and non-credit bearing skills programmes<br>• To empower capacity building of worker leaders of trade unions in the sector<br>• To enable participation of trade unions to meet conditions and requirements for their registration with the Department of Employment and Labour | • Capacitated leaders of trade Unions with required knowledge on labour issues<br>• Challenges and mitigating factors: There are some challenges of incomplete documentation which will be mitigated by verification and completeness assessment. |
| **PROFESSIONAL BODIES** | | | |
| **South African Pharmacy Council (SAPC)** | Framework for co-operation and co-ordination to promote information sharing and research<br>Start date: 01 Jul 2023<br>End date: 30 Jun 2026 | • To cooperate in the following areas.<br>• Stakeholder mapping and profiling project<br>• Policy analysis project<br>• Demand side analysis project<br>• Supply side analysis project<br>• Partnership analysis project<br>• Data sharing for research and evaluation of programmes and projects | This partnership is valuable and has contributed to two research projects namely. 1) The extent and nature of the supply and demand of pharmacy human resource personnel: A case of education and training landscape. 2) Investigating the association between employee wellness (physical and mental health) and the working environment of pharmacy human resources in South Africa |

The determination of the most successful of the strategic partnerships is premised on the partnership approach and strategic outcomes. One of the key strategic outcomes of the HWSETA is to promote linkages between education and the workplace to increase access to work-based learning opportunities for the unemployed in the sector. This strategic outcome is cascaded from NSDP outcome 3 'linking education and the workplace'. In essence, the proposition is that work-based training is a training for employment model. As such, partnerships with employers ensures realisation of HWSETA's sustainable skills pipeline skills priority which enables entry into employment through access to workplace experience. Strategic partnerships that stem from learnership programmes are deemed the most successful given that hey have the greatest number of employers participating. This has been confirmed by evaluation studies on the employment of unemployed beneficiaries upon completion within a short period of time (six months or less). Even during the COVID-19 pandemic, evaluation studies confirmed the resilience of the learnership programme in its outcome of absorption of beneficiaries to employment. Thus, strategic partnerships from learnership programmes are the most successful given its contribution towards the realisation of sustainable skills pipeline in the sector. Research evidence-informed prioritisation of strategic partnerships from learnership programmes in both nursing and pharmacy related qualifications as occupations in demand from intermediate skills levels has yielded employment. With learnership programmes being the most funded programme under the Discretionary grant, this illustrates that HWSETA's resource allocation is responsive to sectoral needs and indeed creates and transfers value back to the sector.

## 4.4 PROPOSED PARTNERSHIPS

The HWSETA has decided to take the partnerships that they have already established to the next level within the constraints of their budget. In addition, new partnerships are proposed that relates to the following:

- A partnership with small and micro enterprises (SMEs) and levy exempt organisations to increase the number of entry-level workplace experience for the youth and to expand production capacity of rural cooperatives.
- A planned partnership between the HWSETA and SACSSP to develop standardised and pilot induction standards for the Social Work Prok Profession for the newly qualified or employed Social Workers.
- A partnership with SAMED for the training of health occupations, particularly unemployed graduates, to obtain the designation of Medical Coders and thus find jobs as Medical Coders. Also, this will increase the number of Certified Medical Coders in the country and thus support the implementation of the NHI.
- A partnership with the South African Society for Physiotherapist in order to support Physiotherapists with the necessary skills for going into Private Practice
- A partnership with the Pharmacy Council to support research on mental health challenges of Pharmacists.
- A partnership with the DPSA in order to gain access into the PERSAL database.
- A partnership with Department of Health on training of health professionals on social determinants of health as a skills programme or continuous professional education.
- A partnership with Public Service SETA (PSETA for sharing of data (WSP/ATRs) and for massification of digital literacy skills to staff in the Departments of Health and Social Development.
- A partnership with South African Medical Association (SAMA) to train unemployed persons as certified ICDL coders which is an international qualification and foundational to successful implementation of the NHI.
- A partnership for co-funding and collaboration in offering training programmes and internships to municipalities. These will include environmental health practitioners, surveillance, and ward-based nurses in the area of primary healthcare.
- A partnership with South African Veterinary Council (SAVC) to train subsistence farmers in animal health and disease prevention.
- A partnership with National Electronic Media Institute of South Africa (MEMISA) to offer training in digital literacy to rural youth.

## 4.5 CONCLUSION

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

All new partnerships will be aligned to the NSDP 2030; the ERRP Skills Strategy 2022; the Gender-Based Violence Policy Framework for Post-school Education and Training System 2020; the Sector Strategy for Employment of Social Service Professionals 2021; and priorities of all other government strategies. HWSETA will continue to work with its current partners and will engage in new partnerships and projects to strengthen mechanisms for skills provision to the health and social welfare sector. HWSETA partnerships produced mixed results in the past: while well-planned partnership structures, supportive networks, and the involvement of all beneficiaries contributed to the success, progress was hampered by a lack of finance, poor stakeholder responses in some instances, labour market constraints that prevented learners from entering gainful employment, most recently consequences of the COVID-19 pandemic, and further budget constraints. Moving forward, the HWSETA will continue to adopt corrective measures and different strategies to advance the successful production of skills. By increasing its capacity to track the progress of partners, providers, and learners through research, the HWSETA will be able to respond to challenges sooner, to improve the outcomes of skills development partnerships. The HWSETA will continue to engage with its stakeholders and conduct research to keep abreast of changing skills needs in the sector.

# 5. SETA MONITORING AND EVALUATION

# 5 SETA MONITORING AND EVALUATION

## 5.1 INTRODUCTION

In terms of the NSDP2030 SETAs are required to monitor and report on their performance regularly. This means that the HWSETA must report on the value that they add and the contribution that they make to the improvement of the skills situation in the country. This chapter outlines the monitoring and evaluation framework and approach of the HWSETA.

## 5.2 MONITORING AND EVALUATION POLICY FRAMEWORK

The HWSETA has a Monitoring and Evaluation Policy (M&EP) which is aligned with the Government-wide Monitoring and Evaluation System (GWM&ES) 2007 as well as the DPME Revised Framework for Strategic and Annual Performance Planning 2019. The GWM&ES is essentially aimed at contributing to 'improved governance, promote learning and enhance the effectiveness of public sector organisations and institutions and accountability reporting'. The GWM&ES objectives also include the collection, collation, analysis, and dissemination of information on the progress and impact of programmes. The M&E policy is essential in strengthening the HWSETA's strategic planning, performance monitoring, evaluation, and reporting system. The monitoring and evaluation policy aspires to strengthen governance within the sector by improving transparency, strengthening accountability relationships, and building a performance culture that will foster better achievement of strategic objectives through good-practice approaches to project management. To ensure that the HWSETA achieves its objectives, regular monitoring and evaluation of projects and programmes are necessary. This enables management to assess the effectiveness of its decisions and actions. It also provides management with information on which they can base future decisions.

The M&E approach adopted by HWSETA defines the SETA as a learning organisation[10], where accurate, quality data and precise analysis inform strategic planning, decision-making, and prioritisation of interventions. This enhances strategic corporate learning and empowers the Accounting Authority with credible data to critically reflect, respond quicker, justify their actions, and account for expenditure. The Performance Monitoring Plan as defined in the M&EP for HWSETA has been designed with several objectives in mind. It provides a tool to:

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

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

## 5.3 APPROACH AND INSTITUTIONALISATION OF MONITORING AND EVALUATION

HWSETA has established the Research, Information, Monitoring, and Evaluation (RIME) unit which accommodates the inter-relatedness of the different functions or processes regarding M&E. The focus of RIME is therefore to strengthen the planning, monitoring, implementation, and reporting framework activities. The tool for the execution of M&E is the Monitoring and Evaluation Reporting Plan (MERP), which is designed to evaluate and monitor how effectively and efficiently strategic output and outcome indicators contributed to the desired change. The overall goal of the MERP is to provide critical information not only to HWSETA and DHET to guide implementation to achieve programme objectives but also to employers and other interested stakeholders. The approach of the HWSETA to monitoring[11] is the following:

- Articulating programme or project objectives;
- Linking activities and resources to programme or project objectives;
- Converting the programme or project objectives into performance indicators and setting targets;
- Regularly collecting data on these programme or project indicators and comparing actual results with targets; and
- Reporting progress on a programme or project to managers and alerting them to complications.

### The approach of the HWSETA in terms of evaluation[12] is the following:

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

### The approach of the HWSETA in terms of impact assessment[13] is the following:

- Reviewing all monitoring and evaluation activities, processes, reports, and analysis;
- Providing an in-depth understanding of various causal relationships and the mechanisms through which they operate; and
- Synthesising a range of programmes and projects and using a tracer study methodology to identify and measure impact indicators that are a direct result of skills development interventions.

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

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

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

## 5.4 MONITORING AND EVALUATION OF STRATEGIC PRIORITIES

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

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

The 2024/2025 SSP update of the HWSETA listed three skills development priorities, and all priorities informed the strategic plan update of 2024/2025 and cascaded to performance indicators for implementation through the annual performance plan. The SSP primarily informs the situational analysis of the strategic document through the synthesis of sectoral needs and priorities identified. The three skills priorities are: skills pipeline into the health and social development sector; professionalisation of the workforce; and vital skills required for the developmental state. The three priorities directly relate and express the ERRP strategic objectives and the obligations of the HWSETA in this regard. For example, the HWSETA increased funding to escalate access to programmes and workplace experiences resulting in qualifications that are in high demand in the health sector, in this way ensuring the skills pipeline (ERRP interventions three and five); and retraining and up-skilling of employees to preserve jobs as well as ensure the continued professionalisation of the workforce (ERRP intervention 7). The priorities are also in line with the Sustainable Development Goals (target 3c) for low- and middle-income countries training and retention of the health workforce.

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

The sustainable skills pipeline enables entry into employment in the health and social development sector at different entry points across PSET sub-systems. The White paper for Post-School Education and Training (2013, p.viii) proposes that "employers must be drawn closer to the education and training process". As an implementation strategy, the National Skills Development Plan (DHET: NSDP 2019 p.16) conceives "the role of SETAs as intermediary bodies [which] is posited as a key factor in linking the world of work and education". More recently, the Skills Strategy that supports the ERRP states under intervention five the importance of "Access to workplace experience". This intervention focuses on ensuring that the strategy considers those individuals who have completed learning but cannot access the workplace in the absence of experience. This supports intervention five of the ERRP: access to workplace experience. In this respect, the sustainable skills pipeline of the HWSETA is primarily implemented through work-based training as a way of managing the linkages between institutional and workplace learning. To this end, the HWSETA establishes partnerships with employers to increase the number of work-based experience opportunities. In terms of M&E Table 5-1 illustrates the extent to which HWSETA allocated its resources and achieved against set targets of the two key indicators of the skills pipeline to enable employment. The third indicator indicates the extent to which the WBL, as the model of implementation, is effective in realising intended outcome.

In 2023/24, the HWSETA performance on the WBL student placement both at partnership level and student achievement level was at the level classified as moderate success [26%-50%]. However, accumulatively from 2020 to 2023, HWSETA performance has been with substantial progress [76%-99%] with respect to WBL student placement both at partnership and achievement level. With respect to completion rates of the WBL programme, significant progress [51%-99%] was achieved in 2023/24 but accumulatively (2020 to 2024) only moderate success [26%-50%] was achieved. Three factors were highlighted to explain this level of performance. These were budget constraints as part of managing the HWSETA's overcommitted state, this reduced number of leaners recruited, and delayed registrations. At the outcome level[14], 73% (substantial progress) of qualified WBL unemployed learners finding employment within six months in 2022/23 financial year. These findings illustrate that the employers in the sector may experience the delayed negative economic effect of COVID-19. This confirms that employment is dependent on both supply and demand side factors. It can therefore be deduced that the HWSETA's skills pipeline priority is being implemented appropriately and efficiently with its outcomes strongly influenced by labour market factors. Further, the HWSETA's skills pipeline illustrates that the health and social development sector is also affected by economic factors, visible in the high national unemployment rate.

14 *2022/23 figures are currently being used since the evaluation studies are ongoing. Thus, updated reporting at outcomes level to be accounted for in the final draft submission in August.*

**Table 5-1 M&E of skills priority 1: The skills pipeline, 2023/24**

## Impact statement 2

The HWSETA contributes to the development of the post-school system that produces increasing productive workers and work-ready graduates for the health and welfare sector by 2030

To be conducted after 5 years

| RESULT CHAIN LEVEL | INDICATOR | TARGET 5YRS | ACHIEVEMENT 2022/2023 | CUMULATIVE ACHIEVEMENT 2020-2023 | COMMENTS |
|---|---|---|---|---|---|
| **Outcome**<br>The HWSETA contributes to increased access, by the unemployed, into occupationally directed programmes of the health and welfare sector in the strategic period. | Percentage of qualified WBL unemployed learners finding employment within six months of completing the learning programme (tracer study) | **60%**<br>Indicator was changed in 2020/21 thus no baseline | **44%**<br>**73%** | **46%**<br>**77%** | **2022/2023:**<br>[26% to 50%] Moderate Success<br>**2020-2023:**<br>[76% to 99%] Substantial Progress |
| The HWSETA promotes linkages between education and the workplace to increase work-based learning opportunities in the health and welfare sector in the strategic period | Percentage of post-school education institutions, professional and employer bodies, and communities of practice who partner with the HWSETA for the education and training of learners funded by the HWSETA in the strategic period | **80%**<br>Indicator was changed in 2020/21 thus no baseline | **53**<br>**66%** | **46**<br>**58%** | **2022/23 & 2020-2023**<br>[51% to 75%] Good Progress |

| RESULT CHAIN LEVEL | INDICATOR | TARGET 2023/2024 | ACHIEVEMENT 2023/2024 | CUMULATIVE ACHIEVEMENT 2020-2023 | COMMENTS |
|---|---|---|---|---|---|
| **Output**<br>Number of unemployed students who complete the artisan, learnership, bursary and internship programme funded by the HWSETA | Number of unemployed students who complete the artisan, learnership, bursary and internship programme funded by the HWSETA | 4 939 | **3 113**<br>**63%** | **6 638**<br>**50%** | **2023/2024:**<br>[51%-75%] Good Progress<br>**2020-2024:**<br>[26%-50%] Moderate Success |
| **Activity**<br>Number of unemployed students who enrolled in the artisan, learnership, bursary, and internship programme funded by the HWSETA | Number of unemployed students entered into WBL programmes (TVET, and university WIL, internships, learnerships, and apprenticeships) | 4 245 | **2 526**<br>**60%** | **15 184**<br>**70%** | **2022-2023:**<br>[51%-75%] Good Progress<br>**2020-2022:**<br>[51%-75%] Good Progress |
| Employers in the sector open up their workplaces for learning through partnerships with the HWSETA in the reporting period | Number of employers in the sector who open up their workplaces for learning through partnerships with HWSETA in the reporting period | 400 | **108**<br>**27%** | **989**<br>**76%** | **2023-2024:**<br>[26%-50%] Moderate Success<br>**2020-2023:**<br>[76%-99%] Substantial Progress |

## b) Professionalisation of the workforce

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

In 2023/24, the HWSETA performance on the workers in the PIVOTAL programmes at entry was at moderate success [26%-50%] while programme completion performance was at achieved/exceeded level [>=100%]. Accumulatively (2020-2024), HWSETA has achieved and exceeded targets for student enrolment capacity and performed with significant progress on their programme completion as shown in Table 5-2. Notwithstanding moderate to low achievement in 2023/24, accumulatively (2020-2024) these findings illustrate that HWSETA's implementation is in the right direction of contributing towards productivity for country's competitiveness in the global economy. It can therefore be deduced that the HWSETA's professionalisation of the workforce is being implemented appropriately and efficiently. Outcomes[15] validate the latter claim as it shows that 94% of workers confirmed that their training funded by HWSETA led to productivity after completion. Further assessment should be conducted on the same cohort after a reasonable time to gauge if there is an increase in progress through promotion.

15 *2022/23 figures are currently being used since the evaluation studies are ongoing. Thus, updated reporting at outcomes level to be accounted for in the final draft submission in August.*

**Table 5-2 M&E of skills priority 2: Professionalisation of the workforce, 2023/2024**

## Impact statement 3

The HWSETA contributes to the improved level of skills for 80% of the workforce within the health and welfare sector by 2030, which is evidenced by higher productivity of employers, and/or career progression either through promotion within the same organization or appointment in a higher position or appointment in a higher position by another organization.

To be conducted after 5 years

| RESULT CHAIN LEVEL | INDICATOR | TARGET 5YRS | ACHIEVEMENT 2022/2023 | CUMULATIVE ACHIEVEMENT 2020-2023 | COMMENTS |
|---|---|---|---|---|---|
| **Outcome statement**<br>The HWSETA contributes to the improvement of level of skills for 50% of the South African workforce through various learning programmes that address the critical skills required by the sector in that strategic period | Number of workers whose training directly leads to productivity after completion of learnership, undergraduate, postgraduate bursary programme, RPL, and lecturer development | **50%** | **47%**<br>**94%** | **60%**<br>**120%** | **2022/2023:**<br>[76%-99%] Substantial Progress<br>**2020-2023:**<br>[76%-99%]: [>=100%] Achieved/ Exceeded |

| RESULT CHAIN LEVEL | INDICATOR | TARGET 2023/2024 | ACHIEVEMENT 2023/2024 | CUMULATIVE ACHIEVEMENT 2020-2023 | COMMENTS |
|---|---|---|---|---|---|
| **Output Statement**<br>Number of employed students who complete the artisan, learnership, bursary, skills, AET, lecturer development, and RPL programmes funded by the HWSETA | Number of workers who completed the PIVOTAL | 6 601 | **794**<br>**12%** | **28 680**<br>**28%** | **2023/2024:**<br>[0%-25%] Low Success<br>**2020-2023:**<br>[76%-99%] Substantial Progress |
| **Activity**<br>Number of employed students who enrolled for the artisan, learnership, bursary, skills, AET, lecturer development, and RPL programmes funded by the HWSETA | Number of workers in the PIVOTAL | 4 245 | **8 732**<br>**28%** | **40 120**<br>**110%** | **2022/2023:**<br>[26%-50%] Moderate Success<br>**2020-2022:**<br>[>=100%] Achieved/ Exceeded |
| **Input** | **Discretionary Grand Budget for the professionalisation of the workforce** | | | | |

## c) Vital skills required for the developmental state

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

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

At an implementation level, the vital skills priority is advanced both at the institutional and individual level to support the capacity of the public sector, TVETs, and CETs. The table below illustrates the institutional support intervention for public sector capacity and interventions at the individual level for TVETs and CETs. In terms of implementation performance, HWSETA overachieved at 167% against set targets for 2023/24 on the number of projects aimed at public sector education and training in the reporting period. At learner/student level intervention, HWSETA achieved moderate success at 67% against the set target of the number of learners supported in TVET colleges, and other public colleges. The same trend was observed from 2020 to 2023 where HWSETA achieved and exceeded set targets at institutional level while having significant progress at student level. The support speaks to TVETs and CETs capacity through expansion of education and training.

**Table 5-3 M&E of skills priority 3: Vital skills required for the developmental state, 2022/24**

| INDICATOR | TARGET 2023-2024 | ACHIEVEMENT 2023-2024 | ACHIEVEMENT 2020-2023 | RATING OF PERFORMANCE |
|---|---|---|---|---|
| **Institutional level:** Number of education and training projects aimed at the public sector (DoH & DSD) | 6 | 10 167% | 52 141% | [>=100%] Achieved/ Exceeded |
| **Learner/student level:** Number of unemployed learners in TVET colleges, other public colleges, and CETs - support TVET and CETs capacity through expansion of education and training | 1 682 | 1 119 67% | 5 904 87% | [76%-99%] Substantial Progress |

## d) Update on the implementation of the ERRP skills Strategy during the 2023/24 financial year

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

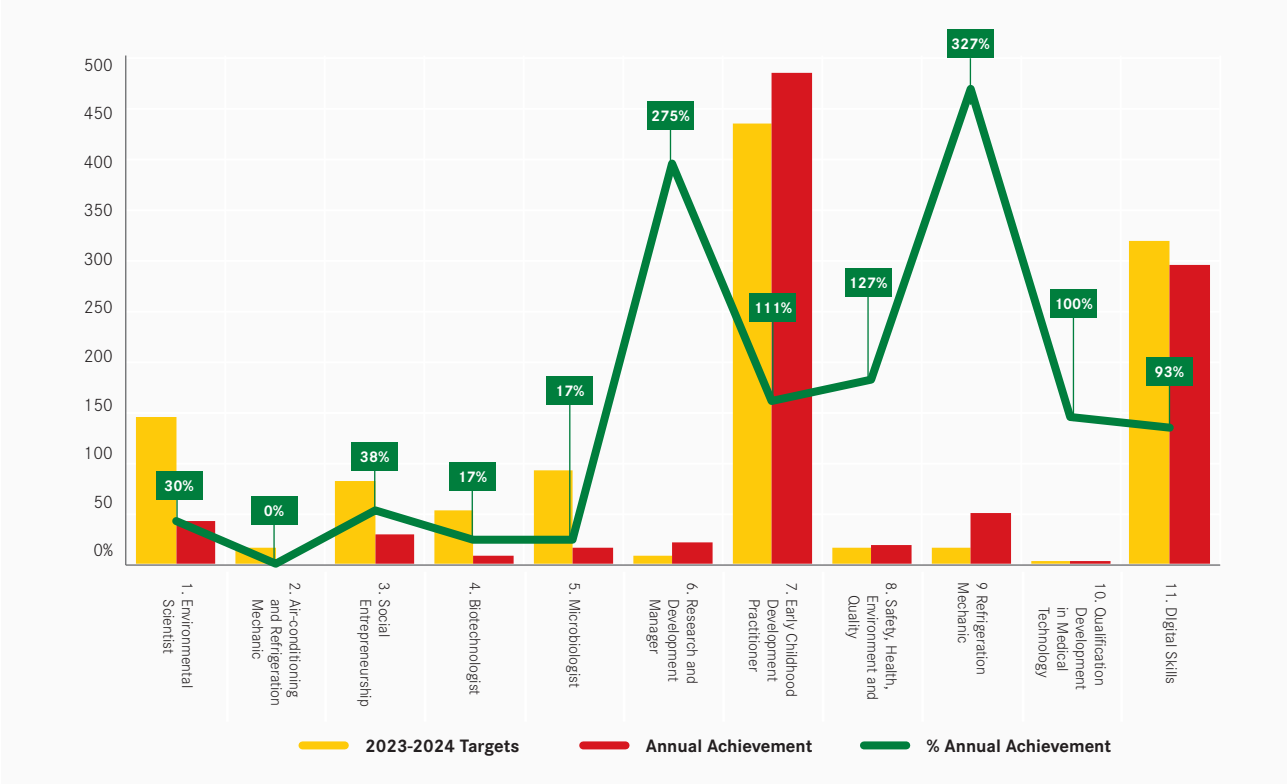
**Table 5 4 Intervention through which ERRP skills strategy will be supported by the HWSETA.**

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

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

Performance of the HWSETA on the development of skills for the ERRP Occupations with skills shortages[16]

**Figure 5-13 Annual Achievement of Strategic Priorities 2023-2024**




Of the 1271 ERRP skills strategy set targets by HWSETA, as shown above, 82% (963/1172) been achieved by end of the 2023/24 financial year. Thus, HWSETA performance in 2023/24 has been with substantial progress [76%-99%] in implementing the ERRP skills strategy.

16 *This information is based on 2023-2024 performance information reports.*

## 5.5 PLAN OF ACTION

The M&E function of the HWSETA met a number of challenges during the strategic period when tracking funded learners who completed skills development interventions. These challenges fast became barriers to measuring the level of success of the HWSETA in achieving its strategic targets. These challenges together with mechanisms to systems strengthening are discussed in the table below:

| CHALLENGE OR LIMITATIONS | BARRIER TO MEASUREMENT OF STRATEGIC OUTCOMES | MECHANISMS TO SYSTEMS STRENGTHENING |
|---|---|---|
| Inaccessibility of funded learners to participate in M&E studies due to contact details (cell-phone or telephone numbers and/or postal addresses) that are no longer in use. Also, the segment of population group funded by the HWSETA, which is the youth are not so responsive to email addresses.<br>Inappropriateness of project plans designed for the implementation of skills development interventions, where outputs will not lead to any outcomes that can be measured. | Strategic target that is planned on the basis of percentage learners that complete funded programmes is compromised as not all learners can be reached. | Strengthening of monitoring function to not only involve compliance monitoring that is conducted mid-programme but to introduce beneficiary monitoring which is continuous in nature. This will require utilisation of mobile applications or web portals to reach learners as these are linked to email addresses and not only cell-phone numbers. |
| Inappropriateness of project plans designed for the implementation of skills development interventions, where outputs will not lead to any outcomes that can be measured. | Deliverables designed for a project that are at an activity level and not output level render an intervention unmeasurable for outcomes. An example, is the offering of a short-learning programme to unemployed persons will not provide any value as the unemployed need documentation that may be verified as credentials or proof of qualification. | Project plans require to be evaluated for appropriateness to strategic outputs and outcomes before implementation in order to ensure measurability of skills development interventions for outcomes. |

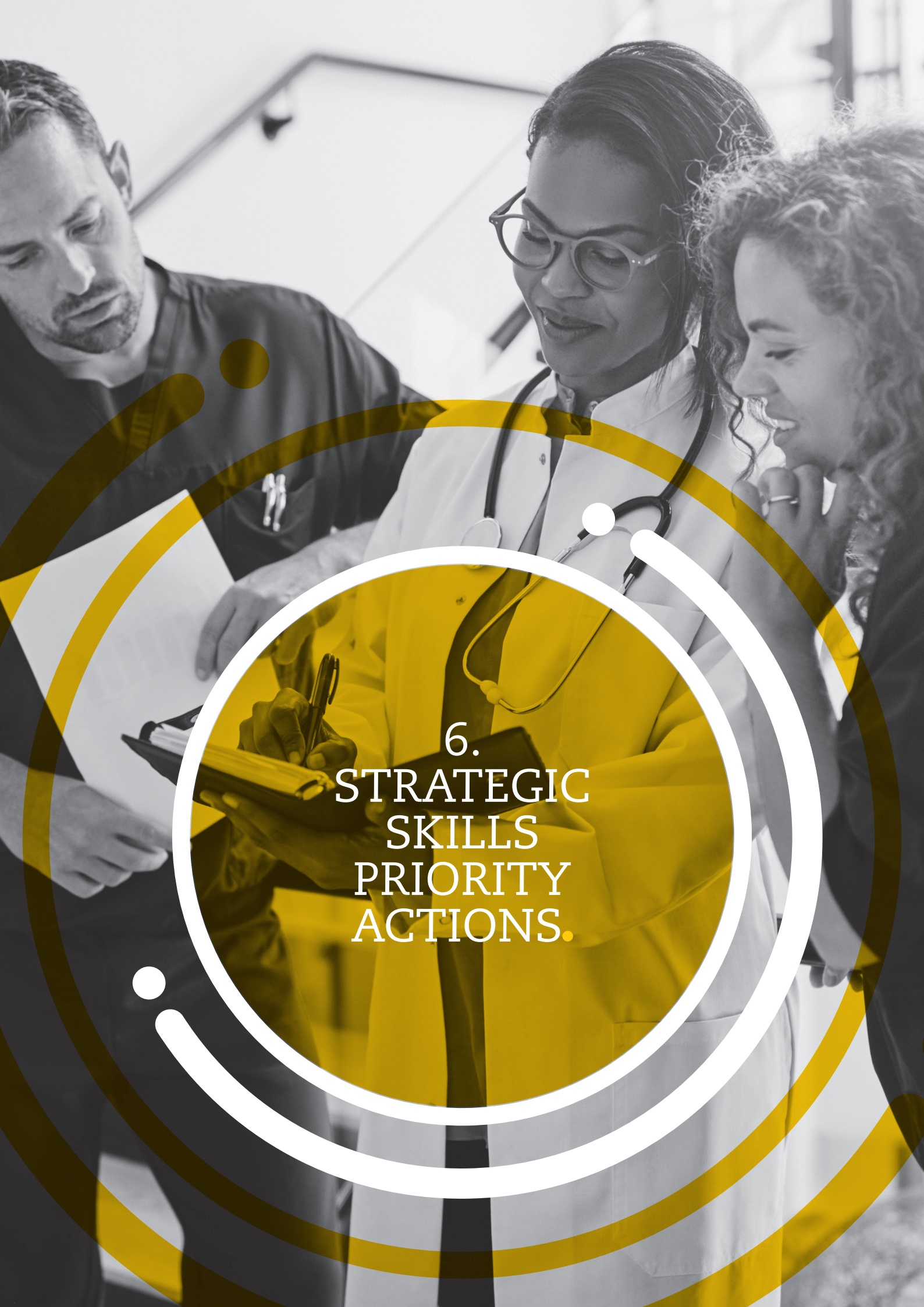
Effective implementation of planning documents faced challenges of misalignment in the linking of strategic priorities to relevant skills development interventions during the 2020-2025 strategic period. As such, measures aimed at improving effective implementation of SETA planning documents are of critical importance for the 2025-2030 strategic period. These are discussed in the table below.

| CHALLENGES | ROOT CAUSE | MEASURES TO IMPROVE THE IMPLEMENTATION OF PLANNING DOCUMENTS |
|---|---|---|
| Lack of integration of strategic priorities with skills development interventions mapped in the results framework contained in the APP results in misalignment between strategic priorities and skills development interventions during implementation. | Decentralisation of the development of operational plans to divisional level, as implementing divisions are expected to develop operational plans that integrate strategic priorities and skills development interventions for implementation. | Develop an organisation-wide operational plan that will integrate all strategic priorities with skills development interventions into one programme-based theory of change. This will facilitate alignment between planning documents and implementation, and thus strengthen the achievement of strategic outcomes. |

To improve skills planning the Research sub-division will enter into strategic partnerships with key stakeholders to gain access to administrative databases that contain information pertinent to provide insights on skills development priorities. Databases containing beneficiaries of the unemployment grant, for example can provide a source for the identification of youth not in employment education and training (NEET) and their inclusion in the career portal database of the HWSETA opening up opportunities for recruitment and selection into skills development interventions for the unemployed. Increased access to administrative data will strengthen triangulation of data sources and credibility of skills planning research.

## 5.6 CONCLUSION

The HWSETA's Strategic Plan is the main source that provides the framework for monitoring progress and measuring and evaluating the impact of skills development interventions in the sector. HWSETA will continue to use the results of M&E to identify the overall programme focus, streamline the implementation of current programmes and inform the development and implementation of new strategies and programmes. This chapter has shown the performance levels toward the sector priority areas. HWSETA's accumulative performance from 2020 to 2024 is an overachievement for vital skills at institutional level with substantial progress at student level. Similarly, accumulative performance of the HWSETA towards professionalisation of the workforce in the sector indicates overachievement on enrolment with substantial progress made on completions. For the unemployed work-based learning programme from 2020 to 2024, enrolment had substantial progress made while performance on completions was at a moderate level.



# 6. STRATEGIC SKILLS PRIORITY ACTIONS.

# 6 STRATEGIC SKILLS PRIORITY ACTIONS

## 6.1 INTRODUCTION

As the HWSETA is only one of several institutions tasked with the funding and provision of skills development for the sector, it is important to outline the specific role that the SETA will play. This chapter consolidates findings from the previous chapters and presents the main skills provision priority areas of the HWSETA for 2025/26 and beyond, although there is a five-year planning period. Skills priority actions are informed by the following: the analysis of the skills situation in the sector; needs identified by stakeholders; the NSDP outcomes; key national policies; and the HWSETA's own goals.

## 6.2 FINDINGS FROM PREVIOUS CHAPTERS

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

### Chapter 1:

- Service provision depends on specialised professionals and skilled paraprofessionals.
- Statutory councils have a core role to regulate almost all aspects of professions and occupations.
- NPOs are vital to state partners in providing community-based healthcare and social services.
- The HWSETA's skills planning and provision must be aligned to regulatory requirements for the sector's workforce and the unique needs of service providers in the sector.
- The estimated increase in the number of people who are dependent on grants places a constraint on the social development budget.
- At the occupational level, the demand for nurses remains a critical issue as they form the majority of the sector's workforce and form the backbone of most services offered.
- The incidence of unemployed medical practitioners due to budget constraints in the public sector is alarming given the fact that there is a shortage of these professionals in the public service.

# Chapter 2:

- The NDP and other change drivers envisage a functional state capable of delivering the full spectrum of human development and healthcare needs.
- The NHI is a major change driver, although final implementation may be slow as there are several legal challenges to the Act from various organisations. However, Government has shown its commitment to it in the 2024/25 budget allocation of funds to the NHI as part of the MTDP 2024-2029. The funding is earmarked to enhance infrastructure and health systems, particularly information systems, address findings from the Office of Health Standards and Compliance, advance the implementation of the ideal clinic initiative, improve medication dispensing through the central chronic medication dispensing and distribution programme, and provide proof of concept by piloting contracting units for primary health care.
- The need for primary care and community-based services, as well as the workforce, is expanding.
- Skills development interventions must link to the NSDP, ERRP, and the MTDP 2024-2029 be targeted, cost-effective, and prioritised to:
    - build the developmental state;
    - enable sustainable skills to pipeline into the sector;
    - strengthen work-integrated learning;
    - expand service capacity via the production of mid-level skills, and to
    - professionalise the workforce.
- Human resources planning in the public and private sectors, specifically in the provinces and rural areas is critical to meet the current and future demands.
- The anticipation is that the recent signing of the Sector Strategy for the Employment of Social Service Practitioners will enhance planning, recruitment, deployment, and management of these professionals, which is much needed.
- The lack of a national integrative HR data system for the sector makes HR planning difficult.
- Technology has a profound effect on the sector; the HWSETA reacts with a digital literacy strategy that supports the National Digital and Future Skills Strategy for South Africa. The anticipation further is that the National Digital Health Strategy for South Africa will strengthen health systems through digital technologies, enhancing health service delivery and engagement.
- The ERRP will remain a primary driver in the sector for the next couple of years and the HWSETA has proof its continued commitment to the implementation of the strategy through its action plan.
- Renewed focus from the MTDP 2024-2029 relates to the aspect of promoting social cohesion and nation-building which seeks to promote the rights of women, youth, children and persons with disabilities

# Chapter 3:

- Effective delivery of national healthcare initiatives and social services programmes depends on a skilled and professionalised workforce.
- Employers face major complex and long-term skills challenges.
- The skills needs for the public service component of the sector are complex and interlinked with the availability of state funding for health and social welfare services.
- Skills demand outstrips supply in certain occupational groups – most of all in the medical and nursing professions.
- The education system does not always 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. Therefore, in line with the ERRP Skills Strategy, the focus will be on the provision of WBL opportunities to ensure the work readiness of entrants to the sector.
- Leadership, strategic, and data analytical skills are needed at a high-level, and occupational health and safety, and customer/client service skills at the medium and lower levels.
- A strategic priority is to strengthen education capacity and clinical and practical training platforms, especially for nurses, medical practitioners, and pharmacists.
- The COVID-19 pandemic increased the demand for certain workers in the sector such as nurses, social workers, and community health workers. However, many of the social- and community health workers could not be retained afterwards. The HWSETA reacts with a strategy to support them to develop social entrepreneurial skills.
- The decrease in output of nurses is critical, therefore the support to the education and training of nurses remains a critical priority. The HWSETA focus on prioritising post-graduate nursing qualifications is an attempt to address the shortage.

# Chapter 4:

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

# Chapter 5:

- An M&E framework adopted by HWSETA is demonstrated as a management tool to assess decisions and actions
- An assessment of the M&E approach and the extent to which M&E has been institutionalised both as technical competency and a system is conducted. Using the HWSETA's three key development priorities, a plan of action to strengthen M&E will be accompanied by program reflection sessions to see what interventions could be implemented to improve our work, this critical to our mitigation measures.

## 6.3 PLANNED STRATEGIC PRIORITY ACTIONS

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

### 6.3.1 Skills Development Priorities

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

a. Sustainable skills pipeline into the health and social development sector.

b. The professionalisation of the current workforce and new entrants to the sector.

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

d. Implementation of skills development initiatives linked to the ERRP and MTDP 2024-2029.

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

The same priorities or strategic positioning of HWSETA remains unchanged in the sector for the coming strategic period because the needs of the sector are the same while becoming more severe. The COVID-19 pandemic exacerbated demand for health services making already existing sectoral needs more severe. With NHI being implemented, it is anticipated to have the same ripple effects. Unemployment and particularly the NEETs continue to characterise the South African problem. State capacity and NPOs remain more than relevant while compounded with challenges such as limited budgets or funding in delivering social services to the population. Thus, the same skills priorities remain but with more emphasis on new tactics in responding to the same but evolving problem.

With respect to a sustainable skills pipeline, HWSETA plans to have more focused or targeted interventions by accessing databases on the NEETs and volunteers to profile and determine their skills needs for entry into employment. With respect to the professionalisation of the workforce, technology changes in the sector requires more nuanced understanding of the workforce's levels of digital literacy to best customise training to the new evolving nature of work. Technology changes will advance productivity in the sector from improving efficiencies while affording more time and focus of personnel to care. As a response to shortage of nurse specialists, the HWSETA plans to focus on prioritising post-graduate nursing qualifications but first prioritising all the previously funded beneficiaries in nurse bridging. With respect to supporting the large-scale skills development interventions and reforms that are taking place in the sector i.e. change in qualifications from legacy qualifications to new qualifications necessitate continued support but with appropriate adjustments.

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

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

| SKILLS DEVELOPMENT PRIORITY AREA | | | KEY CHALLENGES |
|---|---|---|---|
| SUSTAINABLE SKILLS PIPELINE | **NQF levels 1-4** | Secondary school | Gr 12 maths + Physical science and/or Life sciences |
| | | | Effective career guidance |
| | | | Communication skills |
| | | | Low literacy levels of HBCs and CHWs |
| | | TVET Colleges | Lecturer and infrastructure capacity to train in vocational occupations |
| | | | On-site technical training nd links with industry |
| | | | Access to accredited workplace training |
| | | Nursing and Ambulance colleges | The high drop-out rate in nursing colleges |
| | | | Transformation of nursing colleges to teach under new qualifications set in higher education |
| | | | Set academic and 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 and bursary funding |
| | | | Limited academic and 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 and bursary funding |
| | | | Limited academic and clinical training capacity |
| | | | Shortage of advanced nurses and nurse educators, medical specialists, social services technical specialists |
| | **Sustained employment: Up-skill in the workplace** | New entrants | The gap between graduation, professional registration and entry to work in the sector |
| | | | Work-ready with Day One Skills to serve |
| | | | Availability of public sector posts |
| | | Employers | Capacity to provide vocational training and work-integrated learning |
| | | | Slow absorption of new professional graduates in the public sector |
| | | | Leadership, HR and financial management; management of health facilities and social welfare service facilities |
| | | | Retention of health and social services professionals |
| | | | Capacity to meet new norms and quality standards for services |
| | | | Skills development challenges and needs of NGOs |
| | | Current employees | Scarce and critical skills shortages in key professions and occupations |
| | | | Up-skill to meet new norms and standards for the practice |
| | | | Skills distribution: urban vs rural areas |
| | | | Health and social development information systems |

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

### 6.3.2 Strategic goals of the HWSETA

Table 6-2 outlines the HWSETA's outcome-orientated strategic outcomes for the period 2024/2025 which are critical for the achievement of the SETA's legislative and policy mandates. These outcomes also provide context for the HWSETA's skills development priorities over the medium to longer term. These HWSETA strategic outcomes are aligned with the NSDP outcomes and the ERRP.

**Table 6-2 The HWSETA strategic outcomes for the period 2024/2025**

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

### 6.3.3 Measures to support national priorities and plans

This section considers the NDP, national strategies, NSDP, ERRP, SETA High Impact Programmes, Presidential Youth Employment Initiative, and MTDP 2024-2029 which shape skills planning by the HWSETA. Through its multi-dimensional agenda, the NDP gives prominence to three vital areas: economic growth and job creation; education and skills; and building a capable and developmental state. The NDP offers a long-term strategy to grow employment and expand opportunities through education, vocational training, and work experience; strengthen health and nutrition services, and increase social security and community development (NPC 2012a).

In line with NSDP, ERRP, SETA High Impact Programs priorities, and MTDP 2024-2029 all projects and funding programmes of the HWSETA target the participation of learners who are African, women, disabled, youth, and residents of rural areas. Furthermore, HWSETA's partnerships with employers, public education institutions, and private training providers are being strengthened for the integration of education and training. Priority is given to funding projects that support economic transformation through inclusivity, and supporting skills development initiatives of SMEs, NGOs/NPOs, and cooperatives. Priority is also given to new skills that may be emerging due to the 4IR; as a result, the HWSETA undertook research to understand the current level of exposure and adoption of 4IR. The outcome of the research is applied in planning interventions that relate to 4IR.

Table 6-3 shows the link between the NSDP outcomes, the ERRP, SETA High Impact Programmes, MTDP 2024-2029, and the HWSETA's skills priorities.

**Table 6-3 Alignment of NSDP, ERRP, MTDP 2024-2029 outcomes and HWSETA skills development priorities**

| | NSDP | ERRP | SETA HIGH IMPACT PROGRAMS | MTDP 2024-2029 | HWSETA SKILLS DEVELOPMENT PRIORITIES |
|---|---|---|---|---|---|
| 1 | | N/A | Holistic digitisation and advancement of technological infrastructure, research and development | • MTDP priority 1: Inclusive growth and job creation | • Conduct extensive research to understand changing skills needs in general<br>• Engage with stakeholders, training providers, employers and key role-players<br>• Monitor and track the performance of skills development partners & learners |
| 2 | **Increase access to occupationally directed programmes** | Updating or amending technical and vocational education programmes (intervention 2) | Significant reduction in unemployment of young people including graduates | • MTDP priority 1: Inclusive growth and job creation | • Targeted funding to train artisans and learners in vocational occupations<br>• Form partnerships to develop occupational qualifications and fund learning programmes under those qualifications<br>• Support training via learnerships and internships which will also advance the objectives of the Presidential Youth Employment Initiative |
| 3 | **Supporting the growth of public colleges as key providers of skills required for socio-economic development** | N/A | Public sector institutional delivery capacitation | • MTDP priority 2: Reduce poverty and tackle the high cost of living<br>• MTDP priority 3: Build a capable, ethical and developmental state | • Support learners in pre-apprenticeship training<br>• Support vocational training of unemployed learners at TVET colleges |
| 4 | **Linking education and the workplace** | Access to workplace experience (Intervention 5) | Significant reduction in unemployment of young people including graduates | • MTDP priority 1: Inclusive growth and job creation | • Provide funding for experiential learning to produce work-ready graduates<br>• Improve workplace productivity by funding relevant skills programmes<br>• Support skills formation via learnerships and compulsory work experience (WIL) which will also advance the objectives of the Presidential Youth Employment Initiative |
| 5 | **Supporting skills development for entrepreneurship and cooperative development** | N/A | Rural development for community Impact | • MTDP priority 1: Inclusive growth and job creation | • Provide funding to address the skills development needs of NGOs and cooperatives<br>• Support unemployed social workers, social auxiliary workers and community development workers to become social entrepreneurs |
| 6 | **Improving the level of skills** | Increased access to programmes resulting in qualifications in priority sectors (intervention 3) | Public sector Institutional Delivery Capacitation | • MTDP priority 1: Inclusive growth and job creation<br>**&**<br>• MTDP priority 3: Build a capable, ethical and developmental state | • Support adult education and opportunities to enhance the career mobility of disabled persons<br>• Use discretionary grant funding for targeted projects in the public sector<br>• Fund development of critical and scarce skills at high-, medium- and low occupational levels |
| 7. | **Supporting career development services** | N/A | Effective and efficient shared services on information and communication technology for SETA- Wide Learner Management System | • MTDP priority 3: Build a capable, ethical and developmental state | • Career guidance initiatives market occupations in the health and social development sector |
| 8. | **Encouraging and supporting worker-initiated training** | Retraining/ up-skilling of employees (intervention 7) | Public sector institutional delivery capacitation | • MTDP priority 1: Inclusive growth and job creation | • Funding employers to develop the skills of the workforce |

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

### 6.3.4 HWSETA skills priority actions for the period 2025/2026

#### 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. The focus on NEETs (Not in Employment Education and Training) would be prioritised in terms of research and data sharing particularly with stakeholders such as Department of Social Development and Department of Labour and employment to contribute towards NEETs interventions in health and social development sector. In the main, this will be characterised by promotion of rights of women, youth, children and persons with disabilities as per the MTDP 2024-2029.

#### b) Professionalisation

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

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

#### c) Vital skills required for the developmental state

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

- Supporting skills development needed to implement the NHI system.
- Supporting public TVET colleges to improve on-site practical and vocational training capacity.
- Advancing the production of health professionals, especially nurses, and a spectrum of social services practitioners.
- Building skills to advance social- and community development.
- Funding skills development interventions for persons who serve or provide care to persons with disabilities.

- Targeted funding to enable skills development in NPOs, NGOs, and Community-based Organisations.
- Funding skills projects aimed at offering youth and older persons a second chance to enter employment in the health and social development sector.
- Implementing skills development initiatives linked to the ERRP and MTDP 2024-2029

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

The plan of action is premised on HWSETA's strategic stance of monitoring outputs and outcomes towards the pursuit of the desired impact. In this regard, special focus would be on the improvement of the sustainable pipeline from substantial progress towards achievement or overachievement against set targets. This will entail increasing the number of the reached sample through various efforts through the Tracer study going forward. The Work-based learning (WBL) programmes will enforce strong internal controls in collecting contact details (personal cellular number and personal email addresses) of the beneficiaries to increase reached sample of the Tracer study.

## 6.4 CONCLUSION

This Chapter outlined the broad skills development priority areas and actions for the health and social development sector over the period 2024/2025. In designing and implementing skills programmes and skill projects, the HWSETA will be guided by four skills development priority themes:

- Sustainable skills pipeline into the health and social development sector.
- The professionalisation of the current workforce and new entrants to the sector.
- Vital skills and skills set required to enable the state to meet its service delivery obligations as a developmental state; and
- Implementation of skills development initiatives linked to the ERRP and MTDP 2024-2029.

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# Annexure to SSP 2025-2030

### Sectoral Priority Occupations and Intervention List 2025/26

| SETA NAME | PERIOD | OCCUPATION CODE | OCCUPATION | SPECIALISATION/ ALTERNATIVE TITLE | INTERVENTION(S) PLANNED | NQF LEVEL | NQF ALIGNED (Y/N) | QUANTITY NEEDED | QUANTITY TO BE SUPPORTED |
|---|---|---|---|---|---|---|---|---|---|
| HWSETA | 2025-2030 | 222108 | Registered Nurse (Medical) | Hospital Nurse/ General Nurse/ Prison Nurse/ Nursing Prison Officer | Diploma in Nursing | 6 | Y | 1186 | 270 |
| | | | | | Bachelor of Nursing Science | 7 | Y | | 320 |
| | | | | | Advanced Diploma in (Nursing) | 7 | Y | | 10 |
| | | | | | Postgraduate Diploma in Critical care (Adult) | 8 | Y | | 20 |
| HWSETA | 2025-2030 | 221101 | General Medical Practitioner | General Practitioner (GP)/ Medical Practitioner/ Doctor/ Primary health Care Physician/ Sports Physician/ Physician | Bachelor of Medicine and Surgery (MBCHB) | 8 | Y | 384 | 450 |
| HWSETA | 2025-2030 | 222105 | Registered Nurse (Critical Care And Emergency) | Coronary Care Unit Nurse/ Emergency or Trauma Nurse/ Acute Care Nurse/ Intensive Care Nurse | Postgraduate Diploma in Critical care (Adult) | 8 | Y | 269 | 20 |
| | | | | | Postgraduate Diploma in Emergency Care or Nursing | 8 | Y | | 10 |
| HWSETA | 2025-2030 | 532903 | Nursing Support Worker | Assistant in Nursing/ Nursing Attendant/ Hospital Aide/ Nurses' Aide/ Paramedical Aide | Higher certificate in Nursing | 5 | Y | 196 | 170 |
| HWSETA | 2025-2030 | 222111 | Registered Nurse (Operating Theatre) | Operating Room Nurse/ Operating Theatre Nurse/ Recovery Nurse/ Anaesthetic Nurse | Postgraduate Diploma in Operating Theatre Nursing | 8 | Y | 116 | 20 |
| | | | | | Bachelor of Medical and Surgical Nursing Science: Operating Theatre Nursing | 8 | Y | | 25 |
| | | | | | Advanced Diploma in Medical and Surgical Nursing Science | 6 | Y | | 25 |
| HWSETA | 2025-2030 | 263508 | Child And Youth Care Worker | Child and Youth Counsellor | Occupational Certificate: Child and Youth Care Worker | 5 | Y | 46 | 26 |
| | | | | | Bachelor of Child and Youth care | 8 | Y | | 10 |
| | | | | | Postgraduate Diploma in Child and Youth Care | 8 | Y | | 10 |
| HWSETA | 2025-2030 | 134201 | Medical Superintendent | Health Service Manager/ Health Service Coordinator/ Public Health Administrator/ Director of Clinical Services/ Director of Medical Services/ Public Health Manager/ Medical Manager | Postgraduate Diploma in Health Services Management | 8 | Y | 29 | 15 |
| HWSETA | 2025-2030 | 225101 | Veterinarian | Veterinary Parasitologist/ Animal Doctor/ Veterinary Pathologist/ Veterinary Surgeon/ Veterinary Epidemiologist | Bachelor of Veterinary Science | 8 | Y | 23 | 95 |
| HWSETA | 2025-2030 | 222113 | Paediatrics Nurse | Children's nurse | Postgraduate Diploma in Child Nursing | 8 | Y | 22 | 10 |
| HWSETA | 2025-2030 | 263501 | Social Counselling Worker | Trauma Counsellor/ Bereavement Counsellor/ Wellness Counsellor/ HIV/AIDS Counsellor/ Genetic Counsellor/ Women's Welfare Organizer | Occupational Certificate: Social Counselling Worker | 5 | Y | 17 | 17 |

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